

2023 Proceedings of the National Association of Insurance Commissioners

**2023 Summer National Meeting
August 12–16, 2023**

**Held at the
Hyatt Regency Seattle, Hyatt at Olive 8
& Seattle Convention Center Summit Building
Seattle, Washington**

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Information about statutory accounting principles and the procedures necessary for filing financial annual statements and conducting risk-based capital calculations.

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Important answers to common questions about auto, home, health and life insurance — as well as buyer's guides on annuities, long-term care insurance and Medicare supplement plans.

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TABLE OF CONTENTS

Certificate of Incorporation of National Association of Insurance Commissioners— A Nonstock Corporation	i
Bylaws of the National Association of Insurance Commissioners	v
NAIC Policy Statement on Open Meetings	xvi
NAIC Committee Structure	xviii
List of Appointed, Renamed and Disbanded Committee Groups.....	xix
NAIC Members by Zones.....	xx
NAIC Executive (EX) Committee.....	xxi
NAIC Committee, Subcommittee and Task Force Membership	xxii
NAIC Members by State.....	xcviii
NAIC Member Tenure List.....	xcix
NAIC Meeting Record.....	cl
Model Law Listing	clix
OPENING SESSION.....	1-1
SYNOPSIS.....	2-1
EXECUTIVE (EX) COMMITTEE AND PLENARY	3-1
EXECUTIVE (EX) COMMITTEE	4-1
Climate and Resiliency (EX) Task Force	4-13
Government Relations (EX) Leadership Council.....	4-17
Long-Term Care Insurance (EX) Task Force	4-18
Special (EX) Committee on Race and Insurance.....	4-22
LIFE INSURANCE AND ANNUITIES (A) COMMITTEE	5-1
Life Actuarial (A) Task Force	5-10
HEALTH INSURANCE AND MANAGED CARE (B) COMMITTEE.....	6-1
Health Actuarial (B) Task Force	6-24
Regulatory Framework (B) Task Force	6-105
Senior Issues (B) Task Force	6-211

PROPERTY AND CASUALTY INSURANCE (C) COMMITTEE	7-1
Casualty Actuarial and Statistical (C) Task Force	7-86
Surplus Lines (C) Task Force	7-125
Title Insurance (C) Task Force.....	7-130
Workers' Compensation (C) Task Force	7-135
 MARKET REGULATION AND CONSUMER AFFAIRS (D) COMMITTEE.....	8-1
Antifraud (D) Task Force.....	8-102
Market Information Systems (D) Task Force	8-108
Producer Licensing (D) Task Force.....	8-112
 FINANCIAL CONDITION (E) COMMITTEE.....	9-1
Accounting Practices and Procedures (E) Task Force.....	9-142
Capital Adequacy (E) Task Force.....	9-488
Examination Oversight (E) Task Force	9-826
Financial Stability (E) Task Force	9-835
Receivership and Insolvency (E) Task Force	9-866
Reinsurance (E) Task Force.....	9-1050
Risk Retention Group (E) Task Force	9-1057
Valuation of Securities (E) Task Force	9-1058
 FINANCIAL REGULATION STANDARDS AND ACCREDITATION (F) COMMITTEE	10-1
 INTERNATIONAL INSURANCE RELATIONS (G) COMMITTEE.....	11-1
 INNOVATION, CYBERSECURITY, AND TECHNOLOGY (H) COMMITTEE	12-1
 NAIC/CONSUMER LIAISON COMMITTEE	13-1

**CERTIFICATE OF INCORPORATION OF
NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS
a Nonstock Corporation**

I. Name

The name of the Corporation is: **National Association of Insurance Commissioners (NAIC)**.

II. Duration

The period of duration of the NAIC is perpetual.

III. Registered Office and Agent

The NAIC's Registered Office in the State of Delaware is to be located at: 1209 Orange St., in the City of Wilmington, Zip Code 19801. The registered agent in charge thereof is The Corporation Trust Company.

IV. Authority to Issue Stock

The NAIC shall have no authority to issue capital stock.

V. Incorporators

The name and address of the incorporator are as follows:

Catherine J. Weatherford
National Association of Insurance Commissioners
120 W. 12th St., Suite 1100
Kansas City, MO 64106

VI. Purpose

The NAIC is organized exclusively for charitable and educational purposes within the meaning of Section 501(c)(3) of the Internal Revenue Code of 1986, as amended (or the corresponding provision of any future United States Internal Revenue law), including without limitation, to assist state insurance regulators, individually and collectively, in serving the public interest and achieving the following fundamental insurance regulatory goals in a responsive, efficient and cost-effective manner, consistent with the wishes of its members:

- (a) Protect the public interest, promote competitive markets and facilitate the fair and equitable treatment of insurance consumers.
- (b) Promote, in the public interest, the reliability, solvency and financial solidity of insurance institutions.
- (c) Support and improve state regulation of insurance.

VII. Restrictions

- A. No substantial part of the activities of the Corporation shall be the carrying of propaganda, or otherwise attempting to influence legislation except as otherwise permitted by Section 501(h) of the Code and in any corresponding laws of the State of Delaware, and the Corporation shall not participate in or intervene

in including the publishing or distribution of statements concerning any political campaign on behalf of or in opposition to any candidate for public office.

- B. For any period for which the Corporation may be considered a private foundation, as defined in Section 509(a), the Corporation shall be subject to the following restrictions and prohibitions:
1. The Corporation shall not engage in any act of self-dealing as defined in section 4941(d) of the Code.
 2. The Corporations shall make distributions for each taxable year at such time and in such manner so as not to become subject to the tax on undistributed income imposed by section 4942 of the Code.
 3. The Corporation shall not retain any excess business holdings as defined in section 4943(c) of the Code.
 4. The Corporation shall not make any investments in such manner as to subject it to tax under section 4944 of the Code.
 5. The Corporation shall not make any taxable expenditures as defined in section 4945(d) of the Code.

VIII. Membership

The NAIC shall have one class of members consisting of the Commissioners, Directors, Superintendents, or other officials who by law are charged with the principal responsibility of supervising the business of insurance within each State, territory, or insular possession of the United States. Members only shall be eligible to hold office in and serve on the Executive Committee, Committees and Subcommittees of the NAIC. However, a member may be represented on a Committee or Subcommittee by the member's duly authorized representative as defined in the Bylaws. Only one official from each State, territory or insular possession shall be a member and each member shall be limited to one vote. Any insurance supervisory official of a foreign government or any subdivision thereof, which has been diplomatically recognized by the United States government, may attend and participate in all meetings of this Congress but shall not be a member and shall not have the power to vote.

IX. Activities

The NAIC is a nonprofit charitable and educational organization and no part of the net earnings or property for the corporation will inure to the benefit of, or be distributable to its members, directors, officers or other private individuals, except that the NAIC shall be authorized and empowered to pay reasonable compensation for services rendered by employees and contractors, and to make payments and distributions in furtherance of the purposes set forth in Article VI hereof.

X. Powers

The NAIC shall have all of the powers conferred by the Delaware General Corporation Law for non-profit corporations, except that, any other provision of the Certificate to the contrary notwithstanding, the NAIC shall neither have nor exercise any power, nor carry on any other activities not permitted: (a) by a corporation exempt from federal income tax under Section 501(c)(3) of the Internal Revenue Code of 1986, as amended (or the corresponding provision of any future United States Internal Revenue law); or (b) by a corporation contributions to which are deductible under Section 170(c)(2) of the Internal Revenue Code of 1986, as amended, (or the corresponding provision of any future United States Internal Revenue law).

XI. Immunity

All officers and members of the Executive Committee shall be immune from personal liability for any civil damages arising from acts performed in their official capacity, and shall not be compensated for their services as an officer or member of the Executive Committee on a salary or a prorated equivalent basis. The immunity shall extend to such actions for which the member of the Executive Committee or officer would not otherwise be liable, but for the Executive Committee member's or officer's affiliation with the NAIC. This immunity shall not apply to intentional conduct, wanton or willful conduct or gross negligence. Nothing herein shall be construed to create or abolish an immunity in favor of the NAIC itself. Nothing herein shall be construed to abolish any immunities held by the state officials pursuant to their individual state's law.

XII. Exculpation and Indemnification

A member of the Executive Committee shall not be liable to the NAIC or its members for monetary damages for breach of fiduciary duty as a member of the Executive Committee, provided that this provision shall not eliminate or limit the liability of a member of the Executive Committee for any breach of the duty of loyalty to the NAIC or its members, for acts or omissions not in good faith, or which involve intentional misconduct or a knowing violation of law, or for any transaction from which the member of the Executive Committee involved derived an improper personal benefit. Any amendment, modification or repeal of the foregoing sentence shall not adversely affect any right or protection of a member of the Executive Committee of the Corporation hereunder in respect of any act or omission occurring prior to the time of such amendment, modification, or repeal. If the Delaware General Corporation Law hereafter is amended to authorize the further elimination or limitation of the liability of the members of the Executive Committee, then the liability of a member of the Executive Committee, in addition to the limitation provided herein, shall be limited to the fullest extent permitted by the amended Delaware General Corporation Law.

The NAIC shall indemnify to the full extent authorized or permitted by the laws of the State of Delaware, as now in effect or as hereafter amended, any person made or threatened to be made a party to any threatened, pending or completed action, suit or proceeding (whether civil, criminal, administrative or investigative, including an action by or in the right of the NAIC) by reason of the fact that the person is or was a member of the Executive Committee, officer, member, committee member, employee or agent of the NAIC or serves any other enterprise as such at the request of the NAIC.

The foregoing right of indemnification shall not be deemed exclusive of any other rights to which such person may be entitled apart from this Article XII. The foregoing right of indemnification shall continue as to a person who has ceased to be a member of the Executive Committee, officer, member, committee member, employee or agent and shall inure to the benefit of the heirs, the executors and administrators of such a person.

XIII. Dissolution

In the event of the dissolution of the NAIC, the Executive Committee shall, after paying or making provision for the payment of all of the liabilities of the NAIC, dispose of all the assets of the NAIC equitably to any state government which is represented as a member of the NAIC at the time of dissolution, provided that the assets are distributed upon the condition that they be used primarily and effectively to implement the public purpose of the NAIC, or to one or more such organizations organized and operated exclusively for religious, charitable, education, scientific, or literary purposes or similar purposes as shall at the time qualify: (a) as an exempt organization under Section 501(c)(3) of the Internal Revenue Code of 1986, as amended (or the corresponding provision of any future United States Internal Revenue law); and (b) as an organization contributions to which are deductible under Section 170(c) of the Internal Revenue Code of 1986, as amended (or the corresponding provision of any future United States Internal Revenue law), as the Executive Committee shall determine.

XIV. Bylaws

The Bylaws of the NAIC may prescribe the powers and duties of the several officers, members of the Executive Committee and members and such rules as may be necessary for the work of the NAIC provided they are in conformity with the Certificate of Incorporation.

XV. Amendments

This Certificate of Incorporation may be altered or amended at any meeting of the full membership (Plenary Session) of the NAIC by an affirmative vote of two-thirds of the members qualified to vote, or their authorized representatives, provided that previous notice of the proposed amendment has been mailed to all members by direction of the Executive Committee at least thirty (30) days prior to the meeting.

IN WITNESS WHEREOF, this Certificate of Incorporation has been signed this 4th day of October 1999.

/signature/
Catherine J. Weatherford, Incorporator

ADOPTED 1999, Proc. Third Quarter

Adopted October 1999
Amended November 2002
Amended June 2003
Amended March 2004
Amended December 2004
Amended March 2009
Amended September 2009
Amended October 2011
Amended December 2015
Amended December 2021

Bylaws of the NAIC, a Delaware Non-Profit Corporation

**BYLAWS OF THE
 NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS**

ARTICLE I

Name, Organization and Location

The name of this corporation is **NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS** (NAIC). The NAIC is organized under the General Corporation Law of the State of Delaware. The NAIC may have one (1) or more office locations within or without the State of Delaware as the Executive Committee may from time to time determine.

ARTICLE II

Membership

The Membership of the NAIC shall be comprised of those persons designated as members in the Certificate of Incorporation. Each member of the NAIC shall have the power to vote and otherwise participate in the affairs of the NAIC as set forth herein or as required by applicable law. This power may be exercised through a duly authorized representative who shall be a person officially affiliated with the member's department and who is wholly or principally employed by said department.

The organization may charge members an annual assessment, the amount of which shall be determined by the Executive Committee. Members failing to pay all NAIC assessments on a timely basis shall be placed in an inactive status. Members in an inactive status shall not have any voting rights and shall be denied membership on NAIC committees and task forces, access to mailings and services of the NAIC Offices, as well as access to zone examination processes and other benefits of membership in the NAIC.

The NAIC's receipt of full payment from the inactive member of all current and past due assessments shall serve to immediately remove them from inactive status.

The Membership of the NAIC shall be subject to a conflict of interest policy and disclosure form as adopted by the members.

The Executive Committee is empowered to reinstate, in part or in whole, an inactive member's participation on the committees and task forces, access to mailings and services of the NAIC Offices and satellite offices, as well as access to zone examination processes, and other benefits of membership in the NAIC upon good cause shown as determined by the Executive Committee.

ARTICLE III

Officers

The officers of the NAIC shall be a President, a President-Elect, a Vice President, and a Secretary-Treasurer. Annual officer elections shall be held at the last regular National Meeting of each calendar year or at such other plenary session as agreed to by the members. The voting membership, by secret ballot, shall elect officers as provided in these Bylaws. Officers' terms shall be for one year, beginning on January 1 following their election. The officers shall hold office until their death, resignation, removal or the election and qualification of their successors, whichever occurs first. Any Officer may resign at any time by giving notice thereof in writing to the President of the NAIC. Any such resignation will take effect upon delivery if no date is specified, or as of its date, unless some other date is specified therein, in which event it will be effective as of that date. The acceptance of that resignation will not be necessary to make it effective.

If an interim vacancy occurs in the office of President, the President-Elect shall cease to hold his or her office effective immediately and shall assume the office of President. If an interim vacancy occurs in any one or more of the other officer positions, an interim election shall be held to fill the vacancy. No member may hold any office for more than two consecutive years. Notwithstanding the foregoing, at no time shall more than two officer positions be filled by members of the same Zone during the same term. Any officer may be removed from office by the affirmative vote of two-thirds (2/3) of the members, but only after a resolution for removal is adopted by two-thirds (2/3) of the Executive Committee whenever, in their judgment, the best interests of the NAIC would be served thereby.

The President shall serve as Chairman of the Executive Committee and shall preside at all special and regular meetings of the members. The President shall serve as the leader of the organization and its principal spokesperson. The President shall work closely with the Executive Committee to establish and achieve the strategic, business and operational goals of the organization; ensure appropriate policies and procedures for the organization are implemented and followed; and protect the integrity as well as the resources of the organization. After a member completes his or her term or terms as President, he or she shall not be able to hold another officer position for a period of twelve (12) months from the date such member completes his or her term or terms as President, which shall be referred to as a "waiting period"; provided however, the Executive Committee may waive the twelve month waiting period if warranted by exigent circumstances.

The President-Elect shall serve as Vice-Chairman of the Executive Committee. In the absence of the President at a duly convened meeting of the Executive Committee or at a regular or special meeting of the members, the President-Elect shall preside over such meeting to the extent of the President's absence. The President-Elect shall perform such other duties and tasks as may be assigned by the President. Where the President does not run for re-election, the President-Elect shall become President at the conclusion of the President's term of office.

The Vice President, in the absence of the President and President-Elect at a duly convened meeting of the Executive Committee or at a regular or special meeting of the members, shall preside over such meeting to the extent of the President's and the President-Elect's absence; and shall perform such other duties as may be assigned by the President or President-Elect, or in the absence thereof, by the Executive Committee.

The Secretary-Treasurer shall assist the President and, as applicable, the President-Elect or the Vice President in the conduct of meetings of the Executive Committee and members. For member meetings, the Secretary-Treasurer shall call the roll of the membership and certify the presence of a quorum and shall receive, validate and maintain all proxies for elections held at member meetings. The Secretary-Treasurer shall also recommend to the Executive Committee such policies and procedures to maintain the history and continuity of the NAIC. The

Secretary-Treasurer shall also assist the President and President-Elect in all matters relating to the budget, accounting, expenditure and revenue practices of the NAIC; including, but not limited to reviewing the financial information of the organization and consulting with NAIC management, independent auditors, and other necessary parties regarding the financial operations and condition of the organization.

ARTICLE IV

Executive Committee

The business and affairs of the NAIC shall be managed by and under the direction of the Executive Committee. The Executive Committee shall be made up entirely of members of the NAIC. The Executive Committee shall consist of the following members: the officers of the NAIC; the most recent past president; the twelve (12) members of the zones as provided for in Article V of these Bylaws. The members of the Executive Committee shall be subject to a conflict of interest policy as adopted by the members. Any Executive Committee member may resign at any time by giving notice thereof in writing to the members of the NAIC. Resignation as an Executive Committee member also operates as resignation as a Zone officer. Any such resignation will take effect upon delivery if no date is specified, or as of its date, unless some other date is specified therein, in which event it will be effective as of that date. The acceptance of that resignation will not be necessary to make it effective.

1. The Executive Committee shall have the authority and responsibility to:
 - (a) manage the affairs of the NAIC in a manner consistent with the Certificate of Incorporation and Bylaws.
 - (b) make recommendations to achieve the goals of the NAIC based upon either its own initiative or the recommendations of the Standing Committees or Subcommittees reporting to it, for consideration and action by the members at any NAIC Plenary Session.
 - (c) create and terminate one or more Task Forces reporting to it to the extent needed and appropriate.
 - (d) establish and allocate, from time to time, functions and responsibilities to be performed by each Zone.
 - (e) to the extent needed and appropriate, oversee NAIC Offices to assist the NAIC and the individual members in achieving the goals of the NAIC.
 - (f) submit to the NAIC at each National Meeting, during which a Plenary Session is held, its report and recommendations concerning the reports of the Standing Committees. All Standing Committee reports shall be included as part of the Executive Committee report.
 - (g) plan, implement and coordinate communications and activities with other state, federal and local government organizations in order to advance the goals of the NAIC and promote understanding of state insurance regulation.
2. Duties and Operations of the Executive Committee.
 - (a) The Executive Committee shall hold at least two (2) regular meetings annually at a designated time and place. Special meetings may be held when called by the President, or by at least three (3) members of the Executive Committee in writing. In any case, the Executive Committee shall meet at least once per calendar month. At least five (5) days notice shall be given of all regular and special meetings. Meetings

may be held in person or by means of conference telephone or other communication equipment by means of which all persons participating in the meeting can hear each other, and such participation in a meeting shall constitute presence in person at such meeting in accordance with applicable laws. The presiding member of the Executive Committee shall only cast his or her vote in order to break a tie vote. In addition, the Executive Committee may act by written consent as provided by law.

- (b) The Executive Committee may, with the concurrence of two-thirds of the members of the Executive Committee, establish rules for its conduct that shall not conflict with the Certificate of Incorporation and Bylaws. Such rules may be changed only by a concurrence of two-thirds of the members of the Executive Committee after twenty-four (24) hours notice to all members of the Executive Committee.
- (c) Any action required or permitted to be taken at any meeting of the Executive Committee or any committee thereof may be taken without a meeting if all members of the Executive Committee or such committee, as the case may be, consent thereto in writing in accordance with applicable law.
- (d) The Executive Committee shall cause to be kept minutes of its meeting and have information of any action of a general character taken by it published to members qualified to vote.

(e) NAIC OFFICES

- (i) The Executive Committee shall oversee an Executive Office and a Central Office with management and staff personnel and appropriate resources for performance of duties and assigned responsibilities. Additional satellite offices may be established as needed. The Executive Committee shall have the authority to select, employ and terminate a Chief Executive Officer who shall not be a member of the NAIC and who shall have the primary responsibility for the internal management and functioning of the NAIC Offices within the direction of the Executive Committee, as well as other duties assigned by the Executive Committee through execution of an Employment Agreement or other authorization. The Chief Executive Officer appointed by the Executive Committee pursuant to this section shall not be considered an officer for purposes of Article III hereof and shall not be a member of the Executive Committee. The Executive Committee, through the Internal Administration (EX1) Subcommittee, shall provide oversight and direction to the Chief Executive Officer regarding Office operations.
- (ii) Consistent with the purposes of the NAIC, the role of the NAIC Offices is to: (1) provide services to the NAIC through support to the NAIC Committees, Subcommittees, Task Forces or otherwise; (2) provide services to individual State insurance departments; and (3) develop recommendations for consideration as to NAIC policy and administrative decisions of the NAIC.
- (iii) In performing its role, subject to the oversight and direction specified in (paragraph i) the NAIC Offices may engage in a variety of functions including but not limited to the following: research; analysis; information gathering and dissemination; library services; data collection; data base building and maintenance; report generation and dissemination; government liaison; non-regulatory liaison; securities valuation; administration; litigation; legislative and regulatory drafting; and educational development.
- (iv) The Chief Executive Officer shall prepare an annual budget, related to the priorities of the NAIC, for the NAIC Offices to be submitted through the EX1 Subcommittee to the Executive Committee, which shall make its recommendations to the members of the NAIC for action at the next Plenary Session of the NAIC.

3. Internal Administration (EX1) Subcommittee

The Internal Administration (EX1) Subcommittee shall be a Subcommittee reporting to the Executive Committee. Appointments of the Chair and Vice Chair of the Executive Subcommittee and members other than those specifically designated herein shall be made by the President and President-Elect.

This Subcommittee shall be comprised of the President, President-Elect, Vice President, the Secretary-Treasurer, the most recent past President, and three (3) other members of the Executive Committee. The presiding member of the Subcommittee shall only cast his or her vote in order to break a tie vote.

The Internal Administration (EX1) Subcommittee shall:

- (a) Exercise such powers and authority as may be delegated to it by the Executive Committee.
- (b) Generally oversee the NAIC Offices including, without limitation: (i) periodically monitor operations of the NAIC Offices, (ii) review and revise the budget of the NAIC, hold an annual hearing to receive public comments on the budget of the NAIC, and submit the revised budget to the Executive Committee, (iii) approve emergency expenditures which vary from the adopted budget and promptly certify its action in writing to the Executive Committee, (iv) evaluate the Chief Executive Officer and make appropriate recommendations to the Executive Committee, (v) assist the Chief Executive Officer in resolving competing demands for NAIC resources, (vi) review compensation of all senior management and (vii) quarterly prepare a report containing the current budget and expenditures which the Secretary-Treasurer shall present to the Executive Committee.

4. Audit Committee

The Executive Committee shall appoint an Audit Committee made up of at least four (4) members of the NAIC, including at least one member from each zone, in addition to the NAIC Secretary-Treasurer. The NAIC Secretary-Treasurer shall chair the Audit Committee. The Audit Committee shall report to the Executive Committee without any NAIC employees being present. The Audit Committee shall be directly responsible for the appointment, compensation, and oversight of the independent certified public accountant employed to conduct the audit. The Audit Committee shall also have the power, to the extent permitted by law, to: (i) initiate or review the results of an audit or investigation into the business affairs of the NAIC; (ii) review the NAIC's financial accounts and reports; (iii) conduct pre-audit and post-audit reviews with NAIC staff, members and independent auditors; and (iv) exercise such other powers and authority as delegated to it by the Executive Committee.

ARTICLE V

Zones

To accomplish the purposes of the NAIC in a timely and efficient manner, the United States, its territories and insular possessions shall be divided into four Zones. Each Zone shall consist of a group of at least eight States, located in the same geographical area, with each State being contiguous to at least one other State in the group so far as practicable, plus any territory or insular possession that may be deemed expedient, all as determined by majority of the Executive Committee. Members of each Zone shall annually elect a Chairman, a Vice Chairman and a Secretary from among themselves prior to or during the last regular National Meeting of each calendar year or at such time as agreed to by the Zone members. The Chairman, Vice Chairman and Secretary of each Zone shall be members of the Executive Committee with terms of office corresponding to that of the officers. Each Zone shall perform such functions as are designated by the Executive Committee of the

NAIC or by the members of the NAIC as a whole or by the members of the Zone. Each Zone may hold Zone Meetings for such purposes as may be deemed appropriate by members of the Zone.

ARTICLE VI

Standing Committees and Task Forces

1. General

The Standing Committees shall not be subcommittees of the Executive Committee and shall have no power or authority for the management of the business and affairs of the NAIC. Each Standing Committee shall be composed of not more than 15 members, including a Chair and one or more Vice Chairs, appointed by the President and President-Elect, and such appointments shall remain effective until the succeeding President and President-Elect appoint members for the following year. Standing Committees shall meet at least twice a year at National Meetings and may meet more often at the call of the Chair as required to complete its assignments from the Executive Committee in a timely manner.

The Executive Committee shall make all assignments of subject matter to the Standing Committees and shall require coordination between Committees and Task Forces of the subject matter if more than one Committee or Task Force is affected. The format of the Committee reports shall be prescribed by the Executive Committee. All appointments or elections of members of the NAIC to any office or Committee of the NAIC shall be deemed the appointment or election of a particular member and shall not automatically pass to a successor in office.

2. Specific Duties

The Standing Committees of the NAIC, their duties and responsibilities shall be as follows:

- (a) Life Insurance and Annuities (A) Committee: This Standing Committee shall consider issues relating to life insurance and annuities.
- (b) Health Insurance and Managed Care (B) Committee: This Standing Committee shall consider issues relating to health and accident insurance and managed care.
- (c) Property and Casualty Insurance (C) Committee: This Standing Committee shall consider issues relating to personal and commercial lines of property and casualty insurance, worker's compensation insurance, statistical information, surplus lines, and casualty actuarial matters.
- (d) Market Regulation and Consumer Affairs (D) Committee: This Standing Committee shall consider issues involving market conduct in the insurance industry; competition in insurance markets; the qualifications and conduct of agents and brokers; market conduct examination practices; the control and management of insurance institutions; consumer services of State insurance departments; and consumer participation in NAIC activities.
- (e) Financial Condition (E) Committee: This Standing Committee shall consider both administrative and substantive issues as they relate to accounting practices and procedures; blanks; valuation of securities; the Insurance Regulatory Information System (IRIS), as it relates to solvency and profitability; the call, monitoring and concluding report of Zone Examinations; and financial examinations and examiner training.
- (f) Financial Regulation Standards and Accreditation (F) Committee: This Standing Committee shall consider

both administrative and substantive issues as they relate to administration and enforcement of the NAIC Accreditation Program, including without limitation, consideration of standards and revisions of standards for accreditation, interpretation of standards, evaluation and interpretation of states' laws and regulations, and departments' practices, procedures and organizations as they relate to compliance with standards, examination of members for compliance with standards, development and oversight of procedures for examination of members for compliance with standards, qualification and selection of individuals to perform the examination of members for compliance with standards, and decisions regarding whether to accredit members.

(g) International Insurance Relations (G) Committee. This Standing Committee shall have the responsibility for issues relating to international insurance.

(h) Innovation, Cybersecurity and Technology (H) Committee. This Standing Committee shall consider issues related to cybersecurity, innovation, data security and privacy, and emerging technology issues.

3. Task Forces

The Executive Committee, its Subcommittee and the Standing Committees may establish one or more Task Forces, subject to approval of the Executive Committee. The parent Committee or Subcommittee, subject to approval of the Executive Committee, may vote to discontinue a Task Force once its charge has been completed.

Vacancies in the positions of Chair or Vice Chair of any Task Force shall be filled by the parent Committee or Subcommittee from within or outside the present Task Force membership; provided, however, that the chief insurance regulatory official of the state of the former Chair or Vice Chair shall become a member of the Task Force. A vacancy in the position of member shall be filled by the chief insurance regulatory official of the vacating member's state.

If an existing Task Force is dealing with insurance issues that require continuing study, the Executive Committee may adopt the recommendation of the parent Committee or Subcommittee that the Task Force be designated a Standing Task Force. A Standing Task Force shall continue in effect until terminated by the Executive Committee.

ARTICLE VII

Meetings of the Membership

1. Regular Meetings

The NAIC shall hold at least two (2) regular meetings of the members ("National Meetings") each calendar year. Notice, stating the place, day and hour and any special purposes of the National Meeting, shall be delivered by the Executive Committee not less than ten (10) calendar days nor more than sixty (60) calendar days before the date on which the National Meeting is to be held, either personally, by mail or by other lawful means, to each member entitled to be present and vote at such meeting.

2. Special Meetings

Special meetings of the members may be called by any five (5) members of the Executive Committee by giving all members notice of such meeting at least ten (10) but not more than sixty (60) days prior thereto, or by any twenty (20) members of the NAIC by giving all members notice of such meeting at least thirty (30) but not more than sixty (60) days prior thereto. Notice of the special meeting shall state the place, day and hour of the

special meeting and the purpose or purposes for which the special meeting is called, and shall be delivered by the persons calling the meeting within the applicable time period set forth herein, either personally, by mail or by other lawful means, to each member entitled to be present and vote at such meeting.

3. Waiver of Notice; Postponement

Member meetings may be held without notice if all members entitled to notice are present (except when members entitled to notice attend the meeting for the express purpose of objecting, at the beginning of the meeting, because the meeting is allegedly not lawfully called or convened), or if notice is waived by those not present. Any previously scheduled meeting of the members may be postponed by the Executive Committee (or members calling a special meeting, as the case may be) upon notice to members, in person or writing, given at least two (2) days prior to the date previously scheduled for such meeting.

4. Quorum

Except as otherwise provided by law or by the Certificate of Incorporation, the presence, by person or proxy, of a majority of the members shall constitute a quorum at a member meeting, a meeting of a Standing Committee, Task Force or a working group. The chairman of the meeting may adjourn the meeting from time to time, whether or not there is such a quorum. The members present at a duly called member meeting at which a quorum is present may continue to transact business until adjournment, notwithstanding the withdrawal of enough members to leave less than a quorum.

5. Any meeting of the NAIC may be held in executive session as defined in the NAIC policy on open meetings. Any member may attend and participate in any meeting of the NAIC or any meeting of a Standing Committee or Task Force whether or not such member has the right to vote. All National Meetings shall provide for a Plenary Session of the NAIC as a whole in order to consider and take action upon the matters submitted to the NAIC.

ARTICLE VIII

Elections

1. The election of officers of the NAIC shall be scheduled for the plenary session of the last National Meeting of the calendar year or at such other plenary session as agreed to by the members.
2. At the beginning of such Plenary Session, the Secretary-Treasurer shall ascertain and announce the presence of a quorum.
3. Upon the determination of a quorum, the chair shall briefly review the provisions of the Certificate of Incorporation and Bylaws in regard to voting.
4. The President shall ask for and announce all proxies. Proxies shall be held by the Secretary-Treasurer or a designee throughout the election session. Proxies shall be valid, subject to their term, until superseded by the member and shall be governed by ARTICLE IX of the Bylaws.
5. Every individual voting by proxy must meet the requirements of Article II of the Bylaws of the NAIC which requires that such a person be "...officially affiliated with the member's (the member delegating authority to vote) department, and is wholly or principally employed by said department."
6. Prior to opening the nominations for office, the Chair shall appoint three (3) members of the NAIC to act as

voting inspectors. The voting inspectors shall distribute, collect, count and/or verify ballots, and report their findings to the Secretary-Treasurer. If a voting inspector is nominated for an office and does not withdraw as a candidate, he or she shall not be a voting inspector for the election of the office to which he or she is nominated and the chair shall appoint another voting inspector in his or her place.

7. The Chair shall announce the opening of nominations for offices in the following order:
 - (a) President. Provided, however, where the President does not run for re-election, the President-Elect shall become President at the conclusion of the President's term of office. In those cases where the President runs for re-election or where a vacancy exists because the President-Elect fails or is otherwise unable to assume the Presidency, this office will be subject to an election.
 - (b) President-Elect.
 - (c) Vice President.
 - (d) Secretary-Treasurer.
8. Only members or duly authorized proxyholders may make nominations.
9. One nominating speech, not to exceed three (3) minutes in duration, shall be allowed for each nominee.
10. After nominations are closed for each office, each nominee must indicate whether he or she accepts the nomination and, if he or she accepts, shall be permitted to address the membership for a period of up to seven (7) minutes. Such addresses shall be given in the order by which the nominations were made.
11. The votes of members, in person or by proxy, constituting a majority of the quorum present at the meeting shall be necessary for election to such office. If no candidate receives a majority, the two candidates with the most votes will participate in a run-off election. The candidate with the most votes in the run-off election shall win such election.
12. Voting need not be by written ballot, unless otherwise required by these Bylaws, the Certificate of Incorporation, or applicable law.

ARTICLE IX

Proxies; Waiver of Notice

Where the delegation of power to vote or participate in the membership of the NAIC is required by ARTICLE II of these Bylaws to be in writing, such delegation must be effected by proxy. All proxies must be dated, give specific authority to a named individual who meets the requirements of ARTICLE II for duly authorized representatives, and meet any other applicable legal requirement. Documents such as electronic transmission, telegrams, mailgrams, etc. are acceptable as proxies if they otherwise meet the requirements contained herein and applicable law. Proxies should be maintained by NAIC Central Office staff. Notwithstanding the foregoing, a member may not vote by proxy in a meeting of the Executive Committee, Financial Regulation Standards and Accreditation (F) Committee in a vote concerning a state-specific item, Government Relations Leadership Council, or International Insurance Relations Leadership Group, or any respective subcommittees.

Whenever any notice is required to be given to any member (for a meeting of members or the Executive Committee) under the provisions of the Certificate of Incorporation, these Bylaws or applicable law, a written

waiver, signed by the person entitled to notice, or a waiver by electronic transmission by person entitled to notice, whether before or after the time stated therein, shall be deemed equivalent to the giving of such notice. Neither the business to be transacted at, nor the purpose of, any annual or special meeting of the members or any committee, subcommittee or task force need be specified in any waiver of notice of such meeting.

Unless otherwise restricted by the Certificate of Incorporation or these Bylaws, Members may participate in a meeting by means of conference telephone or by any means by which all persons participating in the meeting are able to communicate with one another, and such participation shall constitute presence in person at the meeting.

Any notice required under these Bylaws may be provided by mail, facsimile, or electronic transmission.

ARTICLE X

Procedures: Books and Records

The Executive Committee shall adopt policies and procedures for the conduct of meetings. In the event such policies and procedures conflict with the NAIC's Certificate of Incorporation or Bylaws, the Certificate of Incorporation and Bylaws shall govern.

The books and records of the NAIC may be kept outside the State of Delaware at such place or places as may from time to time be designated by the Internal Administration Subcommittee (EX1) of the Executive Committee.

ARTICLE XI

Amendments

These Bylaws may be altered or repealed and new Bylaws may be adopted at any regular or special meeting of the members by an affirmative vote, in person or by proxy, of a majority of the members entitled to vote at such meeting; provided, however, that any proposed alteration (except to correct typographical or grammatical errors or article, section or paragraph cross- references caused by other alterations, repeals, or adoptions) or repeal of, or the adoption of any Bylaw inconsistent with, Article II [Membership], Article VII, Paragraph 2 [Special Meetings of Members] and Paragraph 4 [Quorum], Article VIII [Elections], or this Article XI [Amendments] of these Bylaws (the "Supermajority Bylaws") by the members shall require the affirmative vote, in person or by proxy, of at least two-thirds (2/3) of the members entitled to vote at such meeting and provided, further, that in the case of any such member action at a special meeting of members, notice of the proposed alteration, repeal or adoption of the new Bylaw or Bylaws must be contained in the notice of such special meeting. Corrections for typographical or grammatical errors or to article, section or paragraph cross- references caused by other alterations, repeals or adoption, shall only be made if approved by the affirmative vote of at least two-thirds (2/3) of the Executive Committee.

Adopted October 1999, see 1999 Proc., Third Quarter page 7

Amended November 2002, see 2002 Proc., Fourth Quarter page 25

Amended June 2003, see 2003 Proc., Second Quarter page 28

Amended March 2004, see 2004 Proc., First Quarter page 119

Amended December 2004, see 2004 Proc., Fourth Quarter page 58

Amended March 2009, see 2009 Proc., First Quarter page 3–67

Amended September 2009, see 2009 Proc., Third Quarter

Amended October 2011, see Proc., Summer 2011

Amended December 2015, see Proc., Spring 2016
Amended December 2021, see Proc., Spring 2022

NAIC Policy Statement on Open Meetings
Revised: April 1, 2014

The NAIC is the U.S. standard-setting and regulatory support organization created and governed by the chief insurance regulators of the 50 states, the District of Columbia and five U.S. territories. NAIC members are the elected and appointed state government officials who, along with their departments and staff, regulate the conduct of insurance companies and agents in their respective state or territory. The NAIC is committed to conducting its business openly. This policy statement applies to meetings of NAIC committees, subcommittees, task forces and working groups. It does not apply to Roundtable discussions, zone meetings, commissioners' conferences, and other like meetings of the members. Applicable meetings will be open unless the discussion or action contemplated will include:

1. Potential or pending litigation or administrative proceedings which may involve the NAIC, any NAIC member, or their staffs, in any capacity involving their official or prescribed duties, requests for briefs of amicus curiae, or legal advice.
2. Pending investigations which may involve either the NAIC or any member in any capacity.
3. Specific companies, entities or individuals, including, but not limited to, collaborative financial and market conduct examinations and analysis.
4. Internal or administrative matters of the NAIC or any NAIC member, including budget, personnel and contractual matters, and including consideration of internal administration of the NAIC, including, but not limited to, by the Internal Administration (EX1) Subcommittee or any subgroup appointed thereunder.
5. Voting on the election of officers of the NAIC.
6. Consultations with NAIC staff members related to NAIC technical guidance, including, but not limited to, Annual and Quarterly Statement Blanks and Instructions, the Accounting Practices and Procedures Manual, and similar materials.
7. Consideration of individual state insurance department's compliance with NAIC financial regulation standards by the Financial Regulation Standards and Accreditation (F) Committee or any subgroup appointed thereunder.
8. Consideration of strategic planning issues relating to federal legislative and regulatory matters or international regulatory matters.
9. Any other subject required to be kept confidential under any Memorandum of Understanding or other agreement, state or federal law or under any judicial or administrative order.

Because not all situations requiring a regulator to regulator discussion can be anticipated at the time a meeting is scheduled, a meeting convened in open session can move into regulator to regulator session on motion by the chair or other member approved by a majority of the members present. Public notice will be provided of all applicable meetings. The reason for holding a meeting in regulator only session will be announced when the meeting notice is published, at the beginning of any regulator only session, and when an open meeting goes into regulator only session.

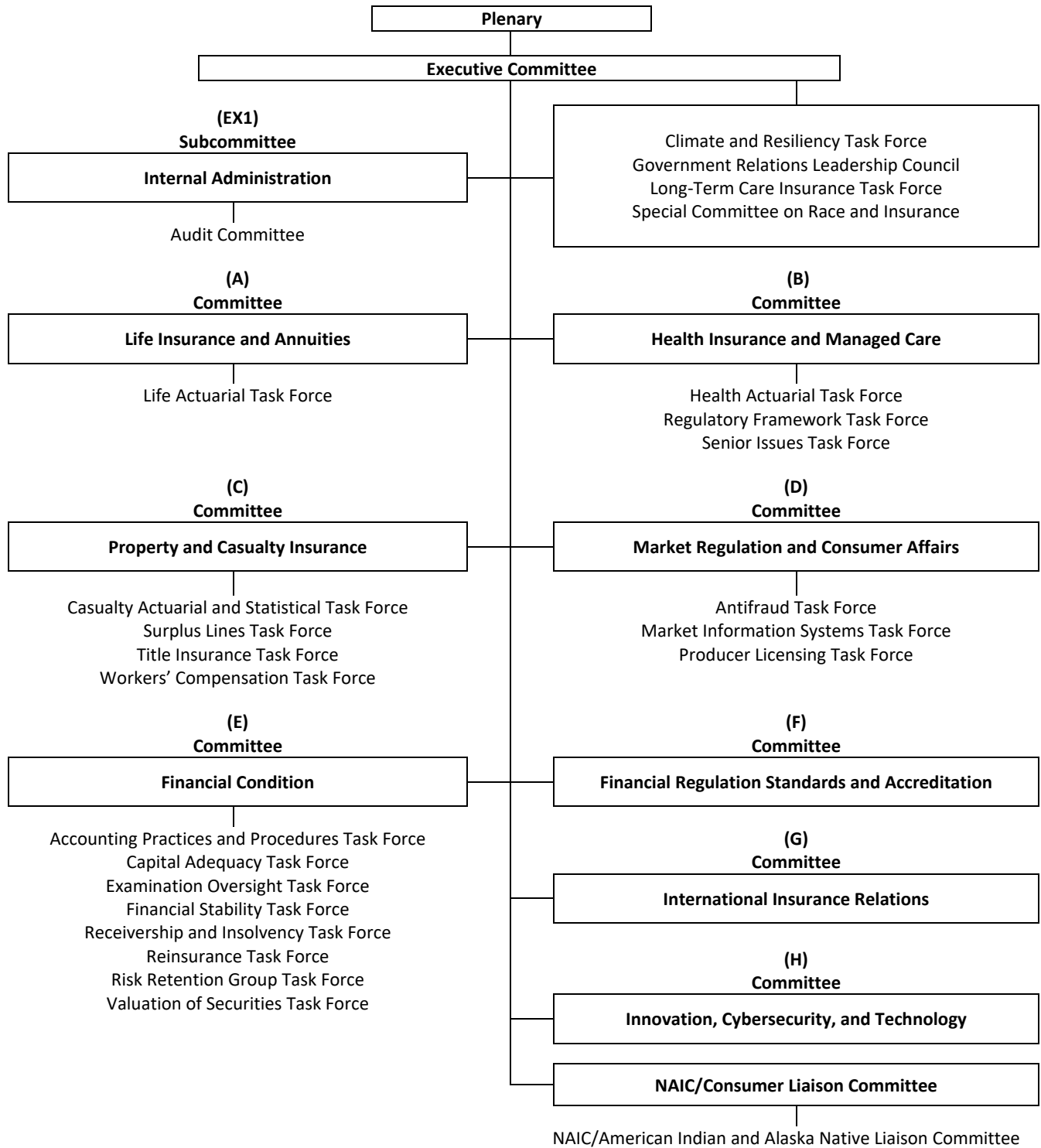
This revised policy statement shall take effect upon adoption by the membership.

[NOTE: (Effective Jan. 1, 1996, conference call meetings are included in the application of the policy statement, by action of the NAIC on June 4, 1995). This policy statement was originally adopted by the NAIC membership during the 1994 Fall National Meeting in Minneapolis, Minnesota, Sept. 18–20, 1994.]

Revisions Adopted by the NAIC Membership, April 1, 2014

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2023 COMMITTEE AND TASK FORCE STRUCTURE



APPOINTED AND DISBANDED

Current and Previous Year

APPOINTED SINCE JANUARY 2023	Effective Date	NAIC Support Staff
RENAMED SINCE JANUARY 2023		
	Effective Date	NAIC Support Staff
DISBANDED SINCE JANUARY 2023		
	Effective Date	NAIC Support Staff
Long-Term Care Pricing (B) Subgroup.....	03/25/2023	Eric King
Long-Term Care Valuation (B) Subgroup	03/25/2023	Eric King
Restructuring Mechanisms (E) Subgroup	03/25/2023	Robin Marcotte
DISBANDED IN 2022		
	Effective Date	NAIC Support Staff
Antifraud Education Enhancement (D) Working Group	04/07/2022	Greg Welker
Guaranteed Issue (GI) Life Valuation (A) Subgroup.....	03/31/2022	Scott O’Neal
Information Systems (EX1) Task Force	01/14/2022	Sherry Stevens
Life Insurance Online Guide (A) Working Group	12/16/2022	Jennifer Cook
Long-Term Care Insurance Model Update (B) Subgroup.....	08/11/2022	David Torian
Long-Term Care Insurance Multistate Rate Review (EX) Subgroup.....	12/16/2022	Eric King
Long-Term Care Insurance Reduced Benefit Options (EX) Subgroup.....	08/11/2022	Eric King
Long-Term Care Insurance Restructuring (E) Subgroup	01/19/2022	Dan Daveline
Pet Insurance (C) Working Group	12/16/2022	Aaron Brandenburg

2023 MEMBERS BY ZONE

Northeast Zone

Kathleen A. Birrane, Chair	Maryland
Trinidad Navarro, Vice Chair	Delaware
Kevin Gaffney, Secretary	Vermont
Andrew N. Mais	Connecticut
Karima M. Woods	District of Columbia
Timothy N. Schott	Maine
Gary D. Anderson	Massachusetts
D.J. Bettencourt	New Hampshire
Justin Zimmerman	New Jersey
Adrienne A. Harris	New York
Michael Humphreys	Pennsylvania
Elizabeth Kelleher Dwyer	Rhode Island

Southeast Zone

James J. Donelon, Chair	Louisiana
Carter Lawrence, Vice Chair	Tennessee
Sharon P. Clark, Secretary	Kentucky
Mark Fowler	Alabama
Alan McClain	Arkansas
Michael Yaworsky	Florida
John F. King	Georgia
Mike Chaney	Mississippi
Mike Causey	North Carolina
Alexander S. Adams Vega	Puerto Rico
Michael Wise	South Carolina
Tregenza A. Roach	U.S. Virgin Islands
Scott A. White	Virginia
Allan L. McVey	West Virginia

Midwest Zone

Doug Ommen, Chair	Iowa
Anita G. Fox, Vice Chair	Michigan
Vicki Schmidt, Secretary	Kansas
Dana Popish Severinghaus	Illinois
Amy L. Beard	Indiana
Grace Arnold	Minnesota
Chlora Lindley-Myers	Missouri
Eric Dunning	Nebraska
Jon Godfred	North Dakota
Judith L. French	Ohio
Glen Mulready	Oklahoma
Larry D. Deiter	South Dakota
Nathan Houdek	Wisconsin

Western Zone

Lori K. Wing-Heier, Chair	Alaska
Michael Conway, Vice Chair	Colorado
Andrew R. Stolfi, Secretary	Oregon
Peni Itula Sapini Teo	American Samoa
Barbara D. Richardson	Arizona
Ricardo Lara	California
Michelle B. Santos	Guam
Gordon I. Ito	Hawaii
Dean L. Cameron	Idaho
Troy Downing	Montana
Francisco D. Cabrera	N. Mariana Islands
Scott Kipper	Nevada
Alice Kane	New Mexico
Cassie Brown	Texas
Jon Pike	Utah
Mike Kreidler	Washington
Jeff Rude	Wyoming

Updated July 5, 2023

2023 EXECUTIVE (EX) COMMITTEE

Chlora Lindley-Myers, President	Missouri
Andrew N. Mais, President-Elect	Connecticut
Jon Godfread, Vice President	North Dakota
Scott A. White, Secretary-Treasurer	Virginia

Most Recent Past President: Dean L. Cameron	Idaho
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Northeast Zone

Kathleen A. Birrane, Chair	Maryland
Trinidad Navarro, Vice Chair	Delaware
Kevin Gaffney, Secretary	Vermont

Southeast Zone

James J. Donelon, Chair	Louisiana
Carter Lawrence, Vice Chair	Tennessee
Sharon P. Clark, Secretary	Kentucky

Midwest Zone

Doug Ommen, Chair	Iowa
Anita G. Fox, Vice Chair	Michigan
Vicki Schmidt, Secretary	Kansas

Western Zone

Lori K. Wing-Heier, Chair	Alaska
Michael Conway, Vice Chair	Colorado
Andrew R. Stolfi, Secretary	Oregon

NAIC Support Staff: Andrew J. Beal/Kay Noonan

Updated January 3, 2023

CLIMATE AND RESILIENCY (EX) TASK FORCE*of the Executive (EX) Committee*

Lori K. Wing-Heier, Co-Chair	Alaska	Mike Chaney	Mississippi
Ricardo Lara, Co-Chair	California	Chlora Lindley-Myers	Missouri
James J. Donelon, Co-Vice Chair	Louisiana	Troy Downing	Montana
Mike Kreidler, Co-Vice Chair	Washington	Francisco D. Cabrera	N. Mariana Islands
Mark Fowler	Alabama	Eric Dunning	Nebraska
Peni Itula Sapini Teo	American Samoa	Scott Kipper	Nevada
Barbara D. Richardson	Arizona	D.J. Bettencourt	New Hampshire
Alan McClain	Arkansas	Justin Zimmerman	New Jersey
Michael Conway	Colorado	Alice Kane	New Mexico
Andrew N. Mais	Connecticut	Adrienne A. Harris	New York
Trinidad Navarro	Delaware	Mike Causey	North Carolina
Karima M. Woods	District of Columbia	Jon Godfread	North Dakota
Michael Yaworsky	Florida	Judith L. French	Ohio
Gordon I. Ito	Hawaii	Glen Mulready	Oklahoma
Dana Popish Severinghaus	Illinois	Andrew R. Stolfi	Oregon
Amy L. Beard	Indiana	Michael Humphreys	Pennsylvania
Doug Ommen	Iowa	Alexander S. Adams Vega	Puerto Rico
Sharon P. Clark	Kentucky	Elizabeth Kelleher Dwyer	Rhode Island
Timothy N. Schott	Maine	Michael Wise	South Carolina
Kathleen A. Birrane	Maryland	Kevin Gaffney	Vermont
Gary D. Anderson	Massachusetts	Scott A. White	Virginia
Anita G. Fox	Michigan	Nathan Houdek	Wisconsin
Grace Arnold	Minnesota	Jeff Rude	Wyoming

NAIC Support Staff: Aaron Brandenburg/Libby Crews

GOVERNMENT RELATIONS (EX) LEADERSHIP COUNCIL

of the Executive (EX) Committee

Chlora Lindley-Myers, Chair	Missouri
Andrew N. Mais, Vice Chair	Connecticut
Alan McClain	Arkansas
Michael Conway	Colorado
Trinidad Navarro	Delaware
John F. King	Georgia
Dean L. Cameron	Idaho
Kathleen A. Birrane	Maryland
Gary D. Anderson	Massachusetts
Grace Arnold	Minnesota
Troy Downing	Montana
Jon Godfread	North Dakota
Glen Mulready	Oklahoma
Carter Lawrence	Tennessee
Scott A. White	Virginia
Mike Kreidler	Washington

NAIC Support Staff: Ethan Sonnichsen/Brian R. Webb

LONG-TERM CARE INSURANCE (EX) TASK FORCE*of the Executive (EX) Committee*

Michael Conway, Chair	Colorado	Chlora Lindley-Myers	Missouri
Andrew R. Stolfi, Vice Chair	Oregon	Troy Downing	Montana
Mark Fowler	Alabama	Eric Dunning	Nebraska
Lori K. Wing-Heier	Alaska	Scott Kipper	Nevada
Barbara D. Richardson	Arizona	D.J. Bettencourt	New Hampshire
Alan McClain	Arkansas	Justin Zimmerman	New Jersey
Ricardo Lara	California	Alice Kane	New Mexico
Andrew N. Mais	Connecticut	Mike Causey	North Carolina
Trinidad Navarro	Delaware	Jon Godfread	North Dakota
Karima M. Woods	District of Columbia	Judith L. French	Ohio
Michael Yaworsky	Florida	Glen Mulready	Oklahoma
Gordon I. Ito	Hawaii	Michael Humphreys	Pennsylvania
Dean L. Cameron	Idaho	Elizabeth Kelleher Dwyer	Rhode Island
Amy L. Beard	Indiana	Larry D. Deiter	South Dakota
Doug Ommen	Iowa	Cassie Brown	Texas
Vicki Schmidt	Kansas	Jon Pike	Utah
Sharon P. Clark	Kentucky	Kevin Gaffney	Vermont
James J. Donelon	Louisiana	Scott A. White	Virginia
Timothy N. Schott	Maine	Mike Kreidler	Washington
Kathleen A. Birrane	Maryland	Allan L. McVey	West Virginia
Gary D. Anderson	Massachusetts	Nathan Houdek	Wisconsin
Anita G. Fox	Michigan	Jeff Rude	Wyoming
Grace Arnold	Minnesota		

NAIC Support Staff: Jeffrey C. Johnston/Jane Koenigsman

SPECIAL (EX) COMMITTEE ON RACE AND INSURANCE*of the Executive (EX) Committee*

Andrew N. Mais, Co-Chair	Connecticut	Grace Arnold	Minnesota
Chlora Lindley-Myers, Co-Chair	Missouri	Troy Downing	Montana
Jon Godfread, Co-Vice Chair	North Dakota	Eric Dunning	Nebraska
Scott A. White, Co-Vice Chair	Virginia	Scott Kipper	Nevada
Mark Fowler	Alabama	Justin Zimmerman	New Jersey
Lori K. Wing-Heier	Alaska	Alice Kane	New Mexico
Peni Itula Sapini Teo	American Samoa	Mike Causey	North Carolina
Alan McClain	Arkansas	Judith L. French	Ohio
Michael Conway	Colorado	Glen Mulready	Oklahoma
Karima M. Woods	District of Columbia	Andrew R. Stolfi	Oregon
Michael Yaworsky	Florida	Michael Humphreys	Pennsylvania
Dean L. Cameron	Idaho	Alexander S. Adams Vega	Puerto Rico
Dana Popish Severinghaus	Illinois	Elizabeth Kelleher Dwyer	Rhode Island
Amy L. Beard	Indiana	Michael Wise	South Carolina
Doug Ommen	Iowa	Larry D. Deiter	South Dakota
Sharon P. Clark	Kentucky	Jon Pike	Utah
James J. Donelon	Louisiana	Kevin Gaffney	Vermont
Timothy N. Schott	Maine	Mike Kreidler	Washington
Kathleen A. Birrane	Maryland	Nathan Houdek	Wisconsin
Gary D. Anderson	Massachusetts	Jeff Rude	Wyoming
Anita G. Fox	Michigan		

NAIC Support Staff: Andrew J. Beal/Kay Noonan

INTERNAL ADMINISTRATION (EX1) SUBCOMMITTEE

Chlora Lindley-Myers, Chair	Missouri
Andrew N. Mais, Vice Chair	Connecticut
Lori K. Wing-Heier	Alaska
Dean L. Cameron	Idaho
Sharon P. Clark	Kentucky
Kathleen A. Birrane	Maryland
Jon Godfread	North Dakota
Scott A. White	Virginia

NAIC Support Staff: Andrew J. Beal/Kay Noonan/Jim Woody

AUDIT COMMITTEE

of the Internal Administration (EX1) Subcommittee

Scott A. White, Chair	Virginia
Andrew N. Mais	Connecticut
Sharon P. Clark	Kentucky
Kathleen A. Birrane	Maryland
Gary D. Anderson	Massachusetts
Chlora Lindley-Myers	Missouri
Eric Dunning	Nebraska
Jon Godfread	North Dakota
Andrew R. Stolfi	Oregon
Larry D. Deiter	South Dakota
Carter Lawrence	Tennessee

NAIC Support Staff: Jim Woody

LIFE INSURANCE AND ANNUITIES (A) COMMITTEE

Judith L. French, Chair	Ohio
Carter Lawrence, Vice Chair	Tennessee
Mark Fowler	Alabama
Barbara D. Richardson	Arizona
Karima M. Woods	District of Columbia
Doug Ommen	Iowa
Vicki Schmidt	Kansas
James J. Donelon	Louisiana
Eric Dunning	Nebraska
Scott Kipper	Nevada
Justin Zimmerman	New Jersey
Adrienne A. Harris	New York
Glen Mulready	Oklahoma
Scott A. White	Virginia
Nathan Houdek	Wisconsin

NAIC Support Staff: Jennifer R. Cook/Jolie H. Matthews

Accelerated Underwriting (A) Working Group

of the Life Insurance and Annuities (A) Committee

Nathan Houdek, Chair	Wisconsin
Grace Arnold, Vice Chair	Minnesota
Jason Lapham	Colorado
Russ Gibson	Iowa
Tom Travis	Louisiana
Nour Benchaaboun	Maryland
Cynthia Amann	Missouri
Maggie Reinert/Megan VanAusdall	Nebraska
Ross Hartley	North Dakota
Daniel Bradford	Ohio
Elizabeth Kelleher Dwyer/Matt Gendron	Rhode Island
Lichiou Lee	Washington

NAIC Support Staff: Jennifer R. Cook

Annuity Suitability (A) Working Group
of the Life Insurance and Annuities (A) Committee

Doug Ommen, Chair	Iowa
Craig VanAalst, Vice Chair	Kansas
Jimmy Gunn	Alabama
Jodi Lerner	California
Jessica Luff	Delaware
Dean L. Cameron	Idaho
Renee Campbell	Michigan
Eric Dunning	Nebraska
Keith Nyhan	New Hampshire
Daniel Bradford	Ohio
Andrew Schallhorn	Oklahoma
Matt Gendron	Rhode Island
Richard Wicka	Wisconsin

NAIC Support Staff: Jolie H. Matthews

LIFE ACTUARIAL (A) TASK FORCE
of the Life Insurance and Annuities (A) Committee

Cassie Brown, Chair	Texas
Scott A. White, Vice Chair	Virginia
Mark Fowler	Alabama
Lori K. Wing-Heier	Alaska
Ricardo Lara	California
Andrew N. Mais	Connecticut
Dana Popish Severinghaus	Illinois
Doug Ommen	Iowa
Vicki Schmidt	Kansas
Timothy N. Schott	Maine
Grace Arnold	Minnesota
Chlora Lindley-Myers	Missouri
Eric Dunning	Nebraska
D.J. Bettencourt	New Hampshire
Justin Zimmerman	New Jersey
Adrienne A. Harris	New York
Judith L. French	Ohio
Glen Mulready	Oklahoma
Michael Humphreys	Pennsylvania
Jon Pike	Utah
Allan L. McVey	West Virginia

NAIC Support Staff: Scott O'Neal/Jennifer Frasier

Experience Reporting (A) Subgroup

of the Life Actuarial (A) Task Force

Fred Andersen, Chair	Minnesota
Ahmad Kamil	California
Wanchin Chou	Connecticut
Nicole Boyd	Kansas
Bill Carmello	New York
Rachel Hemphill	Texas

NAIC Support Staff: Angela McNabb

Indexed Universal Life (IUL) Illustration (A) Subgroup

of the Life Actuarial (A) Task Force

Fred Andersen, Chair	Minnesota
Ted Chang	California
Manny Hidalgo	Connecticut
Vincent Tsang	Illinois
Scott Shover	Indiana
Mike Yanacheak	Iowa
Michael Muldoon	Nebraska
Bill Carmello	New York
Peter Weber	Ohio
Maribel Castillo/Darlene Plyler/Heike Ulrich	Texas
Tomasz Serbinowski	Utah
Craig Chupp	Virginia

NAIC Support Staff: Jennifer Frasier

Index-Linked Variable Annuity (A) Subgroup

of the Life Actuarial (A) Task Force

Peter Weber, Chair	Ohio
Tomasz Serbinowski, Vice Chair	Utah
Sarvjit Samra	California
Vincent Tsang	Illinois
Scott Shover	Indiana
Michael Muldoon	Nebraska
David Wolf	New Jersey
Bill Carmello/Michael Cebula	New York
Rachel Hemphill	Texas
Craig Chupp	Virginia
David Hippen	Washington

NAIC Support Staff: Jim Stinson

Longevity Risk (E/A) Subgroup

of the Life Risk-Based Capital (E) Working Group and Life Actuarial (A) Task Force

Seong-min Eom, Chair	New Jersey
Lei Rao-Knight	Connecticut
Mike Yanacheak	Iowa
Bill Carmello	New York
Peter Weber	Ohio

NAIC Support Staff: Dave Fleming

Valuation Manual (VM)-22 (A) Subgroup

of the Life Actuarial (A) Task Force

Ben Slutsker, Chair	Minnesota
Elaine Lam/Thomas Reedy	California
Lei Rao-Knight	Connecticut
Vincent Tsang	Illinois
Mike Yanacheak	Iowa
Nicole Boyd	Kansas
William Leung	Missouri
Seong-min Eom	New Jersey
Bill Carmello	New York
Rachel Hemphill	Texas
Tomasz Serbinowski	Utah
Craig Chupp	Virginia

NAIC Support Staff: Scott O’Neal

Variable Annuities Capital and Reserve (E/A) Subgroup

of the Life Risk-Based Capital (E) Working Group and Life Actuarial (A) Task Force

Peter Weber, Chair	Ohio
Thomas Reedy	California
Philip Barlow	District of Columbia
Nicole Boyd	Kansas
Fred Andersen	Minnesota
William Leung	Missouri
Seong-min Eom	New Jersey
Bill Carmello	New York
Rachel Hemphill	Texas

NAIC Support Staff: Dave Fleming/Jim Stinson

HEALTH INSURANCE AND MANAGED CARE (B) COMMITTEE

Anita G. Fox, Chair	Michigan
Jon Pike, Co-Vice Chair	Utah
Mike Kreidler, Co-Vice Chair	Washington
Trinidad Navarro	Delaware
John F. King	Georgia
Dean L. Cameron	Idaho
Kathleen A. Birrane	Maryland
Grace Arnold	Minnesota
Mike Chaney	Mississippi
D.J. Bettencourt	New Hampshire
Glen Mulready	Oklahoma
Andrew R. Stolfi	Oregon
Michael Humphreys	Pennsylvania
Alexander S. Adams Vega	Puerto Rico
Allan L. McVey	West Virginia

NAIC Support Staff: Jolie H. Matthews/Brian R. Webb/Jennifer R. Cook

Consumer Information (B) Subgroup

of the Health Insurance and Managed Care (B) Committee

LeAnn Crow, Chair	Kansas
Anthony L. Williams	Alabama
Debra Judy	Colorado
Randy Pipal	Idaho
Michelle Baldock	Illinois
Alex Peck	Indiana
Judith Watters	Maine
Mary Kwei	Maryland
Maybeth Moses	Minnesota
Carrie Couch	Missouri
Susan Brown	Montana
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ALABAMA —Appointed, at the pleasure of the Governor; term concurrent with that of the Governor by whom appointed or for the unexpired portion of the term					
Insurance Commissioner	Mark Fowler	1/16/2023		incumbent	
Acting Insurance Commissioner	Mark Fowler	7/1/2022	1/16/2023	0	6
Insurance Commissioner	Jim L. Ridling (Appointed Sept. 15, 2008; Reappointed Jan. 17, 2011; Reappointed November 2017)	9/15/2008	6/30/2022	9	3
Acting Insurance Commissioner	D. David Parsons	9/1/2008	9/15/2008	0	1
Insurance Commissioner	Walter A. Bell*	1/21/2003	8/31/2008	5	7
Insurance Commissioner	D. David Parsons	12/1/2000	1/21/2003	2	1
Acting Insurance Commissioner	D. David Parsons	1/20/1999	12/1/2000	1	11
Insurance Commissioner	Richard H. Cater	2/1/1998	1/19/1999	0	11
Insurance Commissioner	Michael 'Mickey' DeBellis	3/6/1996	1/31/1998	1	11
Acting Insurance Commissioner	Michael 'Mickey' DeBellis	1/16/1995	3/6/1996	1	2
Insurance Commissioner	James H. 'Jimmy' Dill	5/5/1993	1/16/1995	1	8
Insurance Commissioner	Michael C. 'Mike' Weaver	8/16/1988	5/5/1993	4	9
Insurance Commissioner	John S. Greeno	2/6/1987	8/16/1988	1	6
Insurance Commissioner	Michael 'Mickey' DeBellis	1/1/1986	1/19/1987	1	0
Insurance Commissioner	Tharpe Forrester	6/8/1984	1/1/1986	1	7
Insurance Commissioner	Joseph R. 'Joe' Holt	5/21/1984	6/5/1984	0	1
Insurance Commissioner	William G. 'Bill' Ward, Jr.	1/17/1983	5/21/1984	1	4
Insurance Commissioner	Tharpe Forrester, Jr.	5/19/1980	1/17/1983	2	8
Insurance Commissioner	Haskell H. Sumrall, Jr.	8/15/1979	5/19/1980	0	9
Acting Insurance Commissioner	Albert Jackson 'Jack' Winfield	2/2/1979	8/15/1979	0	6
Insurance Commissioner	Charles H. Payne	1/20/1975	2/2/1979	4	0
Insurance Commissioner	John G. Bookout	1/1/1972	1/20/975	3	0
Superintendent of Insurance	John G. Bookout	1/18/1971	1/1/1972	1	0
Superintendent of Insurance	R. Frank Ussery (Died Nov. 13, 2021)	12/14/1968	1/18/1971	2	1
Superintendent of Insurance	Walter S. Houseal	1/15/1963	12/14/1968	5	11
Superintendent of Insurance	William D. Page	5/23/1961	1/15/1963	1	8
Superintendent of Insurance	Edmon L. Rinehart	1/19/1959	5/23/1961	2	4
Superintendent of Insurance	James H. Horn	10/3/1956	1/19/1959	2	3
Superintendent of Insurance	Leslie Lee Gwaltney, Jr.	1/18/1955	10/3/1956	1	9
Superintendent of Insurance	Herman A. Longshore	1/16/1951	1/18/1955	4	0
Superintendent of Insurance	Leslie Lee Gwaltney, Jr.	1/31/1947	1/16/1951	4	0
Director of Commerce/Superintendent of Insurance	Addie Lee Farish	12/1/1944	1/31/1947	2	1
Superintendent of Insurance	Frank N. Julian* (Died Nov. 30, 1944)	2/1/1935	11/30/1944	9	10
Superintendent of Insurance	Charles C. Greer	2/1/1931	2/1/1935	4	0
Superintendent of Insurance	George H. Thigpen	10/1/1927	2/1/1931	3	4
Superintendent of Insurance	Frank N. Julian* (Died Nov. 30, 1944)	9/30/1923	10/1/1927	4	0
Commissioner of Insurance	Frank N. Julian* (Died Nov. 30, 1944)	3/1/1923	9/30/1923	0	7
Commissioner of Insurance	Russell B. Coleman	11/2/1922	3/1/1923	0	4
Commissioner of Insurance	Albert Walter Briscoe	10/1/1919	11/2/1922	3	1
Commissioner of Insurance	Leonard Y. Dean	7/1/1919	10/1/1919	0	3
Commissioner of Insurance	C. Brooks Smith	10/1/1915	7/1/1919	3	9
Secretary of State	John Purifoy	1/19/1915	10/1/1915	0	9

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NAIC MEMBER TENURE LIST

STATE/MEMBER TITLE	MEMBER NAME	BEG. DATE	END DATE	YRS. SERVED	MOS. SERVED
ALABAMA—Continued					
Secretary of State	Cyrus B. Brown	10/5/1910	1/19/1915	4	3
Secretary of State	Frank N. Julian* (Died Nov. 30, 1944)	1/14/1907	10/5/1910	3	10
Secretary of State	Edmund R. 'Ned' McDavid	5/1/1904	1/14/1907	2	8
Secretary of State	J. Thomas Heflin	1/22/1903	5/1/1904	1	4
Secretary of State	Robert P. McDavid	12/1/1898	1/22/1903	4	1
Secretary of State	James K. Jackson	2/18/1897	12/1/1898	1	10
State Auditor	Walter S. White	12/1/1896	2/18/1897	0	2
State Auditor	John Purifoy	6/5/1892	12/1/1896	3	3
State Auditor	Cyrus D. Hogue (Died June 4, 1892)	12/1/1888	6/4/1892	3	6
State Auditor	Malcolm C. Burke	11/3/1884	11/30/1888	4	0
State Auditor	Jesse M. Carmichael	11/9/1880	11/2/1884	4	0
State Auditor	Willis Brewer	11/25/1876	11/9/1880	4	0
State Auditor	Robert T. Smith	11/26/1872	11/25/1876	4	0
State Auditor	Robert M. Reynolds	5/24/1871	11/25/1872	0	6

ALASKA—Appointed, at the pleasure of the Commissioner of Commerce, Community, and Economic Development					
Insurance Director	Lori K. Wing-Heier	2/25/2014		incumbent	
Acting Insurance Director	Marty Hester	12/20/2013	2/25/2014	0	2
Insurance Director	Bret S. Kolb	5/30/2012	11/30/2013	1	6
Insurance Director	Linda S. Hall	3/3/2003	5/29/2012	9	2
Acting Insurance Director	Stan Ridgeway	1/1/2003	3/3/2003	0	2
Insurance Director	Robert A. 'Bob' Lohr	8/11/1999	1/1/2003	3	5
Insurance Director	John Ference	7/1/1999	8/11/1999	0	1
Insurance Director	Marianne K. Burke	3/1/1995	7/1/1999	4	4
Acting Insurance Director	Thelma Walker	1/1/1995	3/1/1995	0	2
Insurance Director	David J. Walsh*	2/15/1990	1/1/1995	4	11
Acting Insurance Director	Dick Monkman	2/1/1990	2/15/1990	0	1
Acting Insurance Director	James Jordan	9/1/1989	2/1/1990	0	5
Insurance Director	Paul Roller	4/1/1988	9/1/1989	1	5
Insurance Director	John George	11/1/1984	4/1/1988	3	5
Acting Insurance Director	John George	7/1/1984	11/1/1984	0	4
Insurance Director	Kenneth C. Moore	2/28/1979	7/1/1984	5	5
Insurance Director	Richard L. 'Dick' Block	12/7/1975	2/1/1979	3	2
Insurance Director	John J. O'Shea	6/4/1973	6/8/1975	2	0
Insurance Director	Cloyce A. 'Red' Drake	7/1/1971	12/3/1972	1	5
Insurance Director	William W. 'Bill' Fritz	1/1/1967	6/14/1971	4	5
Insurance Director	A. W. Lingle	3/1/1964	12/4/1966	2	9
Director of Insurance	Joseph B. Loonam	6/18/1962	3/1/1964	1	9
Director of Insurance	William M. Scott	5/30/1960	5/29/1962	2	0
Insurance Commissioner	Ross P. Duncan	11/1/1955	12/22/1959	4	1
Insurance Commissioner	Neil Moore	12/4/1950	5/1/1955	4	5
Auditor of Territory	Frank A. Boyle (Died Dec. 15, 1950)	4/1/1933	12/4/1950	17	8
Auditor of Territory	Cash Cole	12/16/1929	4/1/1933	3	4
Secretary of Territory	Karl Theile	7/22/1921	12/16/1929	8	5
Secretary of Territory	Robert J. Sommers	9/25/1919	7/22/1921	1	10
Secretary of Territory	Charles E. 'Chas' Davidson (Died Aug. 8, 1919)	10/18/1913	8/8/1919	5	10

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NAIC MEMBER TENURE LIST

STATE/MEMBER TITLE	MEMBER NAME	BEG. DATE	END DATE	YRS. SERVED	MOS. SERVED
ALASKA—Continued					
Surveyor-General/Secretary	William L. Distin	8/7/1897	10/18/1913	16	2
AMERICAN SAMOA—Appointed, at the pleasure of the Governor					
Insurance Commissioner	Peni 'Ben' Itula Sapini Teo	2/15/2022		incumbent	
Acting Insurance Commissioner	Elizabeth S. Perri	8/5/2021	2/14/2022	0	6
Insurance Commissioner	Peni 'Ben' Itula Sapini Teo	1/3/2021	8/4/2021	0	7
Acting Insurance Commissioner	Elizabeth S. Perri	10/23/2019	1/3/2021	1	3
Insurance Commissioner	Peteru M. 'Peter' Fuimaono	2/12/2019	10/23/2019	0	8
Acting Insurance Commissioner	Elizabeth S. Perri	7/26/2018	2/12/2019	0	7
Insurance Commissioner	Peteru M. 'Peter' Fuimaono	1/16/2017	7/26/2018	1	6
Insurance Commissioner	Tau Fati Tanuvasa	11/25/2013	1/16/2017	3	2
Insurance Commissioner	<i>Position Vacant</i>	2/1/2013	11/25/2013	0	9
Insurance Commissioner	Aomaloo Manupo Turituri	4/28/2010	1/31/2013	2	9
Insurance Commissioner	Fiaigoa A. Paogofie	2/3/2009	4/28/2010	1	2
Insurance Commissioner	Laloulu Tagoilelagi	1/15/2008	2/3/2009	2	1
Insurance Commissioner	Elisara T. Togia	6/2/1997	12/2/2007	10	6
Insurance Commissioner	Tauivi Tuinei	1/1/1997	6/2/1997	0	5
Acting Insurance Commissioner	Tafaoata Gaoteote	12/1/1996	1/1/1997	0	1
Insurance Commissioner	Albert Atuatasi	7/1/1996	12/1/1996	0	5
Insurance Commissioner	Moetulu'i T. Iuvale	1/1/1996	7/1/1996	0	6
Insurance Commissioner	Tauivi Tuinei	2/12/1995	1/1/1996	0	11
Insurance Commissioner	Moetulu'i T. Iuvale	3/7/1993	2/12/1995	2	1
Insurance Commissioner	Fanene Su'a Scanlan	6/4/1989	1/1/1993	3	7
Insurance Commissioner	Afa Roberts	6/9/1985	12/11/1988	3	6
Insurance Commissioner	John W. von Cramm	12/4/1983	12/9/1984	1	0
Acting Insurance Commissioner	Lyle L. Richmond	11/28/1982	12/4/1983	1	1
Insurance Commissioner	Patricia G. Trammel	6/15/1980	11/28/1982	2	5
ARIZONA—Appointed, at the pleasure of the Governor, with the consent of the Arizona State Senate					
Director, Department of Insurance & Financial Institutions (DIFI)	Barbara D. Richardson	3/6/2023		incumbent	
Acting Director, DIFI	Shane W. Foster	1/13/2023	3/5/2023	0	2
Director, DIFI	<i>Position Vacant</i>	1/7/2023	1/12/2023	0	1
Director, DIFI	Evan G. Daniels	7/18/2020	1/6/2023	2	6
Interim Insurance Director	Christina Corieri	2/15/2020	7/17/2020	0	5
Insurance Director	Keith A. Schraad	12/14/2018	2/14/2020	1	2
Interim Insurance Director	Keith A. Schraad	2/12/2018	12/14/2018	0	10
Acting Insurance Director	Robert D. Charlton	1/29/2018	2/11/2018	0	1
Interim Insurance Director	Leslie R. Hess	2/8/2016	1/26/2018	1	11
Insurance Director	Andrew M. Tobin	10/12/2015	2/1/2016	0	4
Interim Insurance Director	Darren T. Ellingson	8/17/2015	10/11/2015	0	2
Insurance Director	Germaine L. 'Gerrie' Marks	11/27/2012	8/15/2015	2	9
Acting Insurance Director	Germaine L. 'Gerrie' Marks	6/30/2012	11/27/2012	0	5
Insurance Director	Christina Urias	11/3/2003	6/30/2012	8	7
Insurance Director	Charles R. 'Chuck' Cohen	10/10/1998	10/31/2003	5	0
Acting Insurance Director	Charles R. 'Chuck' Cohen	9/16/1998	10/10/1998	0	1
Insurance Director	John A. Greene	1/16/1997	9/16/1998	1	8
Acting Insurance Director	John King	8/1/1996	1/15/1997	0	5
Insurance Director	Chris Herstam	1/1/1994	8/1/1996	2	7
Insurance Director	Susan Gallinger	5/1/1988	12/31/1993	5	7

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NAIC MEMBER TENURE LIST

STATE/MEMBER TITLE	MEMBER NAME	BEG. DATE	END DATE	YRS. SERVED	MOS. SERVED
ARIZONA—Continued					
Acting Insurance Director	Vern R. Pierson	10/1/1987	5/1/1988	0	7
Insurance Director	S. David Childers	6/18/1984	9/30/1987	3	3
Insurance Director	J. Michael Low	1/1/1980	6/18/1984	4	5
Insurance Director	John N. 'Jack' Trimble	1/1/1976	1/1/1980	4	0
Insurance Director	Thomas Millard Humphrey	1/29/1969	12/31/1975	6	11
Insurance Director	Jerry P. Shea	2/1/1968	1/28/1969	1	0
Acting Insurance Director	George A. Livermore	10/28/1967	1/31/1968	0	3
Insurance Director	George A. Bushnell	12/12/1951	10/27/1967	15	10
Insurance Director	Roy B. Rummage (Died Dec. 1, 1951)	1/5/1937	12/1/1951	14	11
Insurance Director	George A. Brown	6/1/1933	1/4/1937	3	7
Insurance Director	Glenn D. Grant	9/17/1929	6/1/1933	3	9
Chair, Corporation Commission	Amos A. Betts	6/27/1921	9/17/1929	8	3
Chair, Corporation Commission	Forest A. Jones	9/1/1917	9/1/1920	3	0
Superintendent of Insurance	Cleveland C. Thompson	9/21/1915	8/28/1917	1	11
Chair, Corporation Commission	William P. Geary	7/29/1913	9/21/1915	2	2
ARKANSAS—Appointed, at the pleasure of the Governor, with the advice and consent of the Senate					
Insurance Commissioner	Alan McClain	4/3/2020		incumbent	
Insurance Commissioner	Allen W. Kerr	1/13/2015	3/27/2020	5	2
Insurance Commissioner	Jay Bradford	1/15/2009	1/13/2015	6	0
Interim Insurance Commissioner	Lenita Blasingame	1/1/2009	1/15/2009	0	1
Insurance Commissioner	Julie Benafield Bowman	1/15/2005	12/31/2008	3	11
Insurance Commissioner	J. Michael 'Mike' Pickens*	1/15/1997	1/15/2005	8	0
Insurance Commissioner	Lee Douglass*	12/14/1990	1/15/1997	6	1
Insurance Commissioner	Ron Taylor III	12/23/1988	12/14/1990	2	0
Insurance Commissioner	Robert M. 'Bob' Eubanks III	1/21/1985	12/23/1988	3	11
Insurance Commissioner	Linda N. Garner	1/3/1983	1/21/1985	2	0
Insurance Commissioner	William H. L. Woodyard III*	7/2/1976	12/31/1982	6	6
Insurance Commissioner	Ark Monroe III	10/2/1972	7/2/1976	3	9
Insurance Commissioner	A. Gene Sykes	9/16/1970	10/2/1972	2	1
Acting Insurance Commissioner	Ernest J. W. 'Ernie' Fennell	6/15/1970	9/16/1970	0	3
Insurance Commissioner	Allan W. 'Dick' Horne	2/21/1968	6/15/1970	2	4
Insurance Commissioner	John Norman Harkey	1/30/1967	2/21/1968	1	1
Insurance Commissioner	Harvey G. Combs	4/15/1953	1/30/1967	13	9
Insurance Commissioner	Usco A. Gentry	1/15/1953	4/15/1953	0	3
Insurance Commissioner	J. Herbert Graves	1/11/1949	1/15/1953	4	0
Insurance Commissioner	Jack G. McKenzie	1/15/1945	1/11/1949	4	0
Insurance Commissioner	J. Herbert Graves	1/14/1941	1/15/1945	4	0
Insurance Commissioner	M. J. Harrison	1/15/1937	1/14/1941	4	0
Ins. Cmsr. and State Fire Marshal	Usco A. Gentry	3/4/1933	1/15/1937	3	10
Ins. Cmsr. and State Fire Marshal	Arlander D. DuLaney	3/4/1931	3/4/1933	2	0
Ins. Cmsr. and State Fire Marshal	William E. Floyd	5/23/1929	3/4/1931	1	10
Ins. Cmsr. and State Fire Marshal	John S. Maloney (Died May 22, 1929)	3/8/1927	5/22/1929	2	2
Cmsr. of Insurance and Revenue	J. Frank Beasley	2/8/1927	3/8/1927	0	1
Cmsr. of Insurance and Revenue	William E. Floyd	6/11/1925	2/8/1927	1	8
Acting Cmsr. of Ins. and Revenue	J. W. Hatley	5/15/1925	6/11/1925	0	1
Insurance Commissioner	M. J. Harrison	1/12/1925	5/15/1925	0	5
Insurance Commissioner	Bruce T. Bullion	3/7/1917	12/31/1924	7	9

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NAIC MEMBER TENURE LIST

STATE/MEMBER TITLE	MEMBER NAME	BEG. DATE	END DATE	YRS. SERVED	MOS. SERVED
ARKANSAS—Continued					
State Auditor/Ins. Commissioner	Hogan Oliver	1/10/1917	3/7/1917	0	2
State Auditor/Ins. Commissioner	M. F. Dickinson	3/5/1915	1/10/1917	2	10
State Auditor/Ins. Commissioner	Lafayette L. Coffman	6/23/1913	3/4/1915	1	9
State Auditor/Ins. Commissioner	John M. Oathout (Died June 20, 1913)	1/17/1913	6/20/1913	0	5
State Auditor/Ins. Commissioner	John R. Jobe	1/14/1909	1/17/1913	4	0
State Auditor/Ins. Commissioner	Avery E. Moore	1/12/1905	1/14/1909	4	0
State Auditor/Ins. Commissioner	Thomas C. Monroe	1/18/1901	1/12/1905	4	0
State Auditor/Ins. Commissioner	Clay Sloan	1/15/1897	1/18/1901	4	0
State Auditor/Ins. Commissioner	Charles B. Mills	1/14/1893	1/15/1897	4	0
State Auditor/Ins. Commissioner	William S. Dunlop	11/30/1887	1/14/1893	5	2
State Auditor/Ins. Commissioner	William R. Miller (Died Nov. 29, 1887)	1/14/1887	11/29/1887	0	10
State Auditor/Ins. Commissioner	A.W. Files	1/11/1883	1/14/1887	4	0
State Auditor/Ins. Commissioner	John Crawford	1/11/1877	1/11/1883	6	0
State Auditor/Ins. Commissioner	William R. Miller	11/12/1874	1/11/1877	2	2
Insurance Commissioner	Lucien J. Barnes	4/29/1873	11/12/1874	1	6
State Auditor	Stephen Wheeler	1/6/1873	4/29/1873	0	3
State Auditor	James R. Berry	5/24/1871	1/6/1873	1	8

CALIFORNIA—Elected; 4-year term (not to exceed two 4-year terms)					
Insurance Commissioner	Ricardo Lara (Elected Nov. 6, 2018; Re-elected Nov. 8, 2022)	1/7/2019		incumbent	
Insurance Commissioner	David E. 'Dave' Jones (Elected Nov. 2, 2010; Re-elected Nov. 4, 2014)	1/3/2011	1/6/2019	8	0
Insurance Commissioner	Steve Poizner	1/8/2007	1/3/2011	4	0
Insurance Commissioner	John R. Garamendi	1/6/2003	1/8/2007	4	0
Insurance Commissioner	Harry W. Low	9/18/2000	1/6/2003	2	4
Acting Insurance Commissioner	J. Clark Kelso	7/10/2000	9/18/2000	0	2
Insurance Commissioner	Charles 'Chuck' Quackenbush	1/2/1995	7/10/2000	5	6
Insurance Commissioner	John R. Garamendi	1/7/1991	1/2/1995	4	0
Insurance Commissioner	Roxani M. Gillespie	1/5/1987	12/31/1990	4	0
Insurance Commissioner	Bruce A. Bunner	3/21/1983	7/1/1986	3	4
Insurance Commissioner	Robert C. Quinn	1/1/1981	3/21/1983	2	2
Insurance Commissioner	Wesley J. Kinder*	3/1/1975	1/1/1981	5	10
Insurance Commissioner	Gleeson L. 'Tige' Payne	11/1/1972	3/1/1975	2	4
Insurance Commissioner	Richards D. 'Dick' Barger*	8/21/1968	11/1/1972	4	3
Insurance Commissioner	Richard S. L. Roddis	1/20/1966	1/1/1969	3	0
Insurance Commissioner	Stafford R. Grady	1/1/1964	1/1/1966	2	0
Insurance Commissioner	F. Britton McConnell	1/1/1955	1/1/1964	9	0
Insurance Commissioner	John R. Maloney	1/1/1951	1/1/1955	4	0
Insurance Commissioner	Wallace K. Downey	2/1/1947	1/1/1951	3	11
Insurance Commissioner	Maynard Garrison	10/1/1943	2/1/1947	3	4
Insurance Commissioner	Anthony J. Caminetti, Jr.	6/28/1939	10/1/1943	4	4
Insurance Commissioner	Rex B. Goodcell	7/15/1938	6/28/1939	0	11
Insurance Commissioner	Samuel L. Carpenter, Jr.	4/4/1935	7/15/1938	3	3
Insurance Commissioner	E. Forrest Mitchell	4/24/1929	4/4/1935	6	0
Insurance Commissioner	Charles R. 'Charlie' Detrick*	1/13/1925	4/24/1929	4	3

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NAIC MEMBER TENURE LIST

STATE/MEMBER TITLE	MEMBER NAME	BEG. DATE	END DATE	YRS. SERVED	MOS. SERVED
CALIFORNIA—Continued					
Insurance Commissioner	George D. Squires	3/22/1923	1/13/1925	1	10
Acting Insurance Commissioner	Edward C. Cooper	1/1/1923	3/22/1923	0	2
Insurance Commissioner	Alexander L. McCabe	3/15/1917	1/1/1923	5	10
Insurance Commissioner	Joseph E. Phelps	7/1/1914	3/15/1917	2	8
Insurance Commissioner	Edward C. Cooper	6/16/1910	7/1/1914	4	1
Insurance Commissioner	E. Myron Wolf	4/8/1902	4/8/1910	8	0
Insurance Commissioner	Andrew J. Clunie	3/15/1897	4/8/1902	5	1
Insurance Commissioner	M. R. Higgins	4/8/1894	3/15/1897	2	11
Insurance Commissioner	J. N. E. Wilson	4/8/1890	4/8/1894	4	0
Insurance Commissioner	J. C. L. Wadsworth	4/19/1886	4/8/1890	4	0
Insurance Commissioner	George A. Knight	4/8/1882	4/19/1886	4	0
Insurance Commissioner	J. C. Maynard	4/8/1878	4/8/1882	4	0
Insurance Commissioner	John W. Foard	4/1/1872	4/8/1878	6	0
Insurance Commissioner	George W. Mowe	5/24/1871	4/1/1872	0	11

COLORADO—Appointed, at the pleasure of the Governor; subject to confirmation by the Senate					
Insurance Commissioner	Michael Conway	1/22/2019		incumbent	
Interim Insurance Commissioner	Michael Conway	1/1/2018	1/21/2019	1	0
Insurance Commissioner	Marguerite Salazar	8/19/2013	12/31/2017	4	4
Interim Insurance Commissioner	Doug Dean	7/8/2013	8/14/2013	0	1
Insurance Commissioner	James L. 'Jim' Riesberg	7/1/2011	7/8/2013	2	0
Interim Insurance Commissioner	John J. Postolowski	12/1/2010	7/1/2011	0	7
Insurance Commissioner	Marcy Morrison	1/9/2007	12/1/2010	3	11
Insurance Commissioner	David Rivera	4/20/2005	1/9/2007	1	9
Insurance Commissioner	Doug Dean	1/7/2003	4/20/2005	2	3
Acting Insurance Commissioner	M. Michael Cooke	8/9/2002	1/7/2003	0	5
Insurance Commissioner	William J. Kirven III	2/26/1999	8/9/2002	3	6
Insurance Commissioner	John B. 'Jack' Ehnes	2/11/1994	2/26/1999	5	0
Insurance Commissioner	<i>Position Vacant</i>	1/1/1994	1/31/1994	0	1
Insurance Commissioner	Joanne Hill	10/1/1989	12/31/1993	4	2
Acting Insurance Commissioner	Bruce Smith	7/1/1989	10/1/1989	0	3
Insurance Commissioner	John Kezer	2/5/1985	7/1/1989	4	5
Acting Insurance Commissioner	D. Colaiannia	2/1/1984	2/5/1985	1	0
Insurance Commissioner	J. Richard Barnes	3/23/1964	1/31/1984	19	10
Insurance Commissioner	Sam N. Beery*	1/1/1955	3/1/1964	9	2
Insurance Commissioner	Luke J. Kavanaugh	4/22/1939	12/31/1954	15	8
Insurance Commissioner	Jackson Cochrane	11/1/1921	4/22/1939	17	5
Insurance Commissioner	Earl Wilson	11/5/1920	10/15/1921	0	11
Insurance Commissioner	Claude W. Fairchild*	3/24/1917	11/5/1920	3	8
Acting Insurance Commissioner	Mrs. D. M. Rolph	1/23/1917	3/24/1917	0	2
Insurance Commissioner	Erastus R. Harper	6/14/1915	1/22/1917	1	7
Acting Insurance Commissioner	Mrs. D. M. Rolph	1/16/1915	6/14/1915	0	5
Insurance Commissioner	Saul Epstein	5/10/1913	1/16/1915	1	8
Insurance Commissioner	William L. Clayton	1/31/1909	5/10/1913	4	4
Insurance Commissioner	Elmer E. Rittenhouse	7/1/1907	1/31/1909	1	6
Superintendent of Insurance	Alfred E. Bent	6/1/1905	6/30/1907	2	0
Superintendent of Insurance	John A. Holmberg	6/1/1903	6/1/1905	2	0
Superintendent of Insurance	Charles W. Crouter	6/1/1901	6/1/1903	2	0
Superintendent of Insurance	George W. Temple	6/1/1899	6/1/1901	2	0
Superintendent of Insurance	John M. Lowell	6/1/1897	6/1/1899	2	0

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NAIC MEMBER TENURE LIST

STATE/MEMBER TITLE	MEMBER NAME	BEG. DATE	END DATE	YRS. SERVED	MOS. SERVED
COLORADO—Continued					
Superintendent of Insurance	Clifford C. Parks	6/1/1895	6/1/1897	2	0
Superintendent of Insurance	F. M. Goodykoontz	6/1/1893	6/1/1895	2	0
Superintendent of Insurance	John M. Henderson	6/1/1891	6/1/1893	2	0
Auditor of State	Louis B. Schwanbeck	9/1/1889	6/1/1891	1	9
Auditor of State	Darwin P. Kingsley	9/1/1887	9/1/1889	2	0
Superintendent of Insurance	Hiram A. Spruance	9/1/1885	9/1/1887	2	0
Superintendent of Insurance	John C. Abbott	4/1/1883	9/1/1885	2	5
CONNECTICUT—Appointed, at the pleasure of the Governor with the advice and consent of either house of the General Assembly; 4-year term					
Insurance Commissioner	Andrew N. 'Andy' Mais (Reappointed Jan. 4, 2023)	3/4/2019		incumbent	
Acting Insurance Commissioner	Paul Lombardo	12/20/2018	3/1/2019	0	3
Insurance Commissioner	Katharine L. 'Katie' Wade	3/24/2015	12/19/2018	3	9
Acting Insurance Commissioner	Anne Melissa Dowling	12/11/2014	3/24/2015	0	3
Insurance Commissioner	Thomas B. Leonard	2/4/2011	12/11/2014	3	10
Acting Insurance Commissioner	Barbara C. Spear	11/12/2010	2/4/2011	0	3
Insurance Commissioner	Thomas R. Sullivan	4/1/2007	11/12/2010	3	7
Insurance Commissioner	Susan F. Cogswell	6/22/2000	4/1/2007	6	10
Acting Insurance Commissioner	William J. Gilligan	5/8/2000	6/22/2000	0	1
Insurance Commissioner	George M. Reider Jr.*	5/1/1995	5/5/2000	5	0
Acting Insurance Commissioner	William J. Gilligan	6/1/1994	5/1/1995	0	11
Insurance Commissioner	Robert R. Googins	3/1/1991	6/1/1994	3	3
Acting Insurance Commissioner	Robert R. Googins	2/1/1991	3/1/1991	0	1
Insurance Commissioner	Peter F. Kelly	8/17/1988	2/1/1991	2	6
Acting Insurance Commissioner	William J. Gilligan	7/1/1988	8/1/1988	0	1
Insurance Commissioner	Peter W. Gillies	1/5/1983	7/1/1988	5	6
Insurance Commissioner	Joseph C. Mike	6/1/1977	1/1/1983	5	7
Insurance Commissioner	T. F. Gilroy Daly	6/1/1976	6/1/1977	1	0
Insurance Commissioner	Jay W. Jackson	6/1/1975	6/1/1976	1	0
Insurance Commissioner	Thomas C. White	6/1/1973	6/1/1975	2	0
Insurance Commissioner	Paul B. Altermatt	6/1/1971	6/1/1973	2	0
Insurance Commissioner	Robert F. Claffey	1/1/1971	6/1/1971	0	5
Insurance Commissioner	William R. Cotter	7/1/1966	12/31/1970	4	5
Acting Insurance Commissioner	James G. McCabe	6/1/1966	7/1/1966	0	1
Insurance Commissioner	William R. Cotter	5/4/1964	6/1/1966	2	1
Insurance Commissioner	Alfred N. Premo	6/1/1958	5/4/1964	5	11
Insurance Commissioner	Thomas J. Spellacy	6/1/1955	6/1/1958	3	0
Insurance Commissioner	W. Ellery Allyn*	7/1/1943	6/1/1955	11	11
Insurance Commissioner	John C. Blackall*	7/1/1935	7/1/1943	8	0
Insurance Commissioner	Howard P. Dunham	7/1/1923	7/1/1935	12	0
Insurance Commissioner	Burton Mansfield*	7/1/1911	7/1/1923	12	0
Insurance Commissioner	Theodore H. Macdonald	7/1/1907	7/1/1911	4	0
Insurance Commissioner	Theron Upson	6/1/1902	7/1/1907	5	1
Insurance Commissioner	Edwin L. Scofield	7/1/1899	6/1/1902	2	11
Insurance Commissioner	Frederick A. Betts	7/1/1895	7/1/1899	4	0
Insurance Commissioner	Burton Mansfield*	4/11/1893	7/1/1895	2	3
Acting Insurance Commissioner	John S. Seymour	3/3/1893	4/11/1893	0	1
Insurance Commissioner	Orsamus R. Fyler*	7/1/1886	3/3/1893	6	8
Insurance Commissioner	Ephraim Williams	7/1/1883	7/1/1886	3	0

* NAIC Past President. This person served as NAIC President one or more times during their term(s) of office.

NAIC MEMBER TENURE LIST

STATE/MEMBER TITLE	MEMBER NAME	BEG. DATE	END DATE	YRS. SERVED	MOS. SERVED
CONNECTICUT—Continued					
Insurance Commissioner	John W. Brooks	7/27/1880	7/1/1883	3	0
Insurance Commissioner	John W. Steadman	7/27/1874	7/27/1880	6	0
Insurance Commissioner	George S. Miller	7/27/1871	7/27/1874	3	0
Insurance Commissioner	Benjamin Noyes	5/24/1871	7/27/1871	0	2
DELAWARE—Elected; 4-Year Term					
Insurance Commissioner	Trinidad Navarro <i>(Elected Nov. 8, 2016; Re-elected Nov. 3, 2020)</i>	1/3/2017		incumbent	
Insurance Commissioner	Karen Weldin Stewart	1/6/2009	1/3/2017	8	0
Insurance Commissioner	Matthew Denn	1/4/2005	1/6/2009	4	0
Insurance Commissioner	Donna Lee Williams	1/1/1993	1/4/2005	12	0
Insurance Commissioner	David N. Levinson	1/1/1985	1/1/1993	8	0
Insurance Commissioner	David H. Elliot	1/4/1977	1/1/1985	8	0
Insurance Commissioner	John F. Richardson	4/1/1976	1/4/1977	0	9
Insurance Commissioner	Robert A. Short	1/1/1963	4/1/1976	13	3
Insurance Commissioner	Harry S. Smith	1/1/1955	1/1/1963	8	0
Insurance Commissioner	William R. Murphy	1/1/1951	1/1/1955	4	0
Insurance Commissioner	William J. Swain	1/1/1939	1/1/1951	12	0
Insurance Commissioner	J. Postles Hammond	1/1/1935	1/1/1939	4	0
Insurance Commissioner	James G. Shaw	1/1/1927	1/1/1935	8	0
Insurance Commissioner	Charles M. Hollis	1/1/1923	1/1/1927	4	0
Insurance Commissioner	William J. Swain	7/24/1922	1/1/1923	0	6
Insurance Commissioner	Horace Sudler <i>(Died July 24, 1922)</i>	1/1/1921	7/24/1922	1	6
Insurance Commissioner	Thomas R. Wilson	1/1/1917	1/1/1921	4	0
Insurance Commissioner	William R. McCabe	1/1/1913	1/1/1917	4	0
Insurance Commissioner	Charles H. Maull	1/5/1909	1/1/1913	4	0
Insurance Commissioner	George W. Marshall	1/1/1901	1/5/1909	8	0
Insurance Commissioner	Edward D. Fowler	3/23/1897	1/1/1901	3	10
Insurance Commissioner	Peter K. Meredith	3/22/1893	3/23/1897	4	0
Insurance Commissioner	Isaac N. Fooks	3/23/1889	3/22/1893	4	0
Insurance Commissioner	Nathan Pratt	3/21/1885	3/23/1889	4	0
Insurance Commissioner	Henry C. Douglass <i>(Died Feb. 27, 1885)</i>	4/21/1883	2/27/1885	1	10
Insurance Commissioner	John R. McFee	4/21/1879	4/21/1883	4	0
Secretary of State	Ignatius C. Grubb	1/18/1875	4/21/1879	4	3
Secretary of State	John H. Paynter	5/24/1871	1/18/1875	3	8
DISTRICT OF COLUMBIA—Appointed, at the pleasure of the Mayor; confirmed by the Council of District Columbia					
Commissioner, Dept. of Insurance, Securities & Banking (DISB)	Karima M. Woods	7/28/2020		incumbent	
Acting Commissioner, DISB	Karima M. Woods	1/21/2020	7/28/2020	0	6
Commissioner, DISB	Stephen C. Taylor	11/3/2015	1/20/2020	4	2
Acting Commissioner, DISB	Stephen C. Taylor	6/19/2015	11/3/2015	0	5
Acting Commissioner, DISB	Chester A. McPherson	4/20/2014	6/19/2015	1	2
Interim Commissioner, DISB	Chester A. McPherson	11/15/2013	4/20/2014	0	5
Commissioner, DISB	William P. White	6/7/2011	11/15/2013	2	5
Acting Commissioner, DISB	William P. White	2/14/2011	6/7/2011	0	4
Commissioner, DISB	Gennet Purcell	11/3/2009	2/14/2011	1	3

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NAIC MEMBER TENURE LIST

STATE/MEMBER TITLE	MEMBER NAME	BEG. DATE	END DATE	YRS. SERVED	MOS. SERVED
DISTRICT OF COLUMBIA—Continued					
Acting Commissioner, DISB	Gennet Purcell	9/2/2009	11/3/2009	0	2
Commissioner, DISB	Thomas E. Hampton	5/9/2006	8/28/2009	3	3
Acting Commissioner, DISB	Thomas E. Hampton	10/1/2005	5/9/2006	0	7
Commissioner, DISB	Lawrence H. 'Larry' Mirel	3/1/2004	9/30/2005	1	7
Commissioner of Ins. & Securities	Lawrence H. 'Larry' Mirel	10/5/1999	3/1/2004	4	5
Acting Cmsr. of Ins. & Securities	Lawrence H. 'Larry' Mirel	7/6/1999	10/5/1999	0	3
Acting Cmsr. of Ins. & Securities	Reginald Berry	1/4/1999	7/12/1999	0	6
Commissioner of Ins. & Securities	Patrick E. Kelly	7/21/1998	1/4/1999	0	6
Interim Cmsr. of Ins. & Securities	Patrick E. Kelly	7/22/1997	7/21/1998	1	0
Interim Commissioner of Insurance	Patrick E. Kelly	1/1/1995	7/22/1997	2	6
Commissioner of Insurance	Robert M. Willis (Died Oct. 21, 2020)	8/12/1991	1/1/1995	3	5
Acting Commissioner of Insurance	Patrick E. Kelly	4/1/1991	8/12/1991	0	4
Commissioner of Insurance	Margurite Stokes	4/1/1983	4/1/1991	8	0
Acting Superintendent of Insurance	James R. Montgomery III	11/8/1978	4/1/1983	3	10
Superintendent of Insurance	Maximilian 'Max' Wallach (Died Nov. 7, 1978)	11/24/1973	11/7/1978	4	10
Acting Superintendent of Insurance	Maximilian 'Max' Wallach (Died Nov. 7, 1978)	9/16/1973	11/24/1973	0	2
Superintendent of Insurance	Edward P. Lombard	3/1/1970	9/14/1973	3	6
Acting Superintendent of Insurance	Edward P. Lombard	1/24/1970	3/1/1970	0	2
Superintendent of Insurance	Albert F. Jordan	8/1/1939	1/23/1970	30	5
Superintendent of Insurance	J. Balch Moor (Died July 22, 1939)	3/23/1936	7/22/1939	3	4
Superintendent of Insurance	John A. Marshall	2/19/1934	3/23/1936	2	1
Superintendent of Insurance	Herbert L. Davis	5/1/1931	2/19/1934	2	9
Acting Superintendent of Insurance	Frank B. Bryan, Jr.	4/28/1931	5/1/1931	0	1
Superintendent of Insurance	Thomas M. Baldwin, Jr.	9/16/1924	4/28/1931	7	1
Acting Superintendent of Insurance	Thomas M. Baldwin, Jr.	3/29/1924	9/16/1924	0	6
Superintendent of Insurance	Burt A. Miller	6/22/1922	3/28/1924	1	9
Superintendent of Insurance	Lewis A. Griffith	6/4/1919	6/22/1922	3	0
Superintendent of Insurance	Lee B. Mosher	11/14/1917	5/7/1919	1	6
Acting Superintendent of Insurance	Charles C. Wright	10/22/1917	11/14/1917	0	1
Superintendent of Insurance	Charles F. Nesbit	1/10/1914	10/22/1917	3	9
Superintendent of Insurance	George W. Ingham	11/17/1910	12/22/1913	3	1
Acting Superintendent of Insurance	Daniel E. Curry	7/23/1910	11/17/1910	0	4
Superintendent of Insurance	Thomas E. Drake (Died July 23, 1910)	1/1/1902	7/23/1910	8	6
Assessor of the District	Hopewell H. Darnelle	12/1/1899	12/31/1901	1	1
Assessor of the District	Matthew Trimble	3/16/1890	12/1/1899	9	9
Assessor of the District	Roger Williams	3/19/1889	3/16/1890	1	0
Assessor of the District	Roswell A. Fish	5/23/1887	3/19/1889	1	10
Treasurer and Assessor	Robert P. Dodge (Died May 21, 1887)	7/11/1876	5/21/1887	10	10
Treasurer of the District	James S. Wilson	12/1/1873	7/11/1876	2	8
Treasurer of the District	John T. Johnson	10/18/1871	11/29/1873	2	1

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NAIC MEMBER TENURE LIST

STATE/MEMBER TITLE	MEMBER NAME	BEG. DATE	END DATE	YRS. SERVED	MOS. SERVED
FLORIDA—Appointed, at the Pleasure of the Financial Services Commission					
Insurance Commissioner	Michael Yaworsky	3/13/2023		incumbent	
Interim Insurance Commissioner	Michael Yaworsky	2/10/2023	2/13/2023	0	1
Insurance Commissioner	<i>Position Vacant</i>	12/29/2022	2/9/2023	0	2
Insurance Commissioner	David Altmaier*	4/29/2016	12/28/2022	6	8
Insurance Commissioner	Kevin M. McCarty*	1/9/2003	4/29/2016	13	0
State Treasurer/Ins. Commissioner	C. Thomas 'Tom' Gallagher	1/3/2001	1/3/2003	2	0
State Treasurer/Ins. Commissioner	C. William 'Bill' Nelson	1/3/1995	1/3/2001	6	0
State Treasurer/Ins. Commissioner	C. Thomas 'Tom' Gallagher	1/3/1989	1/3/1995	6	0
State Treasurer/Ins. Commissioner	William D. 'Bill' Gunter*	11/9/1976	1/3/1989	12	2
State Treasurer/Ins. Commissioner	Philip F. Ashler	6/3/1975	11/9/1976	1	5
State Treasurer/Ins. Commissioner	Thomas D. O'Malley	1/5/1971	6/3/1975	4	5
State Treasurer/Ins. Commissioner	Broward Williams	1/25/1965	1/5/1971	5	11
State Treasurer/Ins. Commissioner	J. Edwin Larson* (Died Jan. 24, 1965)	1/7/1941	1/24/1965	24	0
State Treasurer/Ins. Commissioner	William V. Knott	9/28/1928	1/7/1941	12	3
State Treasurer/Ins. Commissioner	John C. Luning* (Died Sept. 26, 1928)	2/19/1912	9/26/1928	16	7
State Treasurer	William V. Knott	3/1/1903	2/19/1912	8	11
State Treasurer	James B. Whitfield	6/19/1897	3/1/1903	5	9
State Treasurer	Clarence B. Collins	1/3/1893	6/19/1897	4	5
State Treasurer	Eduardo J. Triay	12/31/1891	1/3/1893	2	0
State Treasurer	Francis J. Pons (Died Dec. 24, 1891)	1/8/1889	12/24/1891	2	11
State Treasurer	Edward S. Crill	2/19/1885	1/8/1889	3	11
State Treasurer	Henry A. L'Engle	2/1/1881	2/19/1885	4	0
State Treasurer	Walter H. Gwynn	1/9/1877	2/1/1881	3	11
State Treasurer	Charles H. Foster	1/16/1873	1/9/1877	4	0
State Treasurer	Simon B. Conover	5/24/1871	1/16/1873	1	4
FLORIDA (Department of Financial Services)—Elected; 4-Year Term					
Chief Financial Officer	Jimmy T. Patronis, Jr. (Appointed June 25, 2017; Elected Nov. 6, 2018; Re-elected Nov. 8, 2022)	6/30/2017		incumbent	
Chief Financial Officer	Jeffrey H. 'Jeff' Atwater	1/4/2011	6/30/2017	6	6
Chief Financial Officer	Adelaide Alexander 'Alex' Sink	1/2/2007	1/4/2011	4	0
Chief Financial Officer	C. Thomas 'Tom' Gallagher	1/3/2003	1/2/2007	4	0
GEORGIA—Elected; 4-Year Term					
Insurance Commissioner	John F. King (Appointed June 12, 2019; Elected Nov. 8, 2022)	7/1/2019		incumbent	
Insurance Commissioner	<i>Position Vacant</i>	5/17/2019	6/30/2019	0	1
Insurance Commissioner	Jim Beck (Suspended May 16, 2019)	1/14/2019	5/16/2019	0	4
Insurance Commissioner	Ralph T. Hudgens	1/10/2011	1/13/2019	8	0
Insurance Commissioner	John Oxendine	1/20/1995	1/1/2011	16	0
Insurance Commissioner	Tim Ryles	1/20/1991	1/20/1995	4	0
Insurance Commissioner	Warren D. Evans	11/1/1985	1/3/1991	5	2
Ins. Commissioner/Comptroller General	Johnnie L. Caldwell*	1/12/1971	11/1/1985	14	0
Ins. Commissioner/Comptroller General	James L. Bentley*	1/1/1963	11/1/1971	8	10

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NAIC MEMBER TENURE LIST

STATE/MEMBER TITLE	MEMBER NAME	BEG. DATE	END DATE	YRS. SERVED	MOS. SERVED
GEORGIA—Continued					
Ins. Commissioner/Comptroller General	Zachariah D. 'Zack' Cravey	1/1/1947	1/1/1963	16	0
Ins. Commissioner/Comptroller General	William R. Mitchell	6/25/1946	1/1/1947	0	7
Ins. Commissioner/Comptroller General	Homer C. Parker (Died June 22, 1946)	1/14/1941	6/22/1946	5	5
Ins. Commissioner/Comptroller General	C. Downing Musgrove	6/7/1940	1/14/1941	0	7
Ins. Commissioner/Comptroller General	William B. Harrison (Died June 3, 1940)	1/12/1937	6/3/1940	3	5
Ins. Commissioner/Comptroller General	Homer C. Parker	6/16/1936	1/12/1937	0	7
Ins. Commissioner/Comptroller General	Glenn B. Carreker	2/24/1936	6/16/1936	0	4
Ins. Commissioner/Comptroller General	William B. Harrison	9/18/1929	2/24/1936	6	5
Ins. Commissioner/Comptroller General	William A. Wright (Died Sept. 13, 1929)	9/17/1879	9/13/1929	50	0
Comptroller-General	Washington L. Goldsmith	1/11/1873	9/17/1879	6	8
Comptroller-General	Madison Bell	5/24/1871	1/11/1873	1	8

GUAM—Appointed, at the pleasure of the Governor					
Cmsr. of Banking and Insurance	Michelle B. Santos	12/7/2020		incumbent	
Director of Rev. & Taxation/Acting Cmsr. of Banking & Insurance	Dafne M. Shimizu	1/7/2019	12/7/2020	1	11
Director of Rev. & Taxation/Acting Cmsr. of Banking & Insurance	John P. Camacho	2/5/2018	12/31/2018	0	10
Cmsr. of Banking and Insurance	Artemio B. 'Art' Ilagan	5/17/2011	2/5/2018	6	9
Director of Rev. & Taxation/Acting Cmsr. of Banking & Insurance	John P. Camacho	1/3/2011	5/17/2011	0	4
Cmsr. of Banking and Insurance	John P. Camacho	10/29/2008	1/3/2011	2	3
Director of Rev. & Taxation/Acting Cmsr. of Banking & Insurance	Artemio B. 'Art' Ilagan	1/1/2008	10/29/2008	0	9
Cmsr. of Banking and Insurance	John P. Camacho	6/26/2007	1/1/2008	0	7
Director of Rev. & Taxation/Acting Cmsr. of Banking & Insurance	Artemio B. 'Art' Ilagan	3/9/2007	6/26/2007	0	3
Cmsr. of Banking and Insurance	Andreas J. 'Andy' Jordanou	8/27/2004	3/9/2007	2	7
Director of Revenue and Taxation	Artemio B. 'Art' Ilagan	1/6/2003	8/27/2004	1	7
Acting Director of Revenue and Taxation/Acting Insurance Cmsr.	George V. Cruz	9/28/2001	1/6/2003	1	4
Director of Revenue and Taxation/Insurance Commissioner	Joseph T. 'Joey' Duenas	1/1/1995	9/28/2001	6	8
Director of Revenue and Taxation/Insurance Commissioner	Joaquin G. Blaz	1/1/1988	1/1/1995	7	0
Acting Director of Revenue and Taxation/Acting Insurance Cmsr.	J.C. Carr Bettis	1/1/1987	1/1/1988	1	0
Director of Revenue and Taxation/Insurance Commissioner	David J. 'Dave' Santos	1/3/1983	1/1/1987	4	0
Director of Revenue and Taxation/Insurance Commissioner	Jose R. Rivera	1/2/1981	1/3/1983	2	0
Director of Revenue and Taxation/Insurance Commissioner	Ignacio C. Borja	1/2/1979	1/2/1981	2	0
Director of Revenue and Taxation/Insurance Commissioner	Manuel A. Chaco	1/6/1975	1/2/1979	4	0
Director of Revenue and Taxation/Insurance Commissioner	Joaquin G. Blaz	7/20/1969	12/31/1974	4	5
Director of Revenue and Taxation/Insurance Commissioner	Joaquin C. Guerrero	10/1/1968	7/20/1969	0	9

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NAIC MEMBER TENURE LIST

STATE/MEMBER TITLE	MEMBER NAME	BEG. DATE	END DATE	YRS. SERVED	MOS. SERVED
GUAM—Continued					
Director of Finance/Insurance Commissioner	Joaquin C. Guerrero	1/4/1965	10/1/1968	3	9
Acting Director of Finance/Acting Insurance Commissioner	Segundo C. Aguon	6/1/1964	1/4/1965	0	7
Acting Director of Finance/Acting Insurance Commissioner	Robert A. Smith	1/1/1964	6/1/1964	0	5
Director of Finance/Insurance Commissioner	George W. Ingling <i>(Died March 26, 1979)</i>	3/6/1961	1/1/1964	2	10
Director of Finance/Insurance Commissioner	Richard F. 'Dick' Taitano <i>(Died Jan. 4, 1997)</i>	6/8/1959	3/6/1961	0	9

HAWAII—Appointed, at the pleasure of the Director of Commerce and Consumer Affairs; approved by the Governor					
Insurance Commissioner	Gordon I. Ito	12/16/2022		incumbent	
Insurance Commissioner	Colin M. Hayashida <i>(Died Feb. 28, 2023)</i>	1/1/2019	12/16/2022	3	11
Insurance Commissioner	Gordon I. Ito	12/1/2010	12/31/2018	8	0
Acting Insurance Commissioner	Gordon I. Ito	7/20/2010	12/1/2010	0	5
Insurance Commissioner	J. P. Schmidt	2/3/2003	7/1/2010	7	5
Acting Insurance Commissioner	Gordon I. Ito	11/29/2002	2/3/2003	0	3
Insurance Commissioner	Wayne C. Metcalf	3/1/1999	11/1/2002	3	8
Insurance Commissioner	Rey Graulty	2/4/1997	3/1/1999	2	1
Insurance Commissioner	Wayne C. Metcalf	1/1/1995	2/1/1997	2	1
Insurance Commissioner	Lawrence M. Reifurth	3/1/1994	1/1/1995	0	10
Insurance Commissioner	Linda Chu Takayama	12/16/1991	2/28/1994	2	2
Insurance Commissioner	Robin Campaniano	1/1/1987	12/16/1991	4	11
Insurance Commissioner	Mario R. Ramil	5/1/1984	1/1/1987	2	8
Insurance Commissioner	Susan Kee-Young Park	7/1/1982	5/1/1984	1	10
Insurance Commissioner	Mary G. F. Bitterman	2/1/1981	7/1/1982	1	5
Insurance Commissioner	Tany S. Hong	1/1/1979	2/1/1981	1	11
Insurance Commissioner	Wayne Minami	1/1/1975	1/1/1979	4	0
Insurance Commissioner	Edwin H. Honda	1/8/1968	12/31/1974	6	11
Insurance Commissioner	Sidney I. Hashimoto	1/17/1963	1/1/1968	5	0
Insurance Commissioner	Charles H. Silva	1/1/1960	1/17/1963	3	0
Insurance Commissioner	Raymond Y. C. Ho	1/1/1959	1/1/1960	1	0
Insurance Commissioner	Kam Tai Lee	1/1/1953	1/1/1959	6	0
Insurance Commissioner	Sakae Takahashi	1/1/1952	1/1/1953	1	0
Insurance Commissioner	Howard H. Adams	1/1/1951	1/1/1952	1	0
Insurance Commissioner	William B. Brown	12/15/1947	1/1/1951	3	11
Insurance Commissioner	Walter D. Ackerman, Jr.	2/19/1943	12/15/1947	4	10
Insurance Commissioner	Norman D. Godbold, Jr.	11/7/1940	2/19/1943	2	3
Insurance Commissioner	W. C. McGonagle	6/30/1934	11/7/1940	6	5
Insurance Commissioner	E. S. Smith	7/15/1929	6/30/1934	4	11
Insurance Commissioner	Henry C. Hapai	11/1/1922	7/15/1929	6	8
Insurance Commissioner	A. Lewis, Jr.	12/1/1921	11/1/1922	0	11
Insurance Commissioner	Delbert E. Metzger	6/22/1918	12/1/1921	3	6
Insurance Commissioner	Charles J. McCarthy	10/31/1914	6/22/1918	3	8
Insurance Commissioner	David L. Conkling	7/1/1909	10/31/1914	5	3
Insurance Commissioner	A. J. Campbell	1/1/1907	7/1/1909	2	6
Insurance Commissioner	A. N. Keookai	1/1/1903	1/1/1907	4	0

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NAIC MEMBER TENURE LIST

STATE/MEMBER TITLE	MEMBER NAME	BEG. DATE	END DATE	YRS. SERVED	MOS. SERVED
IDAHO—Appointed; 4-year term, subject to earlier removal by the Governor					
Insurance Director	Dean L. Cameron (Reappointed March 19, 2019)	6/15/2015		incumbent	
Acting Insurance Director	Thomas A. 'Tom' Donovan	1/5/2015	6/15/2015	0	5
Insurance Director	William W. 'Bill' Deal	1/2/2007	12/31/2014	7	11
Acting Insurance Director	Shad Priest	7/1/2006	1/1/2007	0	6
Insurance Director	Gary L. Smith	12/1/2004	6/30/2006	1	6
Insurance Director	Mary L. Hartung	1/4/1999	11/30/2004	5	10
Acting Insurance Director	Mary L. Hartung	4/17/1998	1/3/1999	0	9
Insurance Director	James M. Alcorn	3/1/1996	4/17/1998	2	1
Acting Insurance Director	James M. Alcorn	12/1/1995	3/1/1996	0	3
Insurance Director	John Michael 'Mike' Brassey	1/16/1995	12/1/1995	0	11
Acting Insurance Director	James M. Alcorn	6/1/1994	1/16/1995	0	7
Insurance Director	Harry C. Walrath	7/1/1991	6/1/1994	2	11
Acting Insurance Director	George J. Neumayer	3/1/1991	7/1/1991	0	4
Insurance Director	Anthony J. 'Tony' Fagiano	1/5/1987	3/1/1991	4	2
Insurance Director	Wayne L. Soward	5/14/1984	1/5/1987	3	5
Insurance Director	Trent M. Woods	9/12/1980	5/14/1984	3	8
Insurance Director	Monroe C. Gollaher	1/1/1974	9/12/1980	6	8
Acting Insurance Commissioner	Monroe C. Gollaher	8/29/1973	1/1/1974	0	5
Insurance Commissioner	Robert Hay	4/18/1972	8/29/1973	1	4
Insurance Commissioner	John R. Blaine	1/11/1967	4/18/1972	6	3
Insurance Commissioner	Leo O'Connell	7/29/1950	1/11/1967	16	5
Insurance Commissioner	James Hubbard	7/1/1947	7/28/1950	3	0
Insurance Director	Edward B. McMonigle	8/1/1945	7/1/1947	1	11
Acting Insurance Director	Laura E. Dewey	4/5/1945	8/1/1945	0	4
Insurance Director	Howard C. Cullimore	5/21/1944	4/5/1945	0	11
Insurance Director	James A. Dement	4/8/1944	5/21/1944	0	1
Insurance Director	Howard C. Cullimore	1/4/1943	4/8/1944	1	3
Insurance Director	Joel Jenifer	1/7/1941	1/4/1943	2	0
Insurance Director	Ted M. Walrath	3/1/1939	1/7/1941	1	10
Insurance Director	Warren H. Bakes	3/2/1931	3/1/1939	8	0
Insurance Director	David C. Neifert	6/1/1924	3/1/1931	6	9
Insurance Director	Harry D. Smith	12/22/1922	6/1/1924	0	6
Insurance Director	Howard J. Brace	10/18/1919	12/22/1922	3	2
Insurance Director	Willet R. Hyatt	5/15/1917	10/18/1919	1	11
Insurance Commissioner	George F. Steele	7/1/1915	5/15/1917	1	10
Insurance Commissioner	Elmer F. Van Valkenberg	4/1/1913	7/1/1915	2	3
Insurance Commissioner	Isaac C. Hattabaugh	4/1/1911	4/1/1913	2	0
Insurance Commissioner	Charles D. Goaslind	8/24/1909	4/1/1911	1	7

ILLINOIS—Appointed, at the Pleasure of the Governor					
Insurance Director	Dana Popish Severinghaus (Reappointed Feb. 3, 2023)	2/22/2022		incumbent	
Acting Insurance Director	Dana Popish Severinghaus	1/19/2021	2/22/2022	1	1
Interim Acting Insurance Director	Shannon Whalen	12/11/2020	1/18/2021	0	1
Insurance Director	Robert H. Muriel	5/31/2019	12/11/2020	1	7
Acting Insurance Director	Robert H. Muriel	3/11/2019	5/31/2019	0	2
Acting Insurance Director	Kevin Fry	1/25/2019	3/8/2019	0	2
Acting Insurance Director	Karin Zosel	12/12/2018	1/25/2019	0	1
Insurance Director	Jennifer W. Hammer	2/15/2017	12/10/2018	0	10

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NAIC MEMBER TENURE LIST

STATE/MEMBER TITLE	MEMBER NAME	BEG. DATE	END DATE	YRS. SERVED	MOS. SERVED
ILLINOIS—Continued					
Acting Insurance Director	Jennifer W. Hammer	1/17/2017	2/15/2017	0	1
Acting Insurance Director	Anne Melissa Dowling	7/1/2015	1/17/2017	1	6
Acting Insurance Director	James A. Stephens	1/12/2015	7/1/2015	0	6
Insurance Director	Andrew Boron	1/27/2012	1/12/2015	3	0
Acting Insurance Director	Robert E. 'Bob' Wagner	1/1/2012	1/27/2012	0	1
Acting Insurance Director	Andrew R. Stolfi	10/1/2011	12/31/2011	0	2
Acting Insurance Director	Jack Messmore	6/1/2011	10/1/2011	0	4
Insurance Director	Michael T. McRaith	3/21/2005	5/31/2011	6	3
Acting Insurance Director	Deirdre K. Manna	2/17/2004	3/21/2005	1	1
Insurance Director	J. Anthony Clark	3/31/2003	1/31/2004	0	10
Acting Insurance Director	Arnold Dutcher	1/1/2003	3/31/2003	0	2
Insurance Director	Nathaniel S. 'Nat' Shapo	1/19/1999	1/1/2003	4	0
Acting Insurance Director	Arnold Dutcher	2/27/1998	1/19/1999	0	11
Insurance Director	Mark Boozell	7/1/1995	2/27/1998	2	7
Acting Insurance Director	James W. 'Jim' Schacht	2/1/1994	7/1/1995	1	5
Insurance Director	Stephen F. Selcke	9/3/1991	2/1/1994	2	5
Acting Insurance Director	James W. 'Jim' Schacht	2/15/1991	9/3/1991	0	7
Insurance Director	Zachary 'Zack' Stamp	9/14/1989	2/15/1991	1	5
Insurance Director	John E. Washburn*	11/16/1983	9/14/1989	5	10
Acting Insurance Director	James W. 'Jim' Schacht	7/19/1982	11/16/1983	1	4
Insurance Director	Philip R. O'Connor	7/11/1979	7/19/1982	3	0
Insurance Director	Richard L. Mathias	2/2/1977	7/11/1979	2	5
Insurance Director	Michael P. Duncan	7/1/1976	2/2/1977	0	7
Acting Insurance Director	Dennis W. Toivonen	6/14/1976	7/1/1976	0	1
Insurance Director	Robert B. 'Bob' Wilcox	8/13/1974	6/14/1976	1	10
Insurance Director	Fred A. Mauck	1/19/1973	8/13/1974	1	7
Insurance Director	James R. Baylor	1/20/1969	1/19/1973	4	0
Insurance Director	John F. Bolton, Jr.	2/16/1965	1/20/1969	3	11
Insurance Director	Richard G. Hershey	1/29/1963	2/16/1965	2	1
Insurance Director	Joseph S. Gerber	1/11/1957	1/29/1963	6	0
Insurance Director	Justin T. McCarthy	8/30/1954	1/11/1957	2	5
Acting Insurance Director	Laddie T. Pelnar	6/14/1954	8/30/1954	0	2
Insurance Director	Robert E. Barrett (Died June 14, 1954)	1/11/1953	6/14/1954	1	5
Insurance Director	J. Edward Day	9/1/1950	1/11/1953	2	4
Insurance Director	Harry B. Hershey	1/17/1949	9/1/1950	1	8
Insurance Director	Nellis P. Parkinson	4/4/1945	1/17/1949	3	9
Acting Insurance Director	Nellis P. Parkinson	4/15/1944	4/4/1945	1	0
Insurance Director	Paul F. Jones	1/15/1941	4/15/1944	3	3
Insurance Director	C. Hayden Davis	11/7/1940	1/15/1941	0	2
Insurance Director	Ernest Palmer*	7/1/1933	11/7/1940	6	4
Insurance Superintendent	Ernest Palmer*	1/23/1933	7/1/1933	0	6
Insurance Superintendent	Harry W. Hanson	7/1/1930	1/23/1933	2	6
Insurance Superintendent	George W. Huskinson	1/26/1927	7/1/1930	3	6
Director of Trade and Commerce	H. U. Bailey	1/27/1926	1/26/1927	1	0
Director of Trade and Commerce	Clifford C. Ireland	11/15/1923	1/27/1926	2	2
Insurance Superintendent	Thomas J. Houston	8/8/1921	11/15/1923	2	3
Insurance Superintendent	Frederick W. 'Fred' Potter*	5/15/1917	8/8/1921	4	3
Insurance Superintendent	Rufus M. Potts	8/11/1913	5/15/1917	3	9
Insurance Superintendent	Frederick W. 'Fred' Potter*	1/1/1907	8/11/1913	6	7

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NAIC MEMBER TENURE LIST

STATE/MEMBER TITLE	MEMBER NAME	BEG. DATE	END DATE	YRS. SERVED	MOS. SERVED
ILLINOIS—Continued					
Insurance Superintendent	William R. Vredenburg	5/2/1903	1/1/1907	3	8
Insurance Superintendent	Henry Yates (Died May 1, 1903)	5/6/1901	5/1/1903	2	0
Insurance Superintendent	James R. B. Van Cleave	5/1/1897	5/6/1901	4	0
Insurance Superintendent	Bradford K. Durfee*	7/13/1893	5/1/1897	3	10
Auditor of State	David P. Gore	1/10/1893	7/13/1893	0	6
Auditor of State	Charles W. Pavey	1/14/1889	1/10/1893	4	0
Auditor of State	Charles P. Swigert*	1/10/1881	1/14/1889	8	0
Auditor of State	Thomas B. Needles	1/8/1877	1/10/1881	4	0
Auditor of State	Charles E. Lippencott	5/24/1871	1/8/1877	5	8
INDIANA—Appointed, at the Pleasure of the Governor					
Insurance Commissioner	Amy L. Beard	6/2/2021		incumbent	
Insurance Commissioner	Stephen W. 'Steve' Robertson	10/13/2010	6/1/2021	10	8
Acting Insurance Commissioner	Stephen W. 'Steve' Robertson NOTE: Robertson began serving as acting commissioner when Cutter went on medical leave in June 2010.	6/14/2010	10/13/2010	0	4
Insurance Commissioner	Carol Cutter (Died Sept. 6, 2010)	6/22/2009	9/6/2010	1	3
Insurance Commissioner	James D. 'Jim' Atterholt	2/22/2005	6/22/2009	4	4
Acting Insurance Commissioner	James D. 'Jim' Atterholt	1/10/2005	2/22/2005	0	1
Interim Insurance Commissioner	Amy E. Strati	7/15/2004	1/10/2005	0	6
Insurance Commissioner	Sarah Ann 'Sally' McCarty	6/26/1997	7/15/2004	7	1
Insurance Commissioner	John J. Quinn	4/16/1997	6/26/1997	0	2
Insurance Commissioner	Marjorie Maginn	7/12/1996	4/16/1997	0	9
Insurance Commissioner	Donna D. Bennett	6/24/1994	7/12/1996	2	1
Interim Insurance Commissioner	Donna D. Bennett	2/17/1994	6/24/1994	0	4
Insurance Commissioner	John F. 'Jack' Mortell	9/1/1991	2/16/1994	2	5
Acting Insurance Commissioner	John F. 'Jack' Mortell	7/15/1991	9/1/1991	0	2
Insurance Commissioner	John J. Dillon III	7/3/1989	7/15/1991	2	0
Acting Insurance Commissioner	Bettye L. Foy	1/9/1989	7/3/1989	0	6
Insurance Commissioner	Harry E. Eakin	4/1/1985	1/9/1989	3	9
Insurance Commissioner	Donald H. 'Don' Miller	2/16/1981	4/1/1985	4	2
Insurance Commissioner	H. Peter 'Pete' Hudson*	12/10/1979	2/16/1981	1	2
Acting Insurance Commissioner	Richard S. Baldwin	11/15/1979	12/10/1979	0	1
Insurance Commissioner	H. Peter 'Pete' Hudson*	8/4/1975	11/15/1979	4	3
Insurance Commissioner	Lloyd M. Allen	4/23/1973	8/4/1975	2	4
Insurance Commissioner	Oscar H. Ritz	1/13/1969	4/23/1973	4	4
Insurance Commissioner	Joseph G. Wood, Sr.	2/1/1965	1/13/1969	3	11
Insurance Commissioner	Harry E. McClain	1/10/1961	2/1/1965	4	1
Insurance Commissioner	James K. Ashley	6/15/1960	1/10/1961	0	7
Insurance Commissioner	Alden C. Palmer	1/16/1957	6/15/1960	3	5
Insurance Commissioner	William J. Davey	10/15/1955	1/16/1957	1	3
Insurance Commissioner	Harry E. Wells	1/12/1953	10/15/1955	2	9
Insurance Commissioner	Frank J. Viehmann	1/10/1949	1/12/1953	4	0
Insurance Commissioner	John D. Pearson	1/8/1945	1/10/1949	4	0
Insurance Commissioner	Frank J. Viehmann	3/1/1940	1/8/1945	4	10
Insurance Commissioner	George H. Newbauer	2/1/1937	3/1/1940	3	1
Insurance Commissioner	Harry E. McClain	4/1/1933	2/1/1937	3	10

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NAIC MEMBER TENURE LIST

STATE/MEMBER TITLE	MEMBER NAME	BEG. DATE	END DATE	YRS. SERVED	MOS. SERVED
INDIANA—Continued					
Insurance Commissioner	John C. Kidd	1/1/1931	4/1/1933	2	3
Insurance Commissioner	Clarence C. Wysong*	10/1/1926	1/1/1931	4	3
Insurance Commissioner	Thomas S. McMurray, Jr.	4/1/1921	10/1/1926	5	6
Insurance Commissioner	Miles Schaeffer	10/1/1920	4/1/1921	0	6
State Auditor	Otto L. Klauss	12/1/1916	10/1/1920	3	10
State Auditor	Dale J. Crittenberger	12/1/1914	12/1/1916	2	0
State Auditor	William H. O'Brien	12/1/1910	12/1/1914	4	0
State Auditor	John C. Billheimer	11/24/1906	12/1/1910	4	0
State Auditor	Warren Bigler	9/14/1905	11/24/1906	1	2
State Auditor	David E. Sherrick	1/26/1903	9/14/1905	1	8
State Auditor	William H. Hart*	1/26/1899	1/26/1903	4	0
State Auditor	Americus C. Dailey	1/26/1895	1/26/1899	4	0
State Auditor	John O. Henderson	1/26/1891	1/26/1895	4	0
State Auditor	Bruce Carr	1/26/1887	1/26/1891	4	0
State Auditor	James H. 'Jim' Rice	1/27/1883	1/26/1887	4	0
State Auditor	Edward H. Wolfe	1/26/1881	1/27/1883	2	0
State Auditor	Mahlon D. Manson	1/27/1879	1/26/1881	2	0
State Auditor	Ebenezer Henderson	1/26/1875	1/27/1879	4	0
State Auditor	James A. Wildman	1/25/1873	1/26/1875	2	0
State Auditor	John C. Shoemaker	5/24/1871	1/25/1873	1	8

IOWA—Appointed, at the Pleasure of the Governor; 4-Year Term					
Insurance Commissioner	Douglas M. 'Doug' Ommen	1/30/2017		incumbent	
Interim Insurance Commissioner	Douglas M. 'Doug' Ommen	12/26/2016	1/30/2017	0	1
Insurance Commissioner	Nicholas C. 'Nick' Gerhart	2/1/2013	12/23/2016	3	10
Insurance Commissioner	Susan E. Voss*	1/1/2005	1/31/2013	8	1
Insurance Commissioner	Therese M. 'Terri' Vaughan*	8/1/1994	12/31/2004	10	4
Insurance Commissioner	David J. Lyons	11/21/1990	7/1/1994	3	7
Acting Insurance Commissioner	David J. Lyons	6/1/1990	11/21/1990	0	6
Insurance Commissioner	William D. 'Bill' Hager	7/1/1986	5/31/1990	3	11
Insurance Commissioner	Fred M. Haskins	5/19/1986	6/30/1986	0	1
Insurance Commissioner	Bruce W. Foudree*	2/11/1980	5/19/1986	6	3
Acting Insurance Commissioner	Richard S. Baldwin	10/8/1979	2/11/1980	0	4
Insurance Commissioner	Herbert W. Anderson (Died Oct. 8, 1979)	6/17/1976	10/8/1979	3	4
Insurance Commissioner	William H. Huff III*	7/1/1971	6/17/1976	4	11
Insurance Commissioner	Lorne R. Worthington*	1/1/1967	7/1/1971	4	6
Insurance Commissioner	William E. Timmons*	7/1/1959	12/31/1966	7	6
Insurance Commissioner	Oliver P. Bennett	10/12/1955	6/30/1959	3	8
Insurance Commissioner	Charles R. Fischer	7/1/1951	10/12/1955	4	3
Insurance Commissioner	Sterling Alexander	7/1/1947	6/30/1951	4	0
Insurance Commissioner	Charles R. Fischer	2/11/1939	6/30/1947	8	4
Insurance Commissioner	Maurice V. Pew	2/15/1938	2/9/1939	1	0
Insurance Commissioner	Ray Murphy	7/1/1935	2/15/1938	2	7
Insurance Commissioner	Edward W. Clark	6/23/1931	7/1/1935	4	1
Insurance Commissioner	Ray A. Yenter	3/1/1926	6/23/1931	5	3
Insurance Commissioner	William R. C. Kendrick*	2/1/1923	3/1/1926	3	1
Insurance Commissioner	Arthur C. Savage	2/3/1919	2/1/1923	4	0
Insurance Commissioner	John F. Taake	1/16/1918	2/3/1919	1	1
Insurance Commissioner	Emory H. English	7/1/1914	1/16/1918	3	7

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NAIC MEMBER TENURE LIST

STATE/MEMBER TITLE	MEMBER NAME	BEG. DATE	END DATE	YRS. SERVED	MOS. SERVED
IOWA—Continued					
State Auditor	John L. Bleakley	11/3/1908	7/1/1914	5	8
State Auditor	Beryl F. Carroll	11/4/1902	11/3/1908	6	0
State Auditor	Frank F. Merriam	11/8/1898	11/4/1902	4	0
State Auditor	Cornelius G. McCarthy	11/8/1892	11/8/1898	6	0
State Auditor	James A. Lyons	11/2/1886	11/8/1892	6	0
State Auditor	John L. Brown	7/14/1886	11/2/1886	0	4
State Auditor	Charles Beardsley	4/13/1886	7/14/1886	0	3
State Auditor	John L. Brown	1/23/1886	4/13/1886	0	3
State Auditor	Jonathan W. Cattell	3/19/1885	1/23/1886	0	10
State Auditor	John L. Brown	10/7/1882	3/19/1885	2	5
State Auditor	William V. Lucas	11/2/1880	10/7/1882	1	11
State Auditor	Buren R. Sherman	10/13/1874	11/2/1880	6	1
State Auditor	John Russell	10/18/1871	10/13/1874	3	0

KANSAS—Elected; 4-Year Term					
Insurance Commissioner	Vicki Schmidt <i>(Elected Nov. 6, 2018 Re-elected Nov. 8, 2022)</i>	1/14/2019		incumbent	
Insurance Commissioner	Kenneth A. ‘Ken’ Selzer	1/12/2015	1/14/2019	4	0
Insurance Commissioner	Sandra K. ‘Sandy’ Praeger*	1/13/2003	1/12/2015	12	0
Insurance Commissioner	Kathleen Sebelius*	1/9/1995	1/13/2003	8	0
Insurance Commissioner	Ronald L. ‘Ron’ Todd	1/14/1991	1/9/1995	4	0
Insurance Commissioner	W. Fletcher Bell*	1/11/1971	1/14/1991	20	0
Insurance Commissioner	Frank Sullivan*	1/13/1947	1/1/1971	24	0
Insurance Commissioner	Charles F. Hobbs*	1/14/1929	1/13/1947	18	0
Insurance Superintendent	William R. Baker	1/8/1923	1/14/1929	6	0
Insurance Superintendent	Frank L. Travis	1/13/1919	1/8/1923	4	0
Insurance Superintendent	Carey J. Wilson	1/11/1915	1/13/1919	4	0
Insurance Superintendent	Isaac S. ‘Ike’ Lewis	1/9/1911	1/11/1915	4	0
Insurance Superintendent	Charles W. Barnes	1/1/1907	1/9/1911	4	0
Insurance Superintendent	Charles H. Luling	1/1/1903	1/1/1907	4	0
Insurance Superintendent	Willard V. Church	1/1/1899	1/1/1903	4	0
Insurance Superintendent	Webb McNall	1/1/1897	1/1/1899	2	0
Insurance Superintendent	Alexander P. Riddle	1/1/1896	1/1/1897	1	0
Insurance Superintendent	George Tobey Anthony	1/1/1895	1/1/1896	1	0
Insurance Superintendent	Simon H. Snider	1/1/1893	1/1/1895	2	0
Insurance Superintendent	William H. McBride	1/1/1891	1/1/1893	2	0
Insurance Superintendent	Daniel W. Wilder	1/1/1887	1/1/1891	4	0
Insurance Superintendent	Richard D. Morris	1/1/1883	1/1/1887	4	0
Insurance Superintendent	Orrin T. Welch	1/1/1875	1/1/1883	8	0
Insurance Superintendent	Harrison Clarkson	1/1/1874	1/1/1875	1	0
Insurance Superintendent	Edward Russell	1/1/1873	1/1/1874	1	0
Insurance Superintendent	William C. Webb	5/24/1871	1/1/1873	1	8

KENTUCKY—Appointed, at the Pleasure of the Governor					
Insurance Commissioner	Sharon P. Clark	1/6/2020		incumbent	
Insurance Commissioner	Nancy G. Atkins	5/1/2017	1/3/2020	2	8
Insurance Commissioner	Brian Maynard	1/12/2016	4/30/2017	1	3
Insurance Commissioner	Sharon P. Clark	6/30/2008	1/11/2016	7	6
Acting Insurance Commissioner	John Burkholder	3/1/2008	6/30/2008	0	4

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NAIC MEMBER TENURE LIST

STATE/MEMBER TITLE	MEMBER NAME	BEG. DATE	END DATE	YRS. SERVED	MOS. SERVED
KENTUCKY—Continued					
Acting Insurance Commissioner	Timothy LeDonne	12/1/2007	3/1/2008	0	3
Insurance Commissioner	Julie Mix McPeak*	7/17/2006	12/1/2007	1	5
Executive Director	Glenn Jennings	4/27/2005	7/17/2006	1	3
Executive Director	Martin J. Koettters	7/15/2004	4/27/2005	0	9
Acting Insurance Commissioner	Glenn Jennings	12/1/2003	7/15/2004	0	7
Insurance Commissioner	Janie A. Miller	12/1/2000	12/1/2003	3	0
Insurance Commissioner	George Nichols III*	4/1/1996	12/1/2000	4	8
Insurance Commissioner	Theodore 'Ted' Rich	1/24/1996	4/1/1996	0	3
Acting Insurance Commissioner	Laura Douglas	12/29/1995	1/24/1996	0	1
Acting Insurance Commissioner	Suetta Dickinson	12/8/1995	12/29/1995	0	1
Insurance Commissioner	Donald W. 'Don' Stephens	11/16/1992	12/8/1995	3	1
Insurance Commissioner	Ronnie Moore	12/1/1991	11/16/1992	0	11
Insurance Commissioner	Elizabeth Wright	5/1/1990	12/1/1991	1	7
Insurance Commissioner	Leroy Morgan	3/1/1988	5/1/1990	2	2
Insurance Commissioner	Gill McCarty	12/1/1983	3/1/1988	4	3
Insurance Commissioner	Daniel D. Briscoe	1/1/1980	12/1/1983	3	11
Acting Insurance Commissioner	Donald N. Rhody	12/1/1979	12/31/1979	0	1
Insurance Commissioner	Harold B. McGuffey*	12/8/1971	12/1/1979	8	0
Insurance Commissioner	Robert D. Preston	12/1/1968	12/8/1971	3	0
Acting Insurance Commissioner	Robert D. Preston	1/1/1968	12/1/1968	0	11
Insurance Commissioner	S. Roy Woodall, Jr.	12/1/1966	12/31/1967	1	0
Insurance Commissioner	William E. Bivin	1/1/1965	12/1/1966	1	11
Insurance Commissioner	J. Elliott Flanery	12/1/1963	12/31/1964	1	0
Insurance Commissioner	Lawrence D. Cassady	1/1/1963	12/1/1963	0	11
Insurance Commissioner	William T. Hockensmith	11/1/1960	12/31/1962	2	1
Insurance Commissioner	C. P. Thurman	1/1/1957	11/1/1960	3	10
Insurance Commissioner	S. H. Goebel	6/1/1953	12/31/1956	3	6
Insurance Commissioner	Spaulding Southall	5/1/1949	6/1/1953	4	1
Insurance Commissioner	Cad. P. Thurman	4/1/1948	5/1/1949	1	1
Insurance Commissioner	Harry B. Wilson	5/1/1945	4/1/1948	2	11
Insurance Commissioner	Sherman Goodpaster	6/1/1936	5/1/1945	8	11
Insurance Commissioner	J. Dan Talbott	1/31/1936	6/1/1936	0	5
Acting Insurance Commissioner	Charles I. Brown	1/1/1936	1/31/1936	0	1
Insurance Commissioner	McKay Reed	4/11/1935	1/1/1936	0	9
Insurance Commissioner	Gemill B. Senff	11/1/1932	4/1/1935	2	5
Insurance Commissioner	Bush W. Allin	4/1/1929	11/1/1932	3	7
Insurance Commissioner	Shelton M. Saufley	1/1/1924	4/1/1929	5	3
Insurance Commissioner	A. M. Wash	5/1/1923	1/1/1924	0	8
Insurance Commissioner	James F. Ramey	1/1/1920	5/1/1923	3	4
Insurance Commissioner	Charles F. Thomas	3/1/1916	1/1/1920	3	10
Insurance Commissioner	M. C. Clay	3/1/1912	3/1/1916	4	0
Insurance Commissioner	Charles W. Bell	9/1/1907	3/1/1912	4	6
Insurance Commissioner	Henry R. Prewitt	9/1/1904	9/1/1907	3	0
Insurance Commissioner	John B. Chenault	9/1/1900	9/1/1904	4	0
Insurance Commissioner	Will H. Stone	9/1/1898	9/1/1900	2	0
Insurance Commissioner	David N. Comingore	9/22/1896	9/1/1898	2	0
Insurance Commissioner	Henry F. Duncan	8/1/1890	9/1/1896	6	1
Insurance Commissioner	Leslie C. Norman	9/20/1881	8/1/1890	8	11
Insurance Commissioner	Bedford Leslie	9/18/1877	9/1/1881	4	0
Insurance Commissioner	Gustavus W. Smith	5/24/1871	9/19/1876	5	4

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NAIC MEMBER TENURE LIST

STATE/MEMBER TITLE	MEMBER NAME	BEG. DATE	END DATE	YRS. SERVED	MOS. SERVED
LOUISIANA—Elected; 4-Year Term					
Insurance Commissioner	James J. 'Jim' Donelon* (Appointed Feb. 15, 2006; Elected Sept. 30, 2006; Re-elected Oct. 20, 2007; Re-elected Oct. 22, 2011; Re-elected Oct. 24, 2015; Re-elected Oct. 12, 2019)	2/15/2006		incumbent	
Insurance Commissioner	J. Robert 'Robert' Wooley	4/1/2003	2/15/2006	2	10
Acting Insurance Commissioner	J. Robert 'Robert' Wooley	10/1/2000	4/1/2003	2	6
Insurance Commissioner	James H. 'Jim' Brown	12/1/1991	10/1/2000	8	10
Acting Insurance Commissioner	Darrell Cobb	8/1/1991	12/1/1991	0	4
Acting Insurance Commissioner	Hunter O. Wagner, Jr.	3/1/1991	8/1/1991	0	5
Insurance Commissioner	Doug Green	4/1/1988	3/1/1991	2	11
Insurance Commissioner	Sherman A. Bernard	5/1/1972	4/1/1988	15	11
Insurance Commissioner	Dudley A. Guglielmo	5/1/1964	5/1/1972	8	0
Insurance Commissioner	Rufus D. Hayes*	8/1/1956	5/1/1964	7	9
Secretary of State/Insurance Cmsr.	Wade O. Martin, Jr.*	12/4/1944	6/1/1956	11	6
Secretary of State/Insurance Cmsr.	James A. Gremillion	6/24/1940	6/7/1943	3	0
Insurance Commissioner	Eugene A. Conway	6/22/1932	2/19/1940	7	8
Insurance Commissioner	John D. Saint	9/8/1930	5/1/1932	1	8
Insurance Commissioner	James J. Bailey	9/30/1916	12/1/1929	13	3
Insurance Commissioner	William E. Millsaps	9/21/1915	9/29/1916	1	0
Acting Deputy Insurance Commissioner	Richard Flower	3/10/1915	4/1/1915	0	1
Secretary of State/Ins. Commissioner	Alvin E. Hebert (Died March 9, 1915)	7/23/1912	3/9/1915	2	8
Deputy Insurance Commissioner	E. J. O'Brien	5/1/1911	5/1/1912	1	0
Deputy Insurance Commissioner	Edward Everett	1/1/1911	5/1/1911	0	4
Assistant Secretary of State/Ins. Commissioner	Eugene J. McGivney	9/29/1903	9/30/1910	7	0
Secretary of State/Ins. Commissioner	<i>No Record in NAIC Proceedings</i>	9/13/1898	9/25/1902	4	0
Deputy Insurance Commissioner	Edward Newman	1897	1898	1	
Deputy Insurance Commissioner	John J. McCann	1896	1897	0	
Deputy Insurance Commissioner	John T. Michel	1896	1896	0	
Deputy Insurance Commissioner	W. B. Spencer	10/1/1895	1896	1	
Deputy Insurance Commissioner	George Spencer	10/1/1894	10/1/1895	1	0
Deputy Insurance Commissioner	W. B. Spencer	10/1/1891	10/1/1894	3	0
Deputy Insurance Commissioner	L. F. Mason	10/1/1889	10/1/1891	2	0
Secretary of State	Simeon Toby	8/6/1888	10/1/1891	3	2
Deputy Insurance Commissioner	Oscar Orroyo	10/1/1885	10/1/1889	4	0
Deputy Insurance Commissioner	William A. Strong	9/1/1878	9/25/1884	6	0
Secretary of State	<i>No Record in NAIC Proceedings</i>	4/16/1872	8/27/1878	6	4
Secretary of State	Richard Gaines	10/18/1871	4/15/1872	0	6
Secretary of State	George E. Bovee	5/24/1871	10/18/1871	0	5
MAINE—Appointed; 5-Year Term					
Acting Insurance Superintendent	Timothy N. Schott	4/1/2022		incumbent	
Insurance Superintendent	Eric A. Cioppa*	9/27/2011	3/31/2022	10	6
Acting Insurance Superintendent	Eric A. Cioppa*	6/1/2011	9/27/2011	0	3
Insurance Superintendent	Mila Kofman	3/1/2008	5/31/2011	3	2
Acting Insurance Superintendent	Eric A. Cioppa*	1/14/2007	2/28/2008	1	1

* NAIC Past President. This person served as NAIC President one or more times during their term(s) of office.

NAIC MEMBER TENURE LIST

STATE/MEMBER TITLE	MEMBER NAME	BEG. DATE	END DATE	YRS. SERVED	MOS. SERVED
MAINE—Continued					
Insurance Superintendent	Alessandro A. ‘Al’ Iuppa*	2/4/1998	1/13/2007	8	11
Acting Insurance Superintendent	Alessandro A. ‘Al’ Iuppa*	8/30/1997	2/4/1998	0	6
Insurance Superintendent	Brian K. Atchinson*	5/20/1992	8/29/1997	5	3
Acting Insurance Superintendent	Richard Johnson	10/22/1991	5/19/1992	0	7
Acting Insurance Superintendent	Jeri E. Brown	9/1/1991	10/21/1991	0	1
Insurance Superintendent	Joseph A. ‘Joe’ Edwards	6/1/1987	9/1/1991	4	3
Acting Insurance Superintendent	Everard B. Stevens	11/10/1986	6/1/1987	0	7
Insurance Superintendent	Theodore T. ‘Ted’ Briggs	5/21/1979	11/10/1986	7	6
Insurance Superintendent	Frank M. Hogerty, Jr.	10/3/1973	5/20/1979	5	7
Insurance Commissioner	Frank M. Hogerty, Jr.	11/15/1967	10/3/1973	5	11
Acting Insurance Commissioner	Harold E. Trahey	6/2/1967	11/15/1967	0	5
Insurance Commissioner	George F. Mahoney <i>(Died June 1, 1967)</i>	6/18/1951	6/1/1967	16	0
Insurance Commissioner	David B. Soule	6/12/1947	6/18/1951	4	0
Insurance Commissioner	Alfred W. Perkins	1/14/1946	3/5/1947	1	2
Acting Insurance Commissioner	Guy R. Whitten <i>(Alfred W. Perkins on leave of absence for military service)</i>	1/13/1944	1/13/1946	2	0
Insurance Commissioner	Alfred W. Perkins	5/1/1942	1/12/1944	1	8
Insurance Commissioner	Pearce J. Francis <i>(Died Feb. 13, 1942)</i>	12/30/1940	2/13/1942	1	2
Insurance Commissioner	C. Waldo Lovejoy	3/23/1937	11/12/1940	3	8
Insurance Commissioner	Wilbur D. Spencer	5/3/1923	3/22/1937	13	10
Acting Insurance Commissioner	Leon W. Helson	11/26/1922	5/2/1923	0	6
Insurance Commissioner	G. Waldon Smith	4/24/1918	11/25/1922	4	7
Acting Insurance Commissioner	Ivan E. Lang	1/1/1918	4/24/1918	0	3
Insurance Commissioner	Erastus J. Carter	2/1/1915	1/1/1918	2	11
Insurance Commissioner	J. Wallace Blunt	7/1/1913	2/1/1915	1	7
Insurance Commissioner	Andrew P. Havey	12/9/1911	7/1/1913	1	7
Insurance Commissioner	Beecher Putnam	1/1/1909	12/9/1911	2	11
Insurance Commissioner	Stephen W. Carr*	12/26/1893	1/1/1909	15	0
Insurance Commissioner	Joseph O. Smith	1/1/1885	12/26/1893	9	0
Insurance Commissioner	Frank E. Nye	9/1/1884	11/20/1884	0	2
Insurance Commissioner	Oramandal Smith	4/1/1883	9/1/1884	1	5
Insurance Commissioner	Joseph B. Peaks	3/1/1880	4/1/1883	3	1
Insurance Commissioner	William Philbrick	5/5/1879	3/1/1880	0	10
Insurance Commissioner	Joshua Nye	4/26/1873	5/5/1879	6	0
Insurance Commissioner	Albert W. Paine	5/24/1871	4/26/1873	1	11

MARYLAND—Appointed, at the Pleasure of the Governor; 4-Year Term					
Insurance Commissioner	Kathleen A. Birrane	5/18/2020		incumbent	
Insurance Commissioner	Alfred W. ‘Al’ Redmer, Jr.	1/22/2015	5/15/2020	5	4
Insurance Commissioner	Therese M. Goldsmith	6/13/2011	1/21/2015	3	7
Acting Insurance Commissioner	Elizabeth ‘Beth’ Sammis	1/1/2010	6/13/2011	1	5
Insurance Commissioner	Ralph S. Tyler III	9/1/2007	1/1/2010	2	4
Interim Insurance Commissioner	Peggy J. Watson	6/1/2007	9/1/2007	0	3
Insurance Commissioner	R. Steven ‘Steve’ Orr	1/1/2006	5/31/2007	1	4
Acting Insurance Commissioner	James V. ‘Jim’ McMahan	10/1/2005	1/1/2006	0	3
Insurance Commissioner	Alfred W. ‘Al’ Redmer, Jr.	6/1/2003	10/1/2005	2	4
Insurance Commissioner	Steven B. ‘Steve’ Larsen	6/16/1997	6/1/2003	6	0

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NAIC MEMBER TENURE LIST

STATE/MEMBER TITLE	MEMBER NAME	BEG. DATE	END DATE	YRS. SERVED	MOS. SERVED
MARYLAND—Continued					
Acting Insurance Commissioner	Charles B. Kelly III	5/1/1997	6/1/1997	0	1
Insurance Commissioner	Dwight K. Bartlett III	5/1/1993	5/1/1997	4	0
Insurance Commissioner	John A. Donaho	5/1/1989	5/1/1993	4	0
Insurance Commissioner	E. Susan Kellogg	7/1/1988	5/1/1989	0	10
Acting Insurance Commissioner	Martha Roach	1/1/1988	7/1/1988	0	6
Insurance Commissioner	Edward J. Muhl*	7/1/1982	1/1/1988	5	6
Insurance Commissioner	Edward J. Birrane, Jr.	7/1/1976	7/1/1982	5	0
Insurance Commissioner	Thomas J. Hatem	7/16/1970	7/1/1976	6	0
Insurance Commissioner	Newton I. Steers, Jr.	5/15/1967	7/15/1970	3	2
Insurance Commissioner	Norman Polovoy	12/16/1966	5/15/1967	0	5
Insurance Commissioner	Francis B. 'Bill' Burch	7/15/1965	12/16/1966	1	5
Insurance Commissioner	F. Douglass Sears	5/4/1959	6/24/1965	6	2
Insurance Commissioner	Charles S. Jackson	12/17/1952	5/4/1959	6	5
Acting Insurance Commissioner	John H. Coppage	8/18/1952	12/17/1952	0	4
Insurance Commissioner	Harvey M. Chesney <i>(Died Aug. 17, 1952)</i>	5/8/1951	8/17/1952	1	3
Insurance Commissioner	Claude M. Hanley	5/1/1947	5/8/1951	4	0
Insurance Commissioner	Lawrence E. Ensor	9/1/1943	5/1/1947	3	8
Insurance Commissioner	John B. Gontrum	5/1/1939	9/1/1943	4	4
Insurance Commissioner	Wesley S. Hanna	5/1/1935	5/1/1939	4	0
Insurance Commissioner	William C. Walsh	5/1/1931	5/1/1935	4	0
Insurance Commissioner	Harrison Rider	3/1/1929	5/1/1931	2	2
Insurance Commissioner	Carville D. Benson <i>(Died Feb. 8, 1929)</i>	8/1/1924	2/8/1929	4	6
Insurance Commissioner	Harvey L. Cooper	9/1/1922	8/1/1924	1	11
Insurance Commissioner	Thomas J. Keating	4/1/1919	9/1/1922	3	5
Insurance Commissioner	William Mason Shehan	2/1/1912	3/1/1919	7	1
Insurance Commissioner	Emerson C. Harrington	11/9/1910	1/31/1912	1	2
Insurance Commissioner	Benjamin F. Crouse* <i>(Died Nov. 8, 1910)</i>	12/1/1905	11/8/1910	4	11
Insurance Commissioner	Frank I. Duncan	1/10/1905	10/31/1905	0	10
Insurance Commissioner	Lloyd Wilkinson	9/1/1900	1/9/1905	4	4
Insurance Commissioner	F. Albert Kurtz	3/13/1896	9/1/1900	4	0
Insurance Commissioner	Thomas B. Townsend	12/18/1895	3/13/1896	0	3
Insurance Commissioner	I. Freeman Rasin	1/7/1893	12/14/1895	2	11
Insurance Commissioner	J. Frederick C. Talbott	10/1/1889	1/7/1893	3	3
Insurance Commissioner	Jesse K. Hines <i>(Died Sept. 20, 1889)</i>	2/1/1877	9/20/1889	12	7
Insurance Commissioner	John M. Miller	4/29/1876	1/31/1877	0	9
Insurance Commissioner	<i>Position Vacant</i>	1/31/1876	4/29/1876	0	3
Insurance Commissioner	Charles A. Wailes <i>(Died Jan. 31, 1876)</i>	1/1/1872	1/31/1876	4	1
Chief Clerk of the Treasury and Superintendent of Insurance	Charles A. Wailes <i>(Died Jan. 31, 1876)</i>	5/24/1871	1/1/1872	0	7

MASSACHUSETTS—Appointed, at the Discretion of the Governor					
Insurance Commissioner	Gary D. Anderson	10/31/2017		incumbent	
Acting Insurance Commissioner	Gary D. Anderson	2/23/2017	10/31/2017	0	8
Insurance Commissioner	Daniel R. Judson	4/1/2015	2/23/2017	1	10
Acting Insurance Commissioner	Gary D. Anderson	12/1/2014	4/1/2015	0	4

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NAIC MEMBER TENURE LIST

STATE/MEMBER TITLE	MEMBER NAME	BEG. DATE	END DATE	YRS. SERVED	MOS. SERVED
MASSACHUSETTS—Continued					
Insurance Commissioner	Joseph G. Murphy	2/8/2010	12/1/2014	4	10
Acting Insurance Commissioner	Joseph G. Murphy	9/1/2009	2/8/2010	0	5
Insurance Commissioner	Nonnie S. Burnes (Died Aug. 14, 2021)	2/1/2007	9/1/2009	2	7
Acting Insurance Commissioner	Joseph G. Murphy	1/1/2007	2/1/2007	0	1
Insurance Commissioner	Julianne M. 'Julie' Bowler	4/2/2002	1/1/2007	4	9
Insurance Commissioner	Linda L. Ruthardt	8/1/1993	4/2/2002	8	8
Insurance Commissioner	Kay Doughty	7/1/1991	6/30/1993	1	11
Acting Insurance Commissioner	Susan Scott	1/1/1991	7/1/1991	0	6
Insurance Commissioner	Timothy H. Gailey	7/1/1989	1/1/1991	1	6
Insurance Commissioner	Roger M. Singer	7/16/1987	7/1/1989	2	0
Insurance Commissioner	Peter Hiam	4/1/1983	7/16/1987	4	3
Insurance Commissioner	Michael J. Sabbagh	6/1/1979	4/1/1983	3	10
Insurance Commissioner	John G. Ryan	11/1/1971	6/1/1979	7	7
Insurance Commissioner	C. Eugene Farnam	12/1/1962	11/1/1971	8	11
Insurance Commissioner	Otis M. Whitney	1/1/1959	12/1/1962	3	11
Insurance Commissioner	Joseph A. Humphreys	1/1/1954	12/31/1958	4	11
Insurance Commissioner	Edmund S. Cogswell	1/1/1953	12/31/1953	0	11
Insurance Commissioner	Dennis E. Sullivan	1/1/1951	12/31/1952	1	11
Insurance Commissioner	Charles F. J. Harrington*	4/1/1938	12/31/1950	12	8
Insurance Commissioner	Francis J. DeCelles	4/1/1935	4/1/1938	3	0
Insurance Commissioner	Merton L. Brown	12/1/1928	4/1/1935	6	4
Acting Insurance Commissioner	Arthur E. Linnell	9/1/1928	12/1/1928	0	3
Insurance Commissioner	Wesley E. Monk	6/1/1923	9/1/1928	5	3
Insurance Commissioner	Clarence W. Hobbs	3/1/1920	6/1/1923	3	3
Acting Insurance Commissioner	Clarence W. Hobbs	9/1/1919	3/1/1920	0	6
Insurance Commissioner	Frank H. Hardison*	11/1/1907	9/1/1919	11	10
Insurance Commissioner	Frederick L. 'Fred' Cutting*	9/30/1897	11/1/1907	10	1
Insurance Commissioner	George S. Merrill*	9/1/1887	9/30/1897	10	1
Insurance Commissioner	John K. Tarbox* (Died May 28, 1887)	4/21/1883	5/28/1887	4	1
Insurance Commissioner	Julius L. Clarke*	5/24/1871	2/14/1883	12	4
MICHIGAN—Appointed, at the Pleasure of the Governor; 4-Year Term					
Director, Department of Insurance and Financial Services (DIFS)	Anita G. Fox	1/14/2019		incumbent	
Acting Director, DIFS	Judith A. 'Judy' Weaver	12/28/2018	1/14/2019	0	1
Director, DIFS	Patrick M. McPharlin	5/18/2015	12/28/2018	3	7
Director, DIFS	Annette E. Flood	11/1/2013	5/18/2015	1	6
Director, DIFS	R. Kevin Clinton	3/18/2013	11/1/2013	0	7
Commissioner, Office of Financial and Insurance Regulation (OFIR)	R. Kevin Clinton	4/16/2011	3/17/2013	1	11
Commissioner, OFIR	Kenneth 'Ken' Ross	4/6/2008	4/15/2011	3	0
Commissioner, Office of Financial and Insurance Services (OFIS)	Kenneth 'Ken' Ross	2/22/2008	4/5/2008	0	2
Acting Commissioner, OFIS	Kenneth 'Ken' Ross	11/1/2007	2/21/2008	0	3
Commissioner, OFIS	Linda A. Watters	4/11/2003	10/31/2007	4	6
Acting Commissioner, OFIS	Ronald C. Jones, Jr.	2/1/2003	4/11/2003	0	2
Commissioner, OFIS	Frank M. Fitzgerald	4/3/2000	2/1/2003	2	10
Commissioner of Insurance	Frank M. Fitzgerald	1/1/1999	4/2/2000	1	3

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NAIC MEMBER TENURE LIST

STATE/MEMBER TITLE	MEMBER NAME	BEG. DATE	END DATE	YRS. SERVED	MOS. SERVED
MICHIGAN—Continued					
Commissioner of Insurance	E. L. Cox	5/4/1998	1/1/1999	0	8
Acting Commissioner of Insurance	Dominic A. D'Annunzio	8/11/1997	5/4/1998	0	9
Commissioner of Insurance	D. Joseph Olson	4/4/1995	8/11/1997	2	4
Acting Commissioner of Insurance	Patrick M. McQueen	1/1/1995	4/4/1995	0	3
Commissioner of Insurance	David J. Dykhouse	4/1/1991	1/1/1995	3	9
Acting Commissioner of Insurance	Dominic A. D'Annunzio	1/1/1991	4/1/1991	0	3
Acting Commissioner of Insurance	Dhiraj N. Shah	10/3/1988	1/1/1991	2	3
Commissioner of Insurance	Herman W. Coleman	9/1/1985	10/3/1988	3	1
Commissioner of Insurance	Nancy A. Baerwaldt	11/1/1980	9/1/1985	4	10
Acting Commissioner of Insurance	Elbert C. Mackey	6/1/1980	11/1/1980	0	5
Commissioner of Insurance	Richard A. Hemmings	12/1/1979	6/1/1980	0	6
Acting Commissioner of Insurance	Jean K. Carlson	1/1/1979	12/1/1979	0	11
Commissioner of Insurance	Thomas C. Jones	12/1/1975	1/1/1979	3	1
Commissioner of Insurance	Daniel J. Demlow	12/1/1973	12/1/1975	2	0
Commissioner of Insurance	Russell E. Van Hooser*	1/27/1969	12/1/1973	4	10
Commissioner of Insurance	David J. Dykhouse	12/1/1966	1/27/1969	2	2
Acting Commissioner of Insurance	John W. Wickstrom	1/1/1966	12/1/1966	0	11
Commissioner of Insurance	Allen L. Mayerson	12/1/1963	1/1/1966	2	1
Commissioner of Insurance	Sherwood Colburn	1/1/1962	12/1/1963	1	11
Commissioner of Insurance	Frank Blackford	1/1/1959	1/1/1962	3	0
Commissioner of Insurance	Joseph A. Navarre*	1/1/1951	1/1/1959	8	0
Commissioner of Insurance	David A. Forbes*	2/16/1943	1/1/1951	7	11
Acting Commissioner of Insurance	Horace B. Corell	1/2/1943	2/16/1943	0	1
Commissioner of Insurance	Eugene P. Berry	1/6/1941	12/31/1942	2	0
Commissioner of Insurance	John G. Emery	4/1/1939	1/6/1941	1	9
Commissioner of Insurance	Charles E. Gauss	1/1/1937	4/1/1939	2	3
Commissioner of Insurance	John C. Ketcham	1/1/1935	1/1/1937	2	0
Commissioner of Insurance	Charles E. Gauss	2/19/1933	1/1/1935	1	11
Commissioner of Insurance	Charles D. Livingston*	1/12/1927	2/19/1933	6	1
Commissioner of Insurance	Leonard T. Hands	5/18/1921	1/12/1927	5	8
Commissioner of Insurance	Frank H. Ellsworth*	7/1/1917	4/30/1921	3	10
Commissioner of Insurance	John T. Winship	7/1/1913	7/1/1917	4	0
Commissioner of Insurance	Calvin A. 'Puss' Palmer*	2/1/1911	7/1/1913	2	5
Commissioner of Insurance	Marion O. Rowland	11/15/1910	2/1/1911	0	3
Commissioner of Insurance	James V. Barry*	1/1/1901	11/15/1910	9	10
Commissioner of Insurance	Harry H. Stevens	7/1/1899	1/1/1901	1	6
Commissioner of Insurance	Milo D. Campbell	7/1/1897	7/1/1899	2	0
Commissioner of Insurance	Theron F. Giddings	7/1/1893	7/1/1897	4	0
Commissioner of Insurance	William E. Magill	7/1/1891	7/1/1893	2	0
Commissioner of Insurance	Henry S. Raymond	1/1/1885	7/1/1891	6	6
Commissioner of Insurance	Eugene Pringle	3/1/1883	1/1/1885	1	10
Commissioner of Insurance	Samuel H. Row*	5/24/1871	3/1/1883	11	10

MINNESOTA—Appointed, at the Pleasure of the Governor; Confirmed by the Senate					
Commissioner of Commerce	Grace Arnold (Reappointed Jan. 2, 2023; Confirmed Feb. 16, 2023)	4/15/2021		incumbent	
Temporary Cmsr. of Commerce	Grace Arnold	9/11/2020	4/15/2021	0	7
Commissioner of Commerce	Steve Kelley	1/7/2019	9/11/2020	1	8
Commissioner of Commerce	Jessica Looman	11/17/2017	1/7/2019	1	2

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NAIC MEMBER TENURE LIST

STATE/MEMBER TITLE	MEMBER NAME	BEG. DATE	END DATE	YRS. SERVED	MOS. SERVED
MINNESOTA—Continued					
Commissioner of Commerce	Michael J. ‘Mike’ Rothman	1/12/2011	11/17/2017	6	10
Commissioner of Commerce	Glenn Wilson, Jr.	1/6/2003	1/12/2011	8	0
Commissioner of Commerce	James C. ‘Jim’ Bernstein	7/31/2000	1/6/2003	2	6
Acting Commissioner of Commerce	James C. ‘Jim’ Bernstein	2/24/2000	7/31/2000	0	5
Commissioner of Commerce	Steve Minn	8/16/1999	2/24/2000	0	6
Acting Commissioner of Commerce	Gary LaVasseur	8/6/1999	8/16/1999	0	1
Commissioner of Commerce	David M. Jennings	1/4/1999	8/6/1999	0	7
Commissioner of Commerce	David B. ‘Dave’ Gruenes	12/26/1995	1/4/1999	3	0
Commissioner of Commerce	James E. ‘Jim’ Ulland	9/1/1993	12/26/1995	2	4
Commissioner of Commerce	<i>Position Vacant</i>	8/1/1993	9/1/1993	0	1
Commissioner of Commerce	Bert J. McKasy	1/14/1991	8/1/1993	2	7
Acting Commissioner of Commerce	James Miller	1/7/1991	1/14/1991	0	1
Commissioner of Commerce	Thomas H. ‘Tom’ Borman	1/9/1990	1/7/1991	1	0
Commissioner of Commerce	Michael A. Hatch	7/1/1983	1/9/1990	6	6
Commissioner of Insurance	Reynaud L. Harp	1/3/1983	7/1/1983	0	6
Acting Commissioner of Insurance	Thomas L. O’Malley	7/1/1982	1/3/1983	0	6
Commissioner of Insurance	Michael D. ‘Mike’ Markman	3/5/1979	7/1/1982	3	4
Commissioner of Insurance	Berton W. Heaton	4/6/1971	3/5/1979	7	11
Acting Commissioner of Insurance	Alfred O. Anderson	8/1/1970	4/6/1971	0	8
Commissioner of Insurance	Thomas C. Hunt	7/15/1967	7/31/1970	3	0
Acting Commissioner of Insurance	L. Edwin Wang	3/13/1967	7/15/1967	0	4
Acting Commissioner of Insurance	Joseph ‘Joe’ Haveson	11/4/1965	3/9/1967	1	5
Commissioner of Insurance	Cyrus E. Magnusson*	4/15/1959	11/4/1965	6	7
Commissioner of Insurance	Cyril C. Sheehan	2/16/1953	4/15/1959	6	2
Commissioner of Insurance	A. Herbert Nelson	5/15/1951	2/15/1953	1	9
Commissioner of Insurance	Armand W. Harris	12/1/1947	5/15/1951	3	5
Commissioner of Insurance	Newell R. Johnson*	2/1/1941	12/1/1947	6	10
Commissioner of Insurance	Frank Yetka	3/1/1935	2/1/1941	5	11
Commissioner of Insurance	Garfield W. Brown*	10/15/1928	2/29/1935	6	5
Commissioner of Insurance	George W. Wells, Jr.	6/1/1922	10/15/1928	6	4
Commissioner of Insurance	Gustaf Lindquist	7/1/1920	6/1/1922	1	11
Commissioner of Insurance	John B. Sanborn	1/7/1919	7/1/1920	1	6
Commissioner of Insurance	C. Louis Weeks	9/3/1918	1/7/1919	0	4
Commissioner of Insurance	John B. Sanborn	1/7/1917	9/3/1918	1	8
Commissioner of Insurance	Samuel D. Works	1/13/1915	1/7/1917	2	0
Commissioner of Insurance	Ira C. Peterson	1/3/1915	1/13/1915	0	1
Commissioner of Insurance	Jacob A. O. Preus	1/3/1911	1/3/1915	4	0
Commissioner of Insurance	John A. Hartigan*	8/1/1907	1/3/1911	3	5
Commissioner of Insurance	Thomas D. O’Brien	1/12/1905	8/1/1907	2	7
Commissioner of Insurance	Elmer H. Dearth*	1/23/1901	1/12/1905	3	11
Commissioner of Insurance	John A. O’Shaughnessy*	2/27/1899	1/23/1901	2	0
Commissioner of Insurance	Elmer H. Dearth*	1/8/1897	2/27/1899	2	1
Acting Commissioner of Insurance	David C. Lightbourn	6/19/1896	1/8/1897	0	7
Commissioner of Insurance	Christopher H. Smith <i>(Died June 18, 1896)</i>	1/5/1891	6/18/1896	5	6
Commissioner of Insurance	Calvin P. Bailey	1/22/1889	1/5/1891	2	0
Commissioner of Insurance	Charles Shandrew	1/6/1887	1/22/1889	2	0
Commissioner of Insurance	Andrew R. McGill*	12/15/1873	1/6/1887	13	1
Commissioner of Insurance	Pennock Pusey	3/1/1872	12/15/1873	1	9

* NAIC Past President. This person served as NAIC President one or more times during their term(s) of office.

NAIC MEMBER TENURE LIST

STATE/MEMBER TITLE	MEMBER NAME	BEG. DATE	END DATE	YRS. SERVED	MOS. SERVED
MISSISSIPPI—Elected; 4-Year Term					
Commissioner of Insurance	Michael J. ‘Mike’ Chaney <i>(Elected Nov. 6, 2007; Re-elected Nov. 8, 2011; Re-elected Nov. 3, 2015; Re-elected Nov. 5, 2019 Re-elected Nov. 7, 2023)</i>	1/10/2008		incumbent	
Commissioner of Insurance	George Dale	1/1/1976	1/10/2008	32	0
Commissioner of Insurance	Evelyn Gandy	1/1/1972	1/1/1976	4	0
Commissioner of Insurance	Walter D. Davis	6/1/1952	1/1/1972	19	7
Commissioner of Insurance	Jesse L. White	2/2/1944	6/1/1952	8	4
Commissioner of Insurance	John Sharp Williams III* <i>(Died Jan. 29, 1944)</i>	1/1/1936	1/29/1944	8	1
Commissioner of Insurance	James H. Johnson	6/18/1935	1/1/1936	0	7
Commissioner of Insurance	George D. Riley <i>(Died June 18, 1935)</i>	1/18/1932	6/18/1935	3	5
Commissioner of Insurance	Ben S. Lowry	1/16/1928	1/18/1932	4	0
Commissioner of Insurance	Thomas M. Henry	1/18/1908	1/16/1928	20	0
Commissioner of Insurance	William Q. Cole	1/18/1904	1/18/1908	4	0
Auditor of Public Accounts/Cmsr. of Insurance	William Q. Cole	3/5/1902	1/18/1904	1	10
Auditor of Public Accounts	William Q. Cole	1/15/1900	3/5/1902	2	2
Auditor of Public Accounts	William D. Holder	1/20/1896	1/15/1900	4	0
Auditor of Public Accounts	W. W. Stone	1/1/1886	1/20/1896	10	0
Auditor of Public Accounts	Sylvester Gwin	1/1/1878	1/1/1886	6	4
Auditor of Public Accounts	William H. Gibbs	1/1/1874	1/1/1876	2	0
Auditor of Public Accounts	Henry Musgrove	5/24/1871	1/1/1874	3	8

MISSOURI—Appointed, at the Pleasure of the Governor; Confirmed by the Senate					
Director of Insurance	Chlora Lindley-Myers	4/13/2017		incumbent	
Acting Director of Insurance	Chlora Lindley-Myers	3/6/2017	4/13/2017	0	1
Acting Director of Insurance	John F. Rehagen	2/7/2017	3/6/2017	0	1
Director of Insurance	John M. Huff*	2/6/2009	2/6/2017	8	0
Acting Director of Insurance	Kip Stetzler	1/10/2009	2/5/2009	0	1
Acting Director of Insurance	Linda Bohrer	6/1/2008	1/1/2009	0	7
Director of Insurance	Douglas M. ‘Doug’ Ommen	1/2/2007	6/1/2008	1	5
Director of Insurance	W. Dale Finke	1/10/2005	1/2/2007	2	0
Director of Insurance	Scott B. Lakin	3/15/2001	1/10/2005	3	10
Director of Insurance	Keith Wenzel	5/10/1999	3/15/2001	1	10
Acting Director of Insurance	A. W. McPherson	10/31/1998	5/10/1999	0	7
Director of Insurance	Jay Angoff	2/16/1993	10/30/1998	5	8
Director of Insurance	Lewis E. Melahn	7/3/1989	2/11/1993	3	7
Acting Director of Insurance	Larry C. Call	5/24/1989	7/1/1989	0	2
Director of Insurance	William A. Bennett	2/28/1989	5/19/1989	0	3
Acting Director of Insurance	Larry C. Call	10/3/1988	2/27/1989	0	4
Director of Insurance	Lewis R. ‘Lew’ Crist	1/6/1986	10/1/1988	2	9
Acting Director of Insurance	Mary Hall	9/30/1985	1/5/1986	0	4
Director of Insurance	C. Donald Ainsworth	2/18/1981	9/27/1985	4	7
Acting Director of Insurance	William Arthur Jones	9/1/1980	2/17/1981	0	5
Director of Insurance	Richard J. Fredrick	6/1/1979	8/30/1980	1	3
Director of Insurance	Jerry B. Buxton	6/1/1977	5/31/1979	2	0

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NAIC MEMBER TENURE LIST

STATE/MEMBER TITLE	MEMBER NAME	BEG. DATE	END DATE	YRS. SERVED	MOS. SERVED
MISSOURI—Continued					
Superintendent of Insurance	Henry W. Edmiston	6/25/1975	5/31/1977	1	11
Acting Superintendent of Insurance	John Webb	6/1/1975	6/25/1975	0	1
Superintendent of Insurance	Edward G. Farmer, Jr.	4/1/1973	5/31/1975	2	2
Superintendent of Insurance	James P. Dalton	11/1/1972	3/31/1973	0	5
Superintendent of Insurance	William Y. 'Bill' McCaskill	5/22/1969	10/31/1972	3	5
Superintendent of Insurance	Robert D. Scharz	1/11/1965	5/21/1969	4	4
Superintendent of Insurance	Ralph H. Duggins	9/6/1963	1/11/1965	2	2
Superintendent of Insurance	Jack L. Clay	12/8/1961	9/6/1963	1	9
Acting Superintendent of Insurance	Jack L. Clay	11/15/1961	12/8/1961	0	1
Superintendent of Insurance	C. Lawrence Leggett*	11/25/1949	11/15/1961	12	0
Superintendent of Insurance	Owen G. Jackson	11/15/1945	11/24/1949	4	0
Superintendent of Insurance	Edward L. Scheufler	9/29/1941	10/15/1945	4	1
Superintendent of Insurance	Ray B. Lucas	1/10/1939	9/29/1941	2	8
Acting Superintendent of Insurance	F. P. Sizer	1/3/1939	1/9/1939	0	1
Superintendent of Insurance	George A. S. Robertson <i>(Died Jan. 2, 1939)</i>	7/1/1937	1/2/1939	1	6
Superintendent of Insurance	Robert Emmett O'Malley	7/1/1933	7/1/1937	4	0
Superintendent of Insurance	Joseph B. Thompson	3/1/1929	7/1/1933	4	4
Superintendent of Insurance	Ben C. Hyde	10/1/1921	3/1/1929	7	5
Superintendent of Insurance	Alfred L. Harty*	5/1/1918	10/1/1921	3	5
Acting Superintendent of Insurance	Claud L. Clark	3/5/1918	5/1/1918	0	2
Superintendent of Insurance	Walter K. Chorn	9/1/1915	3/5/1918	2	6
Superintendent of Insurance	Charles G. Revelle	3/1/1913	9/1/1915	2	6
Superintendent of Insurance	Frank Blake	11/1/1909	3/1/1913	3	4
Superintendent of Insurance	John Kennish	3/1/1909	11/1/1909	0	8
Superintendent of Insurance	W. D. Vandiver	4/1/1905	3/1/1909	3	11
Superintendent of Insurance	Robert G. Yates	11/1/1902	4/1/1905	2	5
Superintendent of Insurance	Edward E. Yates	6/1/1902	11/1/1902	0	5
Superintendent of Insurance	Thomas H. Wagner	8/1/1901	6/1/1902	0	10
Superintendent of Insurance	Edward T. Orear*	3/1/1897	8/1/1901	4	5
Superintendent of Insurance	James R. Waddill*	3/1/1893	3/1/1897	4	0
Superintendent of Insurance	Christopher P. Ellerbe*	3/1/1889	3/1/1893	4	0
Superintendent of Insurance	Alfred Carr	3/1/1885	3/1/1889	4	0
Superintendent of Insurance	John F. Williams	3/1/1881	3/1/1885	4	0
Superintendent of Insurance	William S. Relfe	3/1/1877	3/1/1881	4	0
Superintendent of Insurance	Celsus Price	7/1/1875	3/1/1877	1	8
Superintendent of Insurance	Francis P. Blair, Jr.	10/1/1873	7/1/1875	1	9
Superintendent of Insurance	William Selby	3/1/1873	10/1/1873	0	7
Superintendent of Insurance	Miles Sells	6/1/1872	3/1/1873	0	9
Superintendent of Insurance	Wyllis King	5/24/1871	6/1/1872	1	1

MONTANA—Elected; 4-Year Term					
Cmsr. of Securities and Insurance / State Auditor	Troy Downing <i>(Elected Nov. 3, 2020)</i>	1/4/2021		incumbent	
Cmsr. of Securities and Insurance / State Auditor	Matthew M. 'Matt' Rosendale <i>(Elected Nov. 8, 2016)</i>	1/2/2017	1/3/2021	4	0
Cmsr. of Securities and Insurance / State Auditor	Monica J. Lindeen* <i>(Elected Nov. 4, 2008; Re-elected Nov. 6, 2012)</i>	1/5/2009	1/2/2017	8	0

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NAIC MEMBER TENURE LIST

STATE/MEMBER TITLE	MEMBER NAME	BEG. DATE	END DATE	YRS. SERVED	MOS. SERVED
MONTANA—Continued					
Cmsr. of Securities and Insurance / State Auditor	John Morrison (Elected Nov. 7, 2000; Re-elected Nov. 2, 2004)	1/1/2001	1/5/2009	8	0
Cmsr. of Insurance/State Auditor	Mark D. O’Keefe (Elected Nov. 3, 1992; Re-elected Nov. 5, 1996)	1/4/1993	1/1/2001	8	0
Cmsr. of Insurance/State Auditor	Andrea M. ‘Andy’ Bennett (Elected Nov. 6, 1984 Re-elected Nov. 8, 1988)	1/7/1985	1/4/1993	8	0
Cmsr. of Insurance/State Auditor	Elmer V. ‘Sonny’ Omholt	5/21/1962	1/7/1985	22	8
Cmsr. of Insurance/State Auditor	John J. Holmes (Died May 12, 1962)	1/3/1933	5/12/1962	29	4
Cmsr. of Insurance/State Auditor	George P. Porter	1/6/1919	1/3/1933	14	0
Cmsr. of Insurance/State Auditor	Rufus G. Poland	6/28/1917	1/6/1919	1	7
Cmsr. of Insurance/State Auditor	William Keating (Died June 23, 1917)	1/6/1913	6/23/1917	4	5
Cmsr. of Insurance/State Auditor	Charles M. McCoy	12/15/1911	1/6/1913	1	1
Cmsr. of Insurance/State Auditor	Henry R. Cunningham	1/1/1905	12/14/1911	6	11
State Auditor	James H. Calderhead	1/7/1901	1/1/1905	4	0
State Auditor	Thomas W. Poindexter, Jr.	1/4/1897	1/7/1901	4	0
State Auditor	Andrew B. Cook	1/2/1893	1/4/1897	4	0
State Auditor	Edwin A. Kenney	6/15/1892	1/2/1893	3	2
NEBRASKA—Appointed, at the Pleasure of the Governor					
Director of Insurance	Eric Dunning (Appointed April 19, 2021; Reappointed Jan. 5, 2023)	4/19/2021		incumbent	
Director of Insurance	Bruce R. Ramge	11/15/2010	4/18/2021	10	5
Acting Director of Insurance	Bruce R. Ramge	10/30/2010	11/15/2010	0	1
Director of Insurance	Ann M. Frohman	11/28/2007	10/30/2010	2	11
Acting Director of Insurance	Ann M. Frohman	10/10/2007	11/28/2007	0	1
Director of Insurance	L. Timothy ‘Tim’ Wagner (Died Oct. 9, 2007)	1/7/1999	10/9/2007	8	9
Director of Insurance	Timothy J. Hall	1/3/1998	1/7/1999	1	0
Director of Insurance	Robert G. Lange	3/1/1995	1/3/1998	2	10
Acting Director of Insurance	Robert G. Lange	2/1/1994	3/1/1995	1	1
Director of Insurance	William H. ‘Bill’ McCartney*	3/2/1987	2/1/1994	6	11
Director of Insurance	Michael J. Dugan	3/1/1983	3/2/1987	4	0
Director of Insurance	Walter D. Weaver	2/1/1979	3/1/1983	4	1
Director of Insurance	M. Berri Balka	1/1/1977	2/1/1979	1	1
Director of Insurance	E. Benjamin ‘Ben’ Nelson	8/15/1975	12/31/1976	1	4
Director of Insurance	James M. Jackson	7/7/1972	8/15/1975	3	1
Director of Insurance	Samuel ‘Sam’ Van Pelt	1/7/1971	7/7/1972	1	6
Director of Insurance	Benjamin C. ‘Ben’ Neff, Jr.	7/1/1967	1/7/1971	3	6
Acting Director of Insurance	Benjamin C. ‘Ben’ Neff, Jr.	1/28/1967	7/1/1967	0	6
Director of Insurance	Frank J. Barrett*	1/5/1961	1/5/1967	6	0
Director of Insurance	William E. Grubbs	1/8/1959	1/5/1961	2	0
Director of Insurance	John H. Binning	7/1/1957	1/8/1959	1	6
Director of Insurance	Thomas R. ‘Tom’ Pansing	1/8/1953	7/1/1957	5	6
Director of Insurance	Loren H. Laughlin	1/1/1952	12/31/1952	1	0
Director of Insurance	Bernard R. Stone	1/9/1947	12/31/1951	6	0

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NAIC MEMBER TENURE LIST

STATE/MEMBER TITLE	MEMBER NAME	BEG. DATE	END DATE	YRS. SERVED	MOS. SERVED
NEBRASKA—Continued					
Director of Insurance	Donald R. 'Don' Hodder	7/1/1946	1/9/1947	0	6
Director of Insurance	Stanley A. Matzke	6/15/1945	7/1/1946	1	0
Director of Insurance	Cecil C. Frazier	1/9/1941	6/15/1945	4	5
Director of Insurance	Charles Smrha	9/9/1935	1/9/1941	5	4
Acting Director of Insurance	John S. Logan	8/5/1935	9/9/1935	0	1
Director of Insurance	Conn W. Moose	1/3/1935	8/5/1935	0	7
Director of Insurance	Robert E. Lee 'Lee' Herdman	4/1/1933	1/3/1935	1	9
Commissioner of Insurance	Robert E. Lee 'Lee' Herdman	6/1/1931	4/1/1933	1	10
Acting Commissioner of Insurance	Joseph L. Kizer	1/3/1931	6/1/1931	0	5
Commissioner of Insurance	Lloyd C. Dort	10/16/1929	1/3/1931	1	3
Acting Commissioner of Insurance	Joseph L. Kizer	2/1/1929	10/16/1929	0	8
Commissioner of Insurance	Charles B. Anderson	1/3/1929	2/1/1929	0	1
Commissioner of Insurance	John R. Dumont	4/10/1925	1/3/1929	3	9
Acting Chief, Bureau of Insurance	Mary A. Fairchild	1/4/1923	4/10/1925	2	3
Chief, Bureau of Insurance	W. Bruce Young	8/23/1919	1/4/1923	3	4
Secretary of Insurance Board /Insurance Commissioner	William B. Eastham	7/23/1915	8/23/1919	4	1
Secretary of Insurance Board /Insurance Commissioner	Lawson G. Brian	7/22/1913	7/23/1915	2	0
State Auditor	William B. Howard	1/9/1913	7/22/1913	0	6
State Auditor	Silas R. Barton	1/7/1909	1/9/1913	4	0
State Auditor	Edward M. Searle, Jr.	1/5/1905	1/7/1909	4	0
State Auditor	Charles E. Weston	1/3/1901	1/5/1905	4	0
State Auditor	John F. Cornell	1/7/1897	1/3/1901	4	0
State Auditor	Eugene Moore	1/13/1893	1/7/1897	4	0
State Auditor	Thomas H. Benton	1/3/1889	1/13/1893	4	0
State Auditor	Heman A. Babcock	1/8/1885	1/3/1889	4	0
State Auditor	John Wallichs	11/12/1880	1/8/1885	4	2
State Auditor	Frederick W. Liedtke	1/9/1879	11/11/1880	1	10
State Auditor	Jefferson B. Weston	1/13/1873	1/9/1879	6	0
State Auditor	John Gillespie	5/24/1871	1/13/1873	1	8
NEVADA—Appointed, at the Pleasure of the Director of the Department of Business and Industry					
Insurance Commissioner	Scott J. Kipper	2/27/2023		Incumbent	
Interim Insurance Commissioner	Nick Stosic	1/6/2023	2/26/2023	0	1
Insurance Commissioner	<i>Position Vacant</i>	12/31/2022	1/5/2023	0	1
Insurance Commissioner	Barbara D. Richardson	3/7/2016	12/30/2022	6	9
Acting Insurance Commissioner	Amy L. Parks	7/7/2015	3/7/2016	0	8
Insurance Commissioner	Scott J. Kipper	10/24/2011	7/2/2015	3	9
Acting Insurance Commissioner	Amy L. Parks	8/12/2011	10/24/2011	0	2
Insurance Commissioner	Brett J. Barratt	7/7/2010	7/1/2011	1	0
Insurance Commissioner	Scott J. Kipper	12/29/2008	6/30/2010	1	6
Acting Insurance Commissioner	Betty Baker	9/1/2008	12/29/2008	0	3
Insurance Commissioner	Alice Molasky-Arman	1/6/1995	9/1/2008	13	8
Insurance Commissioner	Teresa 'Terry' Froncek Rankin	9/6/1991	12/1/1994	3	3
Acting Insurance Commissioner	Teresa 'Terry' Froncek Rankin	2/1/1991	9/6/1991	0	7
Insurance Commissioner	Alessandro A. 'Al' Iuppa*	1/1/1990	2/1/1991	1	1
Insurance Commissioner	David A. Gates*	7/6/1984	1/1/1990	5	6
Insurance Commissioner	Kevin Sullivan	1/3/1983	7/6/1984	1	6
Insurance Commissioner	Patsy Redmond	5/12/1981	1/3/1983	1	8

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NAIC MEMBER TENURE LIST

STATE/MEMBER TITLE	MEMBER NAME	BEG. DATE	END DATE	YRS. SERVED	MOS. SERVED
NEVADA—Continued					
Insurance Commissioner	Donald W. 'Don' Heath	1/1/1979	5/12/1981	2	4
Insurance Commissioner	James L. 'Jim' Wadhams	6/1/1978	1/1/1979	0	7
Insurance Commissioner	Richard L. 'Dick' Rottman*	3/11/1971	6/1/1978	7	3
Insurance Commissioner	Louis T. Mastos	6/1/1965	3/11/1970	5	9
Insurance Commissioner	Paul A. Hammel* (Died April 21, 1965)	4/1/1951	4/21/1965	14	1
Deputy Controller	Paul A. Hammel* (Died April 21, 1965)	1/1/1951	4/1/1951	0	3
State Comptroller	Jerome P. 'Jerry' Donovan	12/1/1947	1/1/1951	3	5
State Comptroller	Henry C. Schmidt	1/8/1935	12/1/1947	12	11
State Comptroller	Edward C. Peterson	1/3/1927	1/8/1935	8	0
State Comptroller	George A. Cole	1/1/1915	1/1/1927	12	0
State Comptroller	Jacob Eggers	1/1/1907	1/1/1915	8	0
State Comptroller	Samuel P. Davis	1/1/1899	1/1/1907	8	0
State Comptroller	C. A. LaGrave	1/1/1895	1/1/1899	4	0
State Comptroller	Robert L. Horton	1/1/1891	1/1/1895	4	0
State Comptroller	James F. Hallock	1/1/1879	1/1/1891	12	0
State Comptroller	William W. Hobart	10/18/1871	1/1/1879	7	3
NEW HAMPSHIRE—Appointed, 5-Year Term; Nominated by the Governor; Approved by the Executive Council					
Acting Insurance Commissioner	David J. 'D.J.' Bettencourt	7/5/2023		Incumbent	
Insurance Commissioner	Christopher R. 'Chris' Nicolopoulos	2/19/2020	7/4/2023	3	5
Acting Insurance Commissioner	Alexander K. 'Alex' Feldvebel	1/1/2020	2/19/2020	0	1
Insurance Commissioner	John Elias	6/11/2018	12/31/2019	1	6
Insurance Commissioner	Roger A. Sevigny*	8/13/2003	6/9/2018	14	10
Insurance Commissioner	Paula T. Rogers	5/12/1999	8/12/2003	4	3
Insurance Commissioner	Charles N. 'Charlie' Blossom	8/1/1996	5/7/1999	2	9
Insurance Commissioner	Sylvio L. Dupuis	1/1/1994	8/1/1996	2	5
Insurance Commissioner	Louis E. Bergeron	7/28/1983	12/31/1993	10	5
Insurance Commissioner	Francis E. 'Frank' Whaland	3/31/1976	7/28/1983	7	4
Acting Insurance Commissioner	Leo W. Fraser, Jr.	4/11/1975	3/31/1976	1	0
Insurance Commissioner	Francis E. 'Frank' Whaland	6/13/1973	4/11/1975	1	10
Insurance Commissioner	John A. Durkin	7/2/1968	6/13/1973	4	11
Insurance Commissioner	Donald 'Don' Knowlton*	6/9/1943	7/2/1968	25	1
Acting Insurance Commissioner	Simon M. Sheldon	4/30/1943	6/9/1943	0	1
Insurance Commissioner	Arthur J. Rouillard	9/17/1937	4/30/1943	5	7
Insurance Commissioner	John E. Sullivan (Died Sept. 6, 1937)	6/16/1931	9/6/1937	6	3
Acting Insurance Commissioner	William N. Johnston	9/26/1930	6/16/1931	0	9
Insurance Commissioner	John E. Sullivan	5/17/1923	9/26/1930	7	4
Insurance Commissioner	John J. Donahue (Died May 8, 1923)	4/2/1919	5/8/1923	4	1
Insurance Commissioner	Rufus N. Elwell (Died Feb. 9, 1919)	11/21/1917	2/9/1919	1	3
Insurance Commissioner	Robert J. Merrill	1/13/1915	11/21/1917	2	10
Insurance Commissioner	Joseph Warren	12/31/1914	1/13/1915	0	1
Insurance Commissioner	Robert J. Merrill	11/23/1911	12/31/1914	3	1
Insurance Commissioner	George H. Adams*	9/25/1905	11/18/1911	6	2

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NAIC MEMBER TENURE LIST

STATE/MEMBER TITLE	MEMBER NAME	BEG. DATE	END DATE	YRS. SERVED	MOS. SERVED
NEW HAMPSHIRE—Continued					
Insurance Commissioner	John C. Linehan* <i>(Died Sept. 19, 1905)</i>	9/25/1890	9/19/1905	15	0
Insurance Commissioner	Henry H. Huse	3/14/1888	9/7/1890	2	6
Insurance Commissioner	Oliver Pillsbury* <i>(Died Feb. 21, 1888)</i>	5/24/1871	2/21/1888	16	9

NEW JERSEY—Appointed, at the Pleasure of the Governor, with the Advice and Consent of the Senate					
Acting Cmsr. of Banking and Ins.	Justin Zimmerman	6/27/2023		incumbent	
Cmsr. of Banking and Insurance	Marlene Caride	6/27/2018	6/26/2023	5	0
Acting Cmsr. of Banking and Ins.	Marlene Caride	1/16/2018	6/27/2018	0	5
Commissioner Designee	Marlene Caride	12/20/2017	1/15/2018	0	1
Cmsr. of Banking and Insurance	Richard J. Badolato	6/21/2016	12/19/2017	1	6
Acting Cmsr. of Banking and Ins.	Richard J. Badolato	8/1/2015	6/21/2016	0	10
Acting Cmsr. of Banking and Ins.	Peter L. Hartt	7/1/2015	8/1/2015	0	1
Cmsr. of Banking and Insurance	Kenneth E. Kobylowski	12/20/2012	6/30/2015	2	6
Acting Cmsr. of Banking and Ins.	Kenneth E. Kobylowski	2/11/2012	12/20/2012	0	10
Cmsr. of Banking and Insurance	Thomas B. 'Tom' Considine	2/1/2010	2/11/2012	2	0
Acting Cmsr. of Banking and Ins.	William Radar	1/1/2010	2/1/2010	0	1
Cmsr. of Banking and Insurance	Neil N. Jasey	7/17/2009	1/1/2010	0	6
Cmsr. of Banking and Insurance	Steven M. Goldman	3/20/2006	7/17/2009	3	4
Acting Cmsr. of Banking and Ins.	Donald Bryan	3/1/2005	3/20/2006	1	0
Cmsr. of Banking and Insurance	Holly C. Bakke	2/4/2002	3/1/2005	3	1
Acting Cmsr. of Banking and Ins.	Donald Bryan	10/15/2001	2/4/2002	0	4
Cmsr. of Banking and Insurance	Karen L. Suter	6/29/2000	10/15/2001	1	4
Acting Cmsr. of Banking and Ins.	Karen L. Suter	1/18/2000	6/29/2000	0	5
Cmsr. of Banking and Insurance	Jayne LaVecchia	9/1/1998	1/18/2000	1	4
Acting Cmsr. of Banking and Ins.	Jayne LaVecchia	8/24/1998	9/1/1998	0	1
Cmsr. of Banking and Insurance	Elizabeth 'Lisa' Randall	10/1/1995	8/24/1998	2	10
Acting Insurance Commissioner	Anita B. Kartalopoulos	9/14/1995	10/1/1995	0	1
Insurance Commissioner	Andrew J. 'Drew' Karpinski	5/1/1994	9/14/1995	1	4
Acting Insurance Commissioner	Andrew J. 'Drew' Karpinski	3/4/1994	5/1/1994	0	2
Insurance Commissioner	Samuel F. Fortunato	4/1/1990	3/1/1994	3	11
Acting Insurance Commissioner	Jasper Jackson	1/1/1990	4/1/1990	0	3
Insurance Commissioner	Kenneth D. Merin	5/1/1986	1/1/1990	3	8
Insurance Commissioner	Hazel Frank Gluck	3/1/1985	5/1/1986	1	2
Acting Insurance Commissioner	Jasper Jackson	1/1/1985	3/1/1985	0	2
Insurance Commissioner	Kenneth D. Merin	10/1/1984	1/1/1985	0	3
Acting Insurance Commissioner	Kenneth D. Merin	4/1/1984	10/1/1984	0	6
Insurance Commissioner	Joseph F. Murphy	2/1/1982	4/1/1984	2	2
Acting Insurance Commissioner	John G. Foley	1/1/1982	2/1/1982	0	1
Insurance Commissioner	James J. Sheeran	1/1/1974	1/1/1982	8	0
Insurance Commissioner	Richard C. McDonough	2/14/1972	1/1/1974	1	11
Insurance Commissioner	Robert L. Clifford	1/1/1970	2/14/1972	2	1
Cmsr. of Banking and Insurance	Horace J. Bryant	3/1/1969	1/1/1970	0	10
Cmsr. of Banking and Insurance	Charles R. Howell*	2/1/1955	3/1/1969	14	1
Acting Cmsr. of Banking and Ins.	Jerome B. McKenna	10/1/1954	2/1/1955	0	4
Cmsr. of Banking and Insurance	Warren N. Gaffney	5/1/1950	10/1/1954	4	5
Acting Cmsr. of Banking and Ins.	Christopher A. Gough	1/1/1949	5/1/1950	1	4
Cmsr. of Banking and Insurance	John J. Dickerson	7/1/1948	1/1/1949	0	6
Acting Cmsr. of Banking and Ins.	Christopher A. Gough	5/1/1948	7/1/1948	0	2

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NAIC MEMBER TENURE LIST

STATE/MEMBER TITLE	MEMBER NAME	BEG. DATE	END DATE	YRS. SERVED	MOS. SERVED
NEW JERSEY—Continued					
Cmsr. of Banking and Insurance	Lawrence B. Carey	2/1/1945	5/1/1948	3	3
Cmsr. of Banking and Insurance	Eugene E. Agger	1/1/1942	2/1/1945	3	1
Cmsr. of Banking and Insurance	Louis A. Reilly	3/1/1938	1/1/1942	3	10
Cmsr. of Banking and Insurance	Carl K. Withers	4/1/1935	3/1/1938	2	11
Cmsr. of Banking and Insurance	William H. Kelly	2/1/1932	4/1/1935	3	2
Cmsr. of Banking and Insurance	Frank H. Smith	2/1/1929	2/1/1932	3	0
Cmsr. of Banking and Insurance	Edward E. Maxson	2/28/1923	2/1/1929	6	0
Cmsr. of Banking and Insurance	William E. Tuttle, Jr. (Died Feb. 11, 1923)	1/1/1921	2/11/1923	2	1
Cmsr. of Banking and Insurance	Frank H. Smith	12/1/1917	1/1/1921	3	1
Cmsr. of Banking and Insurance	George M. La Monte	11/1/1912	12/1/1917	5	1
Cmsr. of Banking and Insurance	Henry J. Ford	4/1/1912	11/1/1912	0	7
Cmsr. of Banking and Insurance	Vivian M. Lewis	4/1/1909	4/1/1912	3	0
Cmsr. of Banking and Insurance	David O. Watkins	4/1/1903	4/1/1909	6	0
Cmsr. of Banking and Insurance	William Bettle	3/1/1897	3/31/1903	6	0
Cmsr. of Banking and Insurance	George W. Wurts	10/1/1896	3/1/1897	0	5
Cmsr. of Banking and Insurance	George S. Duryea	6/1/1891	10/1/1896	5	4
Cmsr. of Banking and Insurance	George B. M. Harvey	4/1/1891	6/1/1891	0	2
Cmsr. of Banking and Insurance	No Record in Proceedings (Represented by Actuary David P. Fackler)	9/20/1881	8/20/1890	8	11
Secretary of State	Henry C. Kelsey	5/24/1871	4/1/1881	9	11

NEW MEXICO—Appointed, by the Insurance Nominating Committee; 4-Year Term					
Superintendent of Insurance	Alice T. Kane	6/12/2023		incumbent	
Interim Superintendent of Insurance	Jennifer A. Catechis	1/21/2023	6/11/2023	0	5
Superintendent of Insurance	Russell Toal	1/1/2020	1/20/2023	3	0
Superintendent of Insurance	John G. Franchini	7/27/2010	12/31/2019	9	5
Acting Superintendent of Insurance	Johnny L. Montoya	6/15/2010	7/27/2010	0	1
Interim Superintendent of Insurance	Craig Dunbar	5/24/2010	6/15/2010	0	1
Interim Superintendent of Insurance	Thomas R. 'Tom' Rushton	5/4/2010	5/24/2010	0	1
Superintendent of Insurance	Morris J. 'Mo' Chavez	10/1/2006	5/4/2010	3	7
Acting Superintendent of Insurance	Thomas R. 'Tom' Rushton	6/14/2006	10/1/2006	0	4
Superintendent of Insurance	Eric P. Serna	2/20/2001	6/14/2006	5	4
Superintendent of Insurance	Donald J. 'Don' Letherer	10/4/1999	1/31/2001	1	3
Acting Superintendent of Insurance	Michael C. Batte	1/1/1999	10/4/1999	0	9
Superintendent of Insurance	Christopher P. 'Chris' Krahling	6/1/1995	12/11/1998	3	6
Acting Superintendent of Insurance	Thomas R. 'Tom' Rushton	4/28/1995	6/1/1995	0	1
Superintendent of Insurance	Fabian Chavez	4/18/1988	4/28/1995	7	0
Superintendent of Insurance	Vicente B. Jasso	8/1/1981	4/18/1988	6	8
Superintendent of Insurance	Manuel A. Garcia, Jr.	6/11/1978	8/1/1981	3	2
Superintendent of Insurance	Kenneth C. Moore	6/1/1976	6/11/1978	3	0
Superintendent of Insurance	Ralph F. Apodaca	10/15/1976	6/11/1978	1	8
Superintendent of Insurance	George A. Biel	8/20/1939	10/15/1976	37	2
Superintendent of Insurance	Eliseo Gonzales	2/15/1935	3/1/1935	0	1
Superintendent of Insurance	Alfonso Aguilar	1/6/1933	2/15/1935	2	1
Superintendent of Insurance	Max Fernandez	1/5/1931	1/6/1933	2	0
Superintendent of Insurance	J. H. Vaughn	2/1/1928	1/5/1931	2	11
Superintendent of Insurance	H. A. Delgado	3/20/1925	2/1/1928	2	11
Bank Examiner of State	L. B. Gregg	3/3/1921	3/20/1925	4	0

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NAIC MEMBER TENURE LIST

STATE/MEMBER TITLE	MEMBER NAME	BEG. DATE	END DATE	YRS. SERVED	MOS. SERVED
NEW MEXICO—Continued					
Superintendent of Insurance and Corporation Commission	Remijio Mirabel	3/6/1919	3/3/1921	2	0
Superintendent of Insurance and Corporation Commission	Cleofas Romero	3/15/1917	3/6/1919	2	0
Superintendent of Insurance	Jacobo Chavez	3/19/1907	3/15/1917	10	0
Superintendent of Insurance	John H. Sloan	1/19/1906	3/19/1907	1	2
Superintendent of Insurance	Pedro Perea (Died Jan. 11, 1906)	3/1/1905	1/11/1906	0	10
Territorial Auditor	William G. Sargent	4/1/1901	3/1/1905	3	11
Territorial Auditor	Luis M. Ortiz	3/14/1899	4/1/1901	2	0
Territorial Auditor	Marcelino Garcia	2/21/1895	3/14/1899	4	0
Territorial Auditor	Demetrio Perez	3/18/1891	2/21/1895	4	0
Territorial Auditor	Trinidad Alarid	8/15/1888	3/18/1891	2	7
NEW YORK—Appointed, at the Pleasure of the Governor					
Superintendent of Financial Services	Adrienne A. Harris	1/25/2022		incumbent	
Acting Superintendent of Fin. Svcs.	Adrienne A. Harris	9/13/2021	1/25/2022	0	4
Acting Superintendent of Fin. Svcs.	Shirin Emami	8/25/2021	9/12/2021	0	1
Superintendent of Financial Services	Linda A. Lacewell	6/21/2019	8/24/2021	2	2
Acting Superintendent of Fin. Svcs.	Linda A. Lacewell	2/4/2019	6/20/2019	0	4
Superintendent of Financial Services	Maria T. Vullo	6/15/2016	2/1/2019	2	8
Acting Superintendent of Fin. Svcs.	Maria T. Vullo	2/22/2016	6/15/2016	0	4
Acting Superintendent of Fin. Svcs.	Shirin Emami	12/1/2015	2/22/2016	0	2
Acting Superintendent of Fin. Svcs.	Anthony J. Albanese	6/18/2015	11/30/2015	0	5
Superintendent of Financial Services	Benjamin M. Lawsky	10/3/2011	6/17/2015	3	8
Superintendent of Insurance	James J. 'Jim' Wrynn	9/11/2009	10/3/2011	2	1
Acting Superintendent of Insurance	James J. 'Jim' Wrynn	8/20/2009	9/11/2009	0	1
Acting Superintendent of Insurance	Kermitt J. Brooks	7/4/2009	8/19/2009	0	1
Superintendent of Insurance	Eric R. Dinallo	4/18/2007	7/3/2009	2	3
Acting Superintendent of Insurance	Eric R. Dinallo	1/29/2007	4/17/2007	0	3
Acting Superintendent of Insurance	Louis W. 'Lou' Pietroluongo	1/1/2007	1/28/2007	0	1
Superintendent of Insurance	Howard D. Mills III	5/18/2005	12/31/2006	1	7
Acting Superintendent of Insurance	Howard D. Mills III	1/18/2005	5/17/2005	0	4
Superintendent of Insurance	Gregory V. 'Greg' Serio	5/9/2001	1/18/2005	3	9
Acting Superintendent of Insurance	Gregory V. 'Greg' Serio	4/5/2001	5/9/2001	0	1
Superintendent of Insurance	Neil D. Levin (Died Sept. 11, 2001)	4/7/1997	4/5/2001	4	0
Acting Superintendent of Insurance	Gregory V. 'Greg' Serio	12/29/1996	4/7/1997	0	4
Superintendent of Insurance	Edward J. Muhl*	2/12/1995	12/29/1996	1	10
Superintendent of Insurance	Salvatore R. Curiale	6/30/1990	12/31/1994	4	6
Acting Superintendent of Insurance	Wendy E. Cooper	1/27/1990	6/29/1990	0	5
Superintendent of Insurance	James P. Corcoran	3/8/1983	1/26/1990	6	10
Superintendent of Insurance	Albert B. Lewis	1/5/1978	3/7/1983	5	2
Acting Superintendent of Insurance	John F. Lennon	7/21/1977	1/4/1978	0	6
Superintendent of Insurance	Thomas A. Harnett	6/24/1975	7/20/1977	2	1
Acting Superintendent of Insurance	John P. Gemma	4/11/1975	6/23/1975	0	2
Superintendent of Insurance	Lawrence W. Keepnews	3/18/1975	4/11/1975	0	1
Acting Superintendent of Insurance	Lawrence O. Monin	3/10/1975	3/18/1975	0	1
Superintendent of Insurance	Benjamin R. Schenck	1/1/1971	3/10/1975	4	2
Superintendent of Insurance	Richard E. 'Dick' Stewart*	1/1/1967	12/31/1970	3	11

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NAIC MEMBER TENURE LIST

STATE/MEMBER TITLE	MEMBER NAME	BEG. DATE	END DATE	YRS. SERVED	MOS. SERVED
NEW YORK—Continued					
Superintendent of Insurance	Henry Root Stern, Jr.	1/28/1964	12/31/1966	2	11
Acting Superintendent of Insurance	Samuel C. Cantor	10/3/1963	1/27/1964	0	3
Superintendent of Insurance	Thomas Thacher	1/27/1959	10/2/1963	4	9
Superintendent of Insurance	Julius S. Wikler	3/17/1958	1/26/1959	0	10
Superintendent of Insurance	Leffert Holz	2/3/1955	3/15/1958	3	1
Acting Superintendent of Insurance	Adelbert G. Straub, Jr.	2/1/1955	2/3/1955	0	1
Superintendent of Insurance	Alfred J. Bohlinger	7/1/1950	1/31/1955	4	6
Superintendent of Insurance	Robert E. Dineen*	9/23/1943	6/30/1950	6	9
Acting Superintendent of Insurance	Thomas J. Cullen	2/1/1943	9/22/1943	0	7
Superintendent of Insurance	Louis H. Pink	5/10/1935	1/31/1943	8	4
Superintendent of Insurance	George S. Van Schaick	3/5/1931	5/9/1935	4	2
Acting Superintendent of Insurance	Henry A. Thellusson	2/17/1931	3/4/1931	0	1
Acting Superintendent of Insurance	Thomas F. Behan	7/1/1930	2/16/1931	0	7
Superintendent of Insurance	Albert Conway	1/1/1929	6/30/1930	1	6
Superintendent of Insurance	James A. Beha	7/1/1924	1/1/1929	4	6
Superintendent of Insurance	Francis R. Stoddard, Jr.	12/1/1921	6/30/1924	2	6
Acting Superintendent of Insurance	Henry D. Appleton	11/1/1921	11/30/1921	0	1
Superintendent of Insurance	Jesse S. Phillips*	7/1/1915	10/31/1921	6	3
Superintendent of Insurance	Frank Hasbrouck	3/27/1914	6/30/1915	1	3
Superintendent of Insurance	William Temple Emmet	2/21/1912	3/26/1914	2	1
Superintendent of Insurance	William H. Hotchkiss	2/18/1909	2/18/1912	3	0
Acting Superintendent of Insurance	Henry D. Appleton	1/14/1909	2/17/1909	0	1
Superintendent of Insurance	Otto Kelsey	5/17/1906	1/13/1909	2	8
Superintendent of Insurance	Francis Hendricks	2/2/1900	5/16/1906	6	3
Superintendent of Insurance	Louis F. Payn	2/11/1897	2/1/1900	3	0
Superintendent of Insurance	James F. Pierce*	2/12/1891	2/10/1897	6	0
Superintendent of Insurance	Robert A. Maxwell	1/1/1886	2/11/1891	5	1
Superintendent of Insurance	John A. McCall, Jr.*	4/23/1883	12/31/1885	2	8
Superintendent of Insurance	Charles G. Fairman	4/27/1880	4/23/1883	3	0
Superintendent of Insurance	John F. Smyth	2/21/1877	4/26/1880	3	2
Acting Superintendent of Insurance	William Smyth	2/1/1876	2/20/1877	1	0
Superintendent of Insurance	Orlow W. Chapman*	11/29/1872	1/31/1876	3	2
Acting Superintendent of Insurance	George B. Church	5/13/1872	11/28/1872	0	6
Superintendent of Insurance	George W. Miller*	5/24/1871	5/12/1872	1	0

NORTH CAROLINA—Elected; 4-Year Term					
Commissioner of Insurance	Mike Causey <i>(Elected Nov. 8, 2016; Re-elected Nov. 3, 2020)</i>	1/1/2017		incumbent	
Commissioner of Insurance	G. Wayne Goodwin	1/10/2009	1/1/2017	8	0
Commissioner of Insurance	James E. 'Jim' Long*	1/5/1985	1/10/2009	24	0
Commissioner of Insurance	John Randolph Ingram	1/10/1973	1/5/1985	12	0
Commissioner of Insurance	Edwin S. Lanier	7/16/1962	1/10/1973	10	6
Commissioner of Insurance	Charles F. Gold	6/1/1953	7/16/1962	9	1
Commissioner of Insurance	Waldo C. Cheek	6/1/1949	6/1/1953	4	0
Commissioner of Insurance	William P. 'Bill' Hodges	9/1/1942	6/1/1949	6	9
Commissioner of Insurance	Daniel C. 'Dan' Boney*	11/15/1927	9/1/1942	14	10
Commissioner of Insurance	Stacey W. Wade	1/1/1921	11/15/1927	6	10
Commissioner of Insurance	James R. Young*	1/1/1899	1/1/1921	22	0
Secretary of State	Cyrus Thompson	1/1/1897	1/1/1899	2	0

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NAIC MEMBER TENURE LIST

STATE/MEMBER TITLE	MEMBER NAME	BEG. DATE	END DATE	YRS. SERVED	MOS. SERVED
NORTH CAROLINA—Continued					
Secretary of State	C. M. Cooke	8/1/1895	1/1/1897	1	5
Secretary of State	Octavius Coke	4/1/1891	8/1/1895	4	4
Secretary of State	William L. Saunders	1/1/1879	4/1/1891	12	3
Secretary of State	J. A. Englehard	1/1/1877	1/1/1879	2	0
Secretary of State	W. H. Howerton	1/1/1873	1/1/1877	4	0
Secretary of State	<i>No Record in Proceedings</i> (Represented by Special Delegate William H. Finch)	10/1/1871	1/1/1873	1	3

NORTH DAKOTA—Elected; 4-Year Term					
Commissioner of Insurance	Jon Godfread <i>(Elected Nov. 8, 2016; Re-elected Nov. 3, 2020)</i>	1/3/2017		incumbent	
Commissioner of Insurance	Adam W. Hamm*	10/9/2007	1/3/2017	9	3
Acting Commissioner of Insurance	Rebecca Ternes	9/1/2007	10/9/2007	0	1
Commissioner of Insurance	James A. ‘Jim’ Poolman	1/1/2001	8/31/2007	6	8
Commissioner of Insurance	Glenn Pomeroy*	1/1/1993	1/1/2001	8	0
Commissioner of Insurance	Earl R. Pomeroy*	1/1/1985	1/1/1993	8	0
Commissioner of Insurance	Jorris O. Wigen	1/1/1981	1/1/1985	4	0
Commissioner of Insurance	Byron Knutson	1/1/1977	1/1/1981	4	0
Commissioner of Insurance	Jorris O. Wigen	1/1/1969	1/1/1977	8	0
Commissioner of Insurance	Karsten O. Nygaard	1/1/1965	1/1/1969	4	0
Commissioner of Insurance	Frank Albers	1/1/1963	1/1/1965	2	0
Commissioner of Insurance	Alfred J. Jensen	1/1/1951	1/1/1963	12	0
Commissioner of Insurance	Otto G. Krueger	9/7/1945	1/1/1951	5	4
Commissioner of Insurance	Oscar E. Erickson <i>(Died Aug. 15, 1945)</i>	1/11/1937	8/15/1945	8	7
Commissioner of Insurance	Harold L. Hopton	1/7/1935	1/11/1937	2	0
Commissioner of Insurance	Sveinung A. Olsness	1/2/1917	1/7/1935	18	0
Commissioner of Insurance	Walter C. Taylor	1/1/1911	1/2/1917	6	0
Commissioner of Insurance	Ernest C. Cooper	1/1/1905	12/31/1910	6	0
Commissioner of Insurance	Ferdinand ‘Ferd’ Leutz	1/1/1901	12/31/1904	4	0
Commissioner of Insurance	George W. Harrison	1/3/1899	12/31/1900	2	0
Commissioner of Insurance	Frederick B. ‘Fred’ Fancher	1/7/1895	1/3/1899	4	0
Commissioner of Insurance	James ‘Jim’ Cudhie	1/3/1893	1/7/1895	2	0
Commissioner of Insurance	A. L. Carey	11/4/1889	1/3/1893	3	2
Territorial Auditor	John C. McManima	9/4/1889	11/4/1889	0	2

NORTHERN MARIANA ISLANDS—Appointed, Concurrent with Current Governor					
Acting Secretary of Commerce	Francisco D. Cabrera	4/26/2023		Incumbent	
Acting Secretary of Commerce	Joseph Rios Jr.	2/1/2023	4/25/2023	0	2
Secretary of Commerce	Edward M. Deleon Guerrero	7/8/2021	2/1/2023	1	7
Acting Secretary of Commerce	Edward M. Deleon Guerrero	3/28/2021	7/8/2021	0	4
Secretary of Commerce	Mark O. Rabauliman	3/6/2015	3/26/2021	6	0
Acting Secretary of Commerce	Mark O. Rabauliman	9/9/2014	3/6/2015	0	6
Secretary of Commerce	Sixto K. Igisomar	1/24/2012	9/9/2014	2	8
Acting Secretary of Commerce	Sixto K. Igisomar	10/8/2010	1/24/2012	1	3
Secretary of Commerce	Michael J. Ada	9/18/2008	10/8/2010	2	1
Acting Secretary of Commerce	Michael J. Ada	8/15/2008	9/18/2008	0	1
Secretary of Commerce	James A. Santos	5/8/2006	8/15/2008	2	3

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NAIC MEMBER TENURE LIST

STATE/MEMBER TITLE	MEMBER NAME	BEG. DATE	END DATE	YRS. SERVED	MOS. SERVED
NORTHERN MARIANA ISLANDS—Continued					
Acting Secretary of Commerce	James A. Santos	1/9/2006	5/8/2006	0	4
Secretary of Commerce	Andrew S. Salas	1/1/2006	1/9/2006	3	0
OHIO—Appointed, at the Pleasure of the Governor; Confirmed by the Senate					
Director of Insurance	Judith L. 'Judi' French	2/8/2021		incumbent	
Interim Director of Insurance	Tynesia Dorsey	8/24/2020	2/7/2021	0	6
Director of Insurance	Jillian E. Froment	3/31/2017	8/24/2020	3	5
Lt. Governor/Director of Insurance	Mary Taylor	1/10/2011	3/31/2017	6	2
Director of Insurance	Mary Jo Hudson	1/8/2007	1/10/2011	4	0
Director of Insurance	Ann H. Womer Benjamin	1/6/2003	1/8/2007	4	0
Interim Director of Insurance	Holly Saelens	11/29/2002	1/6/2003	0	2
Director of Insurance	J. Lee Covington II	5/7/1999	11/29/2002	3	7
Interim Director of Insurance	Alan F. Berlinger	4/1/1999	5/7/1999	0	1
Interim Director of Insurance	David S. Meyer	1/11/1999	4/1/1999	0	3
Director of Insurance	Harold T. Duryee	3/1/1991	1/11/1999	7	10
Acting Director of Insurance	Dana Rudmose	1/14/1991	3/1/1991	0	2
Director of Insurance	George Fabe	2/4/1983	1/14/1991	7	11
Director of Insurance	Robert H. Katz	8/31/1982	2/4/1983	0	5
Director of Insurance	Robert L. Ratchford, Jr.	12/31/1979	8/31/1982	2	8
Director of Insurance	Harry V. Jump	1/13/1975	12/31/1979	4	11
Director of Insurance	Kenneth E. 'Ken' DeShetler	1/11/1971	1/13/1975	4	0
Director of Insurance	Fred B. Smith	2/4/1969	1/11/1971	1	11
Director of Insurance	Eugene P. Brown (Died Jan. 27, 1969)	3/1/1968	1/27/1969	0	10
Superintendent of Insurance	William R. Morris	1/14/1963	3/1/1968	5	2
Superintendent of Insurance	Robert L. Mullins	12/1/1961	1/14/1963	1	1
Acting Superintendent of Insurance	Robert L. Mullins	10/1/1961	12/1/1961	0	2
Superintendent of Insurance	Edward A. 'Ted' Stowell	1/12/1959	10/1/1961	2	9
Superintendent of Insurance	Arthur I. 'Art' Vorys	1/16/1957	1/12/1959	2	0
Superintendent of Insurance	August 'Augie' Pryatel	7/2/1955	1/16/1957	1	6
Superintendent of Insurance	Walter A. Robinson	1/10/1949	7/2/1955	6	6
Superintendent of Insurance	W. Lee Shield	1/13/1947	1/10/1949	2	0
Superintendent of Insurance	Walter Dressel	1/15/1945	1/13/1947	2	0
Superintendent of Insurance	J. Roth Crabbe	3/1/1943	1/15/1945	1	10
Superintendent of Insurance	John A. Lloyd	1/16/1939	3/1/1943	4	2
Superintendent of Insurance	Robert L. Bowen	1/14/1935	1/16/1939	4	0
Superintendent of Insurance	Charles T. Warner	2/1/1931	1/14/1935	3	11
Superintendent of Insurance	Charles S. Younger	1/14/1929	1/31/1931	2	0
Superintendent of Insurance	William A. Doody	12/15/1928	1/14/1929	0	1
Superintendent of Insurance	William C. Safford	4/15/1927	12/15/1928	1	8
Superintendent of Insurance	Harry L. Conn*	2/1/1925	4/15/1927	2	2
Superintendent of Insurance	Emmett L. Savage	6/25/1924	2/1/1925	0	8
Superintendent of Insurance	Harry L. Conn*	1/12/1923	6/25/1924	1	5
Superintendent of Insurance	Bert W. Gearheart	1/25/1921	1/12/1923	2	0
Superintendent of Insurance	Robert T. Crew	7/1/1920	1/25/1921	0	6
Superintendent of Insurance	William H. Tomlinson	6/1/1917	7/1/1920	3	1
Superintendent of Insurance	Frank Taggart	2/11/1915	6/1/1917	2	4
Superintendent of Insurance	Price Russell	11/7/1914	2/11/1915	0	3
Superintendent of Insurance	Robert M. Small	4/18/1914	11/7/1914	0	7
Acting Superintendent of Insurance	Robert M. Small	2/9/1914	4/18/1914	0	2

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NAIC MEMBER TENURE LIST

STATE/MEMBER TITLE	MEMBER NAME	BEG. DATE	END DATE	YRS. SERVED	MOS. SERVED
OHIO—Continued					
Superintendent of Insurance	Edmond H. Moore	5/18/1911	2/9/1914	2	9
Superintendent of Insurance	Charles C. Lemert	12/16/1907	4/30/1911	3	5
Superintendent of Insurance	Arthur I. 'Jake' Vorys*	6/3/1900	12/16/1907	7	6
Superintendent of Insurance	William S. Matthews	6/3/1896	6/3/1900	4	0
Superintendent of Insurance	William M. Hahn*	6/3/1893	6/3/1896	3	0
Superintendent of Insurance	William H. Kinder	6/3/1890	6/3/1893	3	0
Superintendent of Insurance	Samuel E. Kemp	6/3/1887	6/3/1890	3	0
Superintendent of Insurance	Henry J. Reinmund	6/2/1884	6/3/1887	3	0
Superintendent of Insurance	Charles H. Moore	6/2/1881	6/2/1884	3	0
Superintendent of Insurance	Joseph F. Wright	6/2/1878	6/2/1881	3	0
Superintendent of Insurance	William D. Hill	6/2/1875	6/2/1878	3	0
Superintendent of Insurance	William F. Church	6/2/1872	6/2/1875	3	0
Auditor of State	James Williams	1/8/1872	6/2/1872	0	5
Auditor of State	James H. Godman	5/24/1871	1/8/1872	0	8
OKLAHOMA—Elected; 4-Year Term					
Insurance Commissioner	Glen Mulready (Elected Nov. 6, 2018; Re-elected Nov. 8, 2022)	1/14/2019		incumbent	
Insurance Commissioner	John D. Doak	1/10/2011	1/14/2019	8	0
Insurance Commissioner	Kim Holland	1/24/2005	1/10/2011	6	0
Insurance Commissioner	Position Vacant	9/24/2004	1/1/2005	0	3
Insurance Commissioner	Carroll Fisher	1/1/1999	9/24/2004	5	9
Insurance Commissioner	John P. Crawford	1/1/1995	1/1/1999	4	0
Insurance Commissioner	Catherine J. 'Cathy' Weatherford	10/1/1991	1/1/1995	3	3
Insurance Commissioner	Gerald Grimes	1/1/1975	10/1/1991	16	9
Insurance Commissioner	Joe B. Hunt	1/1/1955	1/1/1975	20	0
Insurance Commissioner	Robert L. Birdwell	6/1/1954	1/1/1955	0	7
Insurance Commissioner	Donald F. Dickey	7/21/1946	6/1/1954	7	11
Insurance Commissioner	Jess G. Read* (Died July 20, 1946)	1/6/1924	7/20/1946	22	6
Insurance Commissioner	E. W. Hardin	2/1/1921	1/6/1924	2	11
Insurance Commissioner	A. L. Welch	4/28/1913	2/1/1921	7	10
Insurance Commissioner	Perry A. Ballard	1/9/1911	4/28/1913	2	3
Insurance Commissioner	Milas Lasater	12/3/1909	1/9/1911	1	1
Insurance Commissioner	T. J. McComb	11/1/1907	12/3/1909	2	1
Territorial Secretary	Charles H. Filson	1/1/1906	11/1/1907	1	10
Territorial Secretary	William Grimes	5/1/1901	1/1/1906	4	8
Territorial Secretary	William M. Jenkins	6/1/1897	5/1/1901	3	11
Territorial Secretary	Thomas J. Lowe	9/1/1893	6/1/1897	3	9
Territorial Secretary	Robert Martin	5/1/1890	9/1/1893	3	4
OREGON—Appointed, Indefinite					
Director, Department of Consumer and Business Services (DCBS) / Insurance Commissioner	Andrew R. Stolfi	4/7/2020		incumbent	
Insurance Commissioner	Andrew R. Stolfi	2/1/2018	4/7/2020	2	2
Acting Director, DCBS / Insurance Commissioner	Cameron Smith	12/21/2017	1/31/2018	0	2

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NAIC MEMBER TENURE LIST

STATE/MEMBER TITLE	MEMBER NAME	BEG. DATE	END DATE	YRS. SERVED	MOS. SERVED
OREGON—Continued					
Acting Director, DCBS / Insurance Commissioner	Jean Straight	9/1/2017	12/20/2017	0	3
Insurance Commissioner / Chief Actuary	Laura N. Cali Robison	7/15/2013	8/31/2017	4	1
Insurance Commissioner	Louis D. Savage	5/1/2012	7/15/2013	1	2
Acting Insurance Commissioner	Louis D. Savage	11/1/2011	5/1/2012	0	6
Insurance Administrator	Teresa D. Miller	7/8/2009	11/1/2011	2	4
Acting Insurance Administrator	Teresa D. Miller	10/1/2008	7/8/2009	0	9
Insurance Administrator	Scott J. Kipper	12/1/2007	10/1/2008	0	10
Acting Insurance Administrator	Carl Lundberg	7/1/2007	12/1/2007	0	5
Insurance Administrator (named NAIC member rep. by Dir. Neidig)	Joel S. Ario	12/1/2000	7/1/2007	7	3
Director, DCBS / Insurance Commissioners	Mary C. Neidig (<i>exp. 1/1/2003</i>)	4/27/2000	12/1/2000	2	9
Acting Director, DCBS / Insurance Commissioners	Mary C. Neidig	3/1/2000	4/27/2000	0	1
Acting Director, DCBS / Insurance Commissioners	Deborah Lincoln	3/1/2000	3/1/2000	0	1
Acting Director, DCBS / Insurance Commissioners	Mike Greenfield	7/1/1998	3/1/2000	1	8
Acting Director, DCBS / Insurance Commissioners	Deborah Lincoln	3/1/1998	7/1/1998	0	4
Acting Director, DCBS / Insurance Commissioners	Kerry Barnett	12/1/1993	12/31/1997	4	0
Acting Insurance Commissioner	Geoff Guilfof	10/1/1993	12/1/1993	0	2
Insurance Commissioner	Gary Weeks	3/1/1991	10/1/1993	2	7
Acting Insurance Commissioner	Geoff Guilfof	1/1/1991	3/1/1991	0	2
Insurance Commissioner	Theodore R. Kulongoski	1/1/1987	1/1/1991	4	0
Insurance Commissioner	Josephine M. 'Jo' Driscoll*	12/1/1981	1/1/1987	5	1
Insurance Commissioner	Wilfred W. Fritz	2/1/1978	12/1/1981	3	10
Insurance Commissioner	Lester L. Rawls*	8/1/1972	12/31/1977	5	4
Acting Insurance Commissioner	F. Frank Howatt	4/1/1972	8/1/1972	0	4
Insurance Commissioner	Cornelius C. Bateson	12/1/1969	4/1/1972	2	4
Insurance Commissioner	James R. Faulstich	1/1/1967	12/1/1969	2	11
Insurance Commissioner	Walter G. Korlann	11/1/1961	1/1/1967	5	2
Insurance Commissioner	V. Dean Musser	1/1/1959	11/1/1961	2	10
Insurance Commissioner	Hugh H. Earle	7/1/1957	1/1/1959	1	6
Insurance Commissioner	Robert B. Taylor*	7/1/1949	6/30/1957	7	11
Insurance Commissioner	Seth B. Thompson*	6/1/1940	6/30/1949	9	0
Insurance Commissioner	Hugh H. Earle	7/1/1935	6/1/1939	3	11
Insurance Commissioner	Alva H. Averill	6/1/1931	12/1/1934	3	6
Insurance Commissioner	Clare A. Lee	2/1/1927	12/1/1930	3	10
Insurance Commissioner	Will Moore	8/1/1923	10/1/1926	3	2
Insurance Commissioner	A. C. Barbour	9/1/1920	9/1/1921	1	0
Insurance Commissioner	Harvey W. Wells	9/1/1915	9/1/1919	4	0
Insurance Commissioner	John W. Ferguson	7/1/1912	9/1/1915	3	2
Insurance Commissioner	Samuel A. Kozer	8/1/1911	7/1/1912	0	11
Insurance Superintendent	Samuel A. Kozer	8/24/1909	8/1/1911	2	0
PENNSYLVANIA—Appointed, by the Governor with the Advice and Consent of the Senate					
Insurance Commissioner	Michael M. 'Mike' Humphreys	6/26/2023		incumbent	
Acting Insurance Commissioner	Michael M. 'Mike' Humphreys	2/26/2022	6/26/2023	1	4

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NAIC MEMBER TENURE LIST

STATE/MEMBER TITLE	MEMBER NAME	BEG. DATE	END DATE	YRS. SERVED	MOS. SERVED
PENNSYLVANIA—Continued					
Insurance Commissioner	Jessica K. Altman	3/20/2018	2/25/2022	3	11
Acting Insurance Commissioner	Jessica K. Altman	8/19/2017	3/20/2018	0	7
Insurance Commissioner	Teresa D. Miller	6/3/2015	8/18/2017	2	2
Acting Insurance Commissioner	Teresa D. Miller	1/21/2015	6/3/2015	0	5
Insurance Commissioner	Michael F. 'Mike' Consedine	4/26/2011	1/20/2015	3	9
Acting Insurance Commissioner	Michael F. 'Mike' Consedine	1/19/2011	4/26/2011	0	3
Acting Insurance Commissioner	Robert L. Pratter	8/30/2010	1/18/2011	0	5
Insurance Commissioner	Joel S. Ario	7/3/2008	8/29/2010	2	1
Acting Insurance Commissioner	Joel S. Ario	7/2/2007	7/3/2008	1	0
Acting Insurance Commissioner	Randolph R. 'Randy' Rohrbaugh	2/20/2007	7/1/2007	0	5
Insurance Commissioner	M. Diane Koken*	8/27/1997	2/19/2007	9	6
Acting Insurance Commissioner	Gregory S. Martino	6/30/1997	8/27/1997	0	2
Insurance Commissioner	Linda S. Kaiser	1/30/1995	6/30/1997	2	5
Insurance Commissioner	Cynthia M. Maleski	4/7/1992	1/30/1995	2	10
Acting Insurance Commissioner	Ronald Chronister	2/28/1992	4/7/1992	0	2
Insurance Commissioner	Constance B. Foster	1/20/1987	2/28/1992	5	1
Insurance Commissioner	George F. Grode	7/23/1985	1/20/1987	1	6
Acting Insurance Commissioner	William R. Muir, Jr.	5/1/1984	7/23/1985	1	3
Acting Insurance Commissioner	Anthony A. Geyelin	9/26/1983	5/1/1984	0	7
Insurance Commissioner	Michael L. Browne	7/24/1980	9/26/1983	3	2
Acting Insurance Commissioner	James R. Farley	5/21/1980	7/24/1980	0	2
Insurance Commissioner	Harvey Bartle III	2/23/1979	5/20/1980	1	3
Acting Insurance Commissioner	John J. Sheehy	1/2/1979	2/23/1979	0	2
Insurance Commissioner	William J. Sheppard	4/30/1974	1/1/1979	4	9
Insurance Commissioner	Herbert S. Denenberg	1/25/1971	4/30/1974	3	3
Insurance Commissioner	George F. Reed	9/11/1969	1/25/1971	1	4
Insurance Commissioner	David O. Maxwell	1/17/1967	9/11/1969	2	8
Insurance Commissioner	Audrey R. Kelly	1/15/1963	1/17/1967	4	0
Insurance Commissioner	Theodore S. Gutowicz	7/16/1962	1/15/1963	0	6
Insurance Commissioner	Francis R. Smith	1/18/1955	7/16/1962	7	6
Insurance Commissioner	Artemas C. Leslie	4/8/1950	1/18/1955	4	9
Insurance Commissioner	James F. Malone, Jr.	1/21/1947	4/8/1950	3	3
Insurance Commissioner	Gregg L. Neel	1/10/1943	1/21/1947	4	0
Insurance Commissioner	Ralph H. Alexander	11/5/1942	1/10/1943	0	2
Acting Insurance Commissioner	Ralph H. Alexander	7/23/1942	11/5/1942	0	4
Insurance Commissioner	Matthew H. Taggart <i>(Died July 23, 1942)</i>	1/17/1939	7/23/1942	3	6
Insurance Commissioner	Owen B. Hunt	1/15/1935	1/17/1939	4	0
Acting Insurance Commissioner	Charles H. Groff	2/5/1934	1/15/1935	0	11
Insurance Commissioner	Charles F. Armstrong <i>(Died Feb. 4, 1934)</i>	1/20/1931	2/4/1934	3	1
Insurance Commissioner	Matthew H. Taggart	4/18/1927	1/20/1931	3	9
Insurance Commissioner	Einar Barford	8/16/1926	4/18/1927	0	8
Insurance Commissioner	Samuel W. McCulloch	6/15/1923	8/16/1926	3	2
Insurance Commissioner	Thomas B. Donaldson	5/6/1919	6/15/1923	3	1
Insurance Commissioner	Charles A. Ambler	9/10/1917	5/6/1919	1	8
Insurance Commissioner	J. Denny O'Neil	6/23/1916	9/6/1917	1	3
Acting Insurance Commissioner	Samuel W. McCulloch	3/31/1916	6/23/1916	0	3
Insurance Commissioner	Charles Johnson	11/15/1911	3/30/1916	4	4
Insurance Commissioner	Samuel W. McCulloch	12/23/1909	11/15/1911	1	11

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NAIC MEMBER TENURE LIST

STATE/MEMBER TITLE	MEMBER NAME	BEG. DATE	END DATE	YRS. SERVED	MOS. SERVED
PENNSYLVANIA—Continued					
Insurance Commissioner	David Martin	7/1/1905	12/23/1909	4	5
Insurance Commissioner	Israel W. Durham	1/18/1899	6/30/1905	6	5
Insurance Commissioner	James H. Lambert	1/15/1895	1/18/1899	4	0
Insurance Commissioner	George B. Luper*	5/21/1891	1/15/1895	3	8
Insurance Commissioner	John Montgomery Forster	5/5/1873	5/21/1891	8	0
Auditor General	Harrison Allen	12/2/1872	5/5/1873	0	5
Auditor General	John F. Hartranft	5/24/1871	12/2/1872	1	7
PUERTO RICO—Appointed, Indefinite					
Commissioner of Insurance	Alexander S. Adams Vega	12/20/2021		incumbent	
Commissioner of Insurance	<i>Position Vacant</i>	11/25/2021	12/19/2021	0	1
Commissioner of Insurance	Mariano A. Mier Romeu	1/4/2021	11/24/2021	0	10
Commissioner of Insurance	Rafael Cestero-Lopategui	9/10/2020	1/4/2021	0	4
Acting Commissioner of Insurance	Rafael Cestero-Lopategui	1/23/2020	9/10/2020	0	8
Commissioner of Insurance	Javier Rivera Rios	1/17/2017	1/22/2020	3	0
Commissioner of Insurance	Ángela Weyne	1/2/2013	12/31/2016	3	11
Commissioner of Insurance	Ramón L. Cruz-Colón	1/4/2009	1/2/2013	4	0
Commissioner of Insurance	Dorelisse Juarbe Jiménez	1/7/2004	12/31/2008	4	11
Commissioner of Insurance	Fermin M. Contreras Gómez	3/15/2001	1/7/2004	2	10
Commissioner of Insurance	Juan Antonio Garcia	1/1/1993	3/15/2001	8	2
Commissioner of Insurance	Ralph J. Rexach Chandri	1/14/1992	12/31/1992	0	11
Commissioner of Insurance	Miguel A. Villafañe-Neriz	1/1/1989	1/14/1992	3	0
Commissioner of Insurance	Juan Antonio Garcia	1/4/1982	12/31/1988	6	11
Commissioner of Insurance	Rolando Cruz	1/13/1977	12/18/1981	4	11
Commissioner of Insurance	Manuel Juarbe	4/18/1975	12/31/1976	1	8
Commissioner of Insurance	Carlos R. Rios	7/2/1973	3/25/1975	1	8
Acting Commissioner of Insurance	Juan Antonio Garcia	12/31/1972	7/2/1973	0	6
Commissioner of Insurance	Pedro J. Fernández Badillo	4/17/1969	12/31/1972	3	8
Commissioner of Insurance	Julio R. Hernandez	11/1/1967	3/25/1969	1	5
Commissioner of Insurance	Jorge Soto Garcia	8/1/1964	9/30/1967	3	1
Commissioner of Insurance	Pablo J. Lopez Castro	8/1/1957	7/15/1964	7	0
Superintendent of Insurance	Mariano Nieves Hidalgo (Died June 13, 1957)	1/9/1953	6/13/1957	4	5
Superintendent of Insurance	Jorge Font Saldaña	6/1/1949	12/31/1952	2	7
Superintendent of Insurance	Lorenzo J. Noa	1/9/1943	4/6/1949	6	3
Superintendent of Insurance	Hector R. Ball	5/24/1933	12/31/1942	9	7
Superintendent of Insurance	Augusto R. Soltero	12/9/1930	5/23/1933	4	9
RHODE ISLAND—Appointed, at the Discretion of the Director of Business Regulation					
Superintendent of Insurance	Elizabeth 'Beth' Kelleher Dwyer	1/11/2016		incumbent	
Deputy Director/Insurance and Banking Superintendent	Joseph Torti III	12/16/2002	12/31/2015	13	0
Superintendent of Insurance	Alfonso E. 'Al' Mastrostefano	7/1/1994	12/16/2002	8	5
Superintendent of Insurance	Charles P. Kwolek, Jr.	11/19/1991	7/1/1994	3	8
Insurance Commissioner	Maurice C. Paradis	1/1/1991	11/19/1991	0	10
Insurance Commissioner	Robert J. Janes	10/30/1988	1/1/1991	2	2
Insurance Commissioner	Mark A. Pfeiffer	4/21/1986	10/30/1988	2	6
Insurance Commissioner	Clifton A. Moore	2/1/1985	4/21/1986	1	2
Insurance Commissioner	William F. Carroll	2/3/1984	2/1/1985	1	0
Insurance Commissioner	Thomas J. Caldarone, Jr.	1/16/1977	2/3/1984	6	1

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NAIC MEMBER TENURE LIST

STATE/MEMBER TITLE	MEMBER NAME	BEG. DATE	END DATE	YRS. SERVED	MOS. SERVED
RHODE ISLAND—Continued					
Insurance Commissioner	Peter F. Mullaney	1/10/1969	1/16/1977	9	0
Insurance Commissioner	Ralph A. Petrarca	6/30/1967	1/10/1969	2	6
Insurance Commissioner	Warren R. Campbell	1/1/1963	6/30/1967	4	6
Insurance Commissioner	Thomas J. Coyle	1/9/1961	1/1/1963	2	0
Insurance Commissioner	Hartley F. Roberts	1/20/1959	1/9/1961	2	0
Insurance Commissioner	George A. Bisson	2/11/1947	1/20/1959	11	11
Insurance Commissioner	J. Austin Carroll	7/1/1942	2/1/1947	4	7
Insurance Commissioner	Henri N. Morin	3/1/1939	7/1/1942	3	4
Chief, Division of Banking & Ins.	M. Joseph Cummings	3/4/1935	2/28/1939	4	0
Insurance Commissioner	Oscar L. Heltzen	12/29/1932	3/4/1935	2	2
Insurance Commissioner	Philip H. Wilbour	4/8/1929	12/9/1932	3	8
State Auditor/Ins. Commissioner	Philip H. Wilbour	2/1/1917	4/8/1929	12	2
State Auditor/Ins. Commissioner	Charles M. Arnold	12/23/1916	1/31/1917	0	1
State Auditor/Ins. Commissioner	Charles C. Gray <i>(Died Dec. 21, 1916)</i>	1/16/1899	12/21/1916	17	11
State Auditor/Ins. Commissioner	Albert C. Landers	5/27/1891	1/16/1899	7	7
State Auditor/Ins. Commissioner	Elisha W. Bucklin	5/28/1890	5/27/1891	1	0
State Auditor/Ins. Commissioner	William C. Townsend	5/30/1889	5/28/1890	1	0
State Auditor/Ins. Commissioner	Almon K. Goodwin	6/1/1888	5/30/1889	1	0
State Auditor/Ins. Commissioner	Elisha W. Bucklin	6/1/1887	6/1/1888	1	0
State Auditor/Ins. Commissioner	Samuel H. Cross	6/30/1882	6/1/1887	4	11
State Auditor/Ins. Commissioner	Joel M. Spencer	5/24/1871	6/30/1882	11	1

SOUTH CAROLINA—Appointed, by the Governor upon the Advice and Consent of the Senate					
Director of Insurance	Michael Wise <i>(Appointed April 26, 2023; Confirmed May 11, 2023)</i>	5/11/2023		incumbent	
Acting Director of Insurance	Michael Wise	4/16/2022	5/11/2023	1	1
Director of Insurance	Raymond G. 'Ray' Farmer* <i>(Appointed Nov. 12, 2012; Confirmed Feb. 14, 2013; Reappointed Dec. 12, 2018)</i>	12/3/2012	4/15/2022	9	4
Acting Director of Insurance	Gwendolyn Fuller McGriff	12/29/2011	12/2/2012	1	0
Director of Insurance	David Black <i>(Appointed Jan. 20, 2011; Confirmed Feb. 3, 2011)</i>	2/1/2011	12/28/2011	0	10
Director of Insurance	Scott H. Richardson	2/15/2007	2/1/2011	4	0
Director of Insurance	Eleanor Kitzman	2/1/2005	2/15/2007	2	0
Co-Acting Director of Insurance	Gwendolyn Fuller & Tim Baker	8/1/2004	2/1/2005	0	6
Director of Insurance	Ernst N. 'Ernie' Csiszar*	1/26/1999	8/1/2004	5	7
Director of Insurance	Lee P. Jedziniak	7/1/1995	1/13/1999	3	6
Chief Insurance Commissioner	Susanne K. Murphy	3/1/1995	7/1/1995	0	4
Chief Insurance Commissioner	John G. Richards	3/7/1985	3/1/1995	10	0
Chief Insurance Commissioner	Rogers T. Smith	10/21/1981	3/7/1985	3	5
Acting Insurance Commissioner	Rogers T. Smith	9/3/1981	10/21/1981	0	1
Chief Insurance Commissioner	John W. 'Jack' Lindsay	7/1/1975	9/3/1981	6	2
Chief Insurance Commissioner	Howard B. Clark	1/14/1974	6/30/1975	1	5
Acting Insurance Commissioner	Glen E. Craig	12/1/1973	1/13/1974	0	1
Acting Insurance Commissioner	Lanville H. Mengedoht	1/1/1973	12/1/1973	0	11
Chief Insurance Commissioner	John W. 'Jack' Lindsay	3/2/1970	12/31/1972	2	9
Chief Insurance Commissioner	Leroy M. Brandt	7/1/1968	3/2/1970	1	8

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NAIC MEMBER TENURE LIST

STATE/MEMBER TITLE	MEMBER NAME	BEG. DATE	END DATE	YRS. SERVED	MOS. SERVED
SOUTH CAROLINA—Continued					
Chief Insurance Commissioner	Charles W. Gambrell	2/17/1964	6/30/1968	4	4
Chief Insurance Commissioner	William F. Austin	7/1/1960	2/15/1964	3	7
Insurance Commissioner	R. Lee Kelly	8/5/1954	7/1/1960	5	11
Insurance Commissioner	D. D. 'Pat' Murphy*	9/15/1948	8/4/1954	5	11
Insurance Commissioner	L. George Benjamin, Jr.	11/1/1945	9/15/1948	2	10
Insurance Commissioner	D. D. 'Pat' Murphy*	8/16/1944	11/1/1945	1	3
Insurance Commissioner	William Egleston	9/4/1942	8/16/1944	1	11
Insurance Commissioner	L. George Benjamin, Jr.	4/1/1942	9/4/1942	0	5
Insurance Commissioner	Samuel B. 'Sam' King	4/2/1928	4/1/1942	14	0
Insurance Commissioner	John J. McMahan	4/7/1921	4/2/1928	7	0
Insurance Commissioner	William A. McSwain	3/1/1918	4/7/1921	3	1
Insurance Commissioner	Fitz Hugh McMaster	3/4/1908	3/1/1918	10	0
Comptroller-General of State	Adolphus W. Jones	1/21/1903	3/4/1908	5	2
Comptroller-General of State	John P. Derham	1/26/1898	1/21/1903	5	0
Comptroller-General of State	Layfayette P. Epton	11/2/1897	1/26/1898	0	2
Comptroller-General of State	James W. Norton	11/26/1894	11/2/1897	3	0
Comptroller-General of State	William H. Ellerbe	11/21/1890	11/26/1894	4	0
Comptroller-General of State	John S. Verner	12/22/1887	11/21/1890	2	11
Comptroller-General of State	William E. Stoney	11/23/1882	12/22/1887	5	1
Comptroller-General of State	John Bratton	12/22/1880	11/23/1882	1	11
Comptroller-General of State	John C. Coit	11/30/1880	12/20/1880	0	1
Comptroller-General of State	Johnson Hagood	11/23/1876	11/30/1880	4	0
Comptroller-General of State	Thomas C. Dunn	3/23/1875	11/23/1876	1	8
Comptroller-General of State	Solomon L. Hoge	12/7/1872	3/23/1875	2	3
Comptroller-General of State	John L. Neagle	10/18/1871	12/7/1872	1	2
SOUTH DAKOTA—Appointed, at the Pleasure of the Secretary of the Department of Labor and Regulation					
Director of Insurance	Larry D. Deiter	1/8/2015		incumbent	
Interim Director of Insurance	Larry D. Deiter	12/1/2014	1/8/2015	0	1
Director of Insurance	Merle D. Scheiber	8/8/2005	12/1/2014	9	4
Director of Insurance	Gary L. Steuck	5/12/2003	7/31/2005	2	2
Acting Director of Insurance	Wendell Malsam	1/1/2003	5/12/2003	0	4
Director of Insurance	Darla L. Lyon	1/6/1992	1/1/2003	11	0
Acting Director of Insurance	Darla L. Lyon	10/1/1991	1/6/1992	0	3
Director of Insurance	Mary Jane Cleary	7/6/1987	10/1/1991	4	3
Acting Director of Insurance	Jeff Stingley	5/13/1987	7/6/1987	0	2
Director of Insurance	Susan L. Walker	8/30/1983	5/13/1987	3	8
Director of Insurance	Henry J. Lussem, Jr.	3/1/1980	8/30/1983	3	9
Director of Insurance	Lowell L. Knutson	1/1/1976	3/1/1980	4	2
Acting Director of Insurance	Donald D. Graham	6/30/1975	1/1/1976	0	7
Commissioner of Insurance	Ralph A. Nauman	7/1/1971	6/30/1975	4	0
Commissioner of Insurance	Warren E. Dirks	1/1/1967	7/1/1971	4	6
Acting Commissioner of Insurance	Warren E. Dirks	12/1/1966	1/1/1967	0	1
Commissioner of Insurance	J. R. Menning	6/30/1963	12/1/1966	3	6
Acting Commissioner of Insurance	D. E. Mitchell	6/1/1963	6/30/1963	0	0
Commissioner of Insurance	Robert A. Hurlbut	6/1/1961	6/1/1963	2	0
Commissioner of Insurance	Randolph Bagby	11/15/1960	6/1/1961	0	7
Commissioner of Insurance	William J. 'Bill' Dawson (Died Nov. 15, 1960)	6/1/1959	11/15/1960	1	5
Commissioner of Insurance	D. E. Mitchell	5/1/1956	6/1/1959	3	1

* NAIC Past President. This person served as NAIC President one or more times during their term(s) of office.

NAIC MEMBER TENURE LIST

STATE/MEMBER TITLE	MEMBER NAME	BEG. DATE	END DATE	YRS. SERVED	MOS. SERVED
SOUTH DAKOTA—Continued					
Commissioner of Insurance	George O. Burt	6/1/1952	5/1/1956	4	6
Commissioner of Insurance	D. E. Mitchell	6/1/1951	6/1/1952	1	0
Commissioner of Insurance	George O. Burt	1/2/1950	6/1/1951	1	5
Commissioner of Insurance	Waldemar A. Mueller	7/18/1944	1/2/1950	5	6
Commissioner of Insurance	George K. Burt (Died May 23, 1944)	3/1/1940	5/23/1944	4	3
Commissioner of Insurance	P. J. Dunn	7/1/1937	3/1/1940	2	8
Commissioner of Insurance	William J. 'Bill' Dawson (Died Nov. 15, 1960)	7/1/1933	7/1/1937	4	0
Commissioner of Insurance	Clyde R. Horswill	7/1/1931	7/1/1933	2	0
Commissioner of Insurance	Donald C. 'Don' Lewis	7/1/1927	7/1/1931	4	0
Commissioner of Insurance	G. H. Helgerson	7/1/1925	7/1/1927	2	0
Commissioner of Insurance	William N. Van Camp	3/1/1917	7/1/1925	8	4
Commissioner of Insurance	M. Harry O'Brien	10/1/1915	3/1/1917	1	5
Commissioner of Insurance	Otto K. Stablein	9/1/1913	10/1/1915	2	1
Commissioner of Insurance	Orville S. Basford	9/1/1907	9/1/1913	6	0
Commissioner of Insurance	Len U. Doty	10/1/1906	9/1/1907	0	11
Commissioner of Insurance	John C. Perkins	9/1/1903	10/1/1906	3	1
Commissioner of Insurance	Howard C. Shober	9/1/1901	9/1/1903	2	0
Commissioner of Insurance	F. G. King	9/1/1899	9/1/1901	2	0
Commissioner of Insurance	L. C. Campbell	9/30/1898	9/1/1899	1	0
Commissioner of Insurance	Thomas H. Ayers	9/1/1898	9/30/1898	0	1
Commissioner of Insurance	J. H. Kipp	9/1/1897	9/1/1898	1	0
Commissioner of Insurance	H. E. Mayhew	1/1/1897	9/1/1897	0	8
Auditor of State	J. E. Hipple	1/1/1893	1/1/1897	4	0
Auditor of State	L. C. Taylor	11/2/1889	1/1/1893	3	2
Territorial Auditor	John C. McManima	9/4/1889	11/2/1889	0	2

TENNESSEE—Appointed, at the Discretion of the Governor					
Cmsr. of Commerce and Insurance	Carter Lawrence	11/12/2020		incumbent	
Cmsr. of Commerce and Insurance	Hodgen Mainda	10/1/2019	11/12/2020	1	1
Interim Cmsr. of Commerce & Ins.	Carter Lawrence	6/15/2019	9/30/2019	0	3
Cmsr. of Commerce and Insurance	Julie Mix McPeak*	1/12/2011	6/14/2019	8	5
Cmsr. of Commerce and Insurance	Leslie A. Newman	1/1/2007	1/12/2011	4	0
Cmsr. of Commerce and Insurance	Paula A. Flowers	1/18/2003	1/1/2007	4	0
Cmsr. of Commerce and Insurance	Anne B. Pope	11/1/1999	1/1/2003	3	2
Cmsr. of Commerce and Insurance	Douglas M. 'Doug' Sizemore	1/21/1995	10/31/1999	4	10
Cmsr. of Commerce and Insurance	Allan S. Curtis	4/1/1994	1/21/1995	0	9
Cmsr. of Commerce and Insurance	Elaine A. McReynolds	1/17/1987	4/1/1994	7	3
Cmsr. of Commerce and Insurance	William H. Inman	4/1/1986	1/17/1987	0	9
Commissioner of Insurance	John C. Neff	1/20/1979	4/1/1986	7	3
Commissioner of Insurance	Millard V. Oakley	1/18/1975	1/20/1979	4	0
Commissioner of Insurance	Richard F. Keathley	1/1/1974	1/18/1975	1	0
Cmsr. of Insurance and Banking	Halbert L. Carter, Jr.	1/25/1971	12/31/1973	2	11
Cmsr. of Insurance and Banking	Milton P. Rice	9/5/1969	1/25/1971	1	4
Cmsr. of Insurance and Banking	David M. Pack	1/16/1967	9/2/1969	1	8
Cmsr. of Insurance and Banking	Albert Williams	1/15/1963	1/16/1967	4	0
Cmsr. of Insurance and Banking	John R. Long, Jr.	1/19/1959	1/15/1963	4	0
Cmsr. of Insurance and Banking	Leon Gilbert	1/1/1959	1/19/1959	0	1
Cmsr. of Insurance and Banking	Arch E. Northington*	1/15/1953	12/23/1958	5	11

* NAIC Past President. This person served as NAIC President one or more times during their term(s) of office.

NAIC MEMBER TENURE LIST

STATE/MEMBER TITLE	MEMBER NAME	BEG. DATE	END DATE	YRS. SERVED	MOS. SERVED
TENNESSEE—Continued					
Cmsr. of Insurance and Banking	Robert L. Taylor	12/8/1952	1/15/1953	0	1
Cmsr. of Insurance and Banking	Malcolm O. Allen (Died Nov. 27, 1952)	1/17/1949	11/27/1952	3	10
Cmsr. of Insurance and Banking	James M. McCormack*	1/16/1939	1/17/1949	10	0
Cmsr. of Insurance and Banking	John W. Britton	1/10/1938	1/16/1939	1	0
Cmsr. of Insurance and Banking	James M. McCormack*	1/15/1937	1/10/1938	1	0
Cmsr. of Insurance and Banking	Joseph S. Tobin	1/17/1933	1/15/1937	4	0
Cmsr. of Insurance and Banking	Joseph I. Reece	7/14/1931	1/17/1933	1	6
Cmsr. of Insurance and Banking	Albert S. Caldwell*	2/1/1923	7/14/1931	8	5
Insurance Commissioner	Earl N. Rogers	7/1/1921	2/1/1923	1	8
Insurance Commissioner	Robert L. Carden	1/17/1921	6/30/1921	0	5
Acting Insurance Commissioner	Thomas E. Miles	12/1/1920	1/17/1921	0	1
Insurance Commissioner	Leslie K. Arrington	7/7/1917	12/1/1920	3	5
Insurance Commissioner	William F. Dunbar	6/1/1915	7/1/1917	2	1
Insurance Commissioner	J. Will Taylor	3/1/1913	6/1/1915	2	3
State Treasurer/Ins. Commissioner	G. Thomas 'Tom' Taylor	2/20/1911	3/1/1913	2	1
State Treasurer/Ins. Commissioner	Reau E. Folk*	2/16/1901	2/20/1911	10	0
State Treasurer/Ins. Commissioner	Edward B. Craig	1/26/1893	2/16/1901	8	1
State Treasurer/Ins. Commissioner	Mansfield F. 'Manse' House	2/11/1889	1/26/1893	3	11
State Treasurer/Ins. Commissioner	Atha Thomas	10/26/1886	2/11/1889	2	4
State Treasurer/Ins. Commissioner	James W. Thomas (Died Oct. 25, 1886)	2/3/1885	10/25/1886	1	8
State Treasurer/Ins. Commissioner	Atha Thomas	1/17/1883	2/3/1885	2	1
State Treasurer/Ins. Commissioner	Marshall T. Polk	2/8/1877	1/17/1883	5	11
State Treasurer/Ins. Commissioner	William L. Morrow	5/24/1871	2/8/1877	5	9

TEXAS—Appointed; 2-Year Term					
Insurance Commissioner	Cassie Brown	9/8/2021		incumbent	
Chief Deputy Commissioner	J. Douglas 'Doug' Slape	10/1/2020	9/8/2021	0	11
Insurance Commissioner	Kent Sullivan	9/21/2017	9/30/2020	3	0
Insurance Commissioner	<i>Position Vacant</i>	4/13/2017	9/21/2017	0	5
Insurance Commissioner	David C. Mattax (Died April 13, 2017)	1/13/2015	4/13/2017	2	3
Insurance Commissioner	Julia Rathgeber	5/27/2013	1/13/2015	1	8
Insurance Commissioner	Eleanor Kitzman	8/15/2011	5/27/2013	1	9
Insurance Commissioner	Michael 'Mike' Geeslin	6/7/2005	8/15/2011	6	2
Insurance Commissioner	José Montemayor	2/1/1999	6/7/2005	6	4
Interim Insurance Commissioner	José Montemayor	1/11/1999	2/1/1999	0	1
Insurance Commissioner	Elton L. Bomer	2/2/1995	1/10/1999	3	11
Interim Insurance Commissioner	Rebecca Lightsey	12/11/1994	1/27/1995	0	1
Insurance Commissioner	J. Robert 'Bob' Hunter	11/3/1993	12/11/1994	1	1
Interim Commissioner of Insurance	Edna Ramon Butts	9/1/1993	11/1/1993	0	2
Insurance Commissioner	Georgia D. Flint	3/1/1992	8/31/1993	1	6
Acting Insurance Commissioner	Georgia D. Flint	11/4/1992	3/1/1992	0	4
Insurance Commissioner	Philip W. 'Phil' Barnes	1/8/1991	11/4/1991	0	10
Insurance Commissioner	A. W. 'Woody' Pogue	12/19/1988	11/1/1990	1	11
Acting Insurance Commissioner	A. W. 'Woody' Pogue	11/4/1988	12/19/1988	0	1
Insurance Commissioner	Doyce R. Lee	8/6/1985	11/4/1988	3	4
Insurance Commissioner	Tom Bond	9/24/1982	8/6/1985	2	11
Insurance Commissioner	E. J. Voorhis, Jr.	6/29/1977	9/24/1982	5	3

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NAIC MEMBER TENURE LIST

STATE/MEMBER TITLE	MEMBER NAME	BEG. DATE	END DATE	YRS. SERVED	MOS. SERVED
TEXAS—Continued					
Insurance Commissioner	Joseph D. ‘Joe’ Hawkins	8/1/1975	6/29/1977	1	11
Acting Insurance Commissioner	Thomas I. ‘Tom’ McFarling	5/13/1975	8/1/1975	0	2
Insurance Commissioner	Don B. Odum	1/1/1974	5/13/1975	1	4
Insurance Commissioner	Clay Cotten	11/15/1965	1/1/1974	8	2
Insurance Commissioner	J. N. Nutt	9/1/1963	11/1/1965	2	2
Insurance Commissioner	William A. Harrison	8/5/1957	9/1/1963	6	1
Acting Insurance Commissioner	William A. Harrison	6/21/1957	8/5/1957	0	2
Commissioner of Life Insurance/Chairman of Board	John Osorio	1/1/1957	6/1/1957	0	5
Commissioner of Life Insurance/Chairman of Board	J. Byron Saunders	1/30/1956	1/1/1957	0	11
Commissioner of Life Insurance/Chairman of the Board	Garland A. ‘Chink’ Smith	10/6/1953	1/30/1956	2	4
Commissioner of Life Insurance/Chairman of the Board	George B. Butler <i>(Died Sept. 28, 1953)</i>	2/11/1945	9/28/1953	8	8
Commissioner of Life Insurance/Chairman of the Board	Omicron P. Lockhart	5/12/1941	2/1/1945	3	9
Commissioner of Life Insurance/Chairman of Board	Reuben Williams	1/2/1941	5/12/1941	0	4
Commissioner of Life Insurance/Chairman of the Board	Walter C. Woodward <i>(Died Dec. 17, 1940)</i>	3/6/1939	12/17/1940	1	9
Commissioner of Life Insurance/Chairman of the Board	R. L. Daniel	2/10/1933	3/1/1939	6	1
Commissioner of Life Insurance/Chairman of the Board	William A. Tarver	5/2/1929	2/10/1933	3	9
Commissioner of Life Insurance/Chairman of the Board	Robert B. Cousins, Jr.	9/1/1927	5/1/1929	1	8
Commissioner of Insurance	R. L. Daniel	10/1/1925	9/1/1927	1	11
Commissioner of Insurance	John M. Scott	8/21/1923	10/1/1925	2	1
Cmsr. of Insurance and Banking	James L. Chapman	9/1/1922	8/21/1923	1	0
Cmsr. of Insurance and Banking	Edward ‘Ed’ Hall	1/20/1921	9/1/1922	1	8
Cmsr. of Insurance and Banking	J. T. McMillan	8/1/1920	1/20/1921	0	5
Cmsr. of Insurance and Banking	John C. Chidsey	4/1/1920	8/1/1920	0	4
Cmsr. of Insurance and Banking	George Waverly Briggs	2/1/1919	4/1/1920	1	2
Cmsr. of Insurance and Banking	Charles O. Austin	8/31/1916	1/31/1919	2	5
Cmsr. of Insurance and Banking	John S. Patterson <i>(Died Aug. 29, 1916)</i>	1/20/1915	8/29/1916	1	7
Cmsr. of Insurance and Banking	William W. Collier	7/22/1913	1/20/1915	1	6
Cmsr. of Insurance and Banking	Bennett L. ‘Ben’ Gill	1/17/1911	7/10/1913	2	6
Cmsr. of Insurance and Banking	Frederick C. von Rosenburg	8/4/1910	1/6/1911	0	5
Cmsr. of Insurance and Banking	William E. Hawkins	2/1/1910	8/3/1910	0	6
Cmsr. of Insurance and Banking	Thomas B. Love	9/1/1907	1/31/1910	2	5
Commissioner of Agriculture, Insurance, Statistics and History	Robert T. Milner	8/1/1906	8/31/1907	1	1
Commissioner of Agriculture, Insurance, Statistics and History	William J. Clay	8/1/1901	8/1/1906	5	0
Commissioner of Agriculture, Insurance, Statistics and History	Jefferson Johnson	8/1/1897	8/1/1901	4	0
Commissioner of Agriculture, Insurance, Statistics and History	Archibald J. Rose	1/10/1895	8/1/1897	2	7
Commissioner of Agriculture, Insurance, Statistics and History	John E. Hollingsworth	5/15/1891	1/10/1895	3	8

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NAIC MEMBER TENURE LIST

STATE/MEMBER TITLE	MEMBER NAME	BEG. DATE	END DATE	YRS. SERVED	MOS. SERVED
TEXAS—Continued					
Commissioner of Agriculture, Insurance, Statistics and History	Lafayette L. Foster	1/21/1887	5/5/1891	4	4
Commissioner of Agriculture, Insurance, Statistics and History	Hamilton P. Bee	12/30/1884	1/21/1887	2	1
Commissioner of Agriculture, Insurance, Statistics and History	Henry P. Brewster <i>(Died Dec. 26, 1884)</i>	1/31/1883	12/26/1884	1	11
Commissioner of Agriculture, Insurance, Statistics and History	Ashley W. Spaight	1/26/1881	1/31/1883	2	0
Commissioner of Agriculture, Insurance, Statistics and History	Valentine O. King	9/17/1879	1/26/1881	1	4

UTAH—Appointed, at the Pleasure of the Governor; Confirmed by the Senate					
Commissioner of Insurance	Jonathan T. 'Jon' Pike	2/4/2021		incumbent	
Acting Commissioner of Insurance	Jonathan T. 'Jon' Pike	1/5/2021	2/4/2021	0	1
Interim Commissioner of Insurance	Tanji J. Northrup	10/1/2020	1/5/2021	0	3
Commissioner of Insurance	Todd E. Kiser	12/20/2012	9/30/2020	7	9
Commissioner of Insurance	Neal T. Gooch	5/24/2010	12/20/2012	2	7
Acting Commissioner of Insurance	Neal T. Gooch	1/19/2010	5/24/2010	0	4
Commissioner of Insurance	D. Kent Michie	1/5/2005	1/19/2010	5	0
Commissioner of Insurance	Merwin U. Stewart	2/7/1997	12/31/2004	7	11
Commissioner of Insurance	Robert E. Wilcox	1/27/1993	2/7/1997	4	1
Commissioner of Insurance	Harold C. Yancey	7/1/1985	1/27/1993	7	7
Commissioner of Insurance	Roger C. Day* <i>(Died July 18, 2019)</i>	6/1/1977	7/1/1985	8	1
Commissioner of Insurance	Clifton N. Ottosen	2/1/1965	6/1/1977	12	4
Commissioner of Insurance	E. Virgil Norton	1/1/1961	1/30/1965	3	8
Commissioner of Insurance	Carl A. Hulbert	6/1/1958	12/31/1960	2	7
Commissioner of Insurance	Albert E. 'Buck' Buckwell	3/15/1957	6/1/1958	1	3
Commissioner of Insurance	Walter M. Jones	9/11/1953	3/15/1957	3	6
Commissioner of Insurance	Lewis M. Terry	5/1/1949	9/11/1953	4	4
Acting Commissioner of Insurance	H. J. Timmerman	3/16/1949	5/1/1949	0	2
Commissioner of Insurance	Oscar W. Carlson	9/12/1941	3/16/1949	7	6
Acting Commissioner of Insurance	Clifton N. Ottosen	3/15/1941	9/12/1941	0	6
Commissioner of Insurance	C. Clarence Nelson*	4/1/1937	3/15/1941	4	0
Commissioner of Insurance	Elias A. Smith, Jr.	4/1/1933	4/1/1937	4	0
Commissioner of Insurance	John G. McQuarrie	3/13/1925	4/1/1933	8	1
Commissioner of Insurance	John W. Walker	4/1/1921	3/13/1925	3	11
Commissioner of Insurance	Rulon S. Wells	3/15/1917	4/1/1921	4	1
Commissioner of Insurance	John James	7/10/1914	3/15/1917	2	8
Commissioner of Insurance	Willard Done	10/10/1910	7/10/1914	3	9
Commissioner of Insurance	George B. Squires <i>(Died Sept. 30, 1910)</i>	4/8/1909	9/30/1910	1	6
Secretary of State	Charles S. Tingey	1/2/1905	4/3/1909	4	3
Secretary of State	James T. Hammond	1/6/1896	1/2/1905	9	0
Secretary of Territory	Elijah Sells	5/16/1889	5/6/1893	4	0
Secretary of Territory	William C. Hall	4/6/1887	5/16/1889	2	1
Secretary of Territory	Arthur L. Thomas	9/1/1884	4/6/1887	2	7

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NAIC MEMBER TENURE LIST

STATE/MEMBER TITLE	MEMBER NAME	BEG. DATE	END DATE	YRS. SERVED	MOS. SERVED
VERMONT—Appointed, Biennially by the Governor with the Advice and Consent of the Senate					
Commissioner, Department of Financial Regulation (DFR)	Kevin Gaffney	7/8/2022		incumbent	
Interim Commissioner, DFR	Kevin Gaffney	5/17/2022	7/8/2022	0	2
Commissioner, DFR	Michael S. ‘Mike’ Pieciak <i>(Reappointed Dec. 22, 2016; Reappointed March 1, 2019)</i>	7/5/2016	5/16/2022	5	10
Commissioner, DFR	Susan L. Donegan	1/10/2013	6/30/2016	3	5
Commissioner, DFR	Stephen W. ‘Steve’ Kimbell	4/4/2012	1/9/2013	0	9
Commissioner, Department of Banking, Insurance, Securities, & Health Care Administration (BISHCA)	Stephen W. ‘Steve’ Kimbell	1/7/2011	4/3/2012	1	3
Commissioner, BISHCA	Michael F. ‘Mike’ Bertrand	6/18/2010	1/6/2011	0	7
Commissioner, BISHCA	Paulette J. Thabault	1/22/2007	6/18/2010	3	5
Commissioner, BISHCA	John P. Crowley	1/9/2003	1/5/2007	4	0
Commissioner, BISHCA	Elizabeth R. ‘Betsy’ Costle	8/17/1992	1/9/2003	10	5
Commissioner of Banking and Insurance	Jeffery P. Johnson	1/13/1990	8/14/1992	2	7
Commissioner of Banking and Insurance	Gretchen Babcock	7/10/1987	1/13/1990	2	6
Commissioner of Banking and Insurance	Thomas P. Menson	3/30/1986	7/1/1987	1	3
Commissioner of Banking and Insurance	David T. Bard	1/23/1985	3/7/1986	1	2
Commissioner of Banking and Insurance	George A. Chaffee	3/24/1980	11/16/1984	4	8
Commissioner of Banking and Insurance	Stewart M. Ledbetter	2/16/1977	2/22/1980	3	0
Acting Cmsr. of Banking and Insurance	Jean B. Baldwin	6/23/1976	2/16/1977	0	8
Commissioner of Banking and Insurance	James A. Guest	7/16/1973	6/23/1976	2	11
Acting Cmsr. of Banking and Insurance	Eugene R. Lemke	1/3/1973	7/16/1973	0	6
Commissioner of Banking and Insurance	Charles F. Black	1/9/1969	1/3/1973	4	0
Commissioner of Banking and Insurance	James H. Hunt	7/20/1965	1/8/1969	3	6
Commissioner of Banking and Insurance	Robert E. Cummings, Jr.	6/7/1963	7/19/1965	2	1
Commissioner of Banking and Insurance	Albert D. Pingree	3/1/1961	6/7/1963	2	3
Commissioner of Banking and Insurance	Alexander H. Miller	3/1/1951	2/28/1961	10	0
Acting Cmsr. of Banking and Insurance	Albert D. Pingree	11/15/1950	3/1/1951	0	4
Commissioner of Banking and Insurance	Donald A. Hemenway	12/1/1947	11/15/1950	2	11
Commissioner of Banking and Insurance	Charles E. Burns	7/1/1943	12/1/1947	4	5
Acting Cmsr. of Banking and Insurance	Albert D. Pingree	4/29/1943	7/1/1943	0	2
Commissioner of Banking and Insurance	Reginald T. Cole	2/1/1941	4/29/1943	2	3
Commissioner of Banking and Insurance	Donald A. Hemenway	2/1/1937	2/1/1941	4	0
Commissioner of Banking and Insurance	George B. Carpenter	8/12/1935	2/1/1937	1	6
Commissioner of Banking and Insurance	L. Douglas Meredith	8/1/1934	8/12/1935	1	0
Commissioner of Banking and Insurance	George H.V. Allen	5/1/1934	8/1/1934	0	3
Commissioner of Banking and Insurance	Robert C. Clark	4/15/1923	5/1/1934	11	1
Insurance Commissioner	Laurence A. Kelty	10/1/1922	4/15/1923	0	6
Insurance Commissioner	Joseph G. Brown*	4/11/1917	10/1/1922	5	6
Secretary of State State Treasurer	Guy W. Bailey Walter F. Scott	10/1/1915	4/11/1917	1	6
Secretary of State State Treasurer	Guy W. Bailey Edward H. Deavitt	10/1/1908	10/1/1915	7	0
Secretary of State State Treasurer	F. L. Fleetwood Edward H. Deavitt	10/1/1902	10/1/1908	6	0
Secretary of State State Treasurer	Fred A. Howland John L. Bacon*	10/1/1898	10/1/1902	4	0
Secretary of State State Treasurer	Chauncey W. Browell, Jr. Henry F. Field	10/1/1890	10/1/1898	8	0

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NAIC MEMBER TENURE LIST

STATE/MEMBER TITLE	MEMBER NAME	BEG. DATE	END DATE	YRS. SERVED	MOS. SERVED
VERMONT—Continued					
Secretary of State	Charles W. Porter	10/1/1884	10/1/1890	6	0
State Treasurer	William H. Dubois				
Secretary of State	George Nichols	10/1/1882	10/1/1884	2	0
State Treasurer	William H. Dubois				
Secretary of State	George Nichols	9/17/1873	10/1/1882	9	1
State Treasurer	John B. Page				

U.S. VIRGIN ISLANDS—Elected; 4-Year Term					
Lt. Governor/Ins. Commissioner	Tregenza A. Roach <i>(Elected Nov. 20, 2018; Re-elected Nov. 8, 2022)</i>	1/7/2019		incumbent	
Lt. Governor/Ins. Commissioner	Osbert E. Potter	1/5/2015	1/7/2019	3	11
Lt. Governor/Ins. Commissioner	Gregory R. Francis	1/1/2007	1/5/2015	8	0
Lt. Governor/Ins. Commissioner	Vargrave A. Richards	1/6/2003	1/1/2007	4	0
Lt. Governor/Ins. Commissioner	Gerard Luz James II	1/4/1999	1/6/2003	4	0
Lt. Governor/Ins. Commissioner	Kenneth E. Mapp	5/1/1998	1/4/1999	0	8
Director, Banking & Insurance	Gwendolyn ‘Gwen’ Hall Brady	5/1/1996	5/1/1998	2	0
Acting Director, Banking & Ins.	Gwendolyn ‘Gwen’ Hall Brady	3/4/1996	5/1/1996	0	2
Director, Banking & Insurance	Margery O. Resnick	6/1/1995	3/4/1996	0	9
Lt. Governor/Ins. Commissioner	Kenneth E. Mapp	2/12/1995	6/1/1995	0	4
Director, Banking & Insurance	Larry Diehl	1/2/1995	2/12/1995	1	1
Lt. Governor/Ins. Commissioner	Derek M. Hodge	1/5/1987	1/2/1995	8	0
Lt. Governor/Ins. Commissioner	Julio A. Brady	1/3/1983	1/5/1987	4	0
Lt. Governor/Ins. Commissioner	Henry A. Millan	4/10/1978	1/3/1983	4	9
Lt. Governor/Ins. Commissioner	<i>Position Vacant</i>	1/3/1978	4/9/1978	0	3
Lt. Governor/Ins. Commissioner	Juan Francisco Luis	1/6/1975	1/2/1978	3	0
Lt. Governor/Ins. Commissioner	Athniel C. Ottley	4/5/1973	1/6/1975	1	9
Lt. Governor/Ins. Commissioner	<i>Position Vacant</i>	2/21/1973	4/4/1957	0	2
Lt. Governor/Ins. Commissioner	David E. Maas	10/1/1969	2/20/1973	2	8
Govt. Secretary/Ins. Commissioner	Cyril E. King	5/1/1961	9/30/1969	8	4
Govt. Secretary/Ins. Commissioner	Roy W. Bornn	9/25/1958	5/1/1961	2	8
Govt. Secretary/Ins. Commissioner	John D. Merwin	12/23/1957	9/25/1958	0	9
Govt. Secretary/Ins. Commissioner	<i>Position Vacant</i>	5/31/1957	12/23/1957	0	7
Govt. Secretary/Ins. Commissioner	Charles K. Claunch	4/9/1954	5/31/1957	3	1
Government Secretary	Daniel W. Ambrose	8/1/1952	4/9/1954	1	7

VIRGINIA—Appointed, at the Pleasure of the State Corporation Commission					
Commissioner of Insurance	Scott A. White	1/1/2018		incumbent	
Commissioner of Insurance	Jacqueline K. Cunningham	1/1/2011	12/31/2017	6	11
Commissioner of Insurance	Alfred W. ‘Al’ Gross	8/1/1996	1/1/2011	14	5
Acting Commissioner of Insurance	Alfred W. ‘Al’ Gross	5/1/1996	8/1/1996	0	3
Commissioner of Insurance	Steven T. Foster*	2/9/1987	4/30/1996	9	2
Commissioner of Insurance	James M. Thomson	12/1/1981	2/1/1987	5	2
Commissioner of Insurance	James W. Newman, Jr.	3/1/1979	12/1/1981	2	9
Acting Commissioner of Insurance	James W. Newman, Jr.	12/1/1978	3/1/1979	0	3
Commissioner of Insurance	John G. Day	6/1/1975	12/1/1978	2	6
Commissioner of Insurance	Everette S. Francis	7/1/1969	6/1/1975	5	11
Commissioner of Insurance	T. Nelson Parker*	6/1/1956	7/1/1969	13	1
Commissioner of Insurance	George A. Bowles* <i>(Died June 1, 1956)</i>	4/14/1932	6/1/1956	24	2

* NAIC Past President. This person served as NAIC President one or more times during their term(s) of office.

NAIC MEMBER TENURE LIST

STATE/MEMBER TITLE	MEMBER NAME	BEG. DATE	END DATE	YRS. SERVED	MOS. SERVED
VIRGINIA—Appointed, at the Pleasure of the State Corporation Commission					
Cmsr. of Insurance and Banking	Myron E. Bristow	1/15/1930	4/14/1932	2	3
Cmsr. of Insurance and Banking	T. McCall Frazier	11/6/1929	1/17/1930	0	3
Cmsr. of Insurance and Banking	Joseph L. Button*	3/1/1928	10/15/1929	1	7
Commissioner of Insurance	Joseph L. Button*	7/1/1906	3/1/1928	21	8
Auditor of Public Accounts	Morton Marye	9/4/1889	7/1/1906	16	10
Auditor of Public Accounts	<i>Research Proceedings</i>	1884	1889	5	
Auditor of Public Accounts	S. B. Allen	11/7/1882	1884	2	
Auditor of Public Accounts	John E. Massey	1879	11/7/1882	3	
Auditor of Public Accounts	<i>Research Proceedings</i>	4/1/1872	1879	7	
Special Delegate for Auditor	Edward M. Alfriend	10/18/1871	4/1/1872	0	6
WASHINGTON—Elected; 4-Year Term					
Insurance Commissioner	Mike Kreidler <i>(Elected Nov. 7, 2000; Re-elected Nov. 2, 2004; Re-elected Nov. 4, 2008; Re-elected Nov. 6, 2012; Re-elected Nov. 8, 2016; Re-Elected Nov. 3, 2020)</i>	1/10/2001		incumbent	
Insurance Commissioner	Deborah M. Senn	1/13/1993	1/10/2001	8	0
Insurance Commissioner	Richard G. 'Dick' Marquardt	1/12/1977	1/13/1993	16	0
Insurance Commissioner	Karl V. Herrmann	1/15/1969	1/12/1977	8	0
Insurance Commissioner	Lee I. Kueckelhan*	1/1/1961	1/15/1969	8	0
Insurance Commissioner	William A. Sullivan*	1/11/1933	1/1/1961	28	0
Insurance Commissioner	Herbert O. Fishback*	1/13/1913	1/11/1933	20	0
Insurance Commissioner	John H. Schively	1/1/1909	1/13/1913	4	0
Secretary of State	Sam H. Nichols	1/1/1901	1/1/1909	8	0
Secretary of State	Will D. Jenkins	1/1/1897	1/1/1901	4	0
Secretary of State	James H. Price	1/1/1893	1/1/1897	4	0
Secretary of State	Allen Weir	6/26/1890	1/1/1893	2	7
WEST VIRGINIA—Appointed, at the Pleasure of the Governor					
Insurance Commissioner	Allan L. McVey	9/22/2021		incumbent	
Insurance Commissioner	James A. Dodrill	3/4/2019	9/20/2021	2	6
Acting Insurance Commissioner	Erin K. Hunter	1/25/2019	3/1/2019	0	2
Insurance Commissioner	Allan L. McVey	4/1/2017	1/23/2019	1	10
Acting Insurance Commissioner	Andrew R. Pauley	2/1/2017	3/31/2017	0	2
Insurance Commissioner	Michael D. Riley	1/9/2012	1/31/2017	5	0
Acting Insurance Commissioner	Michael D. Riley	7/1/2011	1/8/2012	0	6
Insurance Commissioner	Jane L. Cline*	1/15/2001	6/30/2011	10	5
Insurance Commissioner	Hanley C. Clark	1/18/1989	1/15/2001	12	0
Acting Insurance Commissioner	Hanley C. Clark	7/1/1988	1/17/1989	0	6
Insurance Commissioner	Fred E. Wright	2/21/1985	6/30/1988	3	4
Insurance Commissioner	Richard G. Shaw	1/17/1977	1/11/1985	8	0
Insurance Commissioner	Donald W. Brown	1/16/1975	1/14/1977	2	0
Insurance Commissioner	Samuel H. Weese	1/31/1969	1/16/1975	6	0
Insurance Commissioner	Robert J. Shipman	10/1/1968	1/30/1969	1	4
Insurance Commissioner	Frank R. Montgomery	1/16/1966	9/30/1968	2	8
Insurance Commissioner	Harlan Justice	9/4/1962	1/15/1966	3	4
Insurance Commissioner	Virginia Mae Brown	5/17/1961	9/3/1962	1	4

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NAIC MEMBER TENURE LIST

STATE/MEMBER TITLE	MEMBER NAME	BEG. DATE	END DATE	YRS. SERVED	MOS. SERVED
WEST VIRGINIA—Continued					
Insurance Commissioner	Hugh N. Mills	1/16/1961	5/16/1961	0	4
Insurance Commissioner	C. Judson Pearson	2/7/1958	1/15/1961	2	11
Insurance Commissioner	Harold E. Neeley	7/1/1957	2/5/1958	0	7
Insurance Commissioner	Louis Miller, Jr.	10/1/1956	6/30/1957	0	9
Insurance Commissioner	Thomas J. Gillooly	7/1/1953	9/30/1956	3	3
Insurance Commissioner	Hugh N. Mills	7/1/1952	6/30/1953	1	0
Insurance Commissioner	Robert A. Crichton	5/1/1949	6/30/1952	3	2
Insurance Commissioner	David S. Butler	7/1/1947	4/30/1949	1	10
State Auditor	Edgar B. Sims	3/4/1933	7/1/1947	14	4
State Auditor	Edgar C. Lawson	3/4/1929	3/4/1933	4	0
State Auditor	Samuel T. 'Sam' Mallison	3/18/1927	3/4/1929	2	0
State Auditor	John C. Bond	3/4/1921	3/15/1927	6	0
State Auditor	John S. Darst*	3/4/1909	3/4/1921	12	0
State Auditor	Arnold C. Sherr	3/4/1901	3/4/1909	8	0
State Auditor	Latelle M. LaFollette	3/4/1897	3/4/1901	4	0
State Auditor	Isaac V. Johnson	3/4/1893	3/4/1897	4	0
State Auditor	Patrick F. Duffy	9/30/1891	3/4/1893	8	0
WISCONSIN—Appointed, at the Pleasure of the Governor					
Insurance Commissioner	Nathan Houdek	1/2/2022		incumbent	
Interim Commissioner	Nathan Houdek	12/18/2021	1/2/2022	0	1
Insurance Commissioner	Mark V. Afable	1/22/2019	12/17/2021	2	11
Insurance Commissioner	Theodore K. 'Ted' Nickel*	1/3/2011	1/7/2019	8	0
Insurance Commissioner	Sean Dilweg	1/1/2007	1/3/2011	4	0
Insurance Commissioner	Jorge Gomez	2/17/2003	12/18/2006	3	10
Acting Insurance Commissioner	Randy Blumer	1/7/2003	2/16/2003	0	1
Insurance Commissioner	Connie L. O'Connell	1/4/1999	1/6/2003	4	0
Acting Insurance Commissioner	Randy Blumer	1/6/1998	1/2/1999	1	0
Insurance Commissioner	Josephine W. 'Jo' Musser*	3/8/1993	1/2/1998	4	10
Insurance Commissioner	<i>Position Vacant</i>	1/1/1993	3/7/1993	0	2
Insurance Commissioner	Robert D. 'Bob' Haase	4/28/1987	12/31/1992	5	8
Insurance Commissioner	Thomas P. Fox	3/1/1983	4/27/1987	4	2
Insurance Commissioner	Ann J. Haney	8/1/1982	2/28/1983	0	7
Insurance Commissioner	Susan M. Mitchell	3/19/1979	7/31/1982	3	4
Insurance Commissioner	Harold R. Wilde, Jr.	4/8/1975	3/18/1979	3	11
Insurance Commissioner	Stanley C. DuRose, Jr.	10/1/1969	4/8/1975	5	6
Insurance Commissioner	Robert D. 'Bob' Haase	9/15/1965	9/7/1969	4	0
Insurance Commissioner	Charles L. Manson	7/2/1959	9/15/1965	6	2
Insurance Commissioner	Paul J. Rogan	11/1/1955	7/2/1959	3	8
Insurance Commissioner	Alfred Van DeZande	7/15/1955	11/1/1955	0	4
Insurance Commissioner	John R. Lange	12/1/1948	6/15/1955	6	6
Insurance Commissioner	John L. Sonderegger	10/1/1948	12/1/1948	0	2
Insurance Commissioner	Morvin Duel	10/1/1939	8/8/1948	8	10
Insurance Commissioner	Harry J. Mortensen	7/1/1931	10/1/1939	8	2
Insurance Commissioner	Milton A. Freedy	1/10/1927	7/1/1931	4	5
Insurance Commissioner	Olaf H. Johnson	6/2/1926	1/10/1927	0	7
Insurance Commissioner	W. Stanley Smith	7/17/1923	6/2/1926	2	11
Insurance Commissioner	Platt Whitman*	4/10/1919	7/17/1923	4	3
Insurance Commissioner	Michael J. 'Mike' Cleary*	7/1/1915	4/10/1919	3	9
Insurance Commissioner	Herman L. Ekern	1/2/1911	7/1/1915	4	6

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NAIC MEMBER TENURE LIST

STATE/MEMBER TITLE	MEMBER NAME	BEG. DATE	END DATE	YRS. SERVED	MOS. SERVED
WISCONSIN—Continued					
Insurance Commissioner	George E. Beedle	1/7/1907	1/2/1911	4	0
Insurance Commissioner	Zeno M. Host	1/5/1903	1/1/1907	4	0
Insurance Commissioner	Emil Giljohann	10/15/1898	1/5/1903	4	3
Insurance Commissioner	William A. Fricke	1/7/1895	10/15/1898	3	9
Insurance Commissioner	Wilbur M. Root	1/5/1891	1/7/1895	4	0
Insurance Commissioner	Philip Cheek, Jr.*	1/3/1887	1/5/1891	4	0
Insurance Commissioner	Philip L. Spooner, Jr.	4/1/1878	1/3/1887	8	9
Secretary of State	Hans B. Warner	1/7/1878	4/1/1878	3	0
Secretary of State	Peter Doyle	1/5/1874	1/7/1878	4	0
Secretary of State	Llewelyn Breese*	5/24/1871	1/5/1874	2	8
WYOMING—Appointed, at the Pleasure of the Governor					
Insurance Commissioner	Jeffrey P. 'Jeff' Rude	9/19/2019		incumbent	
Interim Insurance Commissioner	Jeffrey P. 'Jeff' Rude	6/19/2019	9/19/2019	0	3
Insurance Commissioner	Paul Thomas 'Tom' Glause	1/3/2015	6/19/2019	4	5
Insurance Commissioner	Thomas C. 'Tom' Hirsig	4/16/2012	12/31/2014	2	8
Insurance Commissioner	Kenneth G. 'Ken' Vines	2/21/2003	4/16/2012	9	2
Acting Insurance Commissioner	Kenneth G. 'Ken' Vines	10/16/2002	2/21/2003	0	4
Insurance Commissioner	John P. McBride	5/7/1992	10/1/2002	10	5
Acting Insurance Commissioner	John P. McBride	10/1/1991	5/7/1992	0	7
Insurance Commissioner	Kenneth Erickson	2/1/1990	10/1/1991	1	8
Acting Insurance Commissioner	Ralph Thomas	12/1/1989	2/1/1990	0	2
Insurance Commissioner	Gordon W. Taylor, Jr.	7/1/1986	12/1/1989	3	5
Acting Insurance Commissioner	Monroe D. Lauer	3/1/1986	7/1/1986	0	4
Insurance Commissioner	Robert W. Schrader	6/1/1984	3/1/1986	1	9
Insurance Commissioner	John T. Langdon	1/1/1975	6/1/1984	9	5
Insurance Commissioner	Ben S. Murphy	1/1/1971	1/1/1975	4	0
Insurance Commissioner	Vincent J. Horn, Jr.	6/1/1970	1/1/1971	0	7
Insurance Commissioner	William G. Walton	6/1/1967	6/1/1970	3	0
Insurance Commissioner	Mark Duncan	6/1/1963	6/1/1967	4	0
Insurance Commissioner	Gilbert A.D. Hart	5/1/1960	6/1/1963	3	1
Insurance Commissioner	Robert Adams	3/1/1959	5/1/1960	1	2
Insurance Commissioner	Ford S. Taft	3/1/1951	3/1/1959	8	0
Insurance Commissioner	Rodney Barrus	3/18/1945	3/1/1951	6	0
Insurance Commissioner	Alex MacDonald	2/1/1939	3/18/1945	6	1
Insurance Commissioner	Arthur J. Ham	3/1/1935	2/1/1939	3	11
Insurance Commissioner	Theodore Thulemeyer	2/13/1929	3/1/1935	6	1
Insurance Commissioner	Lyle E. Jay	6/6/1927	2/13/1929	1	8
Insurance Commissioner	John M. Fairfield <i>(Died May 21, 1927)</i>	3/1/1927	5/21/1927	0	2
Insurance Commissioner	Harry A. Loucks	3/1/1923	3/1/1927	4	0
Insurance Commissioner	Donald M. Forsyth	11/8/1920	3/1/1923	2	4
Insurance Commissioner	Robert B. Forsyth	3/1/1919	11/8/1920	1	8
State Auditor	Robert B. Forsyth	1/2/1911	3/1/1919	8	2
State Auditor	LeRoy Grant	1/2/1899	1/2/1911	12	0
State Auditor	William O. Owen	1/7/1895	1/2/1899	4	0
State Auditor	Charles W. Burdick	11/9/1890	1/7/1895	4	2
State Auditor	Mortimer N. Grant	7/10/1890	11/8/1890	0	4
Territorial Auditor	Mortimer N. Grant	3/8/1888	7/10/1890	2	4
Insurance Commissioner	Joseph B. Adams	4/1/1884	3/8/1888	3	11

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NAIC MEMBER TENURE LIST

STATE/MEMBER TITLE	MEMBER NAME	BEG. DATE	END DATE	YRS. SERVED	MOS. SERVED
WYOMING—Continued					
Territorial Auditor	Jesse Knight	4/1/1882	3/31/1884	1	11
Territorial Auditor	John H. Nason	1/4/1880	3/31/1882	2	2
Territorial Auditor	James France	12/13/1877	1/4/1880	2	1

Updated: 8/12/2023

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NAIC MEETING RECORD

The following is a record of officers and list of national meeting locations at which the NAIC has met since its organization.

<u>Mtg</u>	<u>Date</u>	<u>Meeting Site</u>	<u>President</u>	<u>Vice-President</u>	<u>Secretary / Secretary-Treasurer</u>
1	5/24-6/2/1871	New York, NY	George W. Miller, NY	Llewelyn Breese, WI	Henry S. Olcott, NY
2	10/18-30/1871	New York, NY	George W. Miller, NY	Llewelyn Breese, WI	Henry S. Olcott, NY
3	10/--/1872	New York, NY	George W. Miller, NY	Llewelyn Breese, WI	Henry S. Olcott, NY
4	9/17-20/1873	Boston, MA	Llewelyn Breese, WI	John W. Foard, CA	Oliver Pillsbury, NH
5	9/2-5/1874	Detroit, MI	Orlow W. Chapman, NY	Samuel H. Row, MI	Oliver Pillsbury, NH
6	9/20-25/1875	New York, NY	Orlow W. Chapman, NY	Samuel H. Row, MI	Oliver Pillsbury, NH
7	9/19-21/1876	Harrisburg, PA	Samuel H. Row, MI	Oliver Pillsbury, NH	Stephen H. Rhodes, MA
8	9/18/1877	St. Paul, MN	Samuel H. Row, MI	Oliver Pillsbury, NH	Stephen H. Rhodes, MA
9	8/27/1878	Providence, RI	Oliver Pillsbury, NH	Andrew R. McGill, MN	Orrin T. Welch, KS
10	9/17/1879	St. Louis, MO	Oliver Pillsbury, NH	Andrew R. McGill, MN	Orrin T. Welch, KS
11	9/10/1880	Chicago, IL	Andrew R. McGill, MN	Julius L. Clarke, MA	Orrin T. Welch, KS
12	9/20-21/1881	Detroit, MI	Julius L. Clarke, MA	Philip L. Spooner, WI	Orrin T. Welch, KS
13	10/4-5/1882	Niagara Falls, NY	Julius L. Clarke, MA	John A. McCall Jr., NY	Orrin T. Welch, KS
14	9/26-27/1883	Columbus, OH	Oliver Pillsbury, NH	Charles P. Swigert, IL	John W. Brooks, CT
15	9/24-25/1884	Chicago, IL	John A. McCall Jr., NY	Charles H. Moore, OH	Charles P. Swigert, IL
16	9/23-24/1885	Chicago, IL	John A. McCall Jr., NY	Eugene Pringle, MI	Charles P. Swigert, IL
17	9/22-23/1886	St. Paul, MN	Charles P. Swigert, IL	Henry J. Reinmund, OH	Charles Shandrew, MN
18	9/21-22/1887	Niagara Falls, NY	Oliver Pillsbury, NH ¹	Samuel H. Cross, RI ¹	Jacob A. McEwen, OH ¹
19	8/15-16/1888	Madison, WI	Philip Cheek Jr., WI	Orsamus R. Fyler, CT	Jacob A. McEwen, OH
20	9/4-5/1889	Denver, CO	Orsamus R. Fyler, CT	Samuel E. Kemp, OH	George B. Luper, PA
21	8/20-21/1890	Cleveland, OH	George S. Merrill, MA	Samuel E. Kemp, OH	George B. Luper, PA
22	9/30-10/2/1891	St. Louis, MO	Christopher P. Ellerbe, MO	George B. Luper, PA	John J. Brinkerhoff, IL ²
23	6/15-16/1892	St. Paul, MN	George B. Luper, PA	William H. Kinder, OH	John J. Brinkerhoff, IL
24	9/12-13/1893	Chicago, IL	John C. Linehan, NH	Christopher H. Smith, MN	John J. Brinkerhoff, IL
25	9/5-6/1894	Alexandria Bay, NY	James F. Pierce, NY	Bradford K. Durfee, IL	John J. Brinkerhoff, IL
26	9/17-18/1895	Mackinac Island, MI	Bradford K. Durfee, IL	William M. Hahn, OH	Frederick L. 'Fred' Cutting, MA
27	9/22-23/1896	Philadelphia, PA	James R. Waddill, MO ³	Stephen W. Carr, ME ³	Frederick L. 'Fred' Cutting, MA
28	9/7-8/1897	Old Point Comfort, VA	Stephen W. Carr, ME ⁴	Stephen W. Carr, ME ⁴	John J. Brinkerhoff, IL ⁵
29	9/1898	Milwaukee, WI	Stephen W. Carr, ME	William A. Fricke, WI	John J. Brinkerhoff, IL ⁶
30	9/1899	Detroit, MI	Edward T. Orear, MO ⁷	Milo D. Campbell, MI	John J. Brinkerhoff, IL
31	9/1900	Hartford, CT	Edward T. Orear, MO	W. S. Matthews, OH	John J. Brinkerhoff, IL
32	9/1901	Buffalo, NY	William H. Hart, IN ⁸	Edwin L. Scofield, CT	John J. Brinkerhoff, IL
33	9/1902	Columbus, OH	William H. Hart, IN	Fred A. Howland, VT	John J. Brinkerhoff, IL
34	9/1903	Baltimore, MD	Arthur I. Vorys, OH	John L. Bacon, VT	John J. Brinkerhoff, IL
35	9/1904	Indianapolis, IN	John L. Bacon, VT	James V. Barry, MI	John J. Brinkerhoff, IL
36	9/1905	Bretton Woods, NH	Frederick L. 'Fred' Cutting, MA	James V. Barry, MI	John J. Brinkerhoff, IL
37	10/1906	Washington, DC	James V. Barry, MI	Theron Upson, CT	John J. Brinkerhoff, IL
38	9/1907	Richmond, VA	George H. Adams, NH	Reau E. Folk, TN	John J. Brinkerhoff, IL
39	8/1908	Detroit, MI	Reau E. Folk, TN	Beryl F. Carroll, IA	John J. Brinkerhoff, IL
40	8/1909	Colorado Springs, CO	Benjamin F. Crouse, MD	Fred W. Potter, IL	John A. Hartigan, MN
41	9/1910	Mobile, AL	John A. Hartigan, MN	Eugene J. McGivney, LA	Harry R. Cunningham, MT
42	8/1911	Milwaukee, WI	Joseph L. Button, VA	Theodore H. Macdonald, CT ⁹	Harry R. Cunningham, MT
43	7/1912	Spokane, WA	Fred W. Potter, IL	Frank H. Hardison, MA	Fitz Hugh McMaster, SC ¹⁰
44	7/1913	Burlington, VT	Frank H. Hardison, MA	1st James R. Young, NC	Fitz Hugh McMaster, SC
45	9/1914	Asheville, NC	James R. Young, NC	2nd Willard Done, UT	Fitz Hugh McMaster, SC
46	9/1915	Del Monte, CA	John S. Darst, WV	1st Willard Done, UT ¹¹	Fitz Hugh McMaster, SC
47	9/1916	Richmond, VA	Burton Mansfield, CT	2nd John S. Darst, WV	Fitz Hugh McMaster, SC
48	8/1917	St. Paul, MN	Jesse S. Phillips, NY	1st Burton Mansfield, CT	Fitz Hugh McMaster, SC
49	9/1918	Denver, CO	Michael J. 'Mike' Cleary, WI ¹²	2nd John T. Winship, MI	Fitz Hugh McMaster, SC
50	9/1919	Hartford, CT	Claude W. Fairchild, CO	1st John T. Winship, MI	Fitz Hugh McMaster, SC
51	9/1920	Beverly Hills, CA	Joseph G. Brown, VT	2nd W. C. Taylor, ND	Fitz Hugh McMaster, SC
52	9/1921	Louisville, KY	Alfred L. Harty, MO ¹⁵	1st John T. Winship, MI	Fitz Hugh McMaster, SC
53	9/1922	Swampscott, MA	Thomas B. Donaldson, PA	2nd Emory H. English, IA	Fitz Hugh McMaster, SC
54	8/1923	Minneapolis, MN	Herbert O. Fishback, WA ¹⁶	1st Robert J. Merrill, NH ¹²	Joseph L. Button, VA ¹³
55	7/1924	Seattle, WA	Herbert O. Fishback, WA	2nd Walter K. Chorn, MO ¹²	Joseph L. Button, VA
				1st Joseph G. Brown, VT	Joseph L. Button, VA
				2nd Frank H. Ellsworth, MI	Joseph L. Button, VA
				1st Frank H. Ellsworth, MI	Joseph L. Button, VA
				2nd Alfred L. Harty, MO ¹⁴	Joseph L. Button, VA
				1st Thomas B. Donaldson, PA ¹⁵	Joseph L. Button, VA
				2nd Platt Whitman, WI ¹⁵	Joseph L. Button, VA
				1st Platt Whitman, WI	Joseph L. Button, VA
				2nd Herbert O. Fishback, WA	Joseph L. Button, VA
				1st John C. Luning, FL ¹⁶	Joseph L. Button, VA
				2nd John C. Luning, FL ¹⁶	Joseph L. Button, VA
				1st John C. Luning, FL	Joseph L. Button, VA
				2nd Samuel W. McCulloch, PA	Joseph L. Button, VA

<u>Mtg</u>	<u>Date</u>	<u>Meeting Site</u>	<u>President</u>	<u>Vice-President</u>	<u>Secretary / Secretary-Treasurer</u>
56	9/1925	San Antonio, TX	John C. Luning, FL	1st Samuel W. McCulloch, PA 2nd Bruce T. Bullion, AR	Joseph L. Button, VA
57	11/1926	Los Angeles, CA	Harry L. Conn, OH ¹⁷	1st T. M. Henry, MA 2nd Thomas M. Baldwin, Jr., DC	Joseph L. Button, VA
58	9/1927	Cincinnati, OH	Albert S. Caldwell, TN ¹⁸	1st James A. Beha, NY ¹⁸ 2nd Charles R. Detrick, CA	Joseph L. Button, VA
59	9/1928	Rapid City, SD	Albert S. Caldwell, TN	1st Charles R. Detrick, CA 2nd James A. Beha, NY	Joseph L. Button, VA
60	9/1929	Toronto, Canada	Howard P. Dunham, CT ¹⁹	1st Clarence C. Wysong, IN ¹⁹ 2nd Jess G. Read, OK ¹⁹	Joseph L. Button, VA
61	9/1930	Hartford, CT	Howard P. Dunham, CT	1st Clarence C. Wysong, IN 2nd Jess G. Read, OK	Albert S. Caldwell, TN ²⁰
62	9/1931	Portland, OR	Jess G. Read, OK ²¹	1st Charles D. Livingston, MI ²¹ 2nd William A. Tarver, TX ²¹	Albert S. Caldwell, TN
63	10/1932	Dallas, TX	Charles D. Livingston, MI	1st William A. Tarver, TX 2nd Garfield W. Brown, MN	Jess G. Read, OK
64	6/1933	Chicago, IL	Garfield W. Brown, MN ²²	1st Daniel C. 'Dan' Boney, NC ²² 2nd George S. Van Schaick, NY ²²	Jess G. Read, OK
65	12/1934	St. Petersburg, FL	Garfield W. Brown, MN	1st Daniel C. 'Dan' Boney, NC 2nd George S. Van-Schaick, NY	Jess G. Read, OK
66	7/1935	Seattle, WA	Daniel C. 'Dan' Boney, NC	1st George S. Van-Schaick, NY ²³ 2nd Merton L. Brown, MA ²³	Jess G. Read, OK
67	6/1936	St. Paul, MN	William A. Sullivan, WA	1st Ernest Palmer, IL 2nd George A. Bowles, VA	Jess G. Read, OK
68	6/1937	Philadelphia, PA	Ernest Palmer, IL	George A. Bowles, VA	Jess G. Read, OK
69	6/1938	Quebec, Canada	George A. Bowles, VA	Samuel L. Carpenter, Jr., CA	Jess G. Read, OK
70	6/1939	San Francisco, CA	Frank N. Julian, AL	Arthur J. Ham, WY	Jess G. Read, OK
71	6/1940	Hartford, CT	C. Clarence Nelson, UT	John C. Blackall, CT ²⁴	Jess G. Read, OK
72	6/1941	Detroit, MI	John C. Blackall, CT	Charles F. Hobbs, KS	Jess G. Read, OK
73	6/1942	Denver, CO	Charles F. Hobbs, KS	John Sharp Williams III, MS	Jess G. Read, OK
74	6/1943	Boston, MA	John Sharp Williams III, MS	Charles F. J. Harrington, MA	Jess G. Read, OK
75	6/1944	Chicago, IL	Charles F. J. Harrington, MA	Newell R. Johnson, MN	Jess G. Read, OK
76	6/1945	St. Paul, MN	Newell R. Johnson, MN	James M. McCormack, TN	Jess G. Read, OK
77	6/1946	Portland, OR	James M. McCormack, TN	Robert E. Dineen, NY ²⁵	Jess G. Read, OK
78	6/1947	Atlantic City, NJ	Robert E. Dineen, NY	Seth B. Thompson, OR	Nellis P. Parkinson, IL ²⁶
79	6/1948	Philadelphia, PA	Seth B. Thompson, OR	J. Edwin Larson, FL	William P. Hodges, NC
80	6/1949	Seattle, WA	J. Edwin Larson, FL	David A. Forbes, MI	George A. Bowles, VA
81	6/1950	Quebec, Canada	David A. Forbes, MI	W. Ellery Allyn, CT	George A. Bowles, VA
82	6/1951	Swampscott, MA	W. Ellery Allyn, CT	Frank Sullivan, KS	George A. Bowles, VA
83	6/1952	Chicago, IL	Frank Sullivan, KS	Wade O. Martin Jr., LA	George A. Bowles, VA
Reg.	12/1952	New York, NY	Wade O. Martin Jr., LA	D. D. 'Pat' Murphy, SC	George A. Bowles, VA
84	6/1953	San Francisco, CA	Wade O. Martin Jr., LA	D. D. 'Pat' Murphy, SC	George A. Bowles, VA
Reg.	11/1953	Miami Beach, FL	D. D. 'Pat' Murphy, SC	Donald Knowlton, NH ²⁷	George A. Bowles, VA
85	6/1954	Detroit, MI	D. D. 'Pat' Murphy, SC	Donald Knowlton, NH	George A. Bowles, VA
Reg.	11/1954	New York, NY	Donald Knowlton, NH	C. Lawrence Leggett, MO	George A. Bowles, VA
86	5/1955	Los Angeles, CA	Donald Knowlton, NH	C. Lawrence Leggett, MO	George A. Bowles, VA
Reg.	11/1955	New York, NY	C. Lawrence Leggett, MO	Robert B. Taylor, OR	George A. Bowles, VA
87	5/1956	St. Louis, MO	C. Lawrence Leggett, MO	Robert B. Taylor, OR	George A. Bowles, VA
Reg.	12/1956	Miami Beach, FL	Robert B. Taylor, OR	Joseph A. Navarre, MI	Paul A. Hammel, NV ²⁸
88	6/1957	Atlantic City, NJ	Robert B. Taylor, OR	Joseph A. Navarre, MI	Paul A. Hammel, NV
Reg.	12/1957	New York, NY	Joseph A. Navarre, MI	Arch E. Northington, TN	J. Edwin Larson, FL
89	6/1958	Chicago, IL	Joseph A. Navarre, MI	Arch E. Northington, TN	J. Edwin Larson, FL
Reg.	12/1958	New Orleans, LA	Arch E. Northington, TN	Paul A. Hammel, NY	J. Edwin Larson, FL
90	6/1959	Boston, MA	Paul A. Hammel, NV ²⁹	Sam N. Beery, CO ²⁹	J. Edwin Larson, FL
Reg.	11/30-12/4/1959	Miami Beach, FL	Paul A. Hammel, NV	Sam N. Beery, CO	Alfred N. Premo, CT
91	5/30-6/3/1960	San Francisco, CA	Paul A. Hammel, NV	Sam N. Beery, CO	Alfred N. Premo, CT
Reg.	11/28-12/2/1960	New York, NY	Sam N. Beery, CO	T. Nelson Parker, VA	Alfred N. Premo, CT
92	6/5-9/1961	Philadelphia, PA	Sam N. Beery, CO	T. Nelson Parker, VA	Alfred N. Premo, CT
Reg.	12/4-8/1961	Dallas, TX	T. Nelson Parker, VA	Rufus D. Hayes, LA	Harvey G. Combs, AR
93	6/18-22/1962	Montreal, Canada	T. Nelson Parker, VA	Rufus D. Hayes, LA	Harvey G. Combs, AR
Reg.	12/3-7/1962	Chicago, IL	Rufus D. Hayes, LA	Joseph S. Gerber, IL	Harvey G. Combs, AR
94	6/17-21/1963	Seattle, WA	Rufus D. Hayes, LA	Joseph S. Gerber, IL ³⁰	Harvey G. Combs, AR
Reg.	12/2-6/1963	Phoenix, AZ	Lee I. Kueckelhan, WA	Cyrus E. Magnusson, MN	Ralph F. Apodaca, NM
95	6/8-12/1964	Minneapolis, MN	Lee I. Kueckelhan, WA	Cyrus E. Magnusson, MN	Ralph F. Apodaca, NM
Reg.	11/30-12/4/1964	Las Vegas, NV	Cyrus E. Magnusson, MN	William E. Timmons, IA	Ralph F. Apodaca, NM
96	6/7-11/1965	New York, NY	Cyrus E. Magnusson, MN	William E. Timmons, IA	Ralph F. Apodaca, NM
Reg.	11/29-12/3/1965	Miami Beach, FL	William E. Timmons, IA	Frank J. Barrett, NE	Ralph F. Apodaca, NM
97	6/19-24/1966	Richmond, VA	William E. Timmons, IA	Frank J. Barrett, NE	Ralph F. Apodaca, NM
Reg.	12/4-9/1966	Dallas, TX	Frank J. Barrett, NE	James L. Bentley, GA	Ralph F. Apodaca, NM
98	6/11-16/1967	Boston, MA	Frank J. Barrett, NE	James L. Bentley, GA	Ralph F. Apodaca, NM
Reg.	12/3-8/1967	Honolulu, HI	James L. Bentley, GA	Charles R. Howell, NJ	Ralph F. Apodaca, NM
99	6/16-21/1968	Portland, OR	James L. Bentley, GA	Charles R. Howell, NJ	Ralph F. Apodaca, NM
Reg.	12/1-6/1968	Los Angeles, CA	Charles R. Howell, NJ ³¹	Ned Price, TX	Ralph F. Apodaca, NM

<u>Mtg</u>	<u>Date</u>	<u>Meeting Site</u>	<u>President</u>	<u>Vice-President</u>	<u>Secretary / Secretary-Treasurer</u>
100	6/16-20/1969	Philadelphia, PA	Ned Price, TX	Richard E. 'Dick' Stewart, NY	Ralph F. Apodaca, NM
Reg.	12/1-5/1969	New Orleans, LA	Ned Price, TX	Richard E. 'Dick' Stewart, NY	Ralph F. Apodaca, NM
101	6/15-19/1970	Cleveland, OH	Ned Price, TX	Richard E. 'Dick' Stewart, NY	Ralph F. Apodaca, NM
Reg.	12/14-18/1970	Chicago, IL	Richard E. 'Dick' Stewart, NY ³²	Lorne R. Worthington, IA	Ralph F. Apodaca, NM
102	6/14-18/1971	New York, NY	Lorne R. Worthington, IA	Richards D. 'Dick' Barger, CA	Ralph F. Apodaca, NM
Reg.	11/28-12/3/1971	Miami Beach, FL	Richards D. 'Dick' Barger, CA	Russell E. Van Hooser, MI	Ralph F. Apodaca, NM
103	6/12-16/1972	Denver, CO	Richards D. 'Dick' Barger, CA	Russell E. Van Hooser, MI	Ralph F. Apodaca, NM
Reg.	12/3-8/1972	Atlanta, GA	Russell E. Van Hooser, MI	W. Fletcher Bell, KS	Ralph F. Apodaca, NM
104	6/4-8/1973	Washington, DC	Russell E. Van Hooser, MI	W. Fletcher Bell, KS	Ralph F. Apodaca, NM
Reg.	12/2-7/1973	Las Vegas, NV	W. Fletcher Bell, KS	Johnnie L. Caldwell, GA	Ralph F. Apodaca, NM
105	6/2-7/1974	San Francisco, CA	W. Fletcher Bell, KS	Johnnie L. Caldwell, GA	Ralph F. Apodaca, NM
Reg.	12/1-6/1974	Mexico City, Mexico	Johnnie L. Caldwell, GA ³³	Kenneth E. 'Ken' DeShetler, OH ³⁴	Ralph F. Apodaca, NM
106	6/8-12/1975	Seattle, WA	William H. Huff III, IA ³⁴	Richard L. 'Dick' Rottman, NV	Ralph F. Apodaca, NM
Reg.	12/7-11/1975	San Juan, PR	William H. Huff III, IA	Richard L. 'Dick' Rottman, NV	Ralph F. Apodaca, NM
107	6/7-11/1976	New Orleans, LA	Richard L. 'Dick' Rottman, NV	Lester L. Rawls, OR	Ralph F. Apodaca, NM
Reg.	12/6-10/1976	Phoenix, AZ	Richard L. 'Dick' Rottman, NV	Lester L. Rawls, OR	Ralph F. Apodaca, NM
108	6/5-10/1977	Minneapolis, MN	Lester L. Rawls, OR	Harold B. McGuffey, KY	Elmer V. Omholt, MT
Reg.	12/4-9/1977	Miami Beach, FL	Lester L. Rawls, OR	Harold B. McGuffey, KY	Elmer V. Omholt, MT
109	6/11-16/1978	Washington, DC	Harold B. McGuffey, KY	H. Peter 'Pete' Hudson, IN	Elmer V. Omholt, MT
Reg.	12/3-8/1978	Las Vegas, NV	Harold B. McGuffey, KY	H. Peter 'Pete' Hudson, IN	Elmer V. Omholt, MT
110	6/3-8/1979	Chicago, IL	H. Peter 'Pete' Hudson, IN	Wesley J. Kinder, CA	Elmer V. Omholt, MT
Reg.	12/2-7/1979	Los Angeles, CA	H. Peter 'Pete' Hudson, IN ³⁵	Wesley J. Kinder, CA	Elmer V. Omholt, MT
111	6/15-20/1980	Denver, CO	Wesley J. Kinder, CA	William H. L. Woodyard III, AR	Elmer V. Omholt, MT
Reg.	11/30-12/5/1980	New York, NY	Wesley J. Kinder, CA	William H. L. Woodyard III, AR	Elmer V. Omholt, MT
112	6/7-12/1981	Detroit, MI	William H. L. Woodyard, AR	John W. Lindsay, SC ³⁶	Elmer V. Omholt, MT
Reg.	12/13-18/1981	New Orleans, LA	William H. L. Woodyard, AR	Johnnie L. Caldwell, GA ³⁶	Elmer V. Omholt, MT
113	6/6-11/1982	Philadelphia, PA	Lyndon L. Olson Jr., TX	Roger C. Day, UT	Elmer V. Omholt, MT
Zone	9/1982	Nashville, TN	Lyndon L. Olson Jr., TX	Roger C. Day, UT	Elmer V. Omholt, MT
114	11/28-12/3/1982	Dallas, TX	Lyndon L. Olson Jr., TX	Roger C. Day, UT	Elmer V. Omholt, MT
Zone	3/1983	Baltimore, MD	Roger C. Day, UT	William D. 'Bill' Gunter, FL	Elmer V. Omholt, MT
115	6/12-17/1983	St. Louis, MO	Roger C. Day, UT	William D. 'Bill' Gunter, FL	Elmer V. Omholt, MT
Zone	9/1983	Tampa, FL	Roger C. Day, UT	William D. 'Bill' Gunter, FL	Elmer V. Omholt, MT
116	12/4-9/1983	San Diego, CA	Roger C. Day, UT	William D. 'Bill' Gunter, FL	Elmer V. Omholt, MT
Zone	3/1984	Portland, OR	William D. 'Bill' Gunter, FL	Bruce W. Foudree, IA	Elmer V. Omholt, MT
117	6/3-8/1984	New Orleans, LA	William D. 'Bill' Gunter, FL	Bruce W. Foudree, IA	Elmer V. Omholt, MT
Zone	9/1984	Omaha, NE	William D. 'Bill' Gunter, FL	Bruce W. Foudree, IA	Elmer V. Omholt, MT
118	12/9-14/1984	Washington, DC	William D. 'Bill' Gunter, FL	Bruce W. Foudree, IA	Elmer V. Omholt, MT
Zone	3/1985	Williamsburg, VA	Bruce W. Foudree, IA	Josephine M. 'Jo' Driscoll, OR	Elmer V. Omholt, MT
119	6/9-14/1985	Kansas City, MO	Bruce W. Foudree, IA	Josephine M. 'Jo' Driscoll, OR	Elmer V. Omholt, MT
Zone	9/1985	Syracuse, NY	Bruce W. Foudree, IA	Josephine M. 'Jo' Driscoll, OR	Elmer V. Omholt, MT
120	12/8-12/1985	Reno, NV	Bruce W. Foudree, IA	Josephine M. 'Jo' Driscoll, OR	Elmer V. Omholt, MT
Zone	3/1986	San Francisco, CA	Josephine M. 'Jo' Driscoll, OR	Edward J. Muhl, MD	W. Fletcher Bell, KS
121	6/8-12/1986	Boston, MA	Josephine M. 'Jo' Driscoll, OR	Edward J. Muhl, MD	W. Fletcher Bell, KS
Zone	9/1986	Des Moines, IA	Josephine M. 'Jo' Driscoll, OR	Edward J. Muhl, MD	W. Fletcher Bell, KS
122	12/7-11/1986	Orlando, FL	Josephine M. 'Jo' Driscoll, OR	Edward J. Muhl, MD	W. Fletcher Bell, KS
Zone	4/1987	Lexington, KY	Edward J. Muhl, MD	John E. Washburn, IL	W. Fletcher Bell, KS
123	6/21-26/1987	Chicago, IL	Edward J. Muhl, MD	John E. Washburn, IL	W. Fletcher Bell, KS
Zone	9/13-16/1987	Pittsburgh, PA	Edward J. Muhl, MD	John E. Washburn, IL	W. Fletcher Bell, KS
124	12/6-11/1987	Phoenix, AZ	Edward J. Muhl, MD	John E. Washburn, IL	W. Fletcher Bell, KS
Zone	3/13-15/1988	Santa Fe, NM	John E. Washburn, IL	David A. Gates, NV	W. Fletcher Bell, KS
125	6/12-17/1988	New York, NY	John E. Washburn, IL	David A. Gates, NV	W. Fletcher Bell, KS
Zone	9/18-20/1988	Mackinac Island, MI	John E. Washburn, IL	David A. Gates, NV	W. Fletcher Bell, KS
126	12/11-16/1988	New Orleans, LA	John E. Washburn, IL	David A. Gates, NV	W. Fletcher Bell, KS
Zone	3/19-21/1989	Little Rock, AR	David A. Gates, NV	Earl R. Pomeroy, ND	W. Fletcher Bell, KS
127	6/4-8/1989	Cincinnati, OH	David A. Gates, NV	Earl R. Pomeroy, ND	W. Fletcher Bell, KS
Zone	9/10-12/1989	Wilmington, DE	David A. Gates, NV	Earl R. Pomeroy, ND	W. Fletcher Bell, KS
128	12/3-7/1989	Las Vegas, NV	David A. Gates, NV	Earl R. Pomeroy, ND	W. Fletcher Bell, KS
Zone	3/25-27/1990	Salt Lake City, UT	Earl R. Pomeroy, ND	James E. 'Jim' Long, NC	W. Fletcher Bell, KS
129	6/3-7/1990	Baltimore, MD	Earl R. Pomeroy, ND	James E. 'Jim' Long, NC	W. Fletcher Bell, KS
Zone	9/8-11/1990	Kansas City, MO	Earl R. Pomeroy, ND	James E. 'Jim' Long, NC	W. Fletcher Bell, KS
130	12/2-6/1990	Louisville, KY	Earl R. Pomeroy, ND	James E. 'Jim' Long, NC	W. Fletcher Bell, KS
Zone	4/13-16/1991	Charleston, WV	James E. 'Jim' Long, NC	William H. 'Bill' McCartney, NE	Robin Campaniano, HI
131	6/9-13/1991	Indianapolis, IN	James E. 'Jim' Long, NC	William H. 'Bill' McCartney, NE	Robin Campaniano, HI
Zone	9/14-17/1991	Pittsburgh, PA	James E. 'Jim' Long, NC	William H. 'Bill' McCartney, NE	Robin Campaniano, HI
132	12/9-12/1991	Houston, TX	James E. 'Jim' Long, NC	William H. 'Bill' McCartney, NE	Robin Campaniano, HI
Zone	3/28-31/1992	Seattle, WA	William H. 'Bill' McCartney, NE	Steven T. Foster, VA	David J. Walsh, AK
133	6/7-11/1992	Washington, DC	William H. 'Bill' McCartney, NE	Steven T. Foster, VA	David J. Walsh, AK
Zone	9/20-22/1992	Cincinnati, OH	William H. 'Bill' McCartney, NE	Steven T. Foster, VA	David J. Walsh, AK
134	12/6-9/1992	Atlanta, GA	William H. 'Bill' McCartney, NE	Steven T. Foster, VA	David J. Walsh, AK
Zone	3/7-9/1993	Nashville, TN	Steven T. Foster, VA	David J. Walsh, AK	David J. Lyons, IA
135	6/20-23/1993	Chicago, IL	Steven T. Foster, VA	David J. Walsh, AK	David J. Lyons, IA
136	9/19-21/1993	Boston, MA	Steven T. Foster, VA	David J. Walsh, AK	David J. Lyons, IA
137	12/5-8/1993	Honolulu, HI	Steven T. Foster, VA	David J. Walsh, AK	David J. Lyons, IA
138	3/6-8/1994	Denver, CO	David J. Walsh, AK	David J. Lyons, IA	Catherine J. Weatherford, OK
139	6/12-15/1994	Baltimore, MD	David J. Walsh, AK	David J. Lyons, IA ³⁷	Catherine J. Weatherford, OK

<u>Mtg</u>	<u>Date</u>	<u>Meeting Site</u>	<u>President</u>	<u>Vice-President</u>	<u>Secretary / Secretary-Treasurer</u>
140	9/18–20/1994	Minneapolis, MN	David J. Walsh, AK	Lee Douglass, AR ³⁷	Catherine J. Weatherford, OK
141	12/4–7/1994	New Orleans, LA	David J. Walsh, AK	Lee Douglass, AR	Catherine J. Weatherford, OK
142	3/12–14/1995	Miami, FL	Lee Douglass, AR	Brian Atchinson, ME	Josephine W. 'Jo' Musser, WI
143	6/4–7/1995	St. Louis, MO	Lee Douglass, AR	Brian Atchinson, ME	Josephine W. 'Jo' Musser, WI
144	9/10–12/1995	Philadelphia, PA	Lee Douglass, AR	Brian Atchinson, ME	Josephine W. 'Jo' Musser, WI
145	12/2–6/1995	San Antonio, TX	Lee Douglass, AR	Brian Atchinson, ME	Josephine W. 'Jo' Musser, WI
146	3/23–27/1996	Detroit, MI	Brian Atchinson, ME	Josephine W. 'Jo' Musser, WI	Glenn Pomeroy, ND
147	6/1–5/1996	New York, NY	Brian Atchinson, ME	Josephine W. 'Jo' Musser, WI	Glenn Pomeroy, ND
148	9/28–10/2/1996	Anchorage, AK	Brian Atchinson, ME	Josephine W. 'Jo' Musser, WI	Glenn Pomeroy, ND
149	12/14–18/1996	Atlanta, GA	Brian Atchinson, ME	Josephine W. 'Jo' Musser, WI	Glenn Pomeroy, ND
150	3/15–19/1997	Orlando, FL	Josephine W. 'Jo' Musser, WI	Glenn Pomeroy, ND	George M. Reider Jr., CT
151	6/7–11/1997	Chicago, IL	Josephine W. 'Jo' Musser, WI	Glenn Pomeroy, ND	George M. Reider Jr., CT
152	9/22/1997	Washington, DC	Josephine W. 'Jo' Musser, WI	Glenn Pomeroy, ND	George M. Reider Jr., CT
153	12/6–9/1997	Seattle, WA	Josephine W. 'Jo' Musser, WI	Glenn Pomeroy, ND	George M. Reider Jr., CT
154	3/14–18/1998	Salt Lake City, UT	Glenn Pomeroy, ND	George M. Reider Jr., CT	George Nichols, III, KY
155	6/20–24/1998	Boston, MA	Glenn Pomeroy, ND	George M. Reider Jr., CT	George Nichols, III, KY
156	9/12–16/1998	New York, NY	Glenn Pomeroy, ND	George M. Reider Jr., CT	George Nichols, III, KY
157	12/5–9/1998	Orlando, FL	Glenn Pomeroy, ND	George M. Reider Jr., CT	George Nichols, III, KY
158	3/6–10/1999	Washington, DC	George M. Reider Jr., CT	George Nichols, III, KY	Kathleen Sebelius, KS
159	6/5–9/1999	Kansas City, MO	George M. Reider Jr., CT	George Nichols, III, KY	Kathleen Sebelius, KS
160	10/2–6/1999	Atlanta, GA	George M. Reider Jr., CT	George Nichols, III, KY	Kathleen Sebelius, KS
161	12/4–8/1999	San Francisco, CA	George M. Reider Jr., CT	George Nichols, III, KY	Kathleen Sebelius, KS
162	3/11–15/2000	Chicago, IL	George Nichols, III, KY	Kathleen Sebelius, KS	Therese M. 'Terri' Vaughan, IA
163	6/10–14/2000	Orlando, FL	George Nichols, III, KY	Kathleen Sebelius, KS	Therese M. 'Terri' Vaughan, IA
164	9/9–13/2000	Dallas, TX	George Nichols, III, KY	Kathleen Sebelius, KS	Therese M. 'Terri' Vaughan, IA
165	12/2–5/2000	Boston, MA	George Nichols, III, KY	Kathleen Sebelius, KS	Therese M. 'Terri' Vaughan, IA
166	3/24–27/2001	Nashville, TN	Kathleen Sebelius, KS	Therese M. 'Terri' Vaughan, IA	J. Michael 'Mike' Pickens, AR
167	6/9–12/2001	New Orleans, LA	Kathleen Sebelius, KS	Therese M. 'Terri' Vaughan, IA	J. Michael 'Mike' Pickens, AR
N/A	9/2001	Mtg. canceled ³⁸	Kathleen Sebelius, KS	Therese M. 'Terri' Vaughan, IA	J. Michael 'Mike' Pickens, AR
168	12/8–11/2001	Chicago, IL	Kathleen Sebelius, KS	Therese M. 'Terri' Vaughan, IA	J. Michael 'Mike' Pickens, AR
169	3/16–19/2002	Reno, NV	Therese M. 'Terri' Vaughan, IA	J. Michael 'Mike' Pickens, AR	Nathaniel S. 'Nat' Shapo, IL
170	6/8–11/2002	Philadelphia, PA	Therese M. 'Terri' Vaughan, IA	J. Michael 'Mike' Pickens, AR	Nathaniel S. 'Nat' Shapo, IL
171	9/9–12/2002	New Orleans, LA	Therese M. 'Terri' Vaughan, IA	J. Michael 'Mike' Pickens, AR	Nathaniel S. 'Nat' Shapo, IL
172	12/7–10/2002	San Diego, CA	Therese M. 'Terri' Vaughan, IA	J. Michael 'Mike' Pickens, AR	Nathaniel S. 'Nat' Shapo, IL
173	3/8–11/2003	Atlanta, GA	J. Michael 'Mike' Pickens, AR	Ernst N. 'Ernie' Csiszar, SC	Joel S. Ario, OR
174	6/21–24/2003	New York, NY	J. Michael 'Mike' Pickens, AR	Ernst N. 'Ernie' Csiszar, SC	Joel S. Ario, OR
175	9/13–16/2003	Chicago, IL	J. Michael 'Mike' Pickens, AR	Ernst N. 'Ernie' Csiszar, SC	Joel S. Ario, OR
176	12/6–9/2003	Anaheim, CA	J. Michael 'Mike' Pickens, AR	Ernst N. 'Ernie' Csiszar, SC	Joel S. Ario, OR
177	3/13–16/2004	New York, NY	Ernst N. 'Ernie' Csiszar, SC	James A. 'Jim' Poolman, ND	Joel S. Ario, OR
178	6/13–16/2004	San Francisco, CA	Ernst N. 'Ernie' Csiszar, SC ³⁹	James A. 'Jim' Poolman, ND	Joel S. Ario, OR
179	9/11–14/2004	Anchorage, AK	M. Diane Koken, PA ³⁹	Joel S. Ario, OR ³⁹	Alessandro A. 'Al' Iuppa, ME ³⁹
180	12/4–7/2004	New Orleans, LA ⁴⁰	M. Diane Koken, PA	Joel S. Ario, OR	Alessandro A. 'Al' Iuppa, ME

<u>Mtg</u>	<u>Date</u>	<u>Meeting Site</u>	<u>President</u>	<u>President-Elect</u>	<u>Vice President</u>	<u>Secretary-Treasurer</u>
181	3/12–15/2005	Salt Lake City, UT	M. Diane Koken, PA	Alessandro A. 'Al' Iuppa, ME	Joel S. Ario, OR	Sandra K. 'Sandy' Praeger, KS
182	6/11–14/2005	Boston, MA	M. Diane Koken, PA	Alessandro A. 'Al' Iuppa, ME	Joel S. Ario, OR	Sandra K. 'Sandy' Praeger, KS
N/A	9/2005	Mtg. canceled ⁴¹	M. Diane Koken, PA	Alessandro A. 'Al' Iuppa, ME	Joel S. Ario, OR	Sandra K. 'Sandy' Praeger, KS
183	12/3–6/2005	Chicago, IL	M. Diane Koken, PA	Alessandro A. 'Al' Iuppa, ME	Joel S. Ario, OR	Sandra K. 'Sandy' Praeger, KS
184	3/4–7/2006	Orlando, FL	Alessandro A. 'Al' Iuppa, ME	Walter A. Bell, AL	Sandra K. 'Sandy' Praeger, KS	Eric P. Serna, NM ⁴²
185	6/10–13/2006	Washington, DC	Alessandro A. 'Al' Iuppa, ME	Walter A. Bell, AL	Sandra K. 'Sandy' Praeger, KS	Roger A. Sevigny, NH ⁴²
186	9/9–12/2006	St. Louis, MO	Alessandro A. 'Al' Iuppa, ME	Walter A. Bell, AL	Sandra K. 'Sandy' Praeger, KS	Roger A. Sevigny, NH
187	12/9–12/2006	San Antonio, TX	Alessandro A. 'Al' Iuppa, ME	Walter A. Bell, AL	Sandra K. 'Sandy' Praeger, KS	Roger A. Sevigny, NH
188	3/10–13/2007	New York, NY	Walter A. Bell, AL	Sandra K. 'Sandy' Praeger, KS	Roger A. Sevigny, NH	Jane L. Cline, WV
189	6/1–4/2007	San Francisco, CA	Walter A. Bell, AL	Sandra K. 'Sandy' Praeger, KS	Roger A. Sevigny, NH	Jane L. Cline, WV
190	9/29–10/1/2007	Washington, DC	Walter A. Bell, AL	Sandra K. 'Sandy' Praeger, KS	Roger A. Sevigny, NH	Jane L. Cline, WV
191	12/2–4/2007	Houston, TX	Walter A. Bell, AL	Sandra K. 'Sandy' Praeger, KS	Roger A. Sevigny, NH	Jane L. Cline, WV
192	3/29–31/2008	Orlando, FL	Sandra K. 'Sandy' Praeger, KS	Roger A. Sevigny, NH	Jane L. Cline, WV	Susan E. Voss, IA
193	5/31–6/2/2008	San Francisco, CA	Sandra K. 'Sandy' Praeger, KS	Roger A. Sevigny, NH	Jane L. Cline, WV	Susan E. Voss, IA
194	9/22–24/2008	National Harbor, MD	Sandra K. 'Sandy' Praeger, KS	Roger A. Sevigny, NH	Jane L. Cline, WV	Susan E. Voss, IA
195	12/5–8/2008	Grapevine, TX	Sandra K. 'Sandy' Praeger, KS	Roger A. Sevigny, NH	Jane L. Cline, WV	Susan E. Voss, IA
196	3/15–18/2009	San Diego, CA	Roger A. Sevigny, NH	Jane L. Cline, WV	Susan E. Voss, IA	Kevin M. McCarty, FL
197	6/13–15/2009	Minneapolis, MN	Roger A. Sevigny, NH	Jane L. Cline, WV	Susan E. Voss, IA	Kevin M. McCarty, FL
198	9/21–24/2009	National Harbor, MD	Roger A. Sevigny, NH	Jane L. Cline, WV	Susan E. Voss, IA	Kevin M. McCarty, FL
199	12/5–8/2009	San Francisco, CA	Roger A. Sevigny, NH	Jane L. Cline, WV	Susan E. Voss, IA	Kevin M. McCarty, FL
200	3/25–28/2010	Denver, CO	Jane L. Cline, WV	Susan E. Voss, IA	Kevin M. McCarty, FL	Kim Holland, OK
201	8/14–17/2010	Seattle, WA	Jane L. Cline, WV	Susan E. Voss, IA	Kevin M. McCarty, FL	Kim Holland, OK
202	10/18–21/2010	Orlando, FL	Jane L. Cline, WV	Susan E. Voss, IA	Kevin M. McCarty, FL	Kim Holland, OK
203	3/26–29/2011	Austin, TX	Susan E. Voss, IA	Kevin M. McCarty, FL	James J. Donelon, LA	Michael T. McRath, IL ⁴³
N/A	8/2011	Mtg. canceled ⁴⁴	Susan E. Voss, IA	Kevin M. McCarty, FL	James J. Donelon, LA	Adam Hamm, ND ⁴³
204	11/3–6/2011	Washington, DC	Susan E. Voss, IA	Kevin M. McCarty, FL	James J. Donelon, LA	Adam Hamm, ND
205	3/3–6/2012	New Orleans, LA	Kevin M. McCarty, FL	James J. Donelon, LA	Adam Hamm, ND	Monica J. Lindeen, MT
206	8/11–14/2012	Atlanta, GA	Kevin M. McCarty, FL	James J. Donelon, LA	Adam Hamm, ND	Monica J. Lindeen, MT
207	11/29–12/2/2012	National Harbor, MD	Kevin M. McCarty, FL	James J. Donelon, LA	Adam Hamm, ND	Monica J. Lindeen, MT
208	4/6–9/2013	Houston, TX	James J. Donelon, LA	Adam Hamm, ND	Monica J. Lindeen, MT	Michael F. Consedine, PA
209	8/24–27/2013	Indianapolis, IN	James J. Donelon, LA	Adam Hamm, ND	Monica J. Lindeen, MT	Michael F. Consedine, PA
210	12/15–18/2013	Washington, DC	James J. Donelon, LA	Adam Hamm, ND	Monica J. Lindeen, MT	Michael F. Consedine, PA
211	3/29–4/1/2014	Orlando, FL	Adam Hamm, ND	Monica J. Lindeen, MT	Michael F. Consedine, PA	Sharon P. Clark, KY
212	8/16–19/2014	Louisville, KY	Adam Hamm, ND	Monica J. Lindeen, MT	Michael F. Consedine, PA	Sharon P. Clark, KY
213	11/16–19/2014	Washington, DC	Adam Hamm, ND	Monica J. Lindeen, MT	Michael F. Consedine, PA ⁴⁵	Sharon P. Clark, KY
214	3/28–31/2015	Phoenix, AZ	Monica J. Lindeen, MT	John M. Huff, MO ⁴⁵	Sharon P. Clark, KY	Theodore K. 'Ted' Nickel, WI
215	8/15–18/2015	Chicago, IL	Monica J. Lindeen, MT	John M. Huff, MO	Sharon P. Clark, KY	Theodore K. 'Ted' Nickel, WI
216	11/19–22/2015	National Harbor, MD	Monica J. Lindeen, MT	John M. Huff, MO	Sharon P. Clark, KY ⁴⁶	Theodore K. 'Ted' Nickel, WI
217	4/3–6/2016	New Orleans, LA	John M. Huff, MO	Theodore K. 'Ted' Nickel, WI ⁴⁶	Julie Mix McPeak, TN ⁴⁶	Eric A. Cioppa, ME ⁴⁶
218	8/26–29/2016	San Diego, CA	John M. Huff, MO	Theodore K. 'Ted' Nickel, WI	Julie Mix McPeak, TN	Eric A. Cioppa, ME
219	12/10–13/2016	Miami, FL	John M. Huff, MO	Theodore K. 'Ted' Nickel, WI	Julie Mix McPeak, TN	Eric A. Cioppa, ME
220	4/8–11/2017	Denver, CO	Theodore K. 'Ted' Nickel, WI	Julie Mix McPeak, TN	Eric A. Cioppa, ME	David C. Mattax, TX ⁴⁷
221	8/6–9/2017	Philadelphia, PA	Theodore K. 'Ted' Nickel, WI	Julie Mix McPeak, TN	Eric A. Cioppa, ME	Raymond G. Farmer, SC ⁴⁷
222	12/2–4/2017	Honolulu, HI	Theodore K. 'Ted' Nickel, WI	Julie Mix McPeak, TN	Eric A. Cioppa, ME	Raymond G. Farmer, SC
223	3/24–27/2018	Milwaukee, WI	Julie Mix McPeak, TN	Eric A. Cioppa, ME	Raymond G. Farmer, SC	Gordon I. Ito, HI
224	8/4–7/2018	Boston, MA	Julie Mix McPeak, TN	Eric A. Cioppa, ME	Raymond G. Farmer, SC	Gordon I. Ito, HI
225	11/15–18/2018	San Francisco, CA	Julie Mix McPeak, TN	Eric A. Cioppa, ME	Raymond G. Farmer, SC	Gordon I. Ito, HI ⁴⁸
226	4/6–9/2019	Orlando, FL	Eric A. Cioppa, ME	Raymond G. Farmer, SC	David Altmaier, FL ⁴⁸	Dean L. Cameron, ID
227	8/3–6/2019	New York, NY	Eric A. Cioppa, ME	Raymond G. Farmer, SC	David Altmaier, FL	Dean L. Cameron, ID
228	12/7–10/2019	Austin, TX	Eric A. Cioppa, ME	Raymond G. Farmer, SC	David Altmaier, FL	Dean L. Cameron, ID
N/A	3/2020	Mtg. canceled ⁴⁹	Raymond G. Farmer, SC	David Altmaier, FL	Dean L. Cameron, ID	Chlora Lindley-Myers, MO
229	7/27–8/14/2020	Virtual meeting ⁵⁰	Raymond G. Farmer, SC	David Altmaier, FL	Dean L. Cameron, ID	Chlora Lindley-Myers, MO
230	12/3–9/2020	Virtual meeting ⁵¹	Raymond G. Farmer, SC	David Altmaier, FL	Dean L. Cameron, ID	Chlora Lindley-Myers, MO
231	4/7–14/2021	Virtual meeting ⁵²	David Altmaier, FL	Dean L. Cameron, ID	Chlora Lindley-Myers, MO	Andrew N. Mais, CT
232	8/13–17/2021	Columbus, OH ⁵³	David Altmaier, FL	Dean L. Cameron, ID	Chlora Lindley-Myers, MO	Andrew N. Mais, CT
233	12/13–16/2021	San Diego, CA ⁵⁴	David Altmaier, FL	Dean L. Cameron, ID	Chlora Lindley-Myers, MO	Andrew N. Mais, CT
234	4/4–8/2022	Kansas City, MO	Dean L. Cameron, ID	Chlora Lindley-Myers, MO	Andrew N. Mais, CT	Jon Godfread, ND
235	8/9–13/2022	Portland, OR	Dean L. Cameron, ID	Chlora Lindley-Myers, MO	Andrew N. Mais, CT	Jon Godfread, ND
236	12/12–16/2022	Tampa, FL	Dean L. Cameron, ID	Chlora Lindley-Myers, MO	Andrew N. Mais, CT	Jon Godfread, ND
237	3/21–25/2023	Louisville, KY	Chlora Lindley-Myers, MO	Andrew N. Mais, CT	Jon Godfread, ND	Scott A. White, VA
238	8/12–16/2023	Seattle, WA	Chlora Lindley-Myers, MO	Andrew N. Mais, CT	Jon Godfread, ND	Scott A. White, VA

1. Sept. 23, 1886: John K. Tarbox (MA) was elected President for the 1887 Convention; Samuel H. Cross (RI) was elected Vice-President; and Robert B. Brinkerhoff (Ohio chief clerk) was elected Secretary. Commissioner Tarbox died May 28, 1887. Auditor Cross was out of office effective June 1, 1887. Mr. Brinkerhoff was out of office effective June 3, 1887. Oliver Pillsbury (NH) was chosen to preside over the 1887 Convention. It is unknown who acted as Vice-President. Jacob A. McEwen (Ohio chief clerk) was chosen to act as Secretary.
2. Aug. 21, 1890: Charles B. Allan (Nebraska deputy auditor) was elected Secretary for the 1891 Convention; however, he resigned before the Convention assembled. Sept. 30, 1891: John J. Brinkerhoff (Illinois actuary) was elected Secretary for the 1891 Convention.

3. Sept. 18, 1895: William M. Hahn (OH) was elected President for the 1896 Convention and James R. Waddill (MO) was elected Vice-President; however, Superintendent Hahn was out of office effective June 3, 1886. Sept. 22, 1896: Superintendent Waddill was elected President for the 1896 Convention and Stephen W. Carr (ME) was chosen to act as Vice-President.
4. Sept. 23, 1896: James R. Waddill (MO) was elected President for the 1897 Convention and Stephen W. Carr (ME) was elected Vice-President; however, Mr. Waddill was out of office effective March 1, 1897. Sept. 7, 1897: Commissioner Carr was elected President for the 1897 Convention. It is unknown who acted as Vice-President.
5. Sept. 23, 1896: Frederick L. 'Fred' Cutting (MA) was elected Secretary for the 1897 Convention; however, he was out of office on the date of the Convention. Sept. 7, 1897: John J. Brinkerhoff (Illinois actuary) was elected Secretary for the 1897 Convention.
6. Sept. 7, 1897: Frederick L. 'Fred' Cutting (MA) was elected Secretary for the 1898 Convention; however, he declined the offer. Sept. 13, 1898: John J. Brinkerhoff (Illinois actuary) was elected Secretary for the 1898 Convention.
7. Sept. 15, 1898: Elmer H. Dearth (MN) was elected President for the 1899 Convention; however, he was out of office at the date of the Convention. Sept. 5, 1899: Edward T. Orear (MO) was elected President for the 1899 Convention.
8. Sept. 20, 1900: John A. O'Shaughnessy (MN) was elected President for the 1901 Convention; however, he was out of office at the date of the Convention. September 1901: William H. Hart (IN) was elected President for the 1901 Convention.
9. Sept. 29, 1910: Theodore H. Macdonald (CT) was elected Vice-President for the 1911 Convention; however, he was out of office at the date of the Convention. It is unknown who acted as Vice-President.
10. Aug. 25, 1911: Harry R. Cunningham (MT) was elected Secretary for the 1912 Convention; however, he resigned before the Convention assembled. March 1912: Fitz Hugh McMaster (SC) was elected Secretary for the 1912 Convention.
11. Aug. 1, 1913: Willard Done (UT) was elected First Vice-President for the 1914 Convention; however, he resigned before the Convention assembled. It is unknown who acted as First Vice-President.
12. Aug. 31, 1917: Emory H. English (IA) was elected President for the 1918 Convention; Robert J. Merrill (NH) was elected First Vice-President; and Michael J. Cleary (WI) was elected Second Vice-President. November 1917: Mr. Merrill resigned as First Vice-President. Dec. 6, 1917: Mr. Cleary was elected First Vice-President for the 1918 Convention and Walter K. Chorn (MO) was elected Second Vice-President. Jan. 1, 1918: Mr. English resigned as President and Mr. Cleary was elected President for the 1918 Convention by the Executive (EX) Committee. It is unknown who acted as First Vice-President.
13. Aug. 31, 1917: Fitz Hugh McMaster (SC) was elected Secretary for the 1918 Convention; however, he resigned before the Convention assembled. Dec. 6, 1917: Joseph L. Button (VA) was elected Secretary for the 1918 Convention.
14. Sept. 12, 1919: John B. Sanborn (MN) was elected Second Vice-President for the 1920 Convention; however, he resigned before the Convention assembled. June 1920: Alfred L. Harty (MO) was chosen to act as Second Vice-President for the 1920 Convention.
15. Sept. 3, 1920: Frank H. Ellsworth (MI) was elected President for the 1921 Convention; Alfred L. Harty (MO) was elected First Vice-President; and Thomas B. Donaldson (PA) was elected Second Vice-President. Commissioner Ellsworth resigned effective April 30, 1921, as NAIC President and Michigan Insurance Commissioner. June 27, 1921: Superintendent Harty was elected President for the 1921 Convention by the Executive (EX) Committee; Commissioner Donaldson was elected First Vice-President; and Platt Whitman (WI) was elected Second Vice-President.
16. Sept. 8, 1922: Platt Whitman (WI) was elected President for the 1923 Convention; Herbert O. Fishback (WA) was elected First Vice-President; and John C. Luning (FL) was elected Second Vice-President. July 1, 1923: Commissioner Whitman resigned as President; Commissioner Fishback was elected President for the 1923 Convention by the Executive (EX) Committee; and Mr. Luning was elected First Vice-President by the Executive (EX) Committee. It is unknown who acted as Second Vice-President.
17. Sept. 18, 1925: William R. C. Kendrick (IA) was elected President for the 1926 Convention. January 1926: Commissioner Kendrick resigned as NAIC President and Harry L. Conn (OH) was elected President for the 1926 Convention. Commissioner Kendrick remained as Iowa Insurance Commissioner until March 1, 1926.
18. Nov. 19, 1926: Harry L. Conn (OH) was elected President for the 1927 Convention and Albert S. Caldwell (TN) was elected First Vice-President. April 15, 1927: Superintendent Conn resigned as NAIC President and Ohio Insurance Superintendent. May 3, 1927: Commissioner Caldwell was elected President for the 1927 Convention and James A. Beha (NY) was elected First Vice-President.
19. Sept. 26, 1928: Charles R. Detrick (CA) was elected President for the 1929 Convention; James A. Beha (NY) was elected First Vice-President; and Howard P. Dunham (CT) was elected Second Vice-President. Jan. 1, 1929: Superintendent Beha resigned as NAIC First Vice-President and New York Insurance Superintendent. Commissioner Dunham was elected First Vice-President for the 1929 Convention. April 24, 1929: Commissioner Detrick resigned as NAIC President and California Insurance Commissioner. Commissioner Dunham was elected President for the 1929 Convention; Clarence C. Wysong (IN) was elected First Vice-President; and Jess G. Read (OK) was elected Second Vice-President.

20. Sept. 19, 1929: Joseph L. Button (VA) was elected Secretary for the 1930 Convention; however, he resigned effective Oct. 15, 1929, as NAIC Secretary and Virginia Commissioner of Insurance and Banking. Dec. 10, 1929: Albert S. Caldwell (TN) was elected Secretary for the 1930 Convention.
21. Sept. 9, 1930: Clarence C. Wysong (IN) was elected President for the 1931 Convention; Jess G. Read (OK) was elected First Vice-President; and Clare A. Lee (OR) was elected Second Vice-President. January 1931: Commissioner Wysong resigned effective Jan. 1, 1931, as NAIC President and Indiana Insurance Commissioner; Commissioner Lee was no longer serving as Second Vice-President; and Commissioner Read was elected President by the Executive (EX) Committee for the 1931 Convention. June 17, 1931: Charles D. Livingston (MI) was elected First Vice-President by the Executive (EX) Committee for the 1931 Convention and William A. Tarver (TX) was elected Second Vice-President by the Executive (EX) Committee.
22. Oct. 20, 1932: William A. Tarver (TX) was elected President for the 1933 Convention; Garfield W. Brown (MN) was elected First Vice-President; and Daniel C. 'Dan' Boney (NC) was elected Second Vice-President. Commissioner Tarver resigned effective Feb. 10, 1933, as NAIC President and Texas Life Insurance Commissioner. Commissioner Brown was elected President for the 1933 Convention; Commissioner Boney was chosen to act as First Vice-President and George S. Van Schaick (NY) was chosen to act as Second Vice-President.
23. July 1935: It is unclear why no one acted as First Vice-President or Second Vice-President for the 1935 Convention.
24. June 23, 1939: J. Balch Moor (DC) was elected Vice-President; however, he died July 22, 1939, before the 1940 Convention assembled. John C. Blackall (CT) was elected Vice-President by the Executive (EX) Committee to fill the unexpired term.
25. June 6, 1945: Edward L. Scheufler (MO) was elected Vice-President for the 1946 Convention; however, he resigned effective Oct. 15, 1945, as NAIC Vice-President and Missouri Insurance Superintendent. Dec. 3, 1945: Robert E. Dineen (NY) was elected Vice-President by the Executive (EX) Committee for the 1946 Convention.
26. June 11, 1946: Jess G. Read (OK) was elected Secretary for the 1947 Convention; however, he died July 20, 1946. Sept. 4, 1946: Nellis P. Parkinson (IL) was elected Secretary by the Executive (EX) Committee to fill the unexpired term.
27. June 1953: George B. Butler (TX) was elected Vice-President; however, he died Sept. 28, 1953. It is unknown who acted as Vice-President for the November 1953 Convention. Nov. 30, 1953: Donald Knowlton (NH) was elected Vice-President by the Executive (EX) Committee to fill the unexpired term.
28. May 1956: George A. Bowles (VA) was elected Secretary; however, he died June 1, 1956. Paul A. Hammel (NV) was elected Secretary to fill the unexpired term.
29. June 1958: Arch E. Northington (TN) was elected President; however, he resigned effective Dec. 23, 1958, as NAIC President and Tennessee Insurance Commissioner. January 1959: Paul A. Hammel (NV) was elected President and Sam N. Beery (CO) was elected Vice-President by the Executive (EX) Committee to fill the unexpired term.
30. June 1962: Joseph S. Gerber (IL) was elected Vice-President; however, he resigned effective Jan. 29, 1963, as NAIC Vice-President and Illinois Insurance Director. The office of Vice-President was vacant for the June 1963 Convention.
31. June 1968: Charles R. Howell (NJ) was elected President; however, he resigned effective Feb. 28, 1969, as NAIC President and New Jersey Commissioner of Banking and Insurance. Ned Price (TX) was elected by the Executive (EX) Committee to fill the unexpired term.
32. June 1970: Richard E. 'Dick' Stewart (NY) was elected President; however, he resigned as NAIC President effective Dec. 17, 1970, and as New York Insurance Superintendent effective Dec. 31, 1970. Dec. 17, 1970: Lorne R. Worthington (IA) was elected by Plenary to fill the unexpired term.
33. A constitutional amendment moved NAIC officer elections from June to December (commencing December 1974), President Johnnie L. Caldwell (GA) served a six-month term.
34. Kenneth E. 'Ken' DeShetler (OH) was elected President; however, he resigned effective Jan. 13, 1975, as NAIC President and Ohio Insurance Director. William H. Huff, III (IA) was elected by the Executive (EX) Committee to fill the unexpired term.
35. H. Peter 'Pete' Hudson (IN) was elected President; however, he resigned as NAIC President and Indiana Insurance Commissioner effective Nov. 15, 1979. It is unknown who presided over the December 1979 Convention.
36. John W. Lindsay resigned effective Sept. 3, 1981, as NAIC Vice-President and South Carolina Insurance Commissioner. Johnnie L. Caldwell (GA) was elected by the Executive (EX) Committee to fill the unexpired term.
37. David J. Lyons resigned effective June 17, 1994, as NAIC Vice President but remained as Iowa Insurance Commissioner until July 31, 1994. A special interim Plenary election was held June 12, 1994: Arkansas Insurance Commissioner Lee Douglass was elected Vice President to serve June 17, 1994, to Dec. 31, 1994.

38. September 2001: NAIC members unanimously agreed that the 2001 Fall National Meeting should be canceled in the wake of the tragic events that occurred Sept. 11, 2001. The meeting had been scheduled for Sept. 22–25, 2001, at the Marriott and Westin Copley Place hotels in Boston, Massachusetts.
39. Ernst N. ‘Ernie’ Csiszar resigned effective Aug. 18, 2004, as NAIC President and South Carolina Director of Insurance. Approximately two weeks later, James A. ‘Jim’ Poolman resigned as NAIC Vice President but remained as North Dakota Insurance Commissioner. A special interim Plenary election was held Sept. 13, 2004, during the Fall National Meeting in Anchorage, Alaska: Pennsylvania Insurance Commissioner M. Diane Koken was elected President; Oregon Insurance Administrator Joel S. Ario was elected Vice President; and Maine Insurance Superintendent Alessandro A. ‘Al’ Iuppa was elected Secretary-Treasurer to serve from Sept. 13, 2004, to Dec. 31, 2004.
40. December 2004: NAIC members voted at its 2004 Winter National Meeting to adopt amendments to the NAIC Bylaws, which included the creation of a President-Elect position as an NAIC officer.
41. September 2005: NAIC members agreed to cancel the 2005 Fall National Meeting due to the devastation caused by Hurricane Katrina on Aug. 29, 2005. The meeting had been scheduled for Sept. 10–13, 2005, at the Sheraton hotel in New Orleans, Louisiana.
42. Eric P. Serna resigned effective June 14, 2006, as NAIC Secretary-Treasurer and New Mexico Superintendent of Insurance. A special Plenary interim election was held during the 2006 Summer National Meeting: New Hampshire Insurance Commissioner Roger A. Sevigny was elected Secretary-Treasurer to serve from June 14, 2006, to Dec. 31, 2006.
43. Michael T. McRaith resigned effective May 31, 2011, as NAIC Secretary-Treasurer and Illinois Director of Insurance. A special Plenary interim election was held via conference call May 16, 2011: North Dakota Insurance Commissioner Adam Hamm was elected Secretary-Treasurer to serve from May 31, 2011, to Dec. 31, 2011.
44. Aug. 25, 2011: NAIC members agreed to cancel its 2011 Summer National Meeting so members could assist consumers in disaster situations caused by Hurricane Irene. The meeting had been scheduled for Aug. 29–Sept. 1, 2011, at the Marriott Philadelphia Downtown in Philadelphia, Pennsylvania.
45. Michael F. ‘Mike’ Consedine resigned effective Jan. 20, 2015, as NAIC President-Elect and Pennsylvania Insurance Commissioner. A special Plenary interim election was held via conference call Feb. 8, 2015: Missouri Insurance Director John M. Huff was elected President-Elect to serve from Feb. 8, 2015, to Dec. 31, 2015.
46. Sharon P. Clark resigned effective Jan. 11, 2016, as NAIC President-Elect and Kentucky Insurance Commissioner. A special Plenary interim election was held in Bonita Springs, Florida, on Feb. 7, 2016: Wisconsin Insurance Commissioner Theodore K. ‘Ted’ Nickel was elected President-Elect; Tennessee Insurance Commissioner Julie Mix McPeak was elected Vice President; and Maine Insurance Superintendent Eric A. Cioppa was elected Secretary-Treasurer to serve from Feb. 7, 2016, to Dec. 31, 2017.
47. David C. Mattax, NAIC Secretary-Treasurer and Texas Insurance Commissioner, died in office April 13, 2017. A special Plenary interim election was held via conference call on May 12, 2017: South Carolina Insurance Director Raymond G. Farmer was elected Secretary-Treasurer to serve from May 12, 2017, to Dec. 31, 2017.
48. Gordon I. Ito resigned effective Dec. 31, 2018, as NAIC Vice President and Hawaii Insurance Commissioner. A special Plenary interim election was held in La Quinta, California, on Feb. 4, 2019: Florida Insurance Commissioner David Altmaier was elected Vice President to serve from Feb. 4, 2019, to Dec. 31, 2019.
49. March 11, 2020: Due to concerns about the COVID-19 pandemic, the NAIC officers—in consultation with the NAIC membership—decided to hold the 2020 Spring National Meeting in a virtual format. However, on March 23, 2020, the NAIC officers decided to suspend holding any further sessions of the virtual Spring National Meeting to allow NAIC members and staff more time to focus on the health emergency. The meeting had been scheduled for March 21–24, 2020, at the Phoenix Convention Center and the Sheraton Grand and Hyatt Regency hotels in Phoenix, Arizona.
50. June 10, 2020: Given the ongoing health challenges associated with holding large in-person meetings in the midst of the COVID-19 pandemic, the NAIC officers—in consultation with the NAIC membership—decided to hold the 2020 Summer National Meeting in a virtual format. The meeting had been scheduled for Aug. 8–11, 2020, at the Minneapolis Convention Center and the Hilton and Hyatt Regency hotels in Minneapolis, Minnesota.
51. Sept. 21, 2020: Given the ongoing health challenges associated with holding large in-person meetings in the midst of the COVID-19 pandemic, the NAIC officers—in consultation with the NAIC membership—decided to hold the 2020 Fall National Meeting in a virtual format. The meeting had been scheduled for Nov. 14–17, 2020, at the JW Marriott hotel in Indianapolis, Indiana.
52. Feb. 24, 2021: Given the ongoing health challenges associated with holding large in-person meetings in the midst of the COVID-19 pandemic, the NAIC officers—in consultation with the NAIC membership—decided to hold the 2021 Spring National Meeting in a virtual format. The meeting had been scheduled for April 10–13, 2021, at the Gaylord Texan Hotel and Convention Center in Grapevine, Texas.

53. June 1, 2021: Given the ongoing health challenges associated with holding large in-person meetings in the midst of the COVID-19 pandemic, the NAIC officers—in consultation with the NAIC membership—decided to hold the 2021 Summer National Meeting in a hybrid format. In-person meetings took place for NAIC members and interested parties as capacity allowed. Meetings were live-streamed for participants who attended virtually.
54. Oct. 27, 2021: Given the ongoing health challenges associated with holding large in-person meetings in the midst of the COVID-19 pandemic, the NAIC officers—in consultation with the NAIC membership—decided to hold the 2021 Fall National Meeting in a hybrid format. In-person meetings took place for NAIC members and interested parties as capacity allowed. Meetings were live-streamed for participants who attended virtually.

Updated: 10/18/2023

https://naiconline.sharepoint.com/teams/MemberServicesExecutive/Shared Documents/Commissioner/Meeting_Officer_Record/08-Meeting_Officer_Record.docx

NAIC MODEL LAWS, REGULATIONS, AND GUIDELINES

The following is a listing of NAIC model laws, regulations, and guidelines referenced in the *Proceedings* of the 2023 Summer National Meeting.

Advertisements of Accident and Sickness Insurance Model Regulation (#40)

8-106

After Market Parts Model Regulation (#891)

13-2

Annuity Disclosure Model Regulation (#245)

3-116

Coordination of Benefits Model Regulation (#120)

2-9, 6-218

Credit for Reinsurance Model Law (#785)

3-391, 9-481, 9-675, 9-1052, 9-1053, 9-1054

Credit for Reinsurance Model Regulation (#786)

9-675, 9-1054

Guideline for Definition of Reciprocal State in Receivership Laws (#1985)

9-870

Health Carrier Prescription Drug Benefit Management Model Act (#22)

6-206

Health Carrier Grievance Procedure Model Act (#72)

8-20

Health Insurance Reserves Model Regulation (#10)

6-39, 6-41

Health Maintenance Organization Model Act (#430)

3-116

Independent Adjuster Licensing Guideline (#1224)

8-115, 8-119, 8-120

Insurance Consumer Privacy Protections Model (#674)

2-3, 2-27, 3-2, 3-9, 4-10, 4-11, 12-3, 12-8, 12-17, 12-24, 12-20, 12-21, 12-27, 12-24, 12-33, 12-35, 12-36, 12-38, 12-39, 12-40, 12-41, 12-42, 12-43, 12-44,

Insurance Holding Company System Model Regulation With Reporting Forms and Instructions (#450)

2-25, 3-9, 3-116, 10-2, 10-3

Insurance Holding Company System Regulatory Act (#440)

2-25, 3-9, 3-116, 9-159, 9-160, 9-870, 10-2, 10-3

Life and Health Insurance Guaranty Association Model Act (#520)

9-87, 9-869, 9-916, 9-942, 9-965, 9-998, 9-1000, 9-1020

Life and Health Insurance Policy Language Simplification Model Act (#575)

6-119

Life Insurance and Annuities Replacement Model Regulation (#613)

8-20

Life Insurance Illustrations Model Regulation (#582)

5-37, 8-20

Long-Term Care Insurance Model Regulation (#641)

9-472

Market Conduct Surveillance Model Law (#693)

8-20

Model Law on Examinations (#390)

8-20

Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act (#171)

2-3, 2-7, 3-2, 4-9, 6-108, 6-109, 6-110, 6-111, 6-112, 6-114, 6-116, 6-118, 6-119, 6-120, 6-121, 6-122, 6-123, 6-124

Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (#651)

6-108

Mortgage Guaranty Insurance Model Act (#630)

2-1, 2-3, 2-15, 3-1, 3-2, 3-7, 3-8, 3-96, 3-97, 3-98, 3-99, 3-100, 3-101, 3-102, 3-103, 3-104, 3-106, 3-107, 3-108, 3-109, 3-110, 3-111, 3-112, 3-113, 3-114, 3-115, 4-9, 8-20, 9-1, 9-2, 9-7, 9-13, 9-14, 9-15, 9-16, 9-17, 9-18, 9-19, 9-20, 9-21, 9-22, 9-23, 9-24, 9-25, 9-26, 9-27, 9-28, 9-29, 9-30, 9-31, 9-32, 9-33, 9-34, 9-35, 9-36, 9-37, 9-38, 9-39, 9-40, 9-52, 9-53, 9-54, 9-55, 9-56, 9-57, 9-58, 9-59, 9-60, 9-61, 9-62, 9-63, 9-64, 9-65, 9-66, 9-67, 9-68, 9-69, 9-70, 9-71, 9-72, 9-73

NAIC Insurance Information and Privacy Protection Model Act (#670)

12-22, 12-32

NAIC Model Rules Governing Advertisements of Medicare Supplement Insurance With Interpretive Guidelines (#660)

8-106

Nonadmitted Insurance Model Act (#870)

2-1, 2-3, 3-1, 3-2, 3-5, 3-13, 3-14, 3-15, 3-16, 3-17, 3-18, 3-19, 3-20, 3-21, 3-22, 3-23, 3-24, 3-25, 3-26, 3-27, 3-28, 3-29, 3-30, 3-31, 3-32, 3-33, 3-34, 3-35, 3-36, 3-37, 3-38, 3-39, 3-40, 3-41, 3-42, 3-43, 3-44, 3-45, 4-10

Pet Insurance Model Act (#633)

3-116, 8-83, 8-84

Producer Licensing Model Act (#218)

8-20

Property and Casualty Insurance Guaranty Association Model Act (#540)

2-23, 2-24, 3-2, 4-9, 9-80, 9-83, 9-85, 9-866, 9-867, 9-873, 9-875, 9-908, 9-909, 9-910, 9-912, 9-913, 9-914, 9-915, 9-916, 9-917, 9-918, 9-919, 9-920, 9-921, 9-922, 9-923, 9-924, 9-925, 9-926, 9-927, 9-928, 9-929, 9-930, 9-931, 9-932, 9-933, 9-934, 9-935, 9-936, 9-868, 9-869, 9-870, 9-941, 9-942, 9-943, 9-944, 9-945, 9-946, 9-947, 9-948, 9-949, 9-950, 9-951, 9-952, 9-953, 9-954, 9-955, 9-956, 9-957, 9-958, 9-959, 9-960, 9-961, 9-962, 9-963, 9-964, 9-965, 9-966, 9-967, 9-968, 9-969, 9-970, 9-971, 9-972, 9-973, 9-974, 9-975, 9-976, 9-977, 9-978, 9-979, 9-980, 9-981, 9-982, 9-983, 9-984, 9-985, 9-986, 9-987, 9-988, 9-989, 9-990, 9-991, 9-992, 9-993, 9-994, 9-995, 9-996, 9-997, 9-998, 9-999, 9-1000, 9-1001, 9-1002, 9-1003, 9-1004, 9-1005, 9-1006, 9-1007, 9-1008, 9-1009, 9-1010, 9-1011, 9-1012, 9-1013, 9-1014, 9-1019, 9-1020, 9-1021, 9-1022, 9-1023, 9-1024, 9-1025, 9-1026, 9-1027, 9-1028, 9-1029, 9-1030, 9-1031, 9-1032, 9-1033, 9-1034, 9-1035, 9-1036, 9-1037, 9-1038, 9-1039, 9-1040, 9-1041, 9-1042, 9-1043, 9-1044, 9-1045, 9-1046, 9-1047

Public Adjuster Licensing Model Act (#228)

2-12, 3-6, 8-2, 8-4, 8-9, 8-10, 8-114

Real Property Lender-Placed Insurance Model Act (#631)

3-116

Standard Nonforfeiture Law for Individual Deferred Annuities (#805)

3-116, 8-20

Standard Nonforfeiture Law for Life Insurance (#808)

8-20

Standard Valuation Law (#820)

5-233, 5-234, 5-278, 5-287, 5-288, 5-300, 5-301, 5-302, 5-303, 5-304, 5-305, 5-306, 5-307, 5-308, 5-309, 5-310, 5-311, 5-413, 9-183, 9-400, 9-466, 9-851, 9-860, 9-861, 9-862, 9-863, 9-864, 9-865

Suitability in Annuity Transactions Model Regulation (#275)

5-2, 5-7, 8-6, 8-20, 8-88, 8-89, 8-90, 8-94, 12-43

Supplementary and Short-Term Health Insurance Minimum Standards Model Act (#170)

4-9, 6-112, 6-118, 6-121

Term and Universal Life Insurance Reserve Financing Model Regulation (#787)

2-24, 9-1050, 9-1053, 9-1054, 9-1056

Unfair Claims Settlement Practices Act (#900)

8-20

Unfair Discrimination Against Subjects of Abuse in Disability Income Insurance Model Act (#897)

8-20

Unfair Discrimination Against Subjects of Abuse in Health Benefit Plans Model Act (#895)

8-20

Unfair Discrimination Against Subjects of Abuse in Life Insurance Model Act (#896)

8-20

Unfair Discrimination Against Subjects of Abuse in Property and Casualty Insurance (#898)

8-20

Unfair Trade Practices Act (#880)

2-3, 2-6, 2-14, 3-2, 3-4, 3-6, 3-116, 4-10, 6-3, 8-3, 8-20, 8-106, 8-107, 9-52, 9-53, 9-63, 9-64, 9-69, 12-7,
13-9

Uniform Health Carrier External Review Model Act (#76)

8-20

Valuation of Life Insurance Policies Model Regulation (#830)

5-121, 9-1053

*NAIC 2023 Summer National Meeting
Seattle, WA*

OPENING SESSION
August 13, 2023

CALL TO ORDER

Chlora Lindley-Myers, NAIC President

Welcome! The 238th session of the National Association of Insurance Commissioners will now come to order. Good afternoon. I am Chlora Lindley-Myers, the NAIC President and Director of the Missouri Department of Commerce and Insurance. It is my pleasure to open the 2023 NAIC Summer National Meeting.

INTRODUCTION OF HEAD TABLE

Chlora Lindley-Myers, NAIC President

At this time, I will recognize the members of our head table. Please hold your applause until all members are introduced.

Honorable Mike Kreidler, Meeting Host and Commissioner of the Washington Department of Insurance
Honorable Dean L. Cameron, NAIC Immediate Past President and Idaho Insurance Director
Andrew J. Beal, NAIC Acting Chief Executive Officer (CEO), Chief Operating Officer (COO), and Chief Legal Officer (CLO)

Honorable Andrew N. Mais, NAIC President-Elect and Connecticut Insurance Commissioner
Honorable Jon Godfread, NAIC Vice President and North Dakota Insurance Commissioner
Honorable Scott A. White, NAIC Secretary-Treasurer and Virginia Insurance Commissioner
Honorable James J. Donelon, NAIC Past President and Louisiana Insurance Commissioner

Please welcome the members of our NAIC Spring National Meeting head table.

INTRODUCTION OF NEW MEMBERS

Chlora Lindley-Myers, NAIC President

I would also like to recognize our newest Members in this short video. [New Member video plays.]

INTRODUCTION OF SPECIAL GUESTS

Chlora Lindley-Myers, NAIC President

We are pleased to welcome our special guests—federal officials, state officials, and international regulators—to our Summer National Meeting. Here to welcome us to the Emerald City is Washington state’s Insurance Commissioner, Mike Kreidler. Before he comes to the podium, I want to share a few words about Commissioner Kreidler and the impact he has made here in Washington and at the NAIC.

Commissioner Kreidler is the longest-serving elected Commissioner of insurance in the history of the U.S. First elected in 2000, he was re-elected to a sixth term in 2020. His career accomplishments have included serving as a lieutenant colonel in the U.S. Army and as a practicing doctor of optometry; serving 16 years in the Washington State Legislature; and serving as the regional director for the U.S. Department of Health and Human Services (HHS). Since 2007, Commissioner Kreidler has been among the Members chairing the NAIC’s Climate and Resiliency (EX) Task Force. This year, he is also the co-vice chair of the Health Insurance and Managed Care (B) Committee, and he serves on several NAIC executive leadership committees.

Among his many career highlights as a long-serving regulator is his work to pass the strongest law in the country protecting consumers against the practice of surprise medical billing. This accomplishment, as well as many others, is a testament to how much he values his work as a regulator. Thank you for your hard work, Commissioner Kreidler.

HOST COMMISSIONER REMARKS*Commissioner Mike Kreidler*

Thank you, Madam President. Welcome to Washington state! It's an honor to have you all here. I hope you have a chance to experience some of the beauty that makes our part of the world so unique. From several points in Seattle, you can see Mount Rainier and both the Olympic and North Cascades National Parks. In the Evergreen State, we value our expansive nature. It's why we're so invested in protecting our planet. We have a dynamic economy with some of the most recognizable institutions on earth, including Microsoft, Amazon, T-Mobile, REI, Costco, Boeing, and Starbucks. We're also home to the Bill & Melinda Gates Foundation and one of the country's top research institutions, the University of Washington. Another company familiar to all of you, the actuarial and consulting firm Milliman, was founded here in 1947.

We're tied to the rest of the world through our culture and history. Jimi Hendrix, Kurt Cobain, Bruce Lee, and now Brandi Carlile are local icons, and we've got several renowned museums showing off our history and contributions to technology. As you uncover the history and culture of this region, I invite you all to reflect that we're inhabiting land that was once home to people for thousands of years before European settlers came here a mere 160 years ago. You can learn about these cultures at the newly refurbished Burke Museum of Natural History and Culture on the University of Washington campus. If you have time, visit Pike Place Market, just a few blocks away, or take a boat tour or a float plane ride, or go to the top of the Space Needle, which was built for the 1962 World's Fair. It's all a short walk from here. Once again, welcome, and I hope you enjoy your stay.

PRESIDENTIAL ADDRESS*Chlora Lindley-Myers, NAIC President*

Greetings, and welcome to the 2023 National Association of Insurance Commissioners (NAIC) Summer National Meeting. It is great to see all of you! And thank you to those of you attending the meeting virtually. I am pleased to share that we have more than 2,500 registrants. Nearly 1,500 are here in person, which adds to the countless people who have or will visit Seattle this summer. In fact, according to a recent report, Seattle is this year's No. 2 summer travel destination in the U.S. This is based on an estimated 1.6 million flights booked between Memorial Day and Labor Day for visits of up to a week or more.

The growing interest in experiencing the sights and sounds of Seattle is clearly thriving, and from the looks of this room full of regulators, industry partners, and guests, it is apparent to me that interest in insurance is also thriving. I am loving the momentum. This week marks my third trip to the Emerald City this year. Each time I visit, I fall more in love with Seattle. No matter how many times I have been here, I learn something new. For instance, as Washington Commissioner Mike Kreidler mentioned, Boeing and Starbucks were founded here in Seattle, but I did not know that the iconic Stanley insulated drinking cup was designed and tested right here too. And like the Stanley Cup in hockey, I am told that these are hard to come by! I want to thank Commissioner Kreidler for hosting us, and I look forward to the days ahead. I have known Commissioner Kreidler for many years, and if there is one thing I know about him, he is an insurance consumer champion. Thank you, Commissioner Kreidler, for all the work you do on behalf of the state of Washington and the NAIC.

We are pleased to have strong participation from our international colleagues and partners at our national meeting, representing both long-standing relationships and new ones, such as Commissioner Nakama Sana from the Federated States of Micronesia, who joins us here today. Likewise, I want to recognize NAIC COO and Acting CEO Andy Beal. In April, Andy took on extensive duties as the Acting CEO—again. I commend his dedication and his stalwart leadership as we initiate our search to fill the NAIC CEO position. On behalf of the officers and Members, Andy, thank you and the NAIC staff for continuing to keep things going, moving ahead, and helping us meet our goals.

A strong work ethic does not go unnoticed. In a rapidly evolving industry like insurance, we see firsthand how our hard work plays out in the lives of everyday people. As insurance regulators, we have the consumers top of mind in all that we do, and that is especially true today, as this complex industry continues to evolve. We are always “at attention” because we owe it to the consumers we serve.

I want to take a moment to recognize a few regulators for their commitment to serving consumers and the industry. First, I recently learned that Lenita Blasingame passed away on July 4. Lenita joined the Arkansas Insurance Department in 1965. For 50 years, she supported the insurance sector by sharing her knowledge and charismatic personality with all who knew her. Lenita’s accomplishments included being the first person inducted into the Arkansas Insurance Hall of Fame. She retired seven years ago as the Chief Deputy Commissioner of the Arkansas Insurance Department. Her memory and reputation for her hard work lives on. Many say that being around her at an insurance event was like being next to a rock star. I know she did an excellent job preparing Russ Galbraith to step into the Deputy Commissioner role. Thank you, Russ, for all that you do! Lenita will be greatly missed, and our deepest sympathies are with her family, friends, and colleagues at the Arkansas Insurance Department. Let us take a moment to recognize Lenita.

Next, Don Beatty, Deputy Commissioner of the Virginia Bureau of Insurance’s Policy, Compliance, and Administration Division, is attending his last NAIC national meeting. As Don prepares to retire, Commissioner Scott A. White and his team will have a huge void to fill. Don has the distinction of being a 2022 Robert Dineen Award winner. As a member of the Virginia Bureau of Insurance, Don was part of a small group of dedicated regulators who drafted the bylaws of the Interstate Insurance Product Regulation Commission (Compact), as well as the Compact’s 14 rules or operating procedures. Among his many other roles at the Compact, Don served as chair of the Rulemaking and Regulatory Counsel Committees. At the NAIC, Don most recently chaired the Pet Insurance (C) Working Group and the Health Maintenance Organization (HMO) Issues (B) Subgroup to the conclusion of their charges. Don, please stand. I want to thank you for your commitment over the past 23 years to the Commonwealth of Virginia, your work with the NAIC, and your role with the Insurance Compact. We wish you well as you celebrate your retirement.

It is customary during the Summer National Meeting to do a mid-year pulse check. Since we last met at the Spring National Meeting in Louisville, KY, regulators have collaborated on issues that have placed us in positions to pause, assess, and take action. In late July, I participated in a satellite media tour with TV and radio stations across the country to address questions about consumers’ challenges with insurance. The reporters asked me about the availability and affordability of insurance, especially as some insurance companies paused writing new business in specific markets. This is a real, top-of-mind concern among consumers and regulators today. With news reports of severe weather events like extreme heat waves, wildfires, hailstorms, tornadoes, and, yes, the fires on Maui, reporters asked what steps consumers can take to mitigate the risks to their properties in the face of natural disasters. Our thoughts are with my friend and colleague, Gordon I. Ito, Commissioner of Hawaii, as he faces this deadly catastrophe and its aftermath. The reporters also wanted to know how consumers could protect themselves from scams and make sure that they have the right amount of insurance. Educating consumers on how to better engage with the insurance industry is central to our role as regulators and a key pillar of the NAIC’s *State Connected* strategic plan.

The satellite media tour reached more than 18 million viewers nationwide. I hope I was able to help them better understand why insurance is so important and empower them to reach out to their insurance agent or state department of insurance (DOI) with questions. The more consumers know about insurance coverage, the better prepared they will be able to make informed choices for themselves and their families.

Since the NAIC’s founding in 1871, insurance company solvency and consumer protection have been the core of who we are and what we do. As part of our state-based system of insurance regulation in the U.S., the NAIC provides expertise, data, and analysis for insurance regulators to help them effectively regulate the industry, as

well as protect consumers. Through the NAIC, state insurance regulators establish standards and best practices, conduct peer reviews, and coordinate regulatory oversight. NAIC staff support these efforts and represent the collective views of state regulators domestically and internationally.

Although state regulators represent different geographical regions and have diverse perspectives, we do have common goals. These goals include planning for the best scenario but also preparing for the worst. We collaborate often and study industry trends and best practices so we can effectively address issues that affect the industry. Our departments undergo a comprehensive, independent review every five years to ensure we meet financial solvency oversight standards. The NAIC Accreditation Program was established to develop and maintain standards to promote effective insurance company financial solvency regulation. This year, Missouri, New Hampshire, South Dakota, and Texas underwent their independent reviews, and I am delighted to share that these four states have met the NAIC's Accreditation Program requirements and will have their accreditation status continued for another five years.

Beyond the important work of our committees at the NAIC, we also partner with like-minded organizations to achieve our objectives. This spring, we signed a memorandum of understanding with the Insurance Institute for Business and Home Safety (IBHS) to provide state insurance regulators access to IBHS member-only content and additional opportunities to collaborate on select topics concerning disaster preparedness. We have been building on our partnership with IBHS since 2018. Having access to exclusive research, training, and resources will help us better inform policymakers, state lawmakers, and consumers on ways to fortify properties to mitigate the effects of severe weather.

We realize that climate risks are real for every jurisdiction, whether it is inland or coastal, in a colder climate or a warmer climate, or more rural or more urban. State insurance regulators are seeing the economic impacts of severe weather firsthand. That is a reality. We have been grappling with the issue of climate risk and resiliency for more than a decade. Through the NAIC's Climate and Resiliency (EX) Task Force and related efforts, the NAIC has been a first-mover in assessing climate risk and resiliency as it relates to insurer solvency and in pre-disaster mitigation to offset the risks from natural perils. We are encouraged by the progress we have made, along with the other focus areas we have identified as priorities for this year, including:

- Data/artificial intelligence (AI), cybersecurity, and innovation
- Insurer financial oversight and transparency
- Long-term care insurance (LTCI)
- Marketing of insurance products
- Race and insurance/protection gaps and financial inclusion

We will continue to show leadership in all of our committees—yes, even in the committees where we have been hashing out issues since 2018. Yet, those who are participating feel we are rushing our work. Very few would label five years as a rush, but we will continue to reach out, and we will execute. It is clear that our plates are full. However, I am certain we have the right committee leaders and strong NAIC staff support in place to meet our 2023 objectives. As you attend this week's meeting sessions, I hope you agree.

ADJOURNMENT

Chlora Lindley-Myers, NAIC President

Again, it is my honor to welcome you to the NAIC Summer National Meeting. On behalf of my fellow Commissioners and the NAIC staff, thank you for joining us, and we hope you have a wonderful meeting experience.

The opening session of the 238th NAIC national meeting is now adjourned.

Draft: 9/18/2023

**Synopsis of the NAIC Committee, Subcommittee, and Task Force Meetings
2023 Summer National Meeting
August 12–16, 2023**

TO: Members of the NAIC and Interested Parties

FROM: The Staff of the NAIC

Committee Action

NAIC staff have reviewed the committee, subcommittee, and task force reports and highlighted the actions taken by the committee groups during the 2023 Summer National Meeting. The purpose of this report is to provide NAIC Members, state insurance regulators, and interested parties with a summary of these meeting reports.

EXECUTIVE (EX) COMMITTEE AND PLENARY (Joint Session)

Aug. 16, 2023

1. Received the Aug. 14 report of the Executive (EX) Committee. See the Committee listing for details.
2. Adopted by consent the committee, subcommittee, and task force minutes of the Spring National Meeting.
3. Received the report of the Life Insurance Annuities (A) Committee. See the Committee listing for details.
4. Received the report of the Health Insurance and Managed Care (B) Committee. See the Committee listing for details.
5. Received the report of the Property and Casualty Insurance (C) Committee. See the Committee listing for details.
6. Received the report of the Market Regulation and Consumer Affairs (D) Committee. See the Committee listing for details.
7. Received the report of the Financial Condition (E) Committee. See the Committee listing for details.
8. Received the report of the Financial Regulation Standards and Accreditation (F) Committee. See the Committee listing for details.
9. Received the report of the International Insurance Relations (G) Committee. See the Committee listing for details.
10. Received the report of the Innovation, Cybersecurity, and Technology (H) Committee. See the Committee listing for details.
11. Adopted amendments to the 2024 *Valuation Manual*.
12. Adopted revisions to the *Nonadmitted Insurance Model Act* (#870).
13. Adopted the *Understanding the Market for Cannabis Insurance: 2023 Update* white paper.
14. Adopted life risk-based capital (RBC) proposal 2023-09-IRE (Residuals Factor) and proposal 2023-10-IRE (Residual Sensitivity Test Factor for Residuals).
15. Adopted revisions to the *Mortgage Guaranty Insurance Model Act* (#630).
16. Received a status report on states' implementation of NAIC-adopted model laws and regulations.

EXECUTIVE (EX) COMMITTEE

Aug. 14, 2023

1. Adopted the report of the joint meeting of the Executive (EX) Committee and the Internal Administration (EX1) Subcommittee, which met Aug. 13 in regulator-to-regulator session, pursuant to paragraph 4 (internal or administrative matters of the NAIC or any NAIC member) and paragraph 6 (consultations with NAIC staff members related to NAIC technical guidance). During this meeting, the Committee and Subcommittee took the following action:

- A. Adopted its July 11, March 25, and March 22 minutes. During these meetings, the Committee and Subcommittee took the following action:
 - i. Approved the termination of the defined benefit pension plan.
 - ii. Approved the fiscal for an additional full-time employee in Financial Regulatory Services (FRS).
 - iii. Approved a second round of grant funding from the Robert Wood Johnson Foundation (RWJF).
 - iv. Approved changing the dates of the 2024 Summer National Meeting in Chicago, IL.
 - v. Received a May year-to-date (YTD) financial update and an overview of the preliminary 2024 budget.
 - vi. Approved the release of a request for proposal (RFP) to hire an executive search firm.
 - vii. Received an update on the *State Connected* strategic plan.
 - viii. Approved the Succession Planning and Organization Design fiscal.
 - B. Adopted the Executive Committee's May 23 and March 31 minutes. During these meetings, the Committee met in regulator-to-regulator session, pursuant to paragraph 4 (internal or administrative matters of the NAIC or any NAIC member) of the NAIC Policy Statement on Open Meetings, and took the following action:
 - i. Approved Commissioner Scott A. White (VA) to serve on the International Association of Insurance Supervisors (IAIS) Executive Committee.
 - ii. Approved the 2027 national meeting locations:
 - a. Spring National Meeting: Kansas City, MO.
 - b. Summer National Meeting: New York City, NY.
 - c. Fall National Meeting: Nashville, TN.
 - C. Adopted the report of the Audit Committee, which met Aug. 3 and May 24 in regulator-to-regulator session, pursuant to paragraph 4 (internal or administrative matters of the NAIC or any NAIC member) of the NAIC Policy Statement on Open Meetings). During these meetings, the Committee took the following action:
 - i. Received the June 30 financial update.
 - ii. Received an overview of proposed 2024 revenues.
 - iii. Reappointed RubinBrown as the financial audit firm to conduct the 2023 audit.
 - iv. Affirmed the 2024 Audit Committee charter.
 - v. Discussed Grant and Zone financials, including the following potential changes:
 - a. Allowing a one-time allocation of up to \$75,000 from technical training funds to general use.
 - b. Allowing allocations from general funds to the New Avenues to Insurance Careers (N.A.I.C.) Foundation, pending funds balance.
 - vi. Received an update on the Enterprise Resource Planning (ERP) project.
 - vii. Received an update on the 2024 budget calendar.
 - viii. Received the 2022/2023 Service Organization Control (SOC) 1 and SOC 2 audit reports.
 - ix. Received a status report on the 2023 operating reserve analysis.
 - D. Adopted the report of the Internal Administration (EX1) Subcommittee, which met June 6. During this meeting, the Subcommittee took the following action:
 - i. Received the March 31 Long-Term Investment Portfolio report.
 - ii. Received the March 31 Defined Benefit Portfolio report.
 - E. Heard a cybersecurity report.
 - F. Received the report of the Acting Chief Executive Officer (CEO).
2. Adopted the report of the Executive (EX) Committee, which met May 23 and March 31. During these meetings, the Committee took the following action:
 - A. Appointed Commissioner White to serve on the IAIS Executive Committee.
 - B. Approved the 2027 national meeting site locations: Spring National Meeting, Kansas City, MO; Summer National Meeting, New York, NY; and Fall National Meeting, Nashville, TN.
 3. Adopted the report of the Climate and Resiliency (EX) Task Force. See the Task Force listing for details.

4. Adopted the report of the Government Relations (EX) Leadership Council. See the Leadership Council listing for details.
5. Adopted the report of the Long-Term Care Insurance (EX) Task Force. See the Task Force listing for details.
6. Adopted the report of the Special (EX) Committee on Race and Insurance. See the Special Committee listing for details.
7. Received a status report on the implementation of the *State Connected* strategic plan.
8. Received a status report on model law development efforts for amendments to: 1) the *Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act* (#171); 2) the *Property and Casualty Insurance Guaranty Association Model Act* (#540); 3) the *Mortgage Guaranty Insurance Model Act* (#630); 4) the *Nonadmitted Insurance Model Act* (#870); 5) the *Unfair Trade Practices Act* (#880); and 5) the new *Insurance Consumer Privacy Protection Model Law* (#674).
9. Received a status report from the National Insurance Producer Registry (NIPR).
10. Received a status report from the Interstate Insurance Product Regulation Commission (Compact).

Climate and Resiliency (EX) Task Force

Aug. 15, 2023

1. Adopted its Spring National Meeting minutes.
2. Heard a presentation from Arizona State University's Julie Ann Wrigley Global Futures Laboratory about its work on the rise in global temperature and its effects on rising sea levels and other catastrophic perils.
3. Heard a presentation from Ceres about a study on inclusive insurance and on a review of climate risk disclosures.
4. Heard a presentation from the California Department of Insurance (DOI) on atmospheric river storms in Western states.
5. Received an update from its Solvency Workstream, which has been focused on the evaluation and development of a U.S. regulatory approach to climate scenario analysis.

Government Relations (EX) Leadership Council

The Government Relations (EX) Leadership Council did not meet at the Summer National Meeting.

Long-Term Care Insurance (EX) Task Force

Aug. 9, 2023 (in lieu of the Summer National Meeting)

1. During this e-vote, the Task Force adopted its Spring National Meeting minutes, including revisions from Michigan and Minnesota.

Special (EX) Committee on Race and Insurance

Aug. 14, 2023

1. Adopted its Spring National Meeting minutes.
2. Heard an update from America's Health Insurance Plans (AHIP) on health equity.
3. Received an update on the Member Diversity Leadership Forum, highlighting the state insurance regulator diversity training coursework.
4. Received a status report from the Property/Casualty (P/C) Workstream, the Life Workstream, and the Health Workstream.

INTERNAL ADMINISTRATION (EX1) SUBCOMMITTEE

See the Executive (EX) Committee listing for details.

LIFE INSURANCE AND ANNUITIES (A) COMMITTEE

Aug. 15, 2023

1. Adopted its July 19 minutes, which included the following action:
 - A. Adopted its Spring National Meeting minutes.
 - B. Adopted revisions to the *Valuation Manual*.
 - C. Adopted revised charges for the Life Actuarial (A) Task Force.
2. Reported that the Accelerated Underwriting (A) Working Group and the Annuity Suitability (A) Working Group have not met since the Spring National Meeting.
3. Adopted the report of the Life Actuarial (A) Task Force. See the Task Force listing for details.
4. Heard a presentation from Noble Consulting Services on risks facing the life and annuity industry.
5. Heard a presentation from the United States Automobile Association (USAA) on the unique life insurance needs of the military.
6. Received an update on the Life Workstream of the Special (EX) Committee on Race and Insurance.

Life Actuarial (A) Task Force

Aug. 11–12, 2023

1. Adopted its July 20, June 15, June 1, May 18, May 11, May 4, April 27, April 20, and April 13 minutes, which included the following action:
 - A. Adopted its Spring National Meeting minutes.
 - B. Exposed the recommendation on *Valuation Manual* (VM)-20, Requirements for Principle-Based Reserves for Life Products; historical mortality improvement (HMI); and future mortality improvement (FMI) rates for a 30-day public comment period that ended Aug. 23.
 - C. Adopted amended charges to remove the Index-Linked Variable Annuity (A) Subgroup and add the Generator of Economic Scenarios (GOES) (E/A) Subgroup.
 - D. Responded to a referral from the Statutory Accounting Principles (E) Working Group on negative interest maintenance reserves (IMRs).
 - E. Exposed a template with additional disclosures related to company IMRs for a 44-day public comment period that ended July 28.
 - F. Adopted amendment proposal form (APF) 2023-07, which removes the Company-Specific Market Path (CSMP) method from VM-21, Requirements for Principle-Based Reserves for Variable Annuities. The Task Force had previously exposed APF 2023-07 for a 21-day public comment period that ended May 24.
 - G. Adopted APF 2023-05, which revises hedge modeling in VM-21 to address index credit hedging. The Task Force had previously re-exposed APF 2023-05 for a 16-day public comment period that ended May 26.
 - H. Exposed APF 2023-08, which clarifies the treatment of negative IMR, for a 45-day public comment period.
 - I. Discussed the GOES field test results in joint session with the Life Risk-Based Capital (E) Working Group.
 - J. Adopted APF 2021-08, which removes the one-year lag in mortality experience reporting in VM-51, Experience Reporting Formats. The Task Force had previously re-exposed APF 2021-08 for a 10-day public comment period that ended May 8.
 - K. Discussed the Valuation of Securities (E) Task Force referral regarding bond risk measures.
 - L. Discussed the Valuation of Securities (E) Task Force referral regarding structured equity and funds.
 - M. Adopted APF 2023-04, which clarifies company mortality experience disclosures in VM-31, PBR Actuarial Report Requirements for Business Subject to a Principle-Based Valuation.
 - N. Exposed APF 2023-06, which would add a cash surrender value floor to the VM-20 stochastic reserve calculation and change the VM-20 net premium reserve calculation for universal life with secondary guarantee products, for a 21-day public comment period that ended May 10.
 - O. Reported on the Standard Project Amount (SPA) Drafting Group, which met April 6 in regulator-to-regulator session, pursuant to paragraph 3 (specific companies, entities, or individuals) of the NAIC's

Policy Statement on Open Meetings, to share the results of a confidential survey sent to companies requesting data related to the SPA.

2. Adopted the reports of the Longevity Risk (E/A) Subgroup, the Variable Annuities Capital and Reserve (E/A) Subgroup, the Indexed Universal Life (IUL) Illustration (A) Subgroup, and the Experience Reporting (A) Subgroup, which have not met this year.
3. Adopted the report of the Valuation Manual (VM)-22 (A) Subgroup, which met July 26, June 13, May 24, May 10, April 26, April 19, and April 12 minutes. During these meetings, the Subgroup took the following action:
 - A. Exposed the VM-22, Requirements for Principle-Based Reserves for Non-Variable Annuities, standard projection amount (SPA) draft, for a 90-day public comment period ending Oct. 24.
 - B. Discussed comments received on the VM-22 draft.
4. Heard a presentation on findings from state insurance regulator reviews of company filings for *Actuarial Guideline LIII—Application of the Valuation Manual for Testing the Adequacy of Life Insurer Reserves* (AG 53).
5. Heard a presentation from the Society of Actuaries (SOA) on the VM-20 HMI and FMI factors.
6. Exposed APF 2023-09, which adds guidance on the application of HMI and FMI factors in VM-20, for a 45-day public comment period ending Sept. 27.
7. Heard a presentation from the American Academy of Actuaries (Academy) on interest rate acceptance criteria for the GOES.
8. Received an update on the GOES field test C-3 Phase I results.
9. Heard an update from the Interstate Insurance Product Regulation Commission (Compact) on its activities.
10. Heard an update from the Academy on pre-tax versus post-tax IMRs.
11. Heard an update from the SOA on research and education.
12. Heard an update from the Academy's Council on Professionalism and Education (COPE).
13. Heard an update from the Academy's Life Practice Council on its activities.
14. Exposed the Generally Recognized Expense Table (GRET) presentation and recommendation for a 30-day public comment period ending Sept. 12.
15. Discussed IMR guidance, APF 2023-08, and the IMR template.

HEALTH INSURANCE AND MANAGED CARE (B) COMMITTEE

Aug. 14, 2023

1. Adopted its Spring National Meeting minutes.
2. Adopted its June 29 minutes. During this meeting, the Committee took the following action:
 - A. Heard presentations on the Maryland, Michigan, and Nebraska state appeal programs.
 - B. Received an update on the Consumer Information (B) Subgroup's work to educate consumers on their claim appeal rights.
3. Adopted the report of the Health Actuarial (B) Task Force. See the Task Force listing for details.
4. Adopted the report of the Regulatory Framework (B) Task Force. See the Task Force listing for details.
5. Adopted the report of the Senior Issues (B) Task Force. See the Task Force listing for details.
6. Adopted the report of the Consumer Information (B) Subgroup, which met May 25. During this meeting, the Subgroup took the following action:
 - A. Adopted its April 25 minutes. During this e-vote, the Subgroup took the following action:
 - i. Adopted the document titled *Resuming Medicaid Redeterminations: State Insurance Regulator Guide* as a resource for state insurance regulators.
 - B. Adopted its April 17 minutes, which included the following action:
 - i. Adopted its March 2 minutes. During this meeting, the Subgroup took the following action:
 - a. Discussed ideas for future work, including developing a resource document on using social media, developing a guide to forming partnerships with other agencies, creating alternate versions of existing documents, and developing an education piece for consumers who may lose Medicaid.

- ii. Discussed a regulator guide on Medicaid redeterminations.
- C. Discussed other potential Subgroup work related to educating consumers on their claim appeal rights.
- 7. Adopted the report of the Health Innovations (B) Working Group, which met Aug. 13. During this meeting, the Working Group took the following action:
 - A. Adopted its Spring National Meeting minutes.
 - B. Heard presentations from Texas, West Virginia, and America’s Health Insurance Plans (AHIP) on prior authorization and gold card programs.
 - C. Heard a presentation from ArrayRx on multistate prescription drug purchasing.
 - D. Heard a presentation from Pharmaceutical Research and Manufacturers of America (PhRMA) on health equity and diversity in clinical trials.
- 8. Referred two issues to the Health Actuarial (B) Task Force:
 - A. Reach out to the federal Centers for Medicare & Medicaid Services (CMS) about state insurance regulators’ concerns with how the risk adjustment formula affects the current or prospective financial solvency position of new health insurers entering the health insurance marketplace.
 - B. Review how possible changes to the cost-sharing subsidy could affect plan options and costs to consumers.
- 9. Received an update on the work of the Market Regulation and Consumer Affairs (D) Committee that was of interest to the Committee. Specifically, the Committee received an update on the work of the Improper Marketing of Health Insurance (D) Working Group to amend the *Unfair Trade Practices Act* (#880) to address regulatory and enforcement issues with health insurance lead generators.
- 10. Received an update on the Consumer Information (B) Subgroup’s work to educate consumers on their claim appeal rights.
- 11. Heard a panel discussion on preventive services from a consumer-focused perspective. The panelists discussed: the federal Affordable Care Act’s (ACA’s) preventive service requirements and the recent court case, *Braidwood v. Becerra*, challenging those requirements; the health equity implications of increasing access to preventive services; how, despite the ACA preventive care requirements for coverage and no cost-sharing for such services, compliance with such requirements has been a challenge for certain preventive services, particularly with respect to HIV preventive care services, including prescription drugs needed to manage the virus; and the findings from the NAIC consumer representatives preventive care report and their recommendations for state insurance regulators to address the issues in the report’s findings. These issues include using data calls and market conduct examinations to assess compliance, ensuring continued preventive protections with state legislative and regulatory action, establishing uniform billing and coding standards, and holding plans accountable for educating consumers and providers on preventive services requirements.
- 12. Heard a status update on the Medicaid redetermination process following the end of the COVID-19 public health emergency (PHE). The update discussed key findings from the first batch of Medicaid redeterminations data the CMS reported last month in accordance with the federal Consolidated Appropriations Act, 2023 (CAA, 2023). The update also provided updated state renewal timelines; discussed new state flexibilities the U.S. Department of Health and Human Services (HHS) recently announced to help keep Americans covered as states resume Medicaid and Children’s Health Insurance Program (CHIP) renewals; and provided information on federal, state, and health industry resources for consumers and employers to assist them with transitioning through the renewal process and maintaining coverage.
- 13. Received an update on the work of the Special (EX) Committee on Race and Insurance Health Workstream. The Workstream is continuing its meetings on health equity issues. It recently had a meeting focusing on preventative care and lowering barriers to such care, particularly with respect to chronic disease care. The Workstream has planned upcoming meetings on the evolution of ACA Section 1332 waivers and state reinsurance programs, as well as reducing disparities in mental health services. The Workstream is also

piloting a new collaboration space on the NAIC Connect platform to allow Workstream members and other NAIC members to discuss issues related to health equity and other related topics.

Health Actuarial (B) Task Force

Aug. 12, 2023

1. Adopted its Spring National Meeting minutes.
2. Adopted the report of the Long-Term Care Actuarial (B) Working Group, which met Aug. 12 and took the following action:
 - A. Adopted its July 19, June 7, and May 1 minutes. During these meetings, the Working Group took the following action:
 - i. Discussed comments received on a request for comments on various long-term care insurance (LTCI) rate increase review methodologies.
 - ii. Exposed three multistate actuarial (MSA) approaches for a 30-day public comment period that ended July 10.
 - iii. Exposed the draft principles document for a public comment period that ended June 2.
 - B. Discussed drafting changes to VM-25, Health Insurance Reserves Minimum Reserve Requirements, of the *Valuation Manual* to add tables from the American Academy of Actuaries (Academy) and Society of Actuaries (SOA) Research Institute’s final *Long-Term Care Insurance Mortality and Lapse Study*.
 - C. Discussed a referral from the Health Risk-Based Capital (E) Working Group regarding *Actuarial Guideline LI—The Application of Asset Adequacy Testing to Long-Term Care Insurance Reserves* (AG 51).
 - D. Heard a presentation from FTI Consulting on public/private long-term care (LTC) funding solutions.
 - E. Heard an update on a single LTCI multistate rate review approach.
3. Heard an update on SOA Research Institute activities.
4. Heard a presentation on SOA education redesign.
5. Heard an update from the Academy Health Practice Council.
6. Heard an update on Academy professionalism.
7. Discussed an inadequate risk adjustment issue.

Regulatory Framework (B) Task Force

Aug. 13, 2023

1. Adopted its Spring National Meeting minutes.
2. Adopted the report of the Accident and Sickness Insurance Minimum Standards (B) Subgroup, which met Aug. 7, July 24, July 10, June 29, May 15, April 24, April 17, and March 27. During these meetings, the Subgroup took the following action:
 - A. Completed its discussions of the comments received on Section 8—Supplementary and Short-Term Health Minimum Standards for Benefits of the *Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act* (#171), specifically Section 8A—General Rules.
 - B. Completed its discussions of the remainder of Section 8, including revisiting the proposed new subsection on short-term, limited-duration (STLD) plans and the discussion of the Feb. 24 comments received on that section, and Section 7—Prohibited Policy Provisions.
 - C. Discussed the comments received on Section 9—Required Disclosure Revisions of Model #171, including how the recently proposed federal rules on consumer disclosures for STLD plans and hospital indemnity and other fixed indemnity plans could affect proposed revisions to the section.
 - D. Discussed its upcoming work to continue its discussions of the Model #171 revisions and complete those revisions by the end of the year.
3. Adopted the report of the Employee Retirement Income Security Act (ERISA) (B) Working Group, which met Aug. 13 and took the following action:

- A. Heard an update from the U.S. Department of Labor (DOL) on two Notices of Proposed Rulemaking (NPRMs):
 - i. The parity NPRM proposes amendments to regulations implementing the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) and new regulations implementing the non-quantitative treatment limitation (NQTL) comparative analyses requirements under the MHPAEA, as amended by the federal Consolidated Appropriations Act, 2021 (CAA, 2021).
 - ii. The STLD/fixed indemnity NPRM proposes rules to amend the definition of short-term, limited-duration insurance (STLDI), which is excluded from the definition of individual health insurance coverage under the federal Public Health Service Act and sets forth proposed amendments to the requirements for hospital indemnity or other fixed indemnity insurance to be considered an excepted benefit in the group and individual health insurance markets. The proposed rule also includes a comment solicitation on level-funded arrangements.
- B. Received an update on the revisions to the NAIC chart on multiple employer welfare arrangements (MEWAs)/multiple employer trusts (METs) and association plans. The chart will be circulated to the states to be updated.
- C. Adjourned in regulator-to-regulator session, pursuant to paragraph 2 (pending investigations), paragraph 3 (specific companies, entities or individuals), and paragraph 8 (consideration of strategic planning issues) of the NAIC Policy Statement on Open Meetings, to continue work on its goals.
4. Adopted the report of the Mental Health Parity and Addiction Equity Act (MHPAEA) (B) Working Group, which plans to meet Aug. 14 to: 1) hear presentations from the Council of Autism Service Providers (CASP) and the Autism Legal Research Center on treatment standards for autism; and 2) adjourn in regulator-to-regulator session, pursuant to paragraph 8 (consideration of strategic planning issues) of the NAIC Policy Statement on Open Meetings, to continue work on its goals. The Working Group also met March 23. During this meeting, the Working Group took the following action:
 - A. Heard a discussion of the *Wit v. United Behavioral Health* case, a potential landmark case setting a precedent for how care will be covered for individuals seeking treatment for mental health and addiction.
5. Adopted the report of the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup, including its July 27 minutes. During this meeting, the Subgroup took the following action:
 - A. Adopted its Spring National Meeting minutes.
 - B. Adopted its April 17 minutes. During this meeting, the Subgroup took the following action:
 - i. Exposed the pharmacy benefit manager (PBM) white paper for a 45-day public comment period that ended June 1.
 - C. Adopted the PBM white paper and forwarded it to the Task Force for its consideration.
7. Heard a panel presentation from representatives of the Leukemia & Lymphoma Society (LLS), the American Medical Association (AMA), and the Washington Office of the Insurance Commissioner on prior authorization. During the presentation, the panelists discussed patient and consumer experiences with prior authorization and how prior authorization requirements can create a barrier to care and be burdensome to physician practices. The panelists discussed opportunities and solutions for state insurance regulators to reform the prior authorization process and provided examples of how certain states, including Washington, are acting on those solutions to reform the prior authorization process. The panelists also discussed federal actions complementing state actions to reform the prior authorization process.

Senior Issues (B) Task Force

Aug. 13, 2023

1. Adopted its Spring National Meeting minutes.
2. Adopted its April 14 minutes. During this e-vote, the Task Force took the following action:
 - A. Adopted a letter to Congress and a letter to the U.S. Department of Labor (DOL) regarding the conflict between Medicare and the federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)

rules that has led to confusion about which system and set of rules govern eligibility for coverage, as well as how the responsibility for the payment of health care benefits for eligible individuals is determined.

3. Heard a presentation from the federal Centers for Medicare & Medicaid Services (CMS) on its new Medicare Advantage marketing rules and regulations.
4. Heard a presentation from eHealth on lead generators.
5. Heard a presentation from New Mexico Oncology Hematology Consultants (NMOHC) on concerns about adverse risk selection in Medicare Advantage plans.
6. Heard an update on the status of Minnesota's "Own Your Future" initiative and Washington's WA Cares Fund.
7. Received a request to open the *Coordination of Benefits Model Regulation* (#120) and make the necessary correction to alleviate the COBRA/Medicare conflict.

PROPERTY AND CASUALTY INSURANCE (C) COMMITTEE

Aug. 15, 2023

1. Adopted its Spring National Meeting minutes.
2. Adopted the report of the Casualty Actuarial and Statistical (C) Task Force. See the Task Force listing for details.
3. Adopted the report of the Surplus Lines (C) Task Force. See the Task Force listing for details.
4. Adopted the report of the Title Insurance (C) Task Force. See the Task Force listing for details.
5. Adopted the report of the Workers' Compensation (C) Task Force. See the Task Force listing for details.
6. Adopted the report of the Cannabis Insurance (C) Working Group, which met July 18 in lieu of the Summer National Meeting. During this meeting, the Working Group took the following action:
 - A. Adopted its June 20 minutes. During this meeting, the Working Group took the following action:
 - i. Adopted its April 11 minutes. During this meeting, the Working Group took the following action:
 - a. Adopted its 2022 Fall National Meeting minutes.
 - b. Exposed the *Understanding the Market for Cannabis Insurance 2.0* white paper for a 45-day public comment period that ended May 26.
 - c. Discussed the Working Group's work plan.
 - ii. Received an update on the exposed *Understanding the Market for Cannabis Insurance 2.0* white paper.
 - iii. Heard a presentation from the National Association of Mutual Insurance Companies (NAMIC) on the impact of cannabis on the personal lines.
 - iv. Heard a presentation from Wilson Elser on the unique risks of social consumption lounges.
 - B. Adopted the *Understanding the Market for Cannabis Insurance 2.0* white paper.
 - C. Heard a panel discussion on the uncertainties in the treatment of hemp and cannabis.
7. Adopted the report of the Catastrophe Insurance (C) Working Group, which met Aug. 13 in joint session with the NAIC/Federal Emergency Management Agency (FEMA) (C) Advisory Group. During this meeting, the Working Group took the following action:
 - A. Adopted its Spring National Meeting minutes.
 - B. Received an update on the progress of the Catastrophe Modeling Primer. The drafting group formed by the Working Group has been meeting monthly to continue drafting the primer. Several sections have been drafted since the Spring National Meeting. The drafting group hopes to complete the drafting before the Fall National Meeting.
 - C. Heard from Alabama, Louisiana, and Minnesota about their mitigation programs. Alabama started Safe Home Alabama in 2016. Since Safe Home Alabama's inception, Alabama has worked with Louisiana and Minnesota to help them start their own programs. Louisiana and Minnesota used many of the elements of Alabama's program. These programs provide a tremendous amount of health and safety benefits.
 - D. Heard a presentation from the Federal Alliance for Safe Homes (FLASH) on its resilience playbook and state insurance regulator resource guide. The playbook provides resources available to states for mitigation grant programs.

- E. Heard from State Farm about the need to create an efficient process of providing information on behalf of their insureds that can be shared with FEMA to help them obtain federal loans and grants. Suggestions were discussed regarding the use of a uniform process, as the current process leaves consumers with little or no disaster support for weeks following a catastrophic event. NAIC staff will reach out to FEMA following the Summer National Meeting.
 - F. Heard a presentation from the Center for Insurance Policy and Research (CIPR) Center of Excellence (COE) regarding its available programs. The COE is working with partners to provide documents that are beneficial to state insurance regulators, such as catastrophe modeling documentation.
 - G. Heard a recap of the FEMA Region 1 event held in Maynard, MA, May 21–22. The Working Group heard about the various ways in which it could collaborate with FEMA, as well as understanding FEMA’s role. The Region 1 attendees had the following takeaways: 1) there is a need for improvement in consumer education; 2) a need to continue to work with FEMA on messaging; 3) a need for strengthening relationships with agents through education; 4) a need for discussing adjuster access to disasters; and 5) a need to know whom to contact from FEMA following a declared disaster.
8. Adopted the report of the Terrorism Insurance Implementation (C) Working Group, which has not met this year.
 9. Adopted the report of the Transparency and Readability of Consumer Information (C) Working Group, which has not met since March 15.
 10. Adopted the *Understanding the Market for Cannabis Insurance: 2023 Update* white paper, which is an update to a 2019 white paper concerning regulatory issues related to insuring cannabis.
 11. Heard a presentation from the Consumer Federation of America (CFA) on telematics and the need for regulatory guidance regarding transparency, actuarial support for variables, limits on data collection and use, privacy standards, and testing for bias.
 12. Heard a presentation from a consumer representative on the problem of homeowners being underinsured and their recommendation that insurers quote premiums using an algorithm’s estimated reconstruction costs along with one reflecting the reconstruction cost corrected for the error rate.
 13. Discussed public school insurance, including high losses and rising rates. The Committee will discuss the issue in more detail during a future meeting.
 14. Announced that a state insurance regulator drafting group is working to develop a data call to collect property insurance data to meet the Committee’s charge to better understand property insurance markets and the insurance protection gap.

Casualty Actuarial and Statistical (C) Task Force

Aug. 12, 2023

1. Adopted its Spring National Meeting minutes.
2. Adopted its June 13 and May 2 minutes. During these meetings, the Task Force took the following action:
 - A. Discussed the monitoring of other NAIC committee groups.
 - B. Discussed the reviews of future actuarial papers.
 - C. Discussed the Director and Officer (D&O) Insurance Coverage Supplement and the Cyber Insurance Supplement.
 - D. Discussed loss cost multiplier (LCM) form implementation.
 - E. Received a report on the Center for Insurance Policy and Research’s (CIPR’s) Center of Excellence (COE) regarding catastrophes.
3. Adopted the report of the Actuarial Opinion (C) Working Group, including its Aug. 2, July 12, and May 25 minutes. The Working Group also met June 14 in regulator-to-regulator session, pursuant to paragraph 3 (specific companies, entities, or individuals) of the NAIC Policy Statement on Open Meetings, to discuss the 2022 Statement of Actuarial Opinion (SAO). During these meetings, the Working Group took the following action:

- A. Exposed the *Regulatory Guidance on Property and Casualty Statutory Statements of Actuarial Opinion, Actuarial Opinion Summaries, and Actuarial Reports for the Year 2023* for a 30-day public comment period ending Sept. 1.
 - B. Adopted a Financial Analysis (E) Working Group referral on predictive analytics in reserving.
 - C. Discussed actuarial opinion instructions. Working Group members were asked to submit any proposed instruction changes.
4. Adopted the report of the Statistical Data (C) Working Group, including its July 18 minutes. During this e-vote, the Working Group took the following action:
 - A. Adopted the *Auto Database Report Supplement for Average Premium Data* (Auto Supplement).
 5. Voted to submit its written comments to the Actuarial Standards Board (ASB) of the American Academy of Actuaries (Academy) on the proposed enterprise risk management (ERM) Actuarial Standard of Practice (ASOP).
 6. Discussed its work plan regarding the D&O Insurance Coverage Supplement and the Cyber Insurance Supplement.
 7. Received a report on the Capital Adequacy (E) Task Force’s Risk Evaluation Ad Hoc Group.
 8. Heard a presentation from the Academy on its *Approaches to Identify and/or Mitigate Bias in Property and Casualty Insurance* white paper.
 9. Heard from the ASB, the Actuarial Board for Counseling and Discipline (ABCD), the Academy, the Casualty Actuarial Society (CAS), and the Society of Actuaries (SOA) on their activity and research reports.
 10. Heard a report from the SOA on exam changes.

Surplus Lines (C) Task Force

Aug. 13, 2023

1. Adopted its Spring National Meeting minutes.
2. Adopted the report of the Surplus Lines (C) Working Group, which met May 22 in regulator-to-regulator session, pursuant to paragraph 3 (specific companies, entities or individuals) of the NAIC Policy Statement on Open Meetings, to approve three insurers for admittance to the NAIC *Quarterly Listing of Alien Insurers*.
3. Adopted its 2024 proposed charges. Minimal amendments to the charges were proposed to provide additional clarification.
4. Received a summary of 2022 U.S. and alien surplus lines financial results.

Title Insurance (C) Task Force

Aug. 14, 2023

1. Adopted its Spring National Meeting minutes.
2. Received an update on the administration of the *Survey of State Insurance Laws Regarding Title Data and Title Matters*. Microsoft Forms will be used for the survey, which is anticipated to be administered shortly following the Summer National Meeting.
3. Received an update on the compilation of consumer complaint data related to the title industry.
4. Heard a presentation from Stewart Title on issues with Non-Title Recorded Agreements for Personal Services (NTRAPS).
5. Heard a presentation from CertifID on current fraud trends in the title space. The U.S. Secret Service recently issued a notice of a rise in vacant lot fraud.

Workers’ Compensation (C) Task Force

July 20, 2023 (in lieu of the Summer National Meeting)

1. Adopted its Spring National Meeting Minutes.

2. Heard a presentation from Lewis & Ellis on workers' compensation rating. The presentation included how ratemaking is done in the workers' compensation line of business. Information was also presented on the use of predictive modeling and the current status of how predictive modeling is used in workers' compensation.

MARKET REGULATION AND CONSUMER AFFAIRS (D) COMMITTEE

Aug. 15, 2023

1. Adopted its July 27 minutes, which included the following action:
 - A. Adopted its Spring National Meeting minutes.
 - B. Adopted the pet insurance Market Conduct Annual Statement (MCAS) data call and definitions.
 - C. Adopted a new charge for the Producer Licensing (D) Task Force to review and amend, as needed, the *Public Adjuster Licensing Model Act (#228)* to enhance consumer protections in the property/casualty (P/C) claims process.
 - D. Adopted the *Continuing Education Recommended Guidelines for Instructor Approval*.
 - E. Received the Voluntary Market Regulation Certification Program.
2. Adopted revisions to the collaboration actions chapter of the *Market Regulation Handbook*. The focus of these revisions is to provide greater transparency to states about the Multistate Settlement Agreement process.
3. Adopted the Voluntary Market Regulation Certification Program. The revisions are a result of a pilot program involving 18 states. The mission of the Market Regulation Certification Program is to establish and maintain minimum standards that promote sound practices relating to the market conduct examination, market analysis, and related continuum activity functions performed for insurance consumer protection.
4. Adopted the report of the Antifraud (D) Task Force. See the Task Force listing for details.
5. Adopted the report of the Market Information Systems (D) Task Force. See the Task Force listing for details.
6. Adopted the report of the Market Analysis Procedures (D) Working Group, which met July 17 in lieu of the Summer National Meeting. During this meeting, the Working Group took the following action:
 - A. Adopted its June 12 minutes. During this meeting, the Working Group took the following action:
 - i. Adopted its May 8 minutes. During this meeting, the Working Group took the following action:
 - a. Adopted its April 10 minutes. During this meeting, the Working Group took the following action:
 - 1) Adopted its Aug. 22, 2022, minutes.
 - 2) Discussed its charges and goals for 2023.
 - 3) Discussed the proposed other health MCAS ratios.
 - b. Discussed the Market Information Systems (MIS) data.
 - c. Discussed the proposed other health insurance MCAS ratios.
 - ii. Discussed the MIS data.
 - iii. Discussed proposed other health insurance MCAS ratios.
 - iv. Discussed the inclusion of fraternal insurance companies in the MCAS.
 - B. Adopted the other health insurance MCAS ratios.
 - C. Discussed sponsoring "lunch and learn" trainings for all market analysts on a regular schedule.
 - D. Discussed the inclusion of fraternal insurance companies in the MCAS.
7. Adopted the report of the Market Conduct Annual Statement Blanks (D) Working Group, which met July 19 in lieu of the Summer National Meeting. During this meeting, the Working Group took the following action:
 - A. Adopted its June 22 minutes. During this meeting, the Working Group took the following action:
 - i. Adopted its May 30 and May 22 minutes. During these meetings, the Working Group took the following action:
 - a. Adopted its April 6 minutes. During this meeting, the Working Group took the following action:
 - 1) Discussed the MCAS participation requirements.
 - 2) Received a pet subject matter expert (SME) group update.
 - 3) Reviewed the other health data element.
 - 4) Received an update on MCAS filings.

- b. Adopted revisions to the pet MCAS data call and definitions.
 - c. Discussed MCAS directions for determining when a claim is closed on the personal property and homeowners lines of business.
 - d. Discussed the pet insurance MCAS data call and definitions.
 - ii. Discussed MCAS directions for determining when a claim is closed on the private passenger auto (PPA) and homeowners lines of business.
 - iii. Discussed the MCAS data element revision process timeline.
 - B. Discussed the reporting of closed claims for the PPA and homeowners lines of business.
 - C. Discussed the MCAS data element revision process timeline.
 - D. Discussed the filing deadlines for the other health and short-term, limited-duration (STLD) lines of business.
8. Adopted the report of the Market Conduct Examination Guidelines (D) Working Group, which met July 18. During this meeting, the Working Group took the following action:
- A. Adopted its March 28 minutes. During this meeting, the Working Group took the following action:
 - i. Discussed its 2023 charges.
 - ii. Discussed carry-over items from 2022.
 - B. Discussed revisions to the June 6 draft of Chapter 23—Conducting the Life and Annuity Examination of the *Market Regulation Handbook* (Handbook).
 - C. Adopted the June 6 draft of Chapter 4—Collaborative Actions of the Handbook.
9. Adopted the report of the Market Regulation Certification (D) Working Group, which met June 6. During this meeting, the Working Group took the following action:
- A. Adopted its May 9 minutes. During this meeting, the Working Group took the following action:
 - i. Adopted its Spring National Meeting minutes.
 - ii. Reviewed the pilot program’s suggested revisions to the Market Regulation Certification Program.
 - B. Reviewed the pilot program’s suggested revisions to the Market Regulation Certification Program.
10. Adopted the report of the Speed to Market (D) Working Group, which met July 25. During this meeting, the Working Group took the following action:
- A. Adopted its Nov. 10, 2022, minutes.
 - B. Discussed suggestions received for the Life, Health, and Annuities Product Coding Matrix (PCM) and the uniform transmittal document (UTD).
 - C. Heard a report from the Interstate Insurance Product Regulation Commission (Compact).
 - D. Received a report on the System for Electronic Rates & Forms Filing (SERFF) modernization project.
11. Heard an update on international issues from NAIC international policy support staff. This presentation covered the activities of the International Association of Insurance Supervisors’ (IAIS’) Market Conduct Working Group, which include a paper on the use of conduct indicators in insurance supervision and a diversity, equity, and inclusion (DE&I) project.
12. Heard a presentation from Missouri on the use of data visualization for market analysis, which included information on data needs, how to pick the right visualization, best practices for data visualization, and specific examples of market analysis.

Antifraud (D) Task Force

Aug. 14, 2023

1. Adopted its Spring National Meeting minutes.
2. Discussed its 2023 charges. The Task Force reviewed its current charges in preparation for 2024. Its charges will be open for comment through Sept. 22. The Task Force will review the comments received and meet in October to consider adoption of its 2024 proposed charges.
3. Heard a presentation from the United Brotherhood of Carpenters and Joiners of America (UBC) on workers’ compensation premium fraud. The Task Force discussed the importance of workers’ compensation insurance

fraud related to the construction industry. The Task Force advised that it would add this as an agenda topic to discuss further during its regulator-to-regulator discussions.

4. Adopted the report of the Improper Marketing of Health Insurance (D) Working Group. The Working Group reported that it:
 - A. Plans to meet Aug. 14 to:
 - i. Consider adoption of draft amendments to the *Unfair Trade Practices Act* (#880). Revisions include the deletion of the definition of records from Section 2: Definitions and the lead generator devices language concerning “accident and sickness/Medicare supplement” to be replaced with “what is or what purports to be a health insurance product or service.”
 - ii. Hear a presentation from Georgetown University on a research study concerning open enrollment.
 - B. Met July 27 to discuss the newly revised draft amendments to Model #880.
5. Received the report of the Antifraud Technology (D) Working Group. The Working Group chair has been working with NAIC staff on the redesign of the NAIC’s Online Fraud Reporting System (OFRS). The Working Group will continue to meet to discuss necessary enhancements to the OFRS to include fields provided from the National Insurance Crime Bureau (NICB) data.
6. Heard a presentation from Coalition Against Insurance Fraud (CAIF) on a research study on who commits insurance fraud and why. The study showed how different generations view insurance fraud.
7. Heard reports from the CAIF and the NICB on antifraud activity.

Market Information Systems (D) Task Force

July 31, 2023 (in lieu of the Summer National Meeting)

1. Discussed its 2023 charges and goals.
2. Adopted the report of the Market Information Systems Research and Development (D) Working Group, which met May 22 in regulator-to-regulator session, pursuant to paragraph 6 (consultations with NAIC staff members related to NAIC technical guidance) of the NAIC Policy Statement on Open Meetings, to review its goals for 2023.
3. Discussed its 2023 charges and goals.
4. Adopted the report of the Market Information Systems Research and Development (D) Working Group, which met May 22 in regulator-to-regulator session, pursuant to paragraph 6 (consultations with NAIC staff members related to NAIC technical guidance) of the NAIC Policy Statement on Open Meetings, to review its goals for 2023.
5. Received a status report from the Market Analysis Procedures (D) Working Group.
6. Received an update on Market Information Systems (MIS) projects and Uniform System Enhancement Request (USER) forms.

Producer Licensing (D) Task Force

May 31, 2023 (in lieu of the Summer National Meeting)

1. Adopted its 2022 Fall National Meeting minutes.
2. Discussed the template for the 1033 process.
3. Adopted a new public adjuster licensing charge.
4. Adopted the *Continuing Education Recommended Guidelines for Instructor Approval*.
5. Adopted the report of the Uniform Education (D) Working Group, which met May 18 and took the following action:
 - A. Discussed its 2023 charges.
 - B. Discussed exam pass rates.

- C. Discussed the *Continuing Education Recommended Guidelines for Instructor Approval*.
 - D. Discussed producers declining continuing education (CE) credit.
 - E. Discussed accommodations for individuals with disabilities or medical waivers specific to CE credit.
6. Adopted the report of the Adjuster Licensing (D) Working Group, which met March 29 and took the following action:
- A. Discussed its 2023 charges.
 - B. Discussed a question concerning public adjusters and the creation of a Public Adjusters (D) Working Group.
7. Received a report from the National Insurance Producer Registry (NIPR) Board of Directors.

FINANCIAL CONDITION (E) COMMITTEE

Aug. 15, 2023

1. Adopted its Spring National Meeting minutes.
2. Adopted its July 19 minutes. During this meeting, the Committee took the following action:
 - A. Adopted life risk-based capital (RBC) proposals 2023-09-IRE (Residuals Factor) and 2023-10-IRE (Residual Sensitivity Test Factor for Residuals).
 - B. Adopted the *Mortgage Guaranty Insurance Model Act* (#630).
 - C. Appointed a new group titled the Generator of Economic Scenarios (GOES) (E/A) Subgroup of the Life Risk-Based Capital (E) Working Group and adopted new charges as follows:
 - i. Monitor that the economic scenario governance framework is being appropriately followed by all relevant stakeholders involved in scenario delivery.
 - ii. Review material generator of economic scenario (GOES) updates, either driven by periodic model maintenance or changes to the economic environment, and provide recommendations.
 - iii. Regularly review key economic conditions and metrics to evaluate the need for off-cycle or significant GOES updates and maintain a public timeline for GOES updates.
 - iv. Support the implementation of a GOES for use in statutory reserve and capital calculations.
 - v. Develop and maintain acceptance criteria that reflect history as well as plausibly more extreme scenarios.
3. Adopted the report of the Accounting Practices and Procedures (E) Task Force. See the Task Force listing for details.
4. Adopted the report of the Capital Adequacy (E) Task Force. See the Task Force listing for details.
5. Adopted the report of the Examination Oversight (E) Task Force. See the Task Force listing for details.
6. Adopted the report of the Financial Stability (E) Task Force. See the Task Force listing for details.
7. Adopted the report of the Receivership and Insolvency (E) Task Force. See the Task Force listing for details.
8. Adopted the report of the Reinsurance (E) Task Force. See the Task Force listing for details.
9. Adopted the report of the Valuation of Securities (E) Task Force. See the Task Force listing for details.
10. Adopted the report of the Group Capital Calculation (E) Working Group, which met July 27 and June 13. During these meetings, the Working Group took the following action:
 - A. Exposed the group capital calculation (GCC) scalar methodology proposal for a 30-day public comment period that ended July 13.
 - i. Discussed the comment letters received from the American Council of Life Insurers (ACLI) and from UnitedHealth Group (UHG) on the GCC scalar methodology proposal.
 - ii. Discussed the scalar methodology proposal.
 - iii. Adopted the scalar methodology proposal for life insurance companies.
11. Adopted the report of the Mortgage Guaranty Insurance (E) Working Group, which met July 13. During this meeting, the Working Group took the following action:
 - A. Adopted its Spring National Meeting minutes.
 - B. Adopted amendments to Model #630.

12. Adopted the report of the Restructuring Mechanisms (E) Working Group, which met May 4 and took the following action:
 - A. Adopted its April 4 minutes. During this meeting, the Working Group took the following action:
 - i. Noted that the Restructuring Mechanisms (E) Subgroup was merged into the Working Group during the Spring National Meeting.
 - ii. Exposed redline versions for a public comment period that ended April 26.
 - iii. Received an update on RBC runoff referrals.
 - iv. Continued discussion of the review of previously submitted comments, including those on “no worse” language, due process, and pro forma financial statements.
 - B. Received and considered comments on exposed draft best practices guidance and new language to address previous comments.
13. Adopted the report of the Risk-Focused Surveillance (E) Working Group, which met Aug. 14. During this meeting, the Working Group took the following action:
 - A. Discussed proposed changes to the NAIC’s *Financial Analysis Handbook* and *Financial Condition Examiners Handbook* to provide additional guidance for state insurance regulators in reviewing service agreements put in place between insurers and their affiliates. As a result of the discussions held, the Working Group agreed to adjust its proposed guidance on cost-plus reimbursement contracts. The Working Group also agreed to refer the updated guidance to the Financial Analysis Solvency Tools (E) Working Group and the Financial Condition Examiners (E) Handbook Technical Group for consideration of adoption.
 - B. Discussed the next steps to be taken to address a 2022 referral received from the Macroprudential (E) Working Group on affiliated investment management agreements and capital maintenance agreements. Risk and Regulatory Consulting (RRC) provided a presentation on key considerations in the state insurance regulator review of affiliated investment management agreements. The Working Group agreed to form a drafting group to develop guidance for NAIC handbooks in this area.
 - C. Discussed the status of an all-state survey to collect data on financial analyst and examiner compensation for the purposes of adjusting the salary ranges included in the NAIC handbooks.
 - D. Received a report on 2023 peer review training sessions, which included one financial analysis session, one financial examination session, and one Own Risk and Solvency Assessment (ORSA)-focused session.
14. Reported that the Financial Analysis (E) Working Group met Aug. 12, July 20, June 21, June 14, May 25, and May 24 in regulator-to-regulator session, pursuant to paragraph 3 (specific companies, entities, or individuals) of the NAIC Policy Statement on Open Meetings, to discuss letter responses and financial results.
15. Reported that the Valuation Analysis (E) Working Group met Aug. 12, July 20, and May 18 in regulator-to-regulator session, pursuant to paragraph 3 (specific companies, entities, or individuals) of the NAIC Policy Statement on Open Meetings, to discuss valuation items related to specific companies.
16. Reported that the National Treatment and Coordination (E) Working Group met Aug. 2, July 26, and June 15 in regulator-to-regulator session, pursuant to paragraph 6 (consultations with NAIC staff members related to NAIC technical guidance), to continue work on its goals.
17. Adopted the macroprudential reinsurance worksheet.
18. Adopted *Interpretation (INT) 23-01T: Net Negative (Disallowed) IMR*.
19. Heard a presentation from the Office of the Superintendent of Financial Institutions (OSFI) on the use of artificial intelligence (AI).
20. Exposed the *Framework for Regulation of Insurer Investments* for a 45-day public comment period ending Oct. 2.

Accounting Practices and Procedures (E) Task Force

Aug. 14, 2023

1. Adopted its Spring National Meeting minutes.
2. Adopted its 2024 proposed charges, which remain unchanged from its 2023 charges.

3. Adopted the report of the Statutory Accounting Principles (E) Working Group, which met Aug. 13. During this meeting, the Working Group took the following action:
 - A. Adopted its Spring National Meeting minutes.
 - B. Adopted its July 5, June 28, May 16, April 12, and April 10 minutes. During these meetings, the Working Group took the following action:
 - i. Re-exposed a revised *Interpretation (INT) 23-01: Net Negative (Disallowed) Interest Maintenance Reserve* for a public comment period that ended July 21. The INT had previously been exposed April 10 for a public comment period that ended May 5.
 - ii. Reviewed comments received on exposed items.
 - iii. Exposed its maintenance agenda for a public comment period that ended June 30.
 - iv. Discussed a referral from the Valuation of Securities (E) Task Force on the acquisition of commercially available data and deemed a response was not necessary.
 - v. Discussed a referral from the Life Actuarial (A) Task Force on negative interest maintenance reserve (IMR).
 - vi. Exposed *INT 22-02: Third Quarter 2022 through Second Quarter 2023 Reporting of the Inflation Reduction Act – Corporate Alternative Minimum Tax* for a public comment period that ended May 5.
 - C. Adopted the following clarifications to statutory accounting guidance:
 - i. *Statement of Statutory Accounting Principles (SSAP) No. 5R—Liabilities, Contingencies, and Impairments of Assets and Issue Paper No. 168—Updates to the Definition of a Liability*: Adopted revisions to the definition of a liability under statutory accounting. (Ref #2022-01)
 - ii. *SSAP No. 24—Discontinued Operations and Unusual or Infrequent Items*: Adopted revisions to SSAP No. 24 to reject *Accounting Standards Update (ASU) 2021-10, Government Assistance*, and the incorporation of disclosures regarding government assistance. (Ref #2023-06)
 - iii. *SSAP No. 26R—Bonds, SSAP No. 21R—Other Admitted Assets, SSAP No. 43R—Loan-Backed and Structured Securities*, and other affected SSAPs: Refined guidance for the principles-based bond project. (Note that SSAP No. 26R and SSAP No. 43R have updated titles effective Jan. 1, 2025.) (Ref #2019-21)
 - iv. *SSAP No. 34—Investment Income Due and Accrued*: Adopted revisions to clarify and incorporate a practical expedient to the paid-in-kind (PIK) interest aggregate disclosure for SSAP No. 34 and annual statement instruction purposes. (Ref #2023-13)
 - v. *SSAP No. 43R—Loan-Backed and Structured Securities*: Adopted revisions to incorporate changes to add collateralized loan obligations (CLOs) to the financial modeling guidance and to clarify that CLOs are not captured as legacy securities. (Ref #2023-02)
 - vi. *SSAP No. 95—Nonmonetary Transactions and SSAP No. 104R—Share-Based Payments*: Adopted, with modification, *ASU 2019-08, Compensation—Stock Compensation (Topic 718) and Revenue from Contracts with Customers (Topic 606): Codification Improvements—Share-Based Consideration Payable to a Customer*. The revisions add guidance to include share-based consideration payable to customers. (Ref #2023-07)
 - vii. *Interpretation (INT) 20-01: ASU 2020-04 and 2021-01 – Reference Rate Reform*: Adopted proposal to revise the expiration date of INT 20-01 to Dec. 31, 2024. (Ref #2023-05)
 - viii. INT 23-01: Adopted with three editorial revisions. This INT provides optional, limited-time guidance, which allows the admittance of net negative (disallowed) IMR up to 10% of adjusted capital and surplus. As detailed within the INT, it will be effective until Dec. 31, 2025, and automatically nullified on Jan. 1, 2026, but the effective date can be adjusted (e.g., nullified earlier or extended). In addition, the Working Group directed the formation of an ad hoc subgroup to work on a long-term solution. Upon adoption of the INT, NAIC staff will provide the Blanks (E) Working Group with a disclosure memorandum for posting on its website for year-end 2023. Additionally, a blanks proposal will be

- sponsored to incorporate the disclosures and attestation requirements into the notes and general interrogatories for year-end 2024. (Ref #2022-19)
- ix. *Appendix D—Nonapplicable GAAP Pronouncements*: The following U.S. generally accepted accounting principles (GAAP) standards were rejected as they are not applicable to statutory accounting:
 - a. *ASU 2019-07—Codification Updates to SEC Sections: Amendments to SEC Paragraphs Pursuant to SEC Final Rule Releases No. 33-10532, Disclosure Update and Simplification, and Nos. 33-10231 and 33-10442, Investment Company Reporting Modernization, and Miscellaneous Updates*. (Ref #2023-08)
 - b. *ASU 2020-09, Amendments to SEC Paragraphs Pursuant to SEC Release No. 33-10762—Debt (Topic 470)*. (Ref #2023-09)
 - c. *ASU 2022-05, Transition for Sold Contracts*. (Ref #2023-10)
 - D. Exposed the following statutory accounting principle (SAP) concepts and clarifications to statutory accounting guidance until Sept. 29, except for INT 23-02T, INT 23-03T, Ref #2022-11, and Ref #2023-12, which have a comment deadline of Sept. 12:
 - i. *SSAP No. 2R—Cash, Cash Equivalents, Drafts, and Short-Term Investments*: Exposed revisions to further restrict the investments that are permitted for cash equivalent or short-term investment reporting. These revisions are proposed to ensure that certain investment types are captured on designated Schedule BA reporting lines and to eliminate the potential to design investments to specifically qualify for short-term reporting. (Ref #2023-17)
 - ii. *SSAP No. 5R, SSAP No. 92—Postretirement Benefits Other Than Pensions, SSAP No. 102—Pensions, and SSAP No. 103R—Transfers and Servicing of Financial Assets and Extinguishments of Liabilities*: Exposed revisions to adopt with modification certain aspects of *ASU 2016-19—Technical Corrections and Improvements*. Revisions also propose amending SSAP No. 92 guidance on insurance contracts to use the same terminology used in SSAP No. 102. (Ref #2023-18)
 - iii. *SSAP No. 7—Asset Valuation Reserve and Interest Maintenance Reserve*: Exposed the overall concept for a long-term project to capture accounting guidance for asset valuation reserve (AVR) and IMR in SSAP No. 7. (Ref #2023-14)
 - iv. *SSAP No. 20—Nonadmitted Assets and SSAP No. 21R—Other Admitted Assets*: Re-exposed the revisions that clarify that pledged collateral must qualify as an admitted invested asset for a collateral loan to be admitted. The revisions require audits and the use of net equity value for valuation assessments when the pledged collateral is in the form of partnerships, limited liability companies (LLCs), or joint ventures. (Ref #2022-11)
 - v. *SSAP No. 21R and Bond Issue Paper*: Exposed a revised SSAP No. 21R and Bond Issue Paper to provide guidance for the accounting for debt securities that do not qualify as bonds, as well as proposed measurement guidance for residuals. (Ref #2019-21)
 - vi. *SSAP No. 43R*: Exposed updated proposal to reflect revisions from the interim discussions and coordination on revisions to clarify the scope and reporting for investment structures that represent residual interests within SAPs. (Ref #2023-12)
 - vii. *SSAP No. 48—Joint Ventures, Partnerships, and Limited Liability Companies*: Exposure requests industry and regulator comment on a proposal to further define and provide examples for the investments captured as non-registered private funds, joint ventures, partnerships or limited liability companies, or residual interests and reported based on the underlying characteristics of assets. (Ref #2023-16)
 - viii. *SSAP No. 54R—Individual and Group Accident and Health Contracts*: Exposed clarifying revisions and an illustration to clarify that gross premium valuation (under A-010) and cash-flow testing (under *Actuarial Guideline LI—The Application of Asset Adequacy Testing to Long-Term Care Insurance Reserves* [AG 51]) are both required if indicated. (Ref #2023-22)

- ix. SSAP No. 92 and SSAP No. 102: Exposed revisions to SSAP No. 92 and SSAP No. 102 to remove the transition guidance that was included in the initial adoption of SSAP No. 92 and SSAP No. 102, as it is past the 10-year effective period for that transition. (Ref #2023-21)
 - x. *SSAP No. 93—Low-Income Housing Tax Credit Property Investments* and *SSAP No. 94R—Transferable and Non-Transferable State Tax Credits*: Exposed interested party comments on revisions to SSAP No. 93 and SSAP No. 94R, as well as updates made in response to the comments received. (Ref #2022-14)
 - xi. *INT 03-02: Modification to an Existing Intercompany Pooling Arrangement*: Exposed the intent to nullify INT 03-02, as it is inconsistent with *SSAP No. 25—Affiliates and Other Related Parties*. (Ref #2022-12)
 - xii. *INT 23-02: Third Quarter 2023 Inflation Reduction Act – Corporate Alternative Minimum Tax*: Exposed a proposed INT, which recommends that for third-quarter 2023, reporting entities should disclose whatever information is available regarding their applicable reporting entity status. (INT 23-02)
 - xiii. *INT 23-03: Corporate Alternative Minimum Tax Guidance*: Exposed the INT, which provides guidance effective beginning year-end 2023 reporting of the corporate alternative minimum tax, which applies *SSAP No. 101—Income Taxes* with modification and provides disclosures. The exposed INT 23-03 includes that paragraph 11c of SSAP No. 101 should be followed. (Ref #2023-04)
 - xiv. *IMR/AVR Specific Allocations*: Exposed revisions to the *Annual Statement Instructions* to remove the guidance that permits the specific allocation of non-interest-related losses to IMR. (Ref #2023-15)
 - xv. *Appendix D—Nonapplicable GAAP Pronouncements*: The following U.S. GAAP standards were exposed with revisions to reject, as they are not applicable to statutory accounting:
 - a. *ASU 2018-09—Codification Improvements* (Ref #2023-19)
 - b. *ASU 2020-10—Codification Improvements* (Ref #2023-20)
- E. Directed NAIC staff on the following items:
- i. *Review Annual Statement Instructions for Accounting Guidance*: To proceed with a broad project to review the annual statement instructions and ensure accounting guidance is included within the SSAPs. (Ref #2023-01)
 - ii. *Schedule BA Reporting*: To sponsor a blanks proposal to revise Schedule BA: Other Long-Term Assets in accordance with the bond project for debt securities that do not qualify as bonds, with formal notice to the Valuation of Securities (E) Task Force and the Capital Adequacy (E) Task Force on the proposal to allow life reporting entities the ability to use existing Schedule BA reporting provisions for Securities Valuation Office (SVO)-assigned designations in determining risk-based capital (RBC) for debt securities that do not qualify as bonds. (Ref #2019-21)
- F. Received an update on U.S. GAAP exposures, noting that pending items will be addressed during the normal maintenance process.
4. Adopted the report of the Blanks (E) Working Group, which met July 27. During this meeting, the Working Group took the following action:
- A. Adopted its May 31 minutes. During this meeting, the Working Group took the following action:
 - i. Adopted its March 7 minutes.
 - ii. Adopted the following proposals:
 - a. 2022-17BWG Modified: Add a new disclosure paragraph for Note 8—Derivative Instruments and Illustration. The new disclosure is to be data captured. Add electronic-only columns related to derivatives with excluded components to Schedule DB, Part A and Part B for both Section 1 and Section 2. Add new code column instructions for Schedule DB, Part A and B (SAPWG 2021-20).
 - b. 2023-01BWG Modified: Remove pet insurance from the inland marine line of business and add a new line of business to the Appendix—property/casualty (P/C) lines of business. Add a pet insurance line within the existing P/C blank for the Underwriting and Investment Exhibits, Exhibit of Premiums and Losses (State Page), and Insurance Expense Exhibit. Add new Schedule P Parts 1 through 4, specific to pet insurance.

- c. 2023-02BWG Modified: Add an exhibit to identify premiums that are reportable for Market Conduct Annual Statement (MCAS) purposes.
- d. 2023-03BWG: Remove life crosschecks for columns 2, 6, and 10 on the Accident and Health Policy Experience Exhibit (AHPEE).
- e. 2023-04BWG Modified: Add instructions for the appointed actuary and qualified actuary contacts to the Jurat electronic-only section.
- f. 2023-08BWG: Add clarifying language for mutual insurance companies on Schedule Y, Part 3.
- g. 2023-10BWG Modified: Update the three primary issue periods on Long-Term Care Experience Reporting Form 2.
- h. 2023-11BWG Modified: Add additional instructions and illustration to be data captured for Note 7—Investment Income in the Notes to the Financial Statement to disclose more information on interest.
- i. Adopted its editorial listing.
- iii. Deferred three proposals:
 - a. 2023-05BWG: Changes to the cybersecurity supplement.
 - b. 2023-07BWG: Delete the legal entity identifier (LEI) column for the select investment schedules.
 - c. 2023-09BWG: Add a new financial statement Note 37—Life Insurance Net Amount at Risk by Product Characteristics.
- iv. Adopted its editorial listing.
- B. Deferred the following proposals for an additional comment period:
 - i. 2023-05BWG Modified: Changes to the cybersecurity supplement to remove the reference to identity theft insurance from the General Instructions; remove the interrogatory questions from Part 1 that pertain to identity theft insurance; and remove the column for identity theft insurance from Parts 2 and 3. Remove claims-made and occurrence breakdowns, as well as first-party and third-party breakdowns, from data collection, and remove the question in the interrogatories regarding tail policies.
 - ii. 2023-07BWG: Update the code column and delete the LEI column for the following investment schedules: Schedules A, B, BA, D Part 2, D Part 6, and E Part 1.
 - iii. 2023-09BWG: Add a new financial statement Note 37—Life Insurance Net Amount at Risk by Product Characteristics to the life and accident and health/fraternal (H/F) blank for the updates to the life C-2 mortality risk charges for life RBC.
- C. Re-exposed the following proposal for a 75-day public comment period ending Oct. 12:
 - i. 2023-06BWG: Split the Schedule D, Part 1 into two sections: one for issuer credit obligations and the other for asset-backed securities (ABS). Update the other parts of the annual statement that reference the bond lines of business.
- D. Adopted its editorial listing.

Capital Adequacy (E) Task Force

Aug. 14, 2023

1. Adopted its June 30 and April 28 minutes, which included the following action:
 - A. Adopted its Spring National Meeting minutes.
 - B. Adopted proposal 2023-02-P-MOD (Underwriting Risk Line 1 Factors).
 - C. Adopted proposals 2023-09-IRE (Residual Factor for Life) and 2023-10-IRE (Residual Sensitivity Test Factor for Life).
 - D. Adopted the Generator of Economic Scenarios (GOES) (E/A) Subgroup charges.
 - E. Adopted proposal 2022-09-CA-MOD (Revised Affiliated Investments Structure and Instructions).
 - F. Adopted proposal 2022-16-CA (Underwriting Risk Factors – Investment Income Adjustment).

- G. Adopted proposal 2023-01-CA (Stop Loss Premiums).
 - H. Adopted proposal 2023-02-P (Underwriting Risk Line 1 Factors).
 - I. Adopted proposal 2023-03-IRE (Revised Residual Structure for Life).
 - J. Adopted proposal 2023-04-IRE (Residual Sensitivity Test for Life).
 - K. Adopted proposal 2023-05-L (Remove Dual Trend Test).
 - L. Adopted proposal 2023-06-L (C-2 Mortality Risk Structure Changes).
 - M. Adopted proposal 2023-07-L (CM6 & CM7 Mortgages Structures Changes).
 - N. Exposed proposal 2022-16-CA (Underwriting Risk Factors Investment Income Adjustment) for a 30-day public comment period that ended May 27.
 - O. Exposed proposal 2023-01-CA (Stop Loss Premiums) for a 30-day public comment period that ended May 27.
 - P. Discussed the current turmoil in the banking sector.
 - Q. Discussed a referral from the Valuation of Securities (E) Task Force and the Risk-Based Capital Investment Risk and Evaluation (E) Working Group regarding additional market and analytical information for bond investments.
 - R. Received an update from its Risk Evaluation Ad Hoc Group.
2. Adopted the report of the Health Risk-Based Capital (E) Working Group, which met July 25. During this meeting, the Working Group took the following action:
- A. Adopted its May 17 and April 17 minutes. During these meetings, the Working Group took the following action:
 - i. Adopted its Spring National Meeting minutes.
 - ii. Referred proposal 2023-01-CA (Stop Loss Premiums) to the Capital Adequacy (E) Task Force for exposure.
 - iii. Received an update from the American Academy of Actuaries (Academy) on the health care receivables and H2-underwriting risk review projects.
 - iv. Discussed pandemic risk.
 - v. Exposed the proposal on the health test language for a 45-day public comment period that ended June 30.
 - B. Adopted its 2023 health risk-based capital (RBC) newsletter.
 - C. Adopted its 2022 health RBC statistics report.
 - D. Exposed proposal 2023-11-H (XR014 Fee-for-Service & Other Risk Revenue-Medicare & Medicaid) for a 30-day public comment period that ended Aug. 24.
 - E. Referred the health test proposal to the Blanks (E) Working Group.
 - F. Received an update from the Academy on the health care receivable and H2-underwriting risk review projects.
 - G. Adopted its updated working agenda.
 - H. Received an update on the Excessive Growth Charge Ad Hoc Group.
 - I. Discussed a way forward on evaluating pandemic risk in the health RBC formula.
3. Adopted the report of the Risk-Based Capital Investment Risk and Evaluation (E) Working Group, which met Aug. 13. During this meeting, the Working Group took the following action:
- A. Adopted its June 14, May 17, April 20, and Spring National Meeting minutes, which included the following action:
 - i. Discussed comments received on proposed structural and factor changes for residual tranches.
 - ii. Adopted structural changes and factors for the base factor and a sensitivity test for residual tranches.
 - B. Received updates from the Valuation of Securities (E) Task Force and the Statutory Accounting Principles (E) Working Group.
 - C. Heard a presentation from the Academy on principles for structured securities RBC.

4. Adopted the report of the Life Risk-Based Capital (E) Working Group, which met Aug. 13. During this meeting, the Working Group took the following action:
 - A. Adopted its Spring National Meeting minutes.
 - B. Adopted its June 22 and April 14 minutes. During these meetings, the Working Group took the following action:
 - i. Adopted the proposed charges of the Generator of Economic Scenarios (GOES) (E/A) Subgroup.
 - ii. Discussed proposal 2023-08-L (Custody Control Accounts).
 - iii. Discussed its working agenda.
 - iv. Adopted proposal 2023-05-L (Remove Dual Trend Test).
 - v. Adopted proposal 2023-06-L (C-2 Mortality Structure and Instruction Changes).
 - vi. Adopted proposal 2023-07-L (CM6 & CM7 Mortgage Structure Change).
 - vii. Exposed proposal 2023-08-L (Comfort Trusts) for a 45-day public comment period.
 - C. Adopted the 2023 life RBC newsletter.
 - D. Adopted the 2022 life RBC statistics.
 - E. Adopted its working agenda.
 - F. Heard a presentation from the American Council of Life Insurers (ACLI) on a proposal for repurchase agreements and exposed it for a 45-day public comment period.
 - G. Discussed C-2 mortality risk.
5. Adopted the report of the Property and Casualty Risk-Based Capital (E) Working Group, which met July 27 in lieu of the Summer National Meeting. During this meeting, the Working Group took the following action:
 - A. Adopted its June 16 and April 24 minutes. During these meetings, the Working Group took the following action:
 - i. Adopted its Spring National Meeting minutes.
 - ii. Adopted proposal 2023-02-P (UW Risk Line 1 Factors).
 - iii. Adopted proposal 2023-02-P-MOD (UW Risk Line 1 Factors Modification), which updated the health/fraternal (H/F), workers' compensation (WC), and commercial multiple peril (CMP) reserve factors due to an incorrect calculation.
 - iv. Forwarded the referral regarding the deferral of adoption of blanks proposal 2023-01BWG to the Blanks (E) Working Group.
 - v. Discussed annual statement blanks proposal 2022-15BWG.
 - vi. Heard updates on current property/casualty (P/C) RBC projects from the Academy.
 - vii. Discussed the possibility of reviewing and analyzing the P/C RBC charges that have not been reviewed since developed.
 - B. Adopted the report of the Catastrophe Risk (E) Subgroup, which met July 18 in lieu of the Summer National Meeting. During this meeting, the Subgroup took the following action:
 - i. Adopted its Spring National Meeting minutes.
 - ii. Discussed its working agenda.
 - iii. Received an update from its Catastrophe Model Technical Review Ad Hoc Group.
 - iv. Discussed wildfire peril impact analysis.
 - v. Heard a presentation from Verisk on a severe convective storms model update and technical review.
 - vi. Discussed the flood insurance market.
 - C. Adopted the 2023 P/C RBC newsletter.
 - D. Discussed the 2022 P/C RBC statistics report.
 - E. Discussed its working agenda.
 - F. Discussed the possibility of reviewing and analyzing the P/C RBC charges that have not been reviewed since developed.
 - G. Heard an update from the Academy on current P/C RBC projects.
6. Adopted its working agenda.

7. Exposed its 2024 proposed charges for a 30-day public comment period ending Sept. 13.
8. Exposed its revised procedures document for a 30-day public comment period ending Sept. 13.
9. Received an update from its Risk Evaluation Ad Hoc Group.
10. Discussed the implications of the recent market turmoil and its impact on insurer investments.

Examination Oversight (E) Task Force

July 24, 2023 (in lieu of the Summer National Meeting)

1. Adopted its 2022 Fall National Meeting minutes.
2. Adopted the report of the Financial Analysis Solvency Tools (E) Working Group, which met July 12 and June 1 in regulator-to-regulator session, pursuant to paragraph 4 (internal or administrative matters of the NAIC or any NAIC member) of the NAIC Policy Statement on Open Meetings. During its July 12 meeting, the Working Group took the following action:
 - A. Adopted revisions to the *Insurer Profile Summary Sharing Best Practices Guide*.
3. Adopted the report of the Financial Examiners Coordination (E) Working Group, which met April 17 and March 22 in regulator-to-regulator session, pursuant to paragraph 4 (internal or administrative matters of the NAIC or any NAIC member) of the NAIC Policy Statement on Open Meetings, to continue work on its goals.
4. Adopted the report of the Electronic Workpaper (E) Working Group, which has not met this year but provided a brief update regarding the TeamMate+ transition.
5. Adopted the report of the Financial Examiners Handbook (E) Technical Group, which met June 20. During this meeting, the Technical Group took the following action:
 - A. Exposed revisions to Exhibit G—Consideration of Fraud for a 30-day public comment period that ended July 20.
 - B. Exposed revisions to add a reference to a template for a memorandum of understanding into Sections 1–3 of the *Financial Condition Examiners Handbook* (Handbook) for a 30-day public comment period that ended July 20.
 - C. Received a referral from the Financial Analysis (E) Working Group that suggests considering additional guidance that would encourage examiners to review strategic/operational risks faced by health insurers during an on-site examination.
 - D. Received an update on the Climate and Resiliency (EX) Task Force referral and proposed revisions. Working revisions include the following Handbook sections: Investments; Reinsurance (Assuming and Ceding); Underwriting Repositories; Exhibit A (Planning Procedures); Exhibit B (Planning Questionnaire); Exhibit I (Planning Memo); Exhibit V (Prospective Risks), Exhibit Y (Interview Questions); and Exhibit DD (Critical Risk Categories).
6. Adopted the report of the Information Technology (IT) Examination (E) Working Group, which met April 11. During this meeting, the Working Group took the following action:
 - A. Discussed a referral from the Cybersecurity (H) Working Group asking the IT Examination (E) Working Group to consider making cybersecurity a higher priority in the examination process.

Financial Stability (E) Task Force

Aug. 13, 2023 (joint session with the Macroprudential (E) Working Group)

1. Adopted its Spring National Meeting minutes.
2. Adopted its June 20 minutes. During this meeting, the Task Force took the following action:
 - A. Adopted the reinsurance worksheet.
3. Heard an update on Financial Stability Oversight Council (FSOC) developments.
4. Received a Macroprudential (E) Working Group update and a Valuation Analysis (E) Working Group update.

5. Heard an international update, which included an update on the International Association of Insurance Supervisors (IAIS) Global Monitoring Exercise (GME). The GME includes the individual insurers monitoring exercise and the sector-wide monitoring exercise with three more additional topics of interest: credit risk; interest rate risk; and structural changes in life insurance, including reinsurance.

Receivership and Insolvency (E) Task Force

Aug. 14, 2023

1. Adopted its Spring National Meeting minutes.
2. Adopted the report of the Receivership Financial Analysis (E) Working Group. The Working Group will meet Aug. 14 in regulator-to-regulator session, pursuant to paragraph 3 (specific companies, entities, or individuals) of the NAIC Policy Statement on Open Meetings, to discuss companies in receivership and related topics.
3. Adopted the report of the Receivership Law (E) Working Group, which met July 24. During this meeting, the Working Group took the following action:
 - A. Adopted its May 23 minutes. During this meeting, the Working Group took the following action:
 - i. Exposed proposed amendments to the *Property and Casualty Insurance Guaranty Association Model Act* (#540) for restructuring mechanisms and cybersecurity insurance for a 30-day public comment period that ended June 23.
 - B. Adopted proposed amendments to Model #540.
 - C. Heard a presentation from Arcina Risk Group on an extension of file retention of closed receivership estate records.
4. Exposed proposed amendments to Model #540 for restructuring mechanisms and cybersecurity insurance for a 30-day public comment period ending Sept. 14.
5. Exposed a template for describing the U.S. receivership regime for a 30-day public comment period ending Sept. 14. The template is intended for lead state insurance departments to provide consistency in discussions with international regulators and aid in developing resolution plans for internationally active insurance groups (IAIGs).
6. Heard an update on international resolution activities.
7. Discussed Part A financial regulation and accreditation standards and previous review work performed by the Task Force on standards for receivership and insurance guaranty association laws.
8. Heard an update on a proposed receivership tabletop session. The NAIC will review the availability of space and time at the Fall National Meeting.

Reinsurance (E) Task Force

July 24, 2023 (in lieu of the Summer National Meeting)

1. Adopted its Spring National Meeting minutes.
2. Adopted its 2024 proposed charges, which include minor revisions from 2023 to reflect the current duties of the Task Force and the Reinsurance Financial Analysis (E) Working Group.
3. Adopted the report of the Reinsurance Financial Analysis (E) Working Group, which met July 19 and May 2 in regulator-to-regulator session, pursuant to paragraph 3 (specific companies, entities, or individuals) of the NAIC Policy Statement on Open Meetings, to approve several certified and reciprocal jurisdiction reinsurers for passporting.
4. Received a status report on the reinsurance activities of the Mutual Recognition of Jurisdictions (E) Working Group.
5. Discussed ongoing projects at the NAIC that affect reinsurance.
6. Received a status report on states' implementation of the *Term and Universal Life Insurance Reserve Financing Model Regulation* (#787).

Risk Retention Group (E) Task Force

The Risk Retention Group (E) Task Force did not meet at the Summer National Meeting.

Valuation of Securities (E) Task Force

Aug. 14, 2023

1. Adopted its Spring National Meeting minutes.
2. Adopted its July 13 and May 15 minutes. During these meetings, the Task Force took the following action:
 - A. Adopted a *Purposes and Procedures Manual of the NAIC Investment Analysis Office* (P&P Manual) amendment to clarify the meaning of repurchase agreements in the derivatives transaction definition for funds in Part Three of the P&P Manual. The Task Force had previously exposed the amendment for a 45-day public comment period that ended June 30.
 - B. Received comments on a P&P Manual amendment to update the definition of an NAIC designation. The Task Force had previously exposed the amendment for a 45-day public comment period that ended June 30.
 - C. Received a staff report on updates on the proposed collateralized loan obligation (CLO) modeling methodology and CLO Ad Hoc Working Group.
 - D. Exposed a proposed P&P Manual amendment authorizing the procedures for the Securities Valuation Office's (SVO's) discretion over NAIC designations assigned through the filing exemption (FE) process for a 60-day public comment period that ended July 14.
 - E. Discussed a proposal for consideration by the Executive (EX) Committee to change how SVO fees are determined.
3. Adopted its 2024 proposed charges, which remain unchanged from its 2023 charges.
4. Received a report on the projects of the Statutory Accounting Principles (E) Working Group.
5. Received and discussed comments on the proposed P&P Manual amendment to update the definition of an NAIC designation.
6. Received and discussed comments on the proposed P&P Manual amendment authorizing the procedures for the SVO's discretion over NAIC designations assigned through the FE process.
7. Received a status report on the proposed CLO modeling methodology and CLO Ad Hoc Working Group.
8. Received final questions to be answered by credit rating providers (CRPs).
9. Discussed the Fitch Ratings downgrade of its U.S. government credit rating.

FINANCIAL REGULATION STANDARDS AND ACCREDITATION (F) COMMITTEE

Aug. 13, 2023

1. Adopted its Spring National Meeting minutes.
2. Reported that it met Aug. 12 in regulator-to-regulator session, pursuant to paragraph 7 (consideration of individual state insurance department's compliance with NAIC financial regulation standards) of the NAIC Policy Statement on Open Meetings. During this meeting, the Committee took the following action:
 - A. Discussed state-specific accreditation issues.
 - B. Voted to award continued accreditation to the insurance departments of Missouri, New Hampshire, South Dakota, and Texas.
3. Adopted the 2020 revisions to the *Insurance Holding Company System Regulatory Act* (#440) and the *Insurance Holding Company System Model Regulation with Reporting Forms and Instructions* (#450) as significant elements of Part A accreditation standards. The revisions are recommended for all states effective Jan. 1, 2026, and they implement a group capital calculation (GCC) for the purpose of group solvency supervision and a liquidity stress test (LST) for macroprudential surveillance. The revisions include provisions allowing the commissioner to grant exemptions to GCC for groups meeting standards set forth in 21A and 21B of Model #450 without the requirement to file at least once. This exemption applies primarily to risk retention

groups (RRGs).

4. Adopted its 2024 proposed charges, which remain unchanged from its 2023 charges.

INTERNATIONAL INSURANCE RELATIONS (G) COMMITTEE

Aug. 13, 2023

1. Adopted its Spring National Meeting minutes.
2. Adopted its April 13 minutes. During this meeting, the Committee took the following action:
 - A. Discussed NAIC comments on the International Association of Insurance Supervisors (IAIS) public consultation on the issues paper on the roles and functioning of policyholder protection schemes (PPSs).
3. Heard an update from a representative at the government of Canada's Office of the Superintendent of Financial Institutions (OSFI) on international insurance developments and activities in Canada.
4. Heard an update on recent activities and priorities of the IAIS, including: 1) a review of the June 2023 Global Seminar and recent committee meetings; 2) the upcoming comparability assessment process for the aggregation method (AM) and the release for feedback of a U.S.-produced document describing the Provisional AM for use in the comparability assessment; and 3) continuing work at various IAIS forums and steering groups.
5. Heard an update on international activities, including: 1) workstreams of the European Union (EU)-U.S. Insurance Dialogue Project and its recent public stakeholder session in June 2023; 2) recent meetings, events, and speaking engagements with international insurance regulators; 3) recent meetings of the Organisation for Economic Co-operation and Development (OECD) Insurance and Private Pensions Committee; and 4) recent bilateral meetings.

INNOVATION, CYBERSECURITY, AND TECHNOLOGY (H) COMMITTEE

Aug. 13, 2023

1. Adopted its Spring National Meeting minutes.
2. Adopted the report of the Big Data and Artificial Intelligence (H) Working Group, which met Aug. 13. During this meeting, the Working Group took the following action:
 - A. Adopted its Spring National Meeting minutes.
 - B. Received updates on the home artificial intelligence (AI)/machine learning (ML) public report and the life AI/ML survey. The survey was conducted under the market examination authorities of 10 requesting states (Connecticut, Illinois, Iowa, Louisiana, Nevada, North Dakota, Pennsylvania, Rhode Island, Vermont, and Wisconsin) and was completed by insurers who write home insurance in one of the 10 participating states and have at least \$50 million in national homeowners insurance premium for 2020. Out of 194 companies completing the survey, 136 companies currently use, plan to use, or plan to explore using AI/ML as defined for this survey. This equates to approximately 70% of reporting companies. For comparison, approximately 88% of the companies responding to the private passenger auto (PPA) survey reported they currently use, plan to use, or plan to explore using AI/ML. Among insurer operations areas, companies reported varying levels of AI/ML use, from 14% in the loss prevention area to 54% in claims operations. From maximum to minimum use, the percentage of companies using AI/ML by insurer function were: claims, 54%; underwriting and marketing, both at 47%; fraud detection, 42%; rating, 35%; and loss prevention, 14%. The two most popular reasons reported for not using, not planning to use, and not exploring the use of AI/ML were "no compelling business reason" and "waiting for regulatory guidance."
 - C. Heard a presentation from Deloitte on generative AI, which addressed how generative AI currently works, the emerging capabilities of generative AI, how to measure and mitigate AI risk, insurance industry examples of the benefits of AI, and common AI terms and definitions.

3. Adopted the report of the Cybersecurity (H) Working Group, which reported that its drafting group of state insurance regulators has been meeting to develop a Cybersecurity Event Response Plan (CERP).
4. Adopted the report of the E-Commerce (H) Working Group, which reported that its chairs have met several times to discuss the Working Group's next steps and to give NAIC staff guidance on drafting a framework that would serve as a guide for states looking to modernize their regulatory requirements.
5. Adopted the report of the Innovation in Technology and Regulation (H) Working Group, which met April 27. During this meeting, the Working Group took the following action:
 - A. Discussed an overview of its 2023 work plan.
 - B. Discussed the development of a SupTech Forum.
 - C. Discussed the development of an Insurtech Forum program to be held at the 2023 NAIC Insurance Summit.
 - D. Heard a presentation from Aite-Novarica Group on ChatGPT.
6. Adopted the report of the Privacy Protections (H) Working Group, which met Aug. 13. During this meeting, the Working Group took the following action:
 - A. Adopted its Spring National Meeting minutes.
 - B. Adopted its July 25, June 5–6, May 16, May 2, and April 18 minutes, which included the following action:
 - i. Discussed comments received and collaborated on workable language regarding the following seven topics:
 - a. Third-party service providers, including the definition of third-party service providers, third-party service providers not related to an insurance transaction but that have access to consumers' personal information, and contracts with third-party service providers.
 - b. Definitions of insurance transactions and additional permitted transactions.
 - c. Marketing, including marketing insurance products to consumers using consumers' personal information, marketing other products to consumers using consumers' personal information, and affiliate marketing.
 - d. Joint marketing agreements (JMAs), JMAs with affiliates, and JMAs with non-affiliated third parties.
 - e. Opt-in versus opt-out consent to marketing and the difference between marketing insurance and non-insurance products.
 - f. Contents necessary to have in a notice of consumer privacy practices.
 - g. The frequency and methodology of delivery for a notice of consumer privacy protections.
 - ii. Discussed draft *Insurance Consumer Privacy Protection Model Law* (#674) language.
 - iii. Exposed Version 1.2 of the new Model #674 on July 11 because it was based on changes that were discussed at an interim meeting, with a public comment period that ended July 28. The drafting group continued its meetings with industry trade companies privately to discuss current consumer data practices on Aug. 9, Aug. 3, Aug. 2, and July 28.
 - iv. Notified interested parties that so many comment letters have been received since the interim meeting that the Working Group has been unable to post them all prior to the Summer National Meeting. The Working Group will continue posting comments to the website after the national meeting. Due to the sheer volume of comments and the number of one-on-one calls requested, the Working Group has determined that more time is needed to engage the public and continue drafting Model #674.
 - v. Discussed comments received and engaged the public to continue drafting Model #674.
 - vi. Discussed key topics noted in the comments received and an extension of time to develop the new Model #674 due to the volume of comments received on the July 11 Version 1.2 draft.
 - C. Received an update from NAIC staff on state privacy legislation and federal privacy activity.
 - D. Discussed an extension to develop the new Model #674.
 - E. Discussed the sections on marketing, consumer notices, and opt-out/opt-in in the draft of Version 1.2 of Model #674.

7. Received initial public comments on the *NAIC Model Bulletin: Use of Algorithms, Predictive Models, and Artificial Intelligence Systems by Insurers*. Comments were provided by 10 speakers, which included trade group representatives and consumer representatives. Initial observations were offered on the model bulletin's language on third-party oversight, definitions, and principles-based approach to setting governance expectations.

NAIC/CONSUMER LIAISON COMMITTEE

Aug. 12, 2023

1. Adopted its Spring National Meeting minutes.
2. Received a report on the Consumer Board of Trustees meeting.
3. Heard a presentation from the Center for Economic Justice (CEJ) on "A Meaningful Framework for the Supervision of Insurers' Use of Big Data and Artificial Intelligence."
4. Heard a presentation from United Policyholders (UP) and the Automotive Education & Policy Institute (AEPI) on the appraisal process for automotive and property damage claims.
5. Heard a presentation from the Disability Rights Education & Defense Fund (DREDF), the Whitman-Walker Institute, and the Leukemia & Lymphoma Society (LLS) on federal health updates.
6. Heard a presentation from Consumers' Checkbook, Georgians for a Healthy Future (GHF), and the United States of Care on preventative health services.
7. Heard a presentation from the American Kidney Fund (AKF) and the HIV+Hepatitis Policy Institute on health care appeals and denials.

NAIC/AMERICAN INDIAN AND ALASKA NATIVE LIAISON COMMITTEE

Aug. 13, 2023

1. Adopted its Spring National Meeting minutes.
2. Heard an update from Lehotsky Keller Cohn LLP on the *McGirt v. Oklahoma* U.S. Supreme Court case.
3. Heard a presentation from Health Care Service Corporation (HCSC) on the effect of risk adjustment treatment of tribal enrollees under the federal Affordable Care Act (ACA).
4. Heard an update from Alaska on the risk adjustment treatment of Alaska Native enrollees under the ACA.
5. Considered drafting a letter to the federal Centers for Medicare & Medicaid Services (CMS) regarding Native American issues under the ACA.

EXECUTIVE (EX) COMMITTEE AND PLENARY

Executive (EX) Committee and Plenary Aug. 16, 2023, Minutes	3-2
Adopted the Amendments to the 2024 <i>Valuation Manual</i> (Attachment One)	3-11
Adopted Revisions to the <i>Nonadmitted Insurance Model Act</i> (#870) (Attachment Two).....	3-13
Adopted the <i>Regulatory Guide: Understanding the Market for Cannabis Insurance:</i> <i>2023 Update</i> (Attachment Three)	3-46
Adopted Life Risk-Based Capital (RBC) Proposals 2023-09 IRE (Residuals Factor) and 2023-10-IRE (Residual Sensitivity Test Factor for Residuals) (Attachment Four)	3-92
Adopted Revisions to the <i>Mortgage Guaranty Insurance Model Act</i> (#630) (Attachment Five)	3-96
Report on the States' Implementation of NAIC-Adopted Model Laws and Regulations (Attachment Six)	3-116

Draft: 8/29/23

Executive (EX) Committee and Plenary
Seattle, Washington
August 16, 2023

The Executive (EX) Committee and Plenary met in Seattle, WA, Aug. 16, 2023. The following Committee and Plenary members participated: Chlora Lindley-Myers, Chair (MO); Andrew N. Mais, Vice Chair (CT); Jon Godfread, Vice President (ND); Scott A. White, Secretary-Treasurer, represented by Don Beatty (VA); Dean L. Cameron, Most Recent Past President (ID); Lori K. Wing-Heier (AK); Mark Fowler (AL); Alan McClain represented by Russ Galbraith (AR); Peni Itula Sapini Teo (AS); Barbara D. Richardson (AZ); Ricardo Lara represented by Lucy Wang (CA); Michael Conway represented by Peg Brown (CO); Karima M. Woods represented by Sharon Shipp (DC); Trinidad Navarro (DE); John F. King represented by Martin Sullivan (GA); Doug Ommen (IA); Dana Popish Severinghaus represented by Bruce Sartain (IL); Amy L. Beard represented by Victoria Hastings (IN); Vicki Schmidt represented by Justin McFarland (KS); Sharon P. Clark (KY); James J. Donelon (LA); Gary D. Anderson (MA); Kathleen A. Birrane (MD); Timothy N. Schott represented by Sandra Darby (ME); Anita G. Fox (MI); Grace Arnold (MN); Troy Downing (MT); Mike Causey represented by (NC); Eric Dunning (NE); D.J. Bettencourt (NH); Justin Zimmerman (NJ); Alice T. Kane (NM); Scott Kipper (NV); Adrienne A. Harris represented by John Finston (NY); Judith L. French represented by Matt Peters (OH); Glen Mulready (OK); Andrew R. Stolfi (OR); Michael Humphreys (PA); Elizabeth Kelleher Dwyer (RI); Michael Wise (SC); Larry D. Deiter (SD); Carter Lawrence (TN); Cassie Brown (TX); Jon Pike (UT); Tregenza A. Roach (VI); Kevin Gaffney (VT); Mike Kreidler (WA); Allan L. McVey represented by Melinda Kiss (WV); Nathan Houdek represented by Timothy Cornelius (WI); and Jeff Rude (WY).

1. Received the Report of the Executive (EX) Committee

Director Lindley-Myers reported that the Executive (EX) Committee met Aug. 14. During this meeting, it adopted the Aug. 13 report of the joint meeting of the Executive (EX) Committee and the Internal Administration (EX1) Subcommittee.

The Committee also adopted its May 23 and March 31 minutes, which included the following action: 1) approved Commissioner White to serve on the International Association of Insurance Supervisors (IAIS) Executive Committee; and 2) approved the 2027 national meeting locations: Spring National Meeting, Kansas City, MO; Summer National Meeting, New York, NY; and Fall National Meeting, Nashville, TN.

The Committee adopted the reports of its task forces: 1) the Climate and Resiliency (EX) Task Force; 2) the Government Relations (EX) Leadership Council; 3) the Long-Term Care Insurance (EX) Task Force; and 4) the Special (EX) Committee on Race and Insurance.

The Committee received a status report on the *State Connected* strategic plan.

The Committee received a status report on model law development efforts for amendments to: 1) the *Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act* (#171); 2) the *Property and Casualty Insurance Guaranty Association Model Act* (#540); 3) the *Mortgage Guaranty Insurance Model Act* (#630); 4) the *Nonadmitted Insurance Model Act* (#870); 5) the *Unfair Trade Practices Act* (#880); and 5) the new *Insurance Consumer Privacy Protection Model Law* (#674).

The Committee heard reports from the National Insurance Producer Registry (NIPR) and the Interstate Insurance Product Regulation Commission (Compact).

2. Adopted by Consent the Committee, Subcommittee, and Task Force Minutes of the Spring National Meeting

Commissioner Godfreed made a motion, seconded by Commissioner Mais, to adopt by consent the committee, subcommittee, and task force minutes of the Spring National Meeting. The motion passed unanimously.

3. Received the Report of the Life Insurance and Annuities (A) Committee

Commissioner Lawrence reported that the Life Insurance and Annuities (A) Committee met Aug. 15. During this meeting, the Committee adopted its July 19 minutes, which included the following action: 1) adopted its Spring National Meeting minutes; 2) adopted 2024 *Valuation Manual* amendments; and 3) adopted revised Life Actuarial (A) Task Force charges.

The Committee adopted the report of the Life Actuarial (A) Task Force.

The Committee also: 1) heard a presentation from Noble Consulting Services Inc. on risks facing the life and annuity industry; 2) heard a presentation from the United States Automobile Association (USAA) on the unique life insurance needs of the military; and 3) heard an update on the Life Workstream of the Special (EX) Committee on Race and Insurance.

4. Adopted the Amendments to the 2024 *Valuation Manual*

Commissioner Lawrence reported that the *Valuation Manual* includes 12 amendments adopted by the Life Insurance and Annuities (A) Committee during its July 19 meeting.

The majority of the amendments add additional reporting disclosures, clarify requirements, or correct typos in the *Valuation Manual*. However, some of the amendments were substantive, including: 1) reducing the reporting lag for the VM-51, Experience Reporting Formats Table of Contents, mortality experience data collection to allow for more timely creation of mortality tables; 2) allowing alternative hedge treatment for variable annuities with index credit hedging programs; and 3) reducing the governance requirements for variable annuity products not subject to complex modeling.

Commissioner Lawrence made a motion, seconded by Commissioner Donelon, to adopt the amendments to the 2024 *Valuation Manual* (Attachment One).

The motion was adopted by 50 jurisdictions, representing 89.48% of the applicable premiums written.

Director Lindley-Myers confirmed that the vote satisfied the requirements to amend the *Valuation Manual*. The motion passed.

5. Received the Report of the Health Insurance and Managed Care (B) Committee

Director Fox reported that the Health Insurance and Managed Care (B) Committee met Aug. 14. During this meeting, the Committee adopted its June 29 and Spring National Meeting minutes.

During its June 29 meeting, the Committee took the following action: 1) heard presentations on Maryland, Michigan, and Nebraska state appeal programs; and 2) received an update on the Consumer Information (B) Subgroup’s work to educate consumers on their claim appeal rights.

The Committee adopted its subgroup, working group, and task force reports and their interim meeting minutes.

The Committee heard an update on the work of the Improper Marketing of Health Insurance (D) Working Group to amend the *Unfair Trade Practices Act* (#880) to address regulatory and enforcement issues with health insurance lead generators.

The Committee received an update on the Consumer Information (B) Working Group’s work to educate consumers on their claim appeal rights.

The Committee also heard from panelists Anna Schwamlein Howard (American Cancer Society Cancer Action Network—ACS CAN), Carl Schmid (HIV+Hepatitis Policy Institute), and Amy Killelea (Killelea Consulting) on preventive services from a consumer-focused perspective.

The Committee heard a status update on the Medicaid redetermination process following the end of the COVID-19 public health emergency (PHE). The update included key findings from the first batch of Medicaid redeterminations data reported by the federal Centers for Medicare & Medicaid Services (CMS) in accordance with the federal Consolidated Appropriations Act, 2023.

The Committee received an update on the work of the Special (EX) Committee on Race and Insurance Health Workstream. The Workstream is continuing its meetings on health equity issues. It recently had a meeting focused on lowering barriers to preventive care, particularly with respect to chronic disease.

The Workstream has planned upcoming meetings on the evolution of federal Affordable Care Act (ACA) Section 1332 waivers and state reinsurance programs, as well as reducing disparities in mental health services.

The Workstream is also piloting a new collaboration space on the NAIC Connect platform to allow Workstream members and other NAIC members to discuss issues related to health equity and other topics.

6. Received the Report of the Property and Casualty Insurance (C) Committee

Director Deiter reported that the Property and Casualty Insurance (C) Committee met Aug. 15. During this meeting, the Committee adopted its Spring National Meeting minutes.

The Committee adopted the reports of its task forces and working groups: 1) the Casualty Actuarial and Statistical (C) Task Force; 2) the Surplus Lines (C) Task Force; 3) the Title Insurance (C) Task Force; 4) the Workers’ Compensation (C) Task Force; 5) the Cannabis Insurance (C) Working Group; 6) the Catastrophe Insurance (C) Working Group; 7) the Terrorism Insurance Implementation (C) Working Group; and 8) the Transparency and Readability of Consumer Information (C) Working Group.

The Committee adopted a white paper entitled *Regulatory Guide: Understanding the Market for Cannabis Insurance: 2023 Update*, which is an update to a 2019 white paper concerning regulatory issues related to insuring cannabis.

The Committee heard a presentation from the Consumer Federation of America (CFA) on telematics and the need for regulatory guidance regarding transparency, actuarial support for variables, limits on data collection and use, privacy standards, and testing for bias.

The Committee also heard a presentation from a consumer representative on the issue of underinsured homeowners and a recommendation that insurers provide one quote for premiums using an algorithm's estimated reconstruction costs and another quote reflecting the reconstruction cost corrected for the error rate.

The Committee discussed public school insurance, including high losses and rising rates. The Committee will discuss the issue in more detail during a future meeting.

Finally, the Committee reported that in order to meet its charge to assist state insurance regulators in better assessing their markets by developing property market data intelligence, it plans to issue a data call to collect granular data from insurers that will allow state insurance regulators to study coverage issues.

7. Adopted Revisions to the *Nonadmitted Insurance Model Act (#870)*

Director Deiter reported that the Surplus Lines (C) Task Force was charged with amending and modernizing the *Nonadmitted Insurance Model Act (#870)* to conform to the federal Nonadmitted and Reinsurance Reform Act of 2010, which is part of the federal Dodd-Frank Wall Street Reform Act of 2010 (Dodd-Frank Act).

Some of the more significant amendments deal with the integration of the "home state" method of tax allocation and the new "Domestic Surplus Lines Insurer" status. The revisions to Model #870 provide the necessary alignment with federal legislation.

The Surplus Lines (C) Task Force adopted its revisions to Model #870 on March 21. The Property and Casualty (C) Committee adopted the amendments on March 24.

Director Deiter made a motion, seconded by Commissioner Donelon, to adopt the revisions to Model #870 (Attachment Two). The motion passed. New York abstained.

8. Adopted the *Regulatory Guide: Understanding the Market for Cannabis Insurance: 2023 Update*

Director Deiter reported that the Cannabis Insurance (C) Working Group published a white paper, *Regulatory Guide: Understanding the Market for Cannabis Insurance*, in 2019. At that time, the cannabis industry was in its infancy, and there were many insurance gaps for cannabis-related businesses.

Since 2019, the cannabis industry has become more sophisticated. It has also continued to expand rapidly, driving new product development, infrastructure changes, and the need for businesses to provide ancillary services. The state of cannabis regulation, particularly at the state and local levels, has evolved significantly since the white paper was adopted. For these reasons, the white paper needed to be updated.

The Working Group was officially tasked with providing an updated white paper in 2022. Since then, it has explored emerging issues, primarily in the commercial cannabis space, through presentations, panel discussions, and hearings held during open meetings.

The Working Group designated a drafting group to develop the white paper after it reviewed and approved an outline in an open meeting. The drafting group held bi-weekly drafting sessions until completion.

The white paper avoids advocacy-oriented discussion and focuses on issues affecting the affordability and availability of insurance for cannabis-related risks in states that have legalized its use. The white paper finds that although capacity has improved since the first white paper's publishing, most of the commercial insurance for cannabis-related businesses is still found in the nonadmitted market. This affects smaller industry players most as the nonadmitted market does not offer the "off-the-shelf" insurance solutions typically available in the admitted market.

The Working Group adopted the *Regulatory Guide: Understanding the Market for Cannabis Insurance: 2023 Update* during an open meeting July 18. The adoption followed an extensive public comment period.

Director Deiter made a motion, seconded by Commissioner Conway, to adopt the *Regulatory Guide: Understanding the Market for Cannabis Insurance: 2023 Update* (Attachment Three). The motion passed. Idaho, Indiana, Louisiana, Nebraska, and New York abstained.

9. Received the Report of the Market Regulation and Consumer Affairs (D) Committee

Commissioner Pike reported that the Market Regulation and Consumer Affairs (D) Committee met Aug. 15. During this meeting, the Committee adopted its July 27 minutes, which included the following action: 1) adopted a new Pet Insurance Market Conduct Annual Statement (MCAS) data call and definitions; 2) adopted a new charge for the Producer Licensing (D) Task Force to review and amend, as needed, the *Public Adjuster Licensing Model Act* (#228) to enhance consumer protections in the property and casualty (P/C) claims process; and 3) adopted the "Continuing Education Recommended Guidelines for Instructor Approval."

The Committee adopted revisions to the collaboration actions chapter of the *Market Regulation Handbook*. The focus of these revisions is to provide greater transparency to states about the Multistate Settlement Agreement process.

The Committee adopted revisions to the Voluntary Market Regulation Certification Program. The revisions are a result of a pilot program involving 18 states.

The mission of the Voluntary Market Regulation Certification Program is to establish and maintain minimum standards that promote sound practices relating to market conduct examination, market analysis, and related continuum activity functions performed for insurance consumer protection.

Commissioner Pike also reported that the Improper Marketing of Health Insurance (D) Working Group adopted revisions to the *Unfair Trade Practices Model Act* (#880) on Aug. 14. The goal of the revisions is to expand Model #880 to provide greater authority for state insurance departments to regulate lead generators. The Antifraud (D) Task Force and Committee will consider the adoption of Model #880 prior to the Fall National Meeting.

The Committee adopted the reports of its task forces and working groups: 1) the Antifraud (D) Task Force; 2) the Market Information Systems (D) Task Force; 3) the Producer Licensing (D) Task Force; 4) the Advisory Organization (D) Working Group; 5) the Market Analysis Procedures (D) Working Group; 6) the Market Conduct Annual Statement Blanks (D) Working Group; 7) the Market Conduct Examination Guidelines (D) Working Group; 8) the Market Regulation Certification (D) Working Group; and 9) the Speed to Market (D) Working Group.

The Committee heard an update on international issues from NAIC international policy support staff. The presentation covered the activities of the IAIS' Market Conduct Working Group, which included a paper on the use of conduct indicators in insurance supervision and a diversity, equity, and inclusion (DE&I) project.

The Committee heard a presentation from Missouri on the use of data visualization for market analysis, which included information on data needs, how to pick the right visualization, best practices for data visualization, and specific examples of market analysis.

10. Received the Report of the Financial Condition (E) Committee

Superintendent Dwyer reported that the Financial Condition (E) Committee met Aug. 15. During this meeting, the Committee adopted its July 19 and Spring National Meeting minutes. During its July 19 meeting, the Committee took the following action: 1) adopted life risk-based capital (RBC) proposal 2023-09-IRE (Residuals Factor) and proposal 2023-10-IRE (Residual Sensitivity Test Factor for Residuals); 2) adopted amendments to the *Mortgage Guaranty Insurance Model Act* (#630); 3) adopted a new group, the Generator of Economic Scenarios (E/A) Subgroup of the Life Risk-Based Capital (E) Working Group, with the following charges: a) monitor the economic scenario governance to ensure the framework is being appropriately followed by all relevant stakeholders involved in scenario delivery; b) review material economic scenario generator updates, either driven by periodic model maintenance or changes to the economic environment and provide recommendations; c) regularly review key economic conditions and metrics to evaluate the need for off-cycle or significant economic scenario generator updates and maintain a public timeline for economic scenario generator updates; d) support the implementation of an economic scenario generator for use in statutory reserve and capital calculations; and e) develop and maintain acceptance criteria that reflect history as well as more extreme scenarios.

The Committee also: 1) adopted the Macroprudential Reinsurance Worksheet; and 2) adopted *Interpretation (INT) 23-01: Net Negative (Disallowed) Interest Maintenance Reserve (IMR)*.

The Committee adopted the reports of its task forces and working groups: 1) the Accounting Practices and Procedures (E) Task Force; 2) the Capital Adequacy (E) Task Force; 3) the Examination Oversight (E) Task Force; 4) the Financial Stability (E) Task Force; 5) the Receivership and Insolvency (E) Task Force; 6) the Reinsurance (E) Task Force; 7) the Valuation of Securities (E) Task Force; 8) the Group Capital Calculation (E) Working Group; 9) the Mortgage Guaranty Insurance (E) Working Group; 10) the Restructuring Mechanisms (E) Working Group; and 11) the Risk-Focused Surveillance (E) Working Group.

The Committee also: 1) received a presentation regarding the use of artificial intelligence (AI) by Canadian insurance regulators; and 2) discussed a framework for insurer investment regulation.

Note: Items adopted within the Financial Condition (E) Committee's task force and working group reports that are considered technical, noncontroversial, and not significant by NAIC standards—i.e., they do not include model laws, model regulations, model guidelines, or items considered to be controversial—will be considered for adoption by the Executive (EX) Committee and Plenary through the Financial Condition (E) Committee's technical changes report process. Pursuant to this process, which was adopted by the NAIC in 2009, a listing of the various technical changes will be sent to NAIC Members shortly after completion of the national meeting, and the Members will have 10 days to comment with respect to those items. If no objections are received with respect to a particular item, the technical changes will be considered adopted by the NAIC membership and effective immediately.

11. Adopted Life RBC Proposals 2023-09-IRE (Residuals Factor) and 2023-10-IRE (Residual Sensitivity Test Factor for Residuals)

Superintendent Dwyer reported that the core of the life RBC proposals 2023-09-IRE and 2023-10-IRE is the RBC treatment of residual investments in a structured security, which means these are the last tranche of many others in a structured security.

Generally, when assets of a pool of such securities do not perform, the residual security holder absorbs these losses first. Thus, there is the potential need for more capital to be held.

With that as a backdrop, the 2023 factor for these securities will be 30%, with a factor of 45% for 2024 unless data can be presented to show that a different factor (either higher or lower) is more appropriate.

Additionally, this adds a sensitivity test set at 15% for year-end 2023 that allows the regulator to see the RBC impact as if a full 45% had been used instead. Consequently, there is a sensitivity test of 0% for 2024.

Both proposals were unanimously adopted by the Working Group, the Task Force, and the Committee.

Superintendent Dwyer made a motion, seconded by Commissioner Ommen, to adopt life RBC Proposals 2023-09-IRE (Residuals Factor) and 2023-10-IRE (Residual Sensitivity Test Factor for Residuals) (Attachment Four). The motion passed. New York abstained.

12. Adopted Revisions to the *Mortgage Guaranty Insurance Model Act* (#630)

Superintendent Dwyer reported that amendments to the *Mortgage Guaranty Insurance Model Act* (#630) were initiated in 2013 to address some of the concerns that arose during the great financial crisis in mortgage insurance in 2008.

Early on, the development of a capital model to accompany Model #630 was the focus of the Financial Condition (E) Committee. At that time, the Mortgage Guaranty Insurance (E) Working Group used two different consulting firms over several years to attempt to build a capital model. However, this approach was met with several challenges.

As a result, the capital work was paused in 2022, and the focus shifted to improving financial reporting in the annual statement (which is now effective) and finalizing the amendments to Model #630, including revisions to the reserve requirements and contingency reserves, as well as waivers with respect to in-force insurance.

During the past year and a half, the drafting group met 12 times, and Model #630 was exposed for public comment Oct. 7, 2022; Feb. 27, 2023; and May 11, 2023. Comments from both industry and consumers were considered.

Superintendent Dwyer made a motion, seconded by Commissioner Ommen, to adopt the revisions to Model #630 (Attachment Five). The motion passed. New York abstained.

13. Received the Report of the Financial Regulation Standards and Accreditation (F) Committee

Director Wing-Heier reported that the Financial Regulation Standards and Accreditation (F) Committee met Aug. 12 in regulator-to-regulator session, pursuant to paragraph 7 (consideration of individual state insurance department's compliance with NAIC financial regulation standards) of the NAIC Policy Statement on Open

Meetings, and: 1) discussed state-specific accreditation issues; and 2) voted to award continued accreditation to the insurance departments of Missouri, New Hampshire, South Dakota, and Texas.

The Committee met Aug. 13. During this meeting, the Committee adopted its Spring National Meeting minutes.

The Committee adopted the 2020 revisions to the *Insurance Holding Company System Regulatory Act* (#440) and the *Insurance Holding Company System Model Regulation with Reporting Forms and Instructions* (#450) as significant elements of Part A accreditation standards. The revisions implement a group capital calculation (GCC) for the purpose of group solvency supervision and a liquidity stress test (LST) for macroprudential surveillance.

The amendments also include provisions allowing the commissioner to grant exemptions to GCC for groups meeting standards set forth in Sections 21A and 21B of Model #450 without the requirement to file at least once. This exemption applies primarily to risk retention groups (RRGs). States should adopt the amendments by the effective date, Jan. 1, 2026, in order to comply with the accreditation standard.

The Committee adopted its 2024 proposed charges, which remain unchanged from its 2023 charges.

14. Received the Report of the International Insurance Relations (G) Committee

Commissioner Anderson reported that the International Insurance Relations (G) Committee met Aug. 13. During this meeting, the Committee adopted its April 13 and Spring National Meeting minutes, which included a discussion on NAIC comments on the IAIS public consultation on the *Issues Paper on the Roles and Functioning of Policyholder Protection Schemes* (PPSs).

The Committee heard an update on international insurance developments and activities in Canada from Jacqueline Friedland (Government of Canada's Office of the Superintendent of Financial Institutions—OSFI).

The Committee also heard an update on recent activities and priorities of the IAIS, including: 1) review of the June 2023 Global Seminar and recent committee meetings; 2) the upcoming comparability assessment process for the aggregation method (AM) and the release for feedback of a U.S.-produced document describing the Provisional AM for use in the comparability assessment; and 3) continuing work at various IAIS forums and steering groups.

The Committee heard an update on international activities, including: 1) workstreams of the European Union (EU)-U.S. Insurance Dialogue Project and its recent public stakeholder session in June 2023; 2) recent meetings, events, and speaking engagements with international insurance regulators; 3) recent meetings of the Organisation for Economic Co-operation and Development (OECD) Insurance and Private Pensions Committee; and 4) recent bilateral meetings.

15. Received the Report of the Innovation, Cybersecurity, and Technology (H) Committee

Commissioner Birrane reported that the Innovation, Cybersecurity, and Technology (H) Committee met Aug. 13. During this meeting, the Committee adopted its Spring National Meeting minutes.

The Committee adopted the reports of its working groups. The report from the Privacy Protections (H) Working Group included a status report on the continued work on the NAIC's *Insurance Consumer Privacy Protections Model Law* (#674). The Working Group is in the process of drafting the next version of Model #674. Once the draft is complete and released for exposure, the Working Group will request an extension to continue its work on Model #674.

The Committee received initial public comments on the NAIC's *Model Bulletin: Use of Algorithms, Predictive Models, and Artificial Intelligence Systems by Insurers*. Comments were provided by 10 speakers, which included trade groups and consumer representatives. Initial observations were offered on the model bulletin's language on third-party oversight, definitions, and principles-based approach to setting governance expectations.

16. Received a Report on the States' Implementation of NAIC-Adopted Model Laws and Regulations

Director Lindley-Myers referred attendees to the written report for updates on the states' implementation of NAIC-adopted model laws and regulations (Attachment Six).

17. Discussed Other Matters

Commissioner Downing made a motion, seconded by Commissioner Fowler, to distribute the environmental, social, and governance (ESG) for the insurance industry statement to the Membership. The motion passed. Connecticut opposed, and New York abstained.

Having no further business, the Executive (EX) Committee and Plenary adjourned.

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Adopted by the Life Insurance and Annuities (A) Committee July 19, 2023

Adopted by the Executive (EX) Committee and Plenary, Aug. 16, 2023

Amendments for the 2024 Valuation Manual

LATF VM Amendment	Valuation Manual Reference	Valuation Manual Amendment Proposal Descriptions	LATF Adoption Date	Page Number
2022-06	VM-31 Section 3.D.5	This amendment adds in a VM-31 requirement to disclose the inflation assumption for Life PBR.	10/6/22	3
2022-07	VM-20 Section 3.C.1.g, VM-20 Section 6.B.5.d.	This amendment clarifies the intent and calculation of the mortality adjustments to the CSO table when anticipated mortality exceeds the prescribed CSO table. The current wording of Section 3.C.1.g has led to confusion by many and a lack of consistent interpretations.	1/26/23	6
2022-08	VM-21 Section 3.E, VM-31 Section 2.A, VM-G Section 1 and Section 4.A.3.	Clarify requirements on groups of contracts that use the Alternative Method/AG33 in VM-21 and are not subject to a principles-based valuation. Such contracts should not be subject to VM-G but still require a sub-report under VM-31.	1/26/23	12
2022-09	VM-21 and VM-31	This amendment includes a series of reporting requirement enhancements related to VM-21 and fixes some errors in the VM language.	3/2/23	16
2022-10	VM-20 Section 2.A.2, Section 3.B.5, and Section 3.B.6	The purpose of this amendment is to add language to address the possibility of policies in the ULSG Reserving Category having a non-material secondary guarantee, and thus becoming excluded from both DR and SR calculations if they pass both the DET and the SET.	2/23/23	22
2023-02	VM-21 4.D.1.a	This amendment adds disclosure requirements in VM-31 and clarifies language in the Annual Statement Instructions related to reporting in the VM-20 Reserves Supplement.	2/23/23	25
2023-03	VM-20 Section 7.E.2 and Guidance Note below, VM-21 Section 4.D.4.c, VM-20 Section 7.K.3, VM-31 Section 3.D.6.f, VM-20 Section 9.A.4	This amendment would do the following: <ul style="list-style-type: none"> • Add a consideration on the assumed cost of borrowing in VM-20 and VM-21, • Clarification of VM-20 hedge modeling, and • Add additional considerations for risk factors other than interest and equities that are stochastically modeled. 	3/21/23	29
2023-01	VM-21 4.D.1.a	The purpose of this amendment is to make the explanation of the starting asset amount consistent in VM-21 section 4.D.1.a.	3/21/23	34
2023-04	VM-31 Section 3.D.3.1.iv	Clarifies requirements where regulators were seeing an issue with PBR Actuarial Reports and inadequate support showing compliance with the requirement that “the company experience mortality rates shall not be lower than the mortality rates the company expects to emerge”.	4/20/23	36
2021-08	VM-51 Section 2.D.	Revisions to VM-51 to allow for the data experience reporting observation calendar year to be one year prior to the reporting calendar year.	5/11/23	39
2023-05	VM-01, VM-21 Section 4.A.4, VM-21 Section 9, VM-21 Section 9.C.2, VM-31 Section 3.F.8.d	Since the reforms of VM-21 and C3P2, ILVA products have experienced major market growth. Several carriers, with the agreement of regulators and auditors, have interpreted the current VM-21 guidance as permitting the effects of index credit hedging to be reflected in product cash flows instead of within the “best efforts” and “adjusted” scenarios. This amendment clarifies those requirements.	6/1/23	42
2023-07	VM-21 Section 6.A.1	The standard projection amount drafting group found that there is very little use of the Company-Specific Market Path (CSMP) method for the VM-21 standard projection amount. Therefore, we recommend removing this method from VM-21 starting in 2025, which gives time to transition for the few companies that currently employ the CSMP method.	6/1/23	49

REQUEST FOR NAIC MODEL LAW DEVELOPMENT

This form is intended to gather information to support the development of a new model law or amendment to an existing model law. Prior to development of a new or amended model law, approval of the respective Parent Committee and the NAIC's Executive Committee is required. The NAIC's Executive Committee will consider whether the request fits the criteria for model law development. Please complete all questions and provide as much detail as necessary to help in this determination.

Please check whether this is: New Model Law or Amendment to Existing Model

1. Name of group to be responsible for drafting the model:

Surplus Lines (C) Task Force

2. NAIC staff support contact information:

Andy Daleo, Senior Financial Analysis Manager (adaleo@naic.org)

Dan Schelp, Chief Counsel, Regulatory Affairs (dschelp@naic.org)

3. Please provide a brief description of the proposed new model or the amendment(s) to the existing model. If you are proposing a new model, please also provide a proposed title. If an existing model law, please provide the title, attach a current version to this form and reference the section(s) proposed to be amended.

Nonadmitted Insurance Model Act (#870) – See Attached

On August 5, 2020, the Surplus Lines (C) Task Force discussed revisions to Model #870, and directed NAIC staff to form an informal Drafting Group composed of regulators from Louisiana, Oklahoma and Washington to produce a summary document that outlines the significant updates to modernize Model #870 and present a recommendation to the Task Force at a future national meeting. The attached Model #870 contains the Drafting Group's recommendations with respect to modification of Model #870 to both bring it into compliance with the *Nonadmitted and Reinsurance Reform Act (NRRA)* as well as other amendments to modernize the model.

4. Does the model law meet the Model Law Criteria? Yes or No (Check one)

(If answering no to any of these questions, please reevaluate charge and proceed accordingly to address issues).

a. Does the subject of the model law necessitate a national standard and require uniformity amongst all states? Yes or No (Check one)

If yes, please explain why

The *Nonadmitted Insurance Model Act (#870)* has been adopted in 31 states, with other states adopting older versions of the NAIC model, statutes or regulations addressing the same subject matter, or other administrative guidance such as bulletins and notices. Every state, the District of Columbia, Puerto Rico, and the U.S. Virgin Islands have surplus lines guidance in place.

The NRRA was adopted July 21, 2011, and is contained within the *Dodd-Frank Wall Street Reform and Consumer Protection Act (Act)*. The NRRA requirements and the mandate of the federal Act create uniformity for the collection of surplus lines tax payments through the implementation of the "Home State" requirement. All states comply with the NRRA's home state tax approach.

Model 870 was not modified because of the implementation of the NRRRA. However, on October 11, 2011, a *Nonadmitted Insurance Reform Sample Bulletin* (copy attached) was adopted by Executive/Plenary and subsequently distributed to the state insurance departments. It is important to provide guidance for uniformity among the states in order to ensure compliance with the NRRRA.

- b. Does Committee believe NAIC members should devote significant regulator and Association resources to educate, communicate and support this model law?

Yes or No (Check one)

5. What is the likelihood that your Committee will be able to draft and adopt the model law within one year from the date of Executive Committee approval?

1 2 3 4 5 (Check one)

High Likelihood

Low Likelihood

Explanation, if necessary: Due to the previous adoption of the *Nonadmitted Insurance Reform Sample Bulletin* by the NAIC, there is already uniformity of intent with respect to key areas addressed by the NRRRA. The Surplus Lines (C) Task Force should be able to leverage that agreement to quickly and efficiently finish revisions to Model #870.

6. What is the likelihood that a minimum two-thirds majority of NAIC members would ultimately vote to adopt the proposed model law?

1 2 3 4 5 (Check one)

High Likelihood

Low Likelihood

Explanation, if necessary: Surplus Lines is an important industry in every state and U.S. Territory, and it is important to provide uniform guidance to the NAIC members to ensure compliance with the federal NRRRA.

7. What is the likelihood that state legislatures will adopt the model law in a uniform manner within three years of adoption by the NAIC?

1 2 3 4 5 (Check one)

High Likelihood

Low Likelihood

Explanation, if necessary: Model #870 is not an accreditation requirement, but as previously stated it is important to provide uniform guidance to the states to ensure compliance with the NRRRA.

8. Is this model law referenced in the NAIC Accreditation Standards? If so, does the standard require the model law to be adopted in a substantially similar manner?

No

9. Is this model law in response to or impacted by federal laws or regulations? If yes, please explain.

Yes, the proposed revisions to Model #870 are in direct response to the federal NRRRA, which would preempt inconsistent state law.

Draft 3/1/23

Adopted by the Property and Casualty Insurance (C) Committee—3/24/23

NONADMITTED INSURANCE MODEL ACT

Table of Contents

Section 1.	Short Title
Section 2.	Purpose—Necessity for Regulation
Section 3.	Definitions
Section 4.	Placement of Insurance Business
Section 5.	Surplus Lines Insurance
Section 6.	Insurance Independently Procured—Duty to Report and Pay Tax
Section 7.	Penalties
Section 8.	Violations
Section 9.	Service of Process
Section 10.	Legal or Administrative Procedures
Section 11.	Enforcement
Section 12.	Suits by Nonadmitted Insurers
Section 13.	Severability/Parity of Provisions
Section 14.	Effective Date

Section 1. Short Title

This Act shall be known and may be cited as “The Nonadmitted Insurance Act.”

Section 2. Purpose—Necessity for Regulation

This Act shall be liberally construed and applied to promote its underlying purposes which include:

- A. Protecting persons seeking insurance in this state;
- B. Permitting surplus lines insurance to be placed with reputable and financially sound nonadmitted insurers and exported from this state pursuant to this Act;
- C. Establishing a system of regulation which will permit orderly access to surplus lines insurance in this state and encourage admitted insurers to provide new and innovative types of insurance available to consumers in this state;
- D. Providing a system through which persons may purchase insurance other than surplus lines insurance, from nonadmitted insurers pursuant to this Act;
- E. Protecting revenues of this state; and
- F. Providing a system pursuant to this Act which subjects nonadmitted insurance activities in this state to the jurisdiction of the insurance commissioner and state and federal courts in suits by or on behalf of the state.

Section 3. Definitions

As used in this Act:

- A. “Admitted insurer” means an insurer licensed to ~~do engage in an~~ [the business of insurance-business](#) in this state.
- B. [“Affiliate” means, with respect to an insured, any entity that controls, is controlled by, or is under common control with the insured.](#)

C. ~~“Affiliated group” means any group of entities that are all affiliated. “Capital,” as used in the financial requirements of Section 5, means funds paid in for stock or other evidence of ownership.~~

~~DC.~~ “Commissioner” means the insurance commissioner of [insert name of state], or the commissioner’s deputies or staff, or the ~~c~~Commissioner, ~~d~~Director or ~~s~~Superintendent of insurance in any other state.

Drafting Note: Insert the title of the chief insurance regulatory official wherever the term “commissioner” appears.

E. ~~“Control” means with respect to an insured:~~

~~(1) A person, either directly or indirectly, or acting through one or more other persons, owns, controls, or has the power to vote 25 percent or more of any class of voting securities of the other entity; or~~

~~(2) The entity controls in any manner the election of a majority of the directors or trustees of the other entity.~~

F. ~~[OPTIONAL: “Domestic surplus lines insurer” means a surplus lines insurer domiciled in this state, that which may write insurance in this state on as if it were a surplus lines insurer basis domiciled in another state.]~~

G. “Eligible surplus lines insurer” means a nonadmitted insurer with which a surplus lines licensee may place surplus lines insurance pursuant to Section 5 of this Act.

H. ~~“Exempt commercial purchaser” means any person purchasing commercial insurance that, at the time of placement, meets the following requirements:~~

~~(1) ~~n~~Has paid aggregate nationwide commercial property and casualty insurance premiums in excess of \$100,000 in the immediately preceding 12 months; and-~~

~~(2) (a) The person ~~m~~Meets at least one~~l~~ of the following criteria:~~

~~(i) The person ~~P~~possesses a net worth in excess of \$20,000,000;:-~~

~~(ii) The person ~~G~~generates annual revenues in excess of \$50,000,000;:-~~

~~(iii) The person ~~E~~employs more than 500 full-time or full-time equivalent employees per individual insured or is a member of an affiliated group employing more than 1,000 employees in the aggregate;:-~~

~~(iv) The person ~~I~~is a not-for-profit organization or public entity generating annual budgeted expenditures of at least \$30,000,000; or-~~

~~(v) The person ~~i~~is a municipality with a population in excess of 50,000 persons.~~

~~(b) Effective on July 21, 2010, every five years and each fifth January 1 occurring thereafter on January 1, the amounts in Subsections Items (i), (ii), and (iv) of Subparagraph Section 3H(32)(a) of this Paragraph shall be adjusted to reflect the percentage change for such five- year period in the Consumer Price Index for All Urban Consumers published by the Bureau of Labor Statistics of the Department of Labor.~~

Drafting Note: ~~This~~ definition of “Exempt commercial purchaser” follows the language of the federal Nonadmitted and Reinsurance Reform Act (NRRA). ~~Some states have chosen not to adopt the inflation adjustment. The NRRA uses the term “municipality,” which some states may find limiting. States may choose to use terminology consistent with state law to expand this provision to include counties and other public entities.~~

~~EI.~~ “Export” means to place surplus lines insurance with a nonadmitted insurer.

~~F. “Foreign decree” means any decree or order in equity of a court located in any United States jurisdiction, including a federal court of the United States, against any person engaging in the transaction of insurance in this state.~~

J. ~~“Home state,” means with respect to an insured, means:~~

~~(1) The state in which an insured maintains its principal place of business or, in the case of a natural person, the person’s principal place of residence;~~

~~(2) If 100 percent of the insured risk is located out of the state referred to in ~~subParagraph (1)~~Section 3J(1), the state to which the greatest percentage of the insured’s taxable premium for that insurance contract is allocated; ~~or~~~~

~~(3) If the insured is an affiliated group with more than one member listed as a named insured on a single nonadmitted insurance contract, the home state is the home state of the member of the affiliated group that has the largest percentage of premium attributed to it under the insurance contract; ~~or~~~~

~~(4) [Option 1] In the case of an unaffiliated group policy:~~

~~(a) If a group policyholder pays 100% of the premium from its own funds, then the home state is determined according to paragraphs (1) and (2).~~

~~(b) If a group policyholder does not pay 100% of the premium from its own funds, then the home state is determined according to paragraphs (1) and (2) for each member of the group.~~

~~[Option 2] In the case of an unaffiliated group policy, the home state shall be the home state of the group policyholder as determined by the application of paragraphs (1) and (2).~~

Drafting Note:

Comment: The NRRRA definition of “home state” includes ~~Subsections Paragraphs (1), (2), and (3) of Section 3J.~~ The NRRRA definition does not expressly cover unaffiliated groups. States have taken different approaches to the taxation of unaffiliated group policies. Some states tax based on the “home state” of the group policyholder. Other states tax based on the “home state” of the group member or certificate holder under the unaffiliated group policy. Some states assess tax on the “home state” of the person that pays the premium. Not all states have an express provision to address unaffiliated group policies. ~~The Drafting Group could not arrive at language to address each possibility and opted to omit it from the Model. such as risk purchasing groups model language contains two options for addition of that are expressly covering unaffiliated group treating the members of such a group as individual insureds for purposes of placement and taxation.~~

~~K. “Insurer” means any person, corporation, association, partnership, reciprocal exchange, interinsurer, Lloyds insurer, insurance exchange syndicate, fraternal benefit society, and any other legal entity engaged in the business of insurance.~~

~~H. “Kind of insurance” means one of the types of insurance required to be reported in the annual statement which must be filed with the commissioner by admitted insurers.~~

~~K. “Nonadmitted insurance” means any insurance written on properties, risks or exposures, located or to be performed in this state, by an insurer not licensed to engage in the ~~transaction~~ business of insurance in this state [or a domestic surplus lines insurer].~~

~~LI. “Nonadmitted insurer” means an insurer not licensed to ~~do an~~engage in the ~~transaction~~ business of insurance ~~business~~ in this state but does not include a risk retention group pursuant to the federal Liability Risk Retention Act of 1986.~~

~~MI. “Person” means any natural person or ~~other-business~~ entity, including, but not limited to, individuals, partnerships, associations, trusts or corporations.”~~

~~N. “Premium” means any payment made as consideration for an insurance contract.~~

~~N.O.~~ “Principal place of business” means:

- (1) The state where a person maintains its headquarters and where the person’s high-level officers direct, control, and coordinate ~~the~~ business activities; or
- (2) If the person’s high-level officers direct, control, and coordinate the business activities in more than one state, or if the person’s principal place of business is located outside any state, then it is the state to which the greatest percentage of the person’s taxable premium for that insurance contract is allocated.

~~P.O.~~ “Principal residence” means:

- (1) The state where the person resides for the greatest number of days during a calendar year; or
- (2) If the person’s principal residence is located outside any state, the state to which the greatest percentage of the person’s taxable premium for that insurance contract is allocated.

~~“State” includes any state of the United States, the District of Columbia, the Commonwealth of Puerto Rico, Guam, the Northern Mariana Islands, the Virgin Islands, and American Samoa.~~ K. “Policy” or “contract” means any contract of insurance, including but not limited to annuities, indemnity, medical or hospital service, workers’ compensation, fidelity or suretyship.

~~L. “Reciprocal state” means a state that has enacted provisions substantially similar to:~~

- (1) ~~Sections 5F, 5I(5), 5Q(10), 5R(4) and Section 6; and~~
- (2) ~~The allocation schedule and reporting form contained in [cite the regulation on surplus lines taxation].~~

~~M. “Surplus,” as used in the financial requirements of Section 5, means funds over and above liabilities and capital of the company for the protection of policyholders.~~

~~Q.R.N. “Surplus lines insurance” means any property and casualty insurance in this state on properties, risks or exposures, located or to be performed in this state, permitted to be placed through a surplus lines licensee with an nonadmitted insurer eligible surplus lines insurer to accept such insurance, pursuant to Section 5 of this Act.~~

~~Drafting Note: If a state chooses to adopt the alternative Section 5B, this definition of “surplus lines insurance” should be consistent with the acceptable coverage listed in Section 5B. States may choose to extend the definition of “surplus lines insurance” beyond property/casualty insurance.~~ NAIC.

~~R.S. “Surplus lines insurer” means a nonadmitted [or domestic surplus lines] insurer that is eligible to accept the placement of surplus lines insurance pursuant to Section 5 of this Act.~~

~~STO. “Surplus lines licensee” means any person individual, firm or corporation licensed under Section 5 of this Act to place surplus lines insurance on properties, risks or exposures located or to be performed in this state with an nonadmitted insurers eligible surplus lines insurer to accept such insurance.~~

~~TU. “Taxable premium” means any premium less return premium that is not otherwise exempt from tax pursuant to this Act. [OPTIONAL:] Premium on property risk or exposure that is properly allocated to federal or international waters or is under the jurisdiction of a foreign government is not taxable in this state.]~~

~~UVS. “Transaction of insurance”~~

- (+) (1) For purposes of this Act, any of the following acts in this state effected by mail or otherwise by a nonadmitted insurer or by any person acting with the actual or apparent authority of the insurer, on behalf of the insurer, is deemed to constitute the transaction of an insurance business in or from this state:

- (a) The making of or proposing to make, as an insurer, an insurance contract;
 - (b) The making of or proposing to make, as guarantor or surety, any contract of guaranty or suretyship as a vocation and not merely incidental to any other legitimate business or activity of the guarantor or surety;
 - (c) The taking or receiving of an application for insurance;
 - (d) The receiving or collection of any premium, commission, membership fees, assessments, dues or other consideration for insurance or any part thereof;
 - (e) The issuance or delivery in this state of contracts of insurance to residents of this state or to persons authorized to do business in this state;
 - (f) The solicitation, negotiation, procurement or effectuation of insurance or renewals thereof;
 - (g) The dissemination of information as to coverage or rates, or forwarding of applications, or delivery of policies or contracts, or inspection of risks, the fixing of rates or investigation or adjustment of claims or losses or the transaction of matters subsequent to effectuation of the contract and arising out of it, or any other manner of representing or assisting a person or insurer in the transaction of risks with respect to properties, risks or exposures located or to be performed in this state;
 - (h) The transaction of any kind of insurance business specifically recognized as transacting an insurance business within the meaning of the statutes relating to insurance;
 - (i) The offering of insurance or the transacting of insurance business; or
 - (j) Offering an agreement or contract which purports to alter, amend or void coverage of an insurance contract.
- (2) The provisions of this subsection shall not operate to prohibit employees, officers, directors or partners of a commercial insured from acting in the capacity of an insurance manager or buyer in placing insurance on behalf of the employer, provided that the person's compensation is not based on buying insurance.
- (3) The venue of an act committed by mail is ~~at the~~ point location where the matter transmitted by mail is delivered or issued for delivery or takes effect.

Drafting Note: States may need to alter this subsection to reflect their decision as to whether they intend to permit citizens to directly purchase coverage within the state from a nonadmitted insurer, or if self-procurement of coverage will be permitted only when it occurs outside the state. States electing to allow direct procurement will need to insert an appropriate exemption in Section 4A of this Act. Additionally, states should consider whether the preceding definition of “transaction of insurance” is consistent with other statutory definitions of this phrase in the state. Finally, states may want to consider whether group insurance purchases or the maintenance of insurance books and records in this state should fall within the scope of the definition of “transaction of insurance.”

~~Q.~~ —“Type of insurance” means coverage afforded under the particular policy that is being placed.

~~V.F.~~ “Wet marine and transportation insurance” means:

- (1) Insurance upon vessels, crafts, hulls and other interests in them or with relation to them;
- (2) Insurance of marine builder's risks, marine war risks and contracts of marine protection and indemnity insurance;

~~(1)(3)~~ Insurance of freight and disbursements pertaining to a subject of insurance within the scope of this subsection; and

~~(2)~~

(4) Insurance of personal property and interests therein, in the course of exportation from or importation into any country, or in the course of transportation coastwise or on inland waters, including transportation by land, water or air from point of origin to final destination, in connection with any and all risks or perils of navigation, transit or transportation, and while being prepared for and while awaiting shipment, and during any incidental delays, transshipment, or reshipment; provided, however, that insurance of personal property and interests therein shall not be considered wet marine and transportation insurance if the property has:

- (a) Been transported solely by land; or
- (b) Reached its final destination as specified in the bill of lading or other shipping document; or
- (c) The insured no longer has an insurable interest in the property.

Comment: The language added in 1994 to the end of the definition of “wet marine and transportation insurance” {Subparagraphs 4(a), 4(b), and 4(c)} is intended to clarify the scope of the definition, which ultimately affects the exemption of certain risks from this Act. The 1994 amendments address current regulatory concerns and concerns raised by those who drafted the 1983 amendments to the Model Surplus Lines Law. The 1983 drafters wrote: “Several [drafters] felt the term ‘storage’ should not appear in... [the wet marine definition] to ensure that warehousemen and other types of insurance covering risks of storage are not interpreted to be within the purview of this definition. The term ‘delays’ is sufficiently broad to cover temporary storage while in the course of transit.”

Drafting Note: In addition to the definitions provided in this section, individual states may wish to consider adopting definitions for “agent,” “broker” or “producer” in a manner consistent with its other laws. Additionally, states may want to cross-reference the definition of “insurance” as it appears elsewhere in the state insurance code. The definition of insurance should reach illegal unauthorized activities.

Section 4. Placement of Insurance Business

- A. An insurer shall not engage in the transaction of insurance unless authorized by a license in force pursuant to the laws of this state, or exempted by this Act or ~~otherwise exempted by~~ the insurance laws of this state.
- B. A person shall not ~~directly or indirectly~~ engage in a transaction of insurance ~~with or on behalf of or shall in this state directly or indirectly act as agent for, or otherwise represent or aid on behalf of another, a nonadmitted insurer in this state, in the solicitation, negotiation, procurement or effectuation of insurance, or renewals thereof, or forwarding of applications, or delivery of policies or contracts or inspection of risks, or fixing of rates, or investigation or adjustment of claims or losses, or collection or forwarding of premiums, or in any other manner represent or assist the insurer in the transaction of insurance.~~
- C. A person who represents or aids a nonadmitted insurer in violation of this section shall be subject to the penalties set forth in Section 7 of this Act. No insurance contract entered into in violation of this section shall preclude the insured from enforcing his rights under the contract in accordance with the terms and provisions of the contract of insurance and the laws of this state, to the same degree those rights would have been enforceable had the contract been lawfully procured.
- D. If the nonadmitted insurer fails to pay a claim or loss within the provisions of the insurance contract and the laws of this state, a person who assisted or in any manner aided directly or indirectly in the procurement of the insurance contract, shall be liable to the insured for the full amount under the provisions of the insurance contract.

- E. Section 4B or 4D shall not apply to a person in regard to an insured who independently procures insurance as provided under Section 6. This section shall not apply to a person, properly licensed as an agent or broker in this state who, for a fee and pursuant to a written agreement, is engaged solely to offer to the insured advice, counsel or opinion, or service with respect to the benefits, advantages or disadvantages promised under any proposed or in-force policy of insurance if the person does not, directly or indirectly, participate in the solicitation, negotiation or procurement of insurance on behalf of the insured.

Drafting Note: If a state collects tax on unlicensed transactions which violate this Act, it may consider imposing liability for payment of those taxes on persons who violate this Act by assisting in the procurement of nonadmitted insurance.

Drafting Note: Some states permit other licensed professionals to engage in these activities as provided in their insurance statutes or other state statutes. Those states may want to amend Section 4E to include those professionals, to the extent they act within the scope of their licenses.

- F. This section shall not apply to a person acting in material compliance with the insurance laws of this state in the placement of the types of insurance identified in Paragraphs (1), (2), (3) and (4) below:
- (1) Surplus lines insurance as provided in Section 5. For the purposes of this subsection, a licensee shall be deemed to be in material compliance with the insurance laws of this state, unless the licensee committed a violation of Section 5 that proximately caused loss to the insured;
 - (2) Transactions for which a certificate of authority to do business is not required of an insurer under the insurance laws of this state;

~~**Drafting Note:** A number of states exempt from licensing and premium taxation nonprofit educational insurers insuring only nonprofit educational institutions and their employees. Some states require certificates of authority while others require licensing, and the appropriate language should be used in Paragraph (2) above. Additionally, some states may want to consider adding language to establish an option of allowing persons to file for an exemption with the Department of Insurance.~~

- (3) Reinsurance provided that, unless the commissioner waives the requirements of this subsection:
 - (a) The assuming insurer is authorized to ~~do engage in the business of an~~ insurance or reinsurance ~~business by in~~ its domiciliary jurisdiction and is authorized to write the type of reinsurance in its domiciliary jurisdiction; and
 - (b) The assuming insurer satisfies all legal requirements for such reinsurance in the state of domicile of the ceding insurer;
- (4) The property and operation of railroads or aircraft engaged in interstate or foreign commerce, wet marine and transportation insurance;
- (5) Transactions subsequent to issuance of a policy not covering properties, risks or exposures located, or to be performed in this state at the time of issuance, and lawfully solicited, written or delivered outside this state.

Drafting Note: States may also wish to consider exempting from Section 4A of this Act self-procured insurance or industrial insurance purchased by a sophisticated buyer who does not necessarily require the same regulatory protections as an average insurance buyer. Additionally, some states allow other insurance transactions with nonadmitted insurers. Examples include certain aviation and railroad risks. Other states may want to narrow the scope of the exemptions above or reserve the right to approve exemptions on a case-by-case basis.

Section 5. Surplus Lines Insurance

- A. Surplus lines insurance may be placed by a surplus lines licensee if:

- (1) Each insurer is ~~an~~-eligible to write surplus lines insurance~~insurer~~; and
- (2) Each insurer is authorized to write the type of insurance in its domiciliary jurisdiction; and
- (3) Other than for exempt commercial purchasers, ~~t~~The full amount or type of insurance cannot be obtained from insurers who are admitted to ~~do~~engage in the business of insurance in this state. The full amount or type of insurance may be procured from eligible surplus lines insurers, provided that a diligent search is made among the insurers who are admitted to transact and are actually writing the particular type of insurance in this state if any are writing it; and
- (4) All other requirements of this Act are met.

Drafting Note: ~~States may prefer to reference “kind of insurance” rather than “type of insurance” in Section 5A(3). The term utilized should be defined within the Act.~~ The diligent search requirement of Section 5A(3) must be satisfied in accordance with the statutes and regulations of the governing state. ~~Such Diligent search~~ statutes and regulations ~~might~~ vary from state to state in terms of the number of declinations required and the person designated to conduct the search. ~~Several states permit surplus lines placement without a diligent search for or without regard to the availability of admitted coverage. States may want to consider changing diligent search requirements in light of electronic transactions.~~ Section 5A(3) does not prohibit a regulatory system in which a surplus lines licensee may place with an eligible nonadmitted insurer any coverage listed on a current “~~E~~export ~~L~~ist” maintained by the commissioner. The ~~e~~Export list would identify types of insurance for which no admitted market exists. The commissioner may waive the diligent search requirement for any such type of insurance.

Drafting Note: Utilizing the “full amount” standard in Section 5A(3) of this Act may have certain market implications. An alternative to this approach would be to require that whatever part of the coverage is attainable through the admitted market be placed in the admitted market and only the excess part of the coverage may be exported.

- B. Subject to Section 5A(3) of this Act, a surplus lines licensee may place any coverage with an ~~an~~ nonadmitted eligible surplus lines insurer-eligible to accept the insurance, unless specifically prohibited by the laws of this state.

[Alternative Subsection B]

- ~~[C~~B. Subject to Section 5A(3) of this Act, a surplus lines licensee may place only the following types of coverage with an ~~an~~ nonadmitted eligible surplus lines insurer-eligible to accept insurance: (list acceptable coverage).]

Drafting Note: The two statutory alternatives described in Section 5B represent different regulatory approaches to defining those coverages which may be placed in the nonadmitted market and they would impact the admitted market in different manners.

- C. A surplus lines licensee shall not place ~~surplus lines insurance coverage with a nonadmitted insurer~~, unless, at the time of placement, the surplus lines licensee has determined that the ~~nonadmitted insurer~~ is eligible to write surplus lines insurance under one of the following subsections:

~~(1) Has established satisfactory evidence of good repute and financial integrity; and~~

~~(2) Qualifies is eligible to write surplus lines insurance under one of the following subparagraphs:~~

1. **Drafting Note:** Current numbering is retained in this Model to remain consistent with the reference within the NRRA.

2. Is eligible to write surplus lines insurance under one of the following subsections:

(a) For a nonadmitted insurer domiciled in another United States jurisdiction, the insurer shall have both of the following:

(i) ~~is~~ The authority to write the type of insurance in its domiciliary jurisdiction; and

~~(ii)~~ (iii) Has eCapital and surplus or its equivalent under the laws of its domiciliary jurisdiction ~~which~~that equals the greater of:

~~(I)~~ (i) ~~(A)~~ (1) The minimum capital and surplus requirements under the law of this -state; or

~~(B)~~ (B) \$15,000,000;

Drafting Note: ~~States that have not previously increased capital and surplus requirements may wish to consider implementation of the capital and surplus requirements in this subparagraph in a series of phases over a period of up to three (3) years. In some circumstances, implementation of a \$15,000,000 capital and surplus requirement may represent a dramatic increase over existing requirements. States may wish to allow insurers which are eligible under existing law some period of time to increase their capital and surplus to meet the new standards. Current numbering is retained in this Model to remain consistent with the reference within the NRRA.~~

~~(ii)~~ (i) The requirements of Subparagraph ~~(a)~~(i) may be satisfied by an insurer's possessing less than the minimum capital and surplus upon an affirmative finding of acceptability by the commissioner. The finding shall be based upon such factors as quality of management, capital and surplus of any parent company, company underwriting profit and investment income trends, market availability and company record and reputation within the industry. In no event shall the commissioner make an affirmative finding of acceptability when the nonadmitted insurer's capital and surplus is less than \$4,500,000; or

~~a.~~ a. ~~For a nonadmitted insurer domiciled outside the United States, the insurer shall be listed on the Quarterly Listing of Alien Insurers maintained by the International Insurers Department of the National Association of Insurance Commissioners (NAIC); [or]~~

~~(b)~~

~~(c)~~ (c) ~~For an insurer domiciled in this state, the insurer is a domestic surplus lines insurer.]~~

~~(b)~~ (b) ~~In the case of an insurance exchange created by the laws of a state other than this state:~~

~~(i)~~ (i) ~~The syndicates of the exchange shall maintain under terms acceptable to the commissioner capital and surplus, or its equivalent under the laws of its domiciliary jurisdiction, of not less than \$75,000,000 in the aggregate; and~~

~~(ii)~~ (ii) ~~The exchange shall maintain under terms acceptable to the commissioner not less than fifty percent (50%) of the policyholder surplus of each syndicate in a custodial account accessible to the exchange or its domiciliary commissioner in the event of insolvency or impairment of the individual syndicate; and~~

~~(iii)~~ (iii) ~~In addition, each individual syndicate to be eligible to accept surplus lines insurance placements from this state shall meet either of the following requirements:~~

~~(I)~~ (I) ~~For insurance exchanges which maintain funds in an amount of not less than \$15,000,000 for the protection of all exchange policyholders, the syndicate shall maintain under terms acceptable to the commissioner minimum capital and surplus, or its equivalent under the laws of the domiciliary jurisdiction, of not less than \$5,000,000; or~~

~~(II)~~ (II) ~~For insurance exchanges which do not maintain funds in an amount of not less than \$15,000,000 for the protection of all exchange~~

~~policyholders, the syndicate shall maintain under terms acceptable to the commissioner minimum capital and surplus, or its equivalent under the laws of its domiciliary jurisdiction, of not less than the minimum capital and surplus requirements under the laws of its domiciliary jurisdiction or \$15,000,000, whichever is greater; or~~

Drafting Note: Some states may want to cross reference statutory provisions in their own states which provide a grandfather clause for syndicates established with a lower capital and surplus requirement.

- ~~(c) In the case of a Lloyd's plan or other similar group of insurers, which consists of unincorporated individual insurers, or a combination of both unincorporated and incorporated insurers:~~
- ~~(i) The plan or group maintains a trust fund that shall consist of a trustee account representing the group's liabilities attributable to business written in the United States; and~~
 - ~~(ii) In addition, the group shall establish and maintain in trust a surplus in the amount of \$100,000,000; which shall be available for the benefit of United States surplus lines policyholders of any member of the group.~~
 - ~~(iii) The incorporated members of the group shall not be engaged in any business other than underwriting as a member of the group and shall be subject to the same level of solvency regulation and control by the group's domiciliary regulator as are the unincorporated members.~~
 - ~~(iv) The trust funds shall be maintained in an irrevocable trust account in the United States in a qualified financial institution, consisting of cash, securities, letters of credit or investments of substantially the same character and quality as those which are eligible investments for the capital and statutory reserves of admitted insurers to write like kinds of insurance in this state and, in addition, the trust required by item (ii) of this paragraph shall satisfy the requirements of the Standard Trust Agreement required for listing with the National Association of Insurance Commissioners (NAIC) International Insurers Department; or~~
- ~~(d) In the case of a group of incorporated insurers under common administration, which has continuously transacted an insurance business outside the United States for at least three (3) years immediately prior to this time, and which submits to this state's authority to examine its books and records and bears the expense of the examination:~~
- ~~(i) The group shall maintain an aggregate policyholders' surplus of \$10,000,000,000; and~~
 - ~~(ii) The group shall maintain in trust a surplus in the amount of \$100,000,000; which shall be available for the benefit of United States surplus lines policyholders of any member of the group; and~~
 - ~~(iii) Each insurer shall individually maintain capital and surplus of not less than \$25,000,000 per company.~~
 - ~~(iv) The trust funds shall satisfy the requirements of the Standard Trust Agreement requirement for listing with the NAIC International Insurers Department, and shall be maintained in an irrevocable trust account in the United States in a qualified financial institution, and shall consist of cash, securities, letters of credit or investments of substantially the same character and quality as those which are eligible investments for the capital and statutory reserves of admitted insurers to write like kinds of insurance in this state.~~

- ~~(v) — Additionally, each member of the group shall make available to the commissioner an annual certification of the member’s solvency by the member’s domiciliary regulator and its independent public accountant; or~~
- ~~(e) — Except for an exchange or plan complying with Subparagraph (b), (c) or (d), an insurer not domiciled in one of the United States or its territories shall satisfy the capital and surplus requirements of Subsection C(2)(a) of this section and shall have in force a trust fund of not less than the greater of:

 - ~~(i) — \$5,400,000; or~~
 - ~~(ii) — Thirty percent (30%) of the United States surplus lines gross liabilities, excluding aviation, wet marine and transportation insurance liabilities, not to exceed \$60,000,000, to be determined annually on the basis of accounting practices and procedures substantially equivalent to those promulgated by this state, as of December 31 next preceding the date of determination, where:

 - ~~(I) — The liabilities are maintained in an irrevocable trust account in the United States in a qualified financial institution, on behalf of U.S. policyholders consisting of cash, securities, letters of credit or other investments of substantially the same character and quality as those which are eligible investments pursuant to [cite insurance investment law] for the capital and statutory reserves of admitted insurers to write like kinds of insurance in this state. The trust fund, which shall be included in any calculation of capital and surplus or its equivalent, shall satisfy the requirements of the Standard Trust Agreement required for listing with the NAIC International Insurers Department; and~~
 - ~~(II) — The insurer may request approval from the commissioner to use the trust fund to pay valid surplus lines claims; provided, however, that the balance of the trust fund is never less than the greater of \$5,400,000 or thirty percent (30%) of the insurer’s current gross U.S. surplus lines liabilities, excluding aviation, wet marine and transportation insurance liabilities; and~~
 - ~~(III) — In calculating the trust fund amount required by this subsection, credit shall be given for surplus lines deposits separately required and maintained for a particular state or U.S. territory, not to exceed the amount of the insurer’s loss and loss adjustment reserves in the particular state or territory;~~~~~~

Drafting Note: The commissioner may wish to establish the authority to set a higher level on a case-by-case basis.

- ~~(f) — An insurer or group of insurers meeting the requirements to do a surplus lines business in this state at the effective date of this law shall have two (2) years from the date of enactment to meet the requirements of Subparagraph (c), as follows:~~

Year Following Enactment	Trust Fund Requirement
1	15% of U.S. surplus lines liabilities, excluding aviation, wet marine and transportation insurance, with a maximum of \$30,000,000

2

~~30% of U.S. surplus lines liabilities, excluding aviation, wet marine and transportation insurance, with a maximum of \$60,000,000.~~

- ~~(g) — The commissioner shall have the authority to adjust, in response to inflation, the trust fund amounts required by Subparagraph (e).~~
- ~~(3) — In addition to all of the other requirements of this subsection, an insurer not domiciled in the United States or its territories shall be listed by the NAIC International Insurers Department. The commissioner may waive the requirement in Paragraph (3) or the requirements of Section 5C(2)(e)(ii) may be satisfied by an insurer's possessing less than the trust fund amount specified in Section 5C(2)(e)(ii) upon an affirmative finding of acceptability by the commissioner if the commissioner is satisfied that the placement of insurance with the insurer is necessary and will not be detrimental to the public and the policyholder. In determining whether business may be placed with the insurer, the commissioner may consider such factors as:~~
- ~~(a) — The interests of the public and policyholders;~~
- ~~(b) — The length of time the insurer has been authorized in its domiciliary jurisdiction and elsewhere;~~
- ~~(c) — Unavailability of particular coverages from authorized insurers or unauthorized insurers meeting the requirements of this section;~~
- ~~(d) — The size of the company as measured by its assets, capital and surplus, reserves, premium writings, insurance in force or other appropriate criteria;~~
- ~~(e) — The kinds of business the company writes, its net exposure and the extent to which the company's business is diversified among several lines of insurance and geographic locations; and~~
- ~~(f) — The past and projected trend in the size of the company's capital and surplus considering such factors as premium growth, operating history, loss and expense ratios, or other appropriate criteria; and~~
- ~~(4) — Has caused to be provided to the commissioner a copy of its current annual statement certified by the insurer and an actuarial opinion as to the adequacy of, and methodology used to determine, the insurer's loss reserves. The statement shall be provided at the same time it is provided to the insurer's domicile, but in no event more than eight (8) months after the close of the period reported upon, and shall be certified as a true and correct copy by an accounting or auditing firm licensed in the jurisdiction of the insurer's domicile and certified by a senior officer of the nonadmitted insurer as a true and correct copy of the statement filed with the regulatory authority in the domicile of the nonadmitted insurer. In the case of an insurance exchange qualifying under Paragraph (2)(b) of this subsection, the statement may be an aggregate combined statement of all underwriting syndicates operating during the period reported; and~~

Drafting Note: The following paragraph is for use by those states which desire to adopt a "white list" for determining the eligibility of nonadmitted insurers to write surplus lines insurance.

- ~~(5) — In addition to meeting the requirements in Paragraphs (1) to (4) of this subsection an insurer shall be an eligible surplus lines insurer if it appears on the most recent list of eligible surplus lines insurers published by the commissioner from time to time but at least semiannually. Nothing in this paragraph shall require the commissioner to place or maintain the name of any nonadmitted insurer on the list of eligible surplus lines insurers.~~
- ~~(6) — Notwithstanding Section 5A, only that portion of any risk eligible for export for which the full amount of coverage is not procurable from listed eligible surplus lines insurers may be placed with any other nonadmitted insurer which does not appear on the list of eligible surplus lines insurers published by the commissioner pursuant to Paragraph (5) of this subsection but nonetheless meets the requirements set forth in Sections 5C(1) and 5C(2) and any regulations of the commissioner. The surplus lines licensee seeking to provide coverage through an unlisted nonadmitted insurer shall make a filing specifying the amounts and~~

~~percentages of each risk to be placed, and naming the nonadmitted insurers with which placement is intended. Within [insert number] days after placing the coverage, the surplus lines licensee shall also send written notice to the insured or the producing broker that the insurance, or a portion thereof, has been placed with the nonadmitted insurer.~~

- D. ~~The placement of surplus lines insurance shall be subject to the statutory and regulatory requirements solely of the insured's home state.~~

Drafting Note: Section 522(d) of the federal Nonadmitted and Reinsurance Reform Act provides a workers' compensation exception to home state authority; specifically, that this section may not be construed to preempt any State law, rule, or regulation that restricts the placement of workers' compensation insurance or excess insurance for self-funded workers' compensation plans with a nonadmitted insurer. In addition, Section 527(9) of the NRRRA provides that the term "nonadmitted insurance" means any property and casualty insurance permitted to be placed directly or through a surplus lines broker with a nonadmitted insurer eligible to accept such insurance and is not applicable to accident and health insurance. States may consider whether to add language making these exceptions explicit when codifying Section 5D into state law.

- ~~E.D.~~ Insurance procured under this section shall be valid and enforceable as to all parties.

~~E.E.~~ Withdrawal of Eligibility as a Surplus Lines Insurer

F.

If at any time the commissioner has reason to believe that a surplus lines insurer is no longer eligible under Section 5C,[‡]

- ~~(1) — Is in unsound financial condition or has acted in an untrustworthy manner;~~
- ~~(2) — No longer meets standards set forth in Section 5C of this Act;~~
- ~~(3) — Has willfully violated the laws of this state; or~~
- ~~(4) — Does not conduct a proper claims practice.~~

~~The~~the commissioner may, after notice and an opportunity for a hearing, declare it ineligible. The commissioner shall promptly ~~mail~~publish notice of all such declarations in a timely manner reasonably calculated to reach to each surplus lines licensee or surplus lines advisory organization, for distribution to all surplus lines licensees.

Drafting Note: Individual states should consider whether such declarations of ineligibility are appropriate in view of the state's other due process and administrative procedure requirements. Eligibility criteria are independent of other considerations such as compliance with other laws, for example, 18 USC 1033, relating to felons participating in the insurance business.

~~G.F.~~ Surplus Lines Tax

- ~~(1)~~ (1) — In addition to the full amount of gross premiums charged by the insurer for the insurance, every person licensed pursuant to Section 5H of this Act shall collect and pay to the commissioner a sum equal to [insert number] percent of the gross premiums charged, less any return premiums, for surplus lines insurance provided by the licensee pursuant to the license. Where the insurance covers properties, risks or exposures located or to be performed both in and out of this state, the sum payable shall be ~~computed on that portion of the gross premiums allocated to this state pursuant to Paragraph (4) of this subsection less the amount of gross premiums allocated to this state and returned to the insured~~paid entirely to the hHome sState of the insured. The tax on any portion of the premium unearned at termination of insurance having been credited by the state to the licensee shall be returned to the policyholder directly by the surplus lines licensee or through the producing broker, if any. The surplus lines licensee is prohibited from rebating, for any reason, any part of the tax.
- ~~(2)~~ At the time of filing the [insert monthly, quarterly, annual] report as set forth in Subsection ~~S.R~~ of

this section, each surplus lines licensee shall pay the premium tax due for the policies written during the period covered by the report.

- ~~(3) ————— If a surplus lines policy procured through a surplus lines licensee covers properties, risks or exposures only partially located or to be performed in this state, the tax due shall be computed on the portions of the premiums which are attributable to the properties, risks or exposures located or to be performed in this state. In determining the amount of premiums taxable in this state, all premiums written, procured or received in this state shall be considered written on properties, risks or exposures located or to be performed in this state, except premiums which are properly allocated or apportioned and reported as taxable premiums of a reciprocal state. In no event shall the tax payable to this state be less than the tax due pursuant to Paragraph (4) of this subsection; provided, however, in the event that the amount of tax due under this provision is less than \$50 in any jurisdiction, it shall be payable in the jurisdiction in which the affidavit required in Subsection K of this section is filed. The commissioner shall, at least annually furnish to the commissioner of a reciprocal state, as defined in Section 3L, a copy of all filings reporting an allocation of taxes as required by this subsection.~~
- ~~(4) ————— In determining the amount of gross premiums taxable in this state for a placement of surplus lines insurance covering properties, risks or exposures only partially located or to be performed in this state, the tax due shall be computed on the portions of the premiums which are attributable to properties, risks or exposures located or to be performed in this state and which relates to the kinds of insurance being placed as determined by reference to an allocation schedule duly promulgated in a regulation by the commissioner.~~
- ~~(a) ————— If a policy covers more than one classification:~~
- ~~(i) ————— For any portion of the coverage identified by a classification on the Allocation Schedule, the tax shall be computed by using the Allocation Schedule for the corresponding portion of the premium;~~
- ~~(ii) ————— For any portion of the coverage not identified by a classification on the Allocation Schedule, the tax shall be computed by using an alternative equitable method of allocation for the property or risk;~~
- ~~(iii) ————— For any portion of the coverage where the premium is indivisible, the tax shall be computed by using the method of allocation which pertains to the classification describing the predominant coverage.~~
- ~~(b) ————— If the information provided by the surplus lines licensee is insufficient to substantiate the method of allocation used by the surplus lines licensee, or if the commissioner determines that the licensee's method is incorrect, the commissioner shall determine the equitable and appropriate amount of tax due to this state as follows:~~
- ~~(i) ————— By use of the Allocation Schedule where the risk is appropriately identified in the schedule;~~
- ~~(ii) ————— Where the Allocation Schedule does not identify a classification appropriate to the coverage, the commissioner may give significant weight to documented evidence of the underwriting bases and other criteria used by the insurer. The commissioner may also consider other available information to the extent sufficient and relevant, including the percentage of the insured's physical assets in this state, the percentage of the insured's sales in this state, the percentage of income or resources derived from this state, and the amount of premium tax paid to another jurisdiction for the policy.~~

Drafting Note: Subparagraph (b) above may be included in the Act or in a separate regulation at the option of the

~~state. It is highly recommended that the model Allocation Schedule and reporting form be adopted by regulation in conjunction with the adoption of the above language. In order for the model law to work effectively, the allocation schedules used by the states should be as uniform as possible.~~

HG. Collection of Tax

If the tax owed by a surplus lines licensee under this section has been collected and is not paid within the time prescribed, the same shall be recoverable in a suit brought by the commissioner against the surplus lines licensee and the surety on the bond filed under Subsection HI of this section. The commissioner may charge interest at the rate of [insert number] percent per year for the unpaid tax.

IH. Surplus Lines Licenses

- (1) A person shall not procure a contract of surplus lines insurance with a ~~nonadmitted~~ surplus lines insurer unless the person possesses a current surplus lines insurance producer license issued by the commissioner.
- (2) The commissioner may issue a resident surplus lines license to a qualified holder of ~~a current underlying~~ property and casualty ~~agent's or broker's or general agent's~~ licenses, but only when the ~~broker or agent~~ producer has:
 - (a) Remitted the \$[insert amount] annual fee to the commissioner;
 - (b) Submitted a completed license application on a form supplied by the commissioner;
 - ~~(c) Passed a qualifying examination approved by the commissioner, except that all holders of a license prior to the effective date of this Act shall be deemed to have passed such an examination;~~
 - ~~(c)~~ In the case of a resident agent, filed with the commissioner, and continues to maintain during the term of the license, in force and unimpaired, a bond or errors and omissions (E&O) policy in favor of this state in the penal sum of \$[insert amount] aggregate liability, with corporate sureties approved by the commissioner. The bond or E&O policy shall be conditioned that the surplus lines licensee will conduct business in accordance with the provisions of this Act and will promptly remit the taxes as provided by law. No bond or E&O policy shall be terminated unless at least thirty (30) days prior written notice is given to the licensee and commissioner;

Drafting note: Under Public Law No. 106-102 (the “Gramm-Leach-Bliley Act”), it is believed that a requirement for a nonresident agent to file a bond may contravene the reciprocity provisions. The requirement for a resident agent to file a bond would not, seemingly, contravene these provisions, and there may be methodologies whereby such resident bonds could become reciprocal between states. Some states have expressed concern that their bonding requirements constitute important consumer protections, and that elimination of these simply to comply with Gramm-Leach-Bliley may result in unintended consequences, and a lack of ~~control~~ over possibly unscrupulous nonresident agents.

- ~~(de)~~ If a resident, established and continues to maintain an office in this state, ~~and~~
- ~~(f) Designated the commissioner as agent for service of process, thereby designating the commissioner to be the licensee's true and lawful attorney upon whom may be served all lawful process in a proceeding instituted by or on behalf of an insured or beneficiary arising out of any contract of insurance, and shall signify its agreement that such service of process is of the same legal force and validity as personal service of process in this state upon the licensee.~~
- (3) A nonresident person shall receive a nonresident surplus lines license if:

- (a) The person is currently licensed as a surplus lines licensee and in good standing in his or her home state;
- (b) The person has submitted the proper request for licensure and has paid the fees required by [insert appropriate reference to state law or regulation];
- (c) The person has submitted or transmitted to the insurance commissioner the application for licensure that the person submitted to his or her home state, or in lieu of the same, a completed Uniform Application; and
- (d) The person's home state awards nonresident surplus lines licenses to residents of this state on the same basis.

Drafting Note: In accordance with Public Law No. 106-102 (the "Gramm-Leach-Bliley Act") states should not require any additional attachments to the Uniform Application or impose any other conditions on applicants that exceed the information requested within the Uniform Application.

- (4) The insurance commissioner may verify the person's licensing status through the Producer Database maintained by the ~~NAICational Association of Insurance Commissioners~~, its affiliates or subsidiaries.
- (5) A nonresident surplus lines licensee who moves from one state to another state or a resident surplus lines licensee who moves from this state to another state shall file a change of address and provide certification from the new resident state within thirty (30) days of the change of legal residence. No fee or license application is required.
- (6) The insurance commissioner shall waive any requirements for a nonresident surplus lines license applicant with a valid license from his or her home state, except the requirements imposed by this subsection, if the applicant's home state awards nonresident surplus lines licenses to residents of this state on the same basis.
- ~~(7)~~ Each surplus lines license shall expire on [insert date] of each year, and an application for renewal shall be filed before [insert date] of each year upon payment of the annual fee and compliance with other provisions of this section. A surplus lines licensee who fails to apply for renewal of the license before [insert date] shall pay a penalty of \$[insert amount] and be subject to penalties provided by law before the license will be renewed.

Drafting Note: States may wish to reference their specific licensing statutes in this section.

Drafting Note: Some states allow surplus lines licensees to hold binding authorities on behalf of ~~eligible~~ surplus lines insurers. States which allow such binding authorities might want to establish minimum standards for the related agreements. In addition, states might want to consider requiring surplus lines licensees with such binding authorities to submit the related agreements to state regulators for review and approval.

J. Suspension, Revocation or Nonrenewal of Surplus Lines Licensee's License

The commissioner may suspend, revoke or refuse to renew the license of a surplus lines licensee after notice and an opportunity for a hearing as provided under the applicable provision of this state's laws ~~for upon one or more of the following grounds:~~

- ~~(1) — Removal of the resident surplus lines licensee's office from this state;~~
- ~~(2) — Removal of the resident surplus lines licensee's office accounts and records from this state during the period during which the accounts and records are required to be maintained under Subsection Q of this section;~~
- ~~(3) — Closing of the surplus lines licensee's office for a period of more than thirty (30) business days;~~

~~unless permission is granted by the commissioner;~~

~~(4) Failure to make and file required reports;~~

~~(5) Failure to transmit required tax on surplus lines premiums to this state or a reciprocal state to which a tax is owing;~~

~~(6) Failure to maintain required bond;~~

~~(17) Violation of any provision of this Act; or~~

~~(28) For any cause for which an insurance license could be denied, revoked, suspended or renewal refused under Sections [insert applicable citation].~~

~~K.J.~~ Actions Against Eligible Surplus Lines Insurers Transacting Surplus Lines Business

- (1) An eligible surplus lines insurer may be sued upon a cause of action arising in this state under a surplus lines insurance contract made by it or evidence of insurance issued or delivered by the surplus lines licensee. A policy issued by the eligible surplus lines insurer shall contain a provision stating the substance of this section and designating the person to whom the commissioner shall mail process.
- (2) The remedies provided in this section are in addition to any other methods provided by law for service of process upon insurers.

~~L.K.~~ Duty to File Evidence of Insurance and Affidavits

Within [insert number] days after the placing of any surplus lines insurance, each producing broker shall execute and each surplus lines licensee shall execute where appropriate, and file a written report regarding the insurance which shall be kept confidential by the commissioner, including the following:

- (1) The name and address of the insured;
- (2) The identity of the insurer or insurers;
- (3) A description of the subject and location of the risk;
- (4) The amount of premium charged for the insurance;
- (5) Such other pertinent information as the commissioner may reasonably require; and
- (6) An affidavit on a standardized form promulgated by the commissioner as to the diligent efforts to place the coverage with admitted insurers and the results of that effort ~~or the insured is an exempt commercial purchaser~~. The affidavit shall be open to public inspection. The affidavit shall affirm that the insured was expressly advised in writing prior to placement of the insurance that:
 - (a) The surplus lines insurer with whom the insurance was to be placed is not licensed in this state and is not subject to its supervision; and
 - (b) In the event of the insolvency of the surplus lines insurer, losses will not be paid by the state insurance guaranty fund.

Drafting Note: Surplus lines licensees will frequently communicate with the insured through a producing broker rather than communicate with the insured directly. In preparing affidavit forms, states may wish to recognize that, as a result of communications passing through the producing broker, the surplus lines licensee may not be in a position to affirm, based upon personal knowledge, that the insured received from the producing broker the written information required by this subsection.

ML. Surplus Lines Advisory Organizations

- (1) There is hereby created a nonprofit association to be known as the [insert name]. All surplus lines licensees shall be deemed to be members of the association. The association shall perform its functions under the plan of operation established pursuant to Paragraph (3) of this subsection and must exercise its powers through a board of directors established under Paragraph (2) of this subsection. The association shall be supervised by the commissioner. The association shall be authorized and have the duty to:

Drafting Note: The preceding paragraph provides that all surplus lines licensees are “deemed” to be members of the association. Some states, however, may choose not to establish a surplus lines advisory organization; in those states Subsection M would not be necessary.

- (a) Receive, record, and subject to Subparagraph (b) of this paragraph, stamp all surplus lines insurance documents which surplus lines brokers are required to file with the association pursuant to the plan of operation;

Drafting Note: Subparagraph (a) of this paragraph authorizes the association to receive, record and stamp all surplus lines documents which must be submitted to the association pursuant to the plan of operation. Documents to be submitted to the association for stamping are likely to vary by state.

- (b) Refuse to stamp submitted insurance documents, if the association determines that a nonadmitted insurer does not meet minimum state financial standards of eligibility, or the commissioner orders the association not to stamp insurance documents pursuant to Paragraph (9) of this subsection. The association shall notify the commissioner and provide an explanation for any refusal to stamp submitted insurance documents other than a refusal based upon the order of the commissioner;
- (c) Prepare and deliver annually to each licensee and to the commissioner a report regarding surplus lines business. The report shall include a delineation of the classes of business procured during the preceding calendar year, in the form the board of directors prescribes;
- (d) Encourage compliance by its members with the surplus lines law of this state and the rules and regulations of the commissioner relative to surplus lines insurance;
- (e) Communicate with organizations of agents, brokers and admitted insurers with respect to the proper use of the surplus lines market;
- (f) Employ and retain persons as necessary to carry out the duties of the association;
- (g) Borrow money as necessary to effect the purposes of the association;
- (h) Enter contracts as necessary to effect the purposes of the association; and
- (i) Provide such other services to its members as are incidental or related to the purposes of the association.
- (2) The association shall function through a board of directors elected by the association members, and officers who shall be elected by the board of directors.
- (a) The board of directors of the association shall consist of not less than five (5) nor more than nine (9) persons serving terms as established in the plan of operation. The plan of operation shall provide for the election of a board of directors by the members of the association from its membership. The plan of operation shall fix the manner of voting and may weigh each member’s vote to reflect the annual surplus lines insurance premium written by the member.

- (b) The board of directors shall elect officers as provided for in the plan of operation.
- (3) The association shall establish a plan of operation. The plan of operation shall provide for the formation, operation and governance of the association. The plan and any amendments shall be effective upon approval by the commissioner, which shall not be unreasonably withheld or delayed. All association members shall comply with the plan of operation or any amendments to it. Failure to comply with the plan of operation or any amendments shall constitute a violation of the insurance law and the commissioner may issue an order requiring discontinuance of the violation.
- (4) The association shall file with the commissioner:
- (a) A copy of its plan of operation and any amendments to it;
 - (b) A current list of its members revised at least annually;
 - (c) The name and address of a resident of this state upon whom notices or orders of the commissioner or processes issued at the direction of the commissioner may be served; and
 - (d) An agreement that the commissioner may examine the association in accordance with the provisions of Paragraph (5) of this subsection.
- (5) The commissioner shall, at least once in [insert number] years, make or cause to be made an examination of the association. The reasonable cost of an examination shall be paid by the association upon presentation to it by the commissioner of a detailed account of each cost. The officers, managers, agents, and employees of the association may be examined at any time, under oath, and shall exhibit all books, records, accounts, documents or agreements governing its method of operation. The commissioner shall furnish a copy of the examination report to the association and shall notify the association that it may request a hearing within thirty (30) days on the report or on any facts or recommendations contained in it. If the commissioner finds the association to be in violation of this section, the commissioner may issue an order requiring the discontinuance of the violation. A director may be removed from the association's board of directors by the commissioner for cause, stated in writing, after an opportunity has been given to the director to be heard.
- (6) There shall be no liability on the part of and no causes of action of any nature shall arise against the association, its directors, officers, agents or employees for any action taken or omitted by them in the performance of their powers and duties under this section, absent gross negligence or willful misconduct.
- (7) Within [insert number] days after a surplus lines policy is procured, a licensee shall submit to the association for recording and stamping all documents which surplus lines brokers are required to file with the association. Every insurance document submitted to the association pursuant to this subsection shall set forth:
- (a) The name and address of the insured;
 - (b) The gross premium charged;
 - (c) The name of the nonadmitted insurer; and
 - (d) The class of insurance procured.

Drafting Note: The appropriate time limits for submitting documents required for stamping will vary by state.

- (8) It shall be unlawful for an insurance agent, broker or surplus lines broker to deliver in this state any insurance document which surplus lines brokers are required to file with the association unless the

insurance document is stamped by the association or is exempt from such requirements. However, a licensee's failure to comply with the requirements of this subsection shall not affect the validity of the coverage.

- (9) The services performed by the association shall be funded by a stamping fee assessed for each premium-bearing document submitted to the association. The stamping fee shall be established by the board of directors of the association from time to time. The stamping fee shall be paid by the insured.
- (10) The commissioner may declare a nonadmitted insurer ineligible and order the association not to stamp insurance documents issued by the nonadmitted insurer and issue any other appropriate order.

NM. Evidence of the Insurance and Subsequent Changes to the Insurance

- (1) Upon placing surplus lines insurance, the surplus lines licensee shall promptly deliver to the insured or the producing broker the policy, or if the policy is not then available, a certificate as described in Paragraph (4) of this subsection, cover note, binder or other evidence of insurance. The certificate described in Paragraph (4) of this subsection, cover note, binder or other evidence of insurance shall be executed by the surplus lines licensee and shall show the description and location of the subject of the insurance, coverages including any material limitations other than those in standard forms, a general description of the coverages of the insurance, the premium and rate charged and taxes to be collected from the insured, and the name and address of the insured and surplus lines insurer or insurers and proportion of the entire risk assumed by each, and the name of the surplus lines licensee and the licensee's license number.
- (2) A surplus lines licensee shall not issue or deliver any evidence of insurance or purport to insure or represent that insurance will be or has been written by any ~~eligible~~ surplus lines insurer, or a nonadmitted insurer ~~pursuant to Section 5C(4)~~, unless the licensee has authority from the insurer to cause the risk to be insured or has received information from the insurer in the regular course of business that the insurance has been granted.
- (3) If, after delivery of any evidence of insurance, there is any change in the identity of the insurers, or the proportion of the risk assumed by any insurer, or any other material change in coverage as stated in the surplus lines licensee's original evidence of insurance, or in any other material as to the insurance coverage so evidenced, the surplus lines licensee shall promptly issue and deliver to the insured or the original producing broker an appropriate substitute for, or endorsement of the original document, accurately showing the current status of the coverage and the insurers responsible for the coverage.
- (4) As soon as reasonably possible after the placement of the insurance, the surplus lines licensee shall deliver a copy of the policy or, if not available, a certificate of insurance to the insured or producing broker to replace any evidence of insurance previously issued. Each certificate or policy of insurance shall contain or have attached a complete record of all policy insuring agreements, conditions, exclusions, clauses, endorsements or any other material facts that would regularly be included in the policy.
- ~~(5) A surplus lines licensee who fails to comply with the requirements of this subsection shall be subject to the penalties provided in this Act.~~
- ~~(56)~~ The surplus lines licensee shall give the following consumer notice to every person, ~~other than exempt commercial purchasers,~~ applying for insurance with a nonadmitted insurer. The notice shall be printed in 16-point type on a separate document affixed to the application. The applicant shall sign and date a copy of the notice to acknowledge receiving it. The surplus lines licensee shall maintain the signed notice in its file for a period of five (5) years from expiration of the policy. The surplus lines licensee shall tender a copy of the signed notice to the insured at the time of delivery of each policy the licensee transacts with a nonadmitted insurer. The copy shall be a separate document

affixed to the policy.

~~“Notice: 1. A “nonadmitted” or “surplus lines insurer that is not licensed in this state is issuing the insurance policy that you have applied to purchase. These companies are called “nonadmitted” or “surplus lines” insurers. 2. The insurer is not subject to the financial solvency regulation and enforcement that applies to licensed insurers in this state. 3. These insurers generally do not participate in insurance guaranty funds created by state law. These guaranty funds will not pay your claims or protect your assets if the insurer becomes insolvent and is unable to make payments as promised. 4. Some states maintain lists of approved or eligible surplus lines insurers and surplus lines brokers may use only insurers on the lists. Some states issue orders that particular surplus lines insurers can not be used. 5. For additional information about the above matters and about the insurer, you should ask questions of your insurance agent, broker or surplus lines broker. You may also contact your insurance department consumer help line.”~~

Drafting Note: This notice is intended to inform personal lines customers and smaller commercial risks of the nature of the coverage they are purchasing. A state may wish to add language to this statute providing that this notice need not be given to commercial risks meeting defined criteria for size and insurance expertise.

ON. Licensee’s Duty to Notify Insured

- (1) No contract of insurance placed by a surplus lines licensee under this Act shall be binding upon the insured and no premium charged shall be due and payable until the surplus lines licensee or the producing broker ~~shall have~~has notified the insured in writing, in a form acceptable to the commissioner, a copy of which shall be maintained by the licensee or the producing broker with the records of the contract and available for possible examination, that:
 - (a) The insurer [other than a domestic surplus lines insurer] with which the licensee places the insurance is not licensed by this state and is not subject to its supervision; and
 - (b) In the event of the insolvency of the surplus lines insurer, losses will not be paid by the state insurance guaranty fund.
- (2) Nothing herein contained shall nullify any agreement by any insurer to provide insurance.

Drafting Note: To ensure the meaningfulness of the notice required by this subsection, the commissioner might want to establish criteria related to readability, type face~~font~~, and type~~size~~ of the notice.

PO. Effect of Payment to Surplus Lines Licensee

A payment of premium to a surplus lines licensee acting for a person other than itself in procuring, continuing or renewing any policy of insurance procured under this section shall be deemed to be payment to the insurer, whatever conditions or stipulations may be inserted in the policy or contract notwithstanding.

QP. Surplus Lines Licensees May Accept Business from Other Producers

A surplus lines licensee may originate surplus lines insurance or accept such insurance from any other producing broker duly licensed as to the kinds of insurance involved, and the surplus lines licensee may compensate the producing broker for the business.

RQ. Records of Surplus Lines Licensee

- (1) Each surplus lines licensee shall keep ~~in this state~~ a full and true record of each surplus lines insurance contract placed by or through the licensee, including a copy of the policy, certificate, cover note or other evidence of insurance showing each of the following items applicable:
 - (~~a~~) Amount of the insurance, risks and perils insured;

- (2b) Brief description of the property insured and its location;
 - (3c) Gross premium charged;
 - (4d) Any return premium paid;
 - (5e) Rate of premium charged upon the several items of property;
 - (6f) Effective date and terms of the contract;
 - (7g) Name and address of the insured;
 - (8h) Name and address of the insurer;
 - (9i) Amount of tax and other sums to be collected from the insured;
 - ~~(10) Allocation of taxes by state as referred to in Subsection F of this section;~~ and
 - (11j) Identity of the producing broker, any confirming correspondence from the insurer or its representative, and the application.
- (2) The record of each contract shall be kept open at all reasonable times to examination by the commissioner without notice for a period not less than five (5) years following termination of the contract. In lieu of maintaining offices in this state, each nonresident surplus lines licensee shall make available to the commissioner any and all records that the commissioner deems necessary for examination.

Drafting Note: States may wish to extend the five-year period prescribed for open access to insurance records because of the long-term nature of this business.

SR. Reports—Summary of Exported Business

On or before the end of the month following each [insert month, quarter, year], each surplus lines licensee shall file with the commissioner, on forms prescribed by the commissioner, a verified report in duplicate of all surplus lines insurance transacted during the preceding period, showing:

- (1) Aggregate gross premiums written;
- (2) Aggregate return premiums;
- (3) Amount of aggregate tax remitted to this state; and
- (4) Amount of aggregate tax due or remitted to each other state for which an allocation is made pursuant to Subsection ~~GF~~ of this section.

Drafting Note: States desiring to have taxes remitted annually may call for more frequent detailed listing of business.

T. [OPTIONAL: Domestic Surplus Lines Insurers]

- (1) The commissioner may designate a domestic insurer as a domestic surplus lines insurer upon its application, which shall include, as a minimum, an authorizing resolution of the board of directors and evidence to the commissioner's satisfaction that the insurer has capital and surplus of not less than fifteen million dollars.
- (2) A domestic surplus lines insurer:

- (a) ~~(a)~~ Shall be limited in its authority in this state to providing surplus lines insurance.
- (b) May be authorized to write any type of property and casualty [or accident and health] insurance in this state that may be placed with a surplus lines insurer pursuant to this Subpart.
- (c) Be subject to the legal and regulatory requirements applicable to domestic insurers, except for theas following:
- (i) Premium taxes, fees, and assessments applicable to admitted insurance;
- (ii) ~~Regulation of rates and forms requiring the filing of rates and forms for approval;~~
- (iii) ~~Assessment or coverage by insurance guaranty funds.]~~

Section 6. Insurance Independently Procured—Duty to Report and Pay Tax

- A. Each insured whose home state is in this state, who procures or continues or renews insurance with a nonadmitted insurer ~~on properties, risks or exposures located or to be performed in whole or in part in this state~~, other than insurance procured through a surplus lines licensee, shall, within [insert number] days after the date the insurance was so procured, continued or renewed, file a written report with the commissioner, upon forms prescribed by the commissioner, showing the name and address of the insured or insureds, name and address of the insurer, the subject of the insurance, a general description of the coverage, the amount of premium currently charged, and additional pertinent information reasonably requested by the commissioner.
- ~~For the purposes of this subsection, properties, risks or exposures only partially located or to be performed in this state, which are covered under a multistate policy placed by a surplus lines licensee in another state, shall be deemed to be insurance independently procured unless the insurer is an admitted insurer.~~

Drafting Note: Subsection A may need to be revised in those states exempting from taxation insurance procured by nonprofit educational institutions and their employers, from nonprofit educational insurers.

- B. ~~Gross~~ Premiums charged for the insurance, less any return premiums, is subject to a tax at the rate of [insert number] percent. At the time of filing the report required in Subsection A of this section, the insured whose home state is this state shall pay the tax on all taxable pPremium to the commissioner, who shall transmit the same for distribution as provided in this Act.

Drafting Note: Existing state laws and procedures may require that the tax report be forwarded to another state agency, such as the Department of the Treasury, rather than to the commissioner. In addition, some states may require the tax to be paid on a periodic basis (e.g., annually) rather than at the time of the filing required by Subsection A. Subsections A and B may need to be revised in these states.

- ~~C. If an independently procured policy covers properties, risks or exposures only partially located or to be performed in this state, the tax payable shall be computed on the portion of the premium properly attributable to the properties, risks or exposures located or to be performed in this state, as set forth in Sections 5F(3) and 5F(4) of this Act.~~
- ~~C~~D. Delinquent taxes hereunder shall bear interest at the rate of [insert number] percent per year.
- ~~D~~E. This section does not abrogate or modify; and shall not be construed or deemed to abrogate or modify any other provision of this Act.

Section 7. Penalties

- A. A person who in this state represents or aids a nonadmitted insurer in violation of this Act may be found guilty of a criminal act and subject to a fine not in excess of \$[insert amount].

Drafting Note: Some states might want to specify “misdemeanor” or “felony” rather than “criminal act” in Section 7A.

- B. In addition to any other penalty provided herein or otherwise provided by law, including any suspension, revocation or refusal to renew a license, any person, firm, association or corporation violating any provision of this Act shall be liable to a civil penalty not exceeding \$[insert amount] for the first offense, and not exceeding \$[insert amount] for each succeeding offense.
- C. The above penalties are not exclusive remedies. Penalties may also be assessed under [insert citation to trade practices and fraud statute] of the insurance code of this state.

Section 8. Violations

Whenever there is evidence satisfactory to the commissioner ~~believes, from evidence satisfactory to him or her,~~ that a person is violating or about to violate the provisions of this Act, the commissioner may cause a complaint to be filed in the [insert appropriate court] Court for restitution and to enjoin and restrain the person from continuing the violation or engaging in or doing any act in furtherance thereof. The court shall have jurisdiction of the proceeding and shall have the power to make and enter an order of judgment awarding such preliminary or final injunctive relief and restitution as in its judgment is proper.

Section 9. Service of Process

- A. Any act of transacting insurance by an unauthorized person or a nonadmitted insurer is equivalent to and shall constitute an irrevocable appointment by the unauthorized person or insurer, binding upon it, its executor or administrator, or successor in interest of the [insert title of appropriate state official] or his or her successor in office, to be the true and lawful attorney of the unauthorized person or insurer upon whom may be served all lawful process in any action, suit or proceeding in any court by the commissioner or by the state and upon whom may be served any notice, order, pleading or process in any proceeding before the commissioner and which arises out of transacting insurance in this state by the unauthorized person or insurer. Any act of transacting insurance in this state by a nonadmitted insurer shall signify its acceptance of its agreement that any lawful process in such court action, suit or proceeding and any notice, order, pleading or process in such administrative proceeding before the commissioner so served shall be of the same legal force and validity as personal service of process in this state upon the unauthorized person or insurer.
- B. Service of process in the action shall be made by delivering to and leaving with the [insert title of appropriate state official], or some person in apparent charge of the office, two (2) copies thereof and by payment to the [insert title of appropriate state official] of the fee prescribed by law. Service upon the [insert title of appropriate state official] as attorney shall be service upon the principal.

Drafting Note: Existing state laws and procedures may require that service of process be made upon either the commissioner or another state official.

- C. The [insert title of appropriate state official] shall forward by certified mail one of the copies of the process or notice, order, pleading or process in proceedings before the commissioner to the defendant in the court proceeding or to whom the notice, order, pleading or process in the administrative proceeding is addressed or directed at its last known principal place of business and shall keep a record of all process so served on the commissioner which shall show the day and hour of service. Service is sufficient, provided:
 - (1) Notice of service and a copy of the court process or the notice, order, pleading or process in the administrative proceeding are sent within ten (10) days by certified mail by the plaintiff or the plaintiff’s attorney in the court proceeding or by the commissioner in the administrative proceeding to the defendant in the court proceeding or to whom the notice, order, pleading or process in the administrative proceeding is addressed or directed at the last known principal place of business of the defendant in the court or administrative proceeding; and
 - (2) The defendant’s receipt or receipts issued by the post office with which the letter is registered, showing the name of the sender of the letter and the name and address of the person or insurer to

whom the letter is addressed, and an affidavit of the plaintiff or the plaintiff's attorney in a court proceeding or of the commissioner in an administrative proceeding, showing compliance are filed with the clerk of the court in which the action, suit or proceeding is pending or with the commissioner in administrative proceedings, on or before the date the defendant in the court or administrative proceeding is required to appear or respond, or within such further time as the court or commissioner may allow.

- D. A plaintiff shall not be entitled to a judgment or a determination by default in any court or administrative proceeding in which court process or notice, order, pleading or process in proceedings before the commissioner is served under this section until the expiration of forty-five (45) days from the date of filing of the affidavit of compliance.
- E. Nothing in this section shall limit or affect the right to serve any process, notice, order or demand upon any person or insurer in any other manner now or hereafter permitted by law.
- F. Each nonadmitted insurer assuming insurance in this state, or relative to property, risks or exposures located or to be performed in this state, shall be deemed to have subjected itself to this Act.
- G. ~~Notwithstanding~~Notwithstanding conditions or stipulations in the policy or contract, a nonadmitted insurer may be sued upon any cause of action arising in this state, or relative to property, risks or exposures located or to be performed in this state, under any insurance contract made by it.
- H. ~~Notwithstanding~~Except with regard to exempt commercial purchasers, independently procured insurance, [aviation], and wet marine and transportation insurance, conditions or stipulations in the policy or contract ~~notwithstanding,~~ a nonadmitted insurer subject to arbitration or other alternative dispute resolution mechanism ~~arising in this state or relative to property, risks or exposures located or to be performed in this state under an insurance contract made by it~~ shall conduct the arbitration or other alternative dispute resolution mechanism ~~in this state in the home state of the insured.~~

Drafting Note: Provisions of a state's constitution, statutes, regulations, and public policy may necessitate amendment of the prior ~~sub~~Section 9H. States should consider adoption or modification of priorSection 9H in light of their own laws on arbitration or other alternative dispute resolution in insurance and commercial transactions. States should cross-reference their state insurance code to verify the inclusion of "Aviation" within this provision.

- I. A policy or contract issued by the nonadmitted insurer or one which is otherwise valid and contains a condition or provision not in compliance with the requirements of this Act is not thereby rendered invalid but shall be construed and applied in accordance with the conditions and provisions which would have applied had the policy or contract been issued or delivered in full compliance with this Act.

Section 10. Legal or Administrative Procedures

- A. Before any nonadmitted insurer files or causes to be filed any pleading in any court action, suit or proceeding or in any notice, order, pleading or process in an administrative proceeding before the commissioner instituted against the person or insurer, by services made as provided in this Act, the insurer shall either:
 - (1) Deposit with the clerk of the court in which the action, suit or proceeding is pending, or with the Commissioner of Insurance in administrative proceedings before the commissioner, cash or securities, or file with the clerk or commissioner a bond with good and sufficient sureties, to be approved by the clerk or commissioner in an amount to be fixed by the court or commissioner sufficient to secure the payment of any final judgment which may be rendered in the action or administrative proceeding; or
 - (2) Procure a certificate of authority to transact the business of insurance in this state. In considering the application of an insurer for a certificate of authority, for the purposes of this paragraph the commissioner need not assert the provisions of [insert sections of insurance laws relating to retaliation] against the insurer with respect to its application if the commissioner determines that the

company would otherwise comply with the requirements for a certificate of authority.

- B. The Commissioner of Insurance, in any administrative proceeding in which service is made as provided in this Act, may in the commissioner's discretion, order such postponement as may be necessary to afford the defendant reasonable opportunity to comply with the provisions of Subsection A of this section and to defend the action.
- C. Nothing in Subsection A of this section shall be construed to prevent a nonadmitted insurer from filing a motion to quash a writ or to set aside service thereof made in the manner provided in this Act, on the ground that the nonadmitted insurer has not done any of the acts enumerated in the pleadings.
- D. Nothing in Subsection A of this section shall apply to placements of insurance which were lawful in the home state of the insured in which the placement took place and which were not unlawful placements under the laws of this state. Without limiting the generality of the foregoing, nothing in Subsection A shall apply to a placement made pursuant to Section 5 of this Act.

Section 11. Enforcement

- A. The commissioner shall have the authority to proceed in the courts of this state or any other United States jurisdiction to enforce an order or decision in any court proceeding or in any administrative proceeding before the commissioner of Insurance.

~~A. Filing and Status of Foreign Decrees~~

~~A copy of a foreign decree authenticated in accordance with the statutes of this state may be filed in the office of the clerk of any [insert proper court] Court of this state. The clerk, upon verifying with the commissioner that the decree or order qualifies as a "foreign decree" shall treat the foreign decree in the same manner as a decree of a [insert proper court] Court of this state. A foreign decree so filed has the same effect and shall be deemed a decree of a [insert proper court] Court of this state, and is subject to the same procedures, defenses and proceedings for reopening, vacating or staying as a decree of a [insert proper court] Court of this state and may be enforced or satisfied in like manner.~~

~~B. Notice of Filing~~

- ~~(1) At the time of the filing of the foreign decree, the plaintiff shall make and file with the clerk of the court an affidavit setting forth the name and last known post office address of the defendant.~~
- ~~(2) Promptly upon the filing of the foreign decree and the affidavit, the clerk shall mail notice of the filing of the foreign decree to the defendant at the address given and to the commissioner of this state and shall make a note of the mailing in the docket. In addition, the plaintiff may mail a notice of the filing of the foreign decree to the defendant and to the commissioner of this state and may file proof of mailing with the clerk. Lack of mailing notice of filing by the clerk shall not affect the enforcement proceedings if proof of mailing by the plaintiff has been filed.~~
- ~~(3) No execution or other process for enforcement of a foreign decree filed hereunder shall issue until thirty (30) days after the date the decree is filed.~~

~~**Drafting Note:** This section presumes that the commissioner has authority to proceed without the cooperation of the state's attorney general. Governing state laws might require that a person other than the commissioner or the attorney general serve as the plaintiff. The title of that person shall be substituted for "commissioner" or "plaintiff" in Section 11 whenever required by state law.~~

~~C. Stay of the Foreign Decree~~

- ~~(1) If the defendant shows the [insert proper court] Court that an appeal from the foreign decree is pending or will be taken, or that a stay of execution has been granted, the court shall stay enforcement of the foreign decree until the appeal is concluded, the time for appeal expires, or the stay of execution expires or is vacated, upon proof that the defendant has furnished the security for~~

~~the satisfaction of the decree required by the state in which it was rendered.~~

~~(2) — If the defendant shows the [insert proper court] Court any ground upon which enforcement of a decree of any [insert proper court] Court of this state would be stayed, the court shall stay enforcement of the foreign decree for an appropriate period, upon requiring the same security for satisfaction of the decree which is required in this state.~~

~~B.~~ ~~D.~~ — It shall be the policy of this state that the insurance commissioner shall cooperate with regulatory officials in other United States jurisdictions to the greatest degree reasonably practicable in enforcing lawfully issued orders of such other officials subject to public policy and the insurance laws of the state. Without limiting the generality of the foregoing, the commissioner may enforce an order lawfully issued by other officials provided the order does not violate the laws or public policy of this state.

Section 12. Suits by Nonadmitted Insurers

A nonadmitted insurer may not commence or maintain an action ~~at~~ in law or in equity, including arbitration or any other dispute resolution mechanism, in this state to enforce any right arising out of any insurance transaction except with respect to:

- A. Claims under policies lawfully placed pursuant to the law of the home state of the insured~~written in this state;~~
- B. Liquidation of assets and liabilities of the insurer (other than collection of new premium), resulting from its former authorized operations in this state;
- C. Transactions subsequent to issuance of a policy not covering domestic risks at the time of issuance, and lawfully procured under the laws of the jurisdiction where the transaction took place;
- D. Surplus lines insurance placed by a licensee under authority of Section 5 of this Act;
- E. Reinsurance placed under the authority of [insert citations of state's reinsurance intermediary act and other reinsurance laws];
- F. The continuation and servicing of life insurance, health insurance policies or annuity contracts remaining in force as to residents of this state where the formerly authorized insurer has withdrawn from the state and is not transacting new insurance in the state;
- G. Servicing of policies written by an admitted insurer in a state to which the insured has moved but in which the company does not have a certificate of authority until the term expires;
- H. Claims under policies covering wet marine and transportation insurance;
- I. Placements of insurance which were lawful in the jurisdiction in which the transaction took place and which were not unlawful placements under the laws of this state.

Drafting Note: Provisions of a state's constitution, statutes, regulations, and public policy may necessitate amendment of the opening paragraph of this section.

Section 13. ~~Separability Severability Clause of Provisions~~

If any provisions of this Act, or the application of the provision to any person or circumstance, shall be held invalid, the remainder of the Act and the application of the provision to persons or circumstances other than those as to which it is held invalid, shall not be affected thereby.

Section 14. Effective Date

This Act shall take effect [insert appropriate date].

Chronological Summary of Actions (all references are to the Proceedings of the NAIC).

1994 Proc. 3rd Quarter 14, 16-17, 24, 28-46 (adopted).
 1996 Proc. 3rd Quarter 9, 42, 1110, 1168, 1169-1173, 1189-1190 (amended).
 1997 Proc. 4th Quarter 25, 27-28, 1004, 1029 (amended).
 1999 Proc. 3rd Quarter 25, 26, 1080, 1135, 1151-1153 (amended).
 2002 Proc. 2nd Quarter 14, 250-251, 344, 347, 349-350 (amended).

This model draws from and replaces three earlier NAIC models:

Model Surplus Lines Law

1983 Proc. I 6, 36, 834, 900, 913-922 (adopted).
 1985 Proc. II 11, 24, 702, 722, 723-724 (amended).
 1986 Proc. I 9-10, 24, 799, 813, 814-821 (amended).
 1990 Proc. I 6, 30, 840-841, 897-898, 900-901 (amended).
 1991 Proc. I 9, 18, 908, 949, 950, 952-961 (amended and reprinted).

Unauthorized Insurers Model Act

1969 Proc. I 168, 218, 222-227, 271 (adopted).
 1978 Proc. I 13, 15, 348, 350 (amended).
 1990 Proc. II 7, 13-14, 159-160, 187-191 (amended and reprinted).

Model Nonadmitted Insurance Act

1983 Proc. I 6, 36, 834, 899-900, 923-926 (adopted).

PROJECT HISTORY

NONADMITTED INSURANCE MODEL ACT (#870)

1. Description of the Project, Issues Addressed, etc.

The 2023 revisions to the NAIC *Nonadmitted Insurance Model Act* (#870) are intended to conform Model #870 to the federal Nonadmitted and Reinsurance Reform Act of 2010 (NRRRA), which was part of the federal Dodd-Frank Wall Street Reform and Consumer Protection Act (Dodd-Frank Act). The current Model #870 was adopted in 1994 to combine three NAIC models that date as far back as 1969: 1) the Unauthorized Insurers Model Act; 2) the Model Surplus Lines Law; and 3) the Model Nonadmitted Insurance Act. Since the adoption of Model #870 on Sept. 18, 1994, the NAIC has amended it on the following dates: 1) Dec. 16, 1996; 2) March 18, 1998; 3) Dec. 6, 1999; and 4) Sept. 10, 2002. The 2002 modifications resulted from the passage of the federal Gramm-Leach-Bliley Act (GLBA) by the U.S. Congress (Congress). Currently, 31 states have adopted Model #870.

The most recent activity regarding Model #870 is related to the NRRRA. Model #870 was not modified as a result of the implementation of the NRRRA. On Oct. 11, 2011, the *Nonadmitted Insurance Reform Sample Bulletin* (Bulletin), which was distributed to the state insurance departments, was adopted by the Executive (EX) Committee and Plenary. The Bulletin outlined federally mandated regulatory changes that affect the placement of nonadmitted insurance. Specifically, the Bulletin addressed the scope of the NRRRA, the application of “Home State” for the purposes of jurisdictional authority and paying premium tax, licensure requirements for brokers, diligent search requirements, and eligibility requirements for nonadmitted insurers.

During the implementation of the NRRRA, the Surplus Lines (C) Task Force and NAIC staff were working on state tax allocation proposals. The leading proposals were the Surplus Lines Insurance Multistate Compliance Compact (SLIMPACT), which predated the NRRRA, and the Nonadmitted Insurance Multistate Agreement (NIMA), which was developed by the Task Force in response to the NRRRA. The SLIMPACT failed to obtain the 10 states needed to become operative. The NIMA clearinghouse operated for only a few years before the NIMA was dissolved in 2016. With the focus on achieving a system of tax allocation before the NRRRA deadline in July 2012, the decision was made to draft the Bulletin rather than amend Model #870.

During the 2020 Summer National Meeting of the Task Force, the chair directed staff to develop a drafting group to produce a summary document that outlined significant updates needed to modernize Model #870 and present a recommendation to the Task Force at a future national meeting. The drafting group consisted of Tom Travis (LA), Jeff Baughman (WA), Eli Snowbarger (OK), Andy Daleo (NAIC), and Dan Schelp (NAIC). The drafting group met Sept. 30 and Oct. 27, 2020. As a result of those meetings, the drafting group outlined numerous proposed revisions to Model #870.

During the 2020 Fall National Meeting, the Task Force adopted the Request for NAIC Model Law Development. During the 2021 Spring National Meeting, the Executive (EX) Committee approved the Request for NAIC Model Law Development.

2. Name of Group Responsible for Drafting the Model and States Participating

The Surplus Lines (C) Task Force and the drafting group consisting of Louisiana, Chair; Colorado; Illinois; Texas; and Washington.

3. Project Authorized by What Charge and Date First Given to the Group

The charges of the Surplus Lines (C) Task Force state, “Develop or amend relevant NAIC model laws, regulations, and/or guidelines.” Also, as described in charge #1, the Request for NAIC Model Law Development was approved by the Executive (EX) Committee during the 2021 Spring National Meeting.

4. A General Description of the Drafting Process (e.g., drafted by a subgroup, interested parties, the full group, etc). Include any parties outside the members that participated

During the 2021 Summer National Meeting, the Surplus Lines (C) Task Force formally developed the Model #870 Drafting Group that consisted of Travis, chair; Rolf Kaumann (CO); Marcy Savage (IL); Jamie Walker (TX); and Jeff Baughman (WA).

The Drafting Group began its work on Model #870 on Aug. 19, 2021. During that call the Drafting Group discussed the overall approach to updating the model, initial comments received, and a timeline.

5. A General Description of the Due Process (e.g., exposure periods; public hearings; or any other means by which widespread input from industry, consumers, and legislators was solicited)

The Drafting Group met Aug. 19, 2021, for a regulator-only planning session. Following the initial meeting, the Drafting Group met in open session Sept. 28, Oct. 20, Nov. 4, and Dec. 1, 2021. During these sessions, interested state insurance regulators and parties submitted comment letters to the Drafting Group. The Drafting Group held regulator-only discussion and planning calls on Jan. 10, March 15, and May 3, 2022. During a Surplus Lines (C) Task Force call on May 23, 2022, Model #870 was exposed for a 60-day public comment period. Comments were received from the American Property Casualty Insurance Association (APCIA), CRC Group: Wholesale and Specialty Insurance; Lloyd's of London; McDermott Will & Emery; the National Risk Retention Association (NRRRA); Surplus Line Association of Illinois (SLAI); the Council of Insurance Agents & Brokers (CIAB); and the Wholesale & Specialty Insurance Association (WSIA). The Drafting Group held a regulator-only discussion and planning call on Aug. 3, 2022 and the Task Force held a call on Oct. 17 to discuss the comments received and on Oct. 27, 2022 it exposed Model #870 for a 30-day public comment period. Comments were received from the Maine Bureau of Insurance; the APCIA; Lloyd's of London; and the WSIA. During the Fall National Meeting, the Task Force heard a summary of the comments received. The Drafting Group held a regulator-only discussion and planning call on Jan. 18, 2023 to discuss comments received and on Jan. 23 exposed a new draft of Model #870 for a 14-day public comment period. Comments were received from the California Department of Insurance; the APCIA; the CIAB; Lloyd's of London; McDermott Will & Emery; and the WSIA. On Feb. 10 the drafting group held a regulatory-only discussion and planning call and integrated edits into Model #870.

6. A Discussion of the Significant Issues (e.g., items of some controversy raised during the due process and the group's response)

The most significant issue raised was related to the methodology of determining the "Home State" for unaffiliated groups as outlined within Section 2 of the model. Following comments from various interested parties and discussion among Drafting Group members, an agreed-upon revision resulted in clarification via a drafting note.

7. List the Key Provisions of the Model (e.g., sections considered most essential to state adoption)

Section 5C(2)(b) – Non-U.S. Insurers

- For a Nonadmitted Insurer domiciled outside the U.S., the insurer shall be listed on the *Quarterly Listing of Alien Insurers* maintained by the International Insurers Department (IID) of the NAIC.

Section 5G – Surplus Lines Tax

- In addition to the full amount of gross Premium charged by the insurer for the insurance, every Person licensed pursuant to Section 5J of this Act shall collect and pay to the commissioner a sum equal to [insert number] percent of the gross Premium charged, less any return Premium, for Surplus Lines Insurance provided by the licensee pursuant to the license. Where the insurance covers properties, risks or exposures located or to be performed both in and out of this state, the sum payable shall be paid entirely to the Home State of the insured. The tax on any portion of the Premium unearned at the termination of insurance having been credited by the state to the licensee shall be returned to the policyholder directly by the Surplus Lines Licensee or through the producing broker, if any. The Surplus Lines Licensee is prohibited from rebating, for any reason, any part of the tax.

Section 5T – Domestic Surplus Lines Insurer

- The commissioner may designate a domestic insurer as a domestic Surplus Lines Insurer upon its application, which shall include, as a minimum, an authorizing resolution of the board of directors and evidence to the commissioner's satisfaction that the insurer has capital and surplus of not less than \$15 million. (Although this was added to the model as optional, it remains an important part of the model.).

8. Any Other Important Information (e.g., amending an accreditation standard)

There were no discussions held regarding making Model #870 an accreditation standard.

Adopted by the Cannabis Insurance (C) Working Group—July 18, 2023
Adopted by the Property and Casualty Insurance (C) Committee, Aug. 15, 2023
Adopted by the Executive (EX) Committee and Plenary, Aug. 16, 2023

REGULATORY GUIDE
UNDERSTANDING THE MARKET FOR CANNABIS INSURANCE: 2023 UPDATE

NAIC White Paper

Drafted by the
Cannabis Insurance (C) Working Group
of the
Property and Casualty Insurance (C) Committee

TABLE OF CONTENTS

I. INTRODUCTION.....3
II. UNDERSTANDING CANNABIS CONCEPTS AND TERMS.....4
III. THE EXPANSION OF STATES LEGALIZING CANNABIS.....7
IV. FEDERAL LEGISLATION ACTIVITY INTENSIFIES.....10
V. CANNABIS BUSINESS REGULATORY, LICENSING AND EDUCATION LANDSCAPE.....13
VI. CANNABIS OPERATING AND ORGANIZATIONAL STRUCTURES EVOLVE.....24
VII. CANNABIS INSURANCE NEEDS AND COVERAGE AVAILABILITY.....26
VIII. MARKET CONSIDERATIONS FOR COMMERCIAL CANNABIS INSURANCE.....33
IX. RESPONDING TO EMERGING TRENDS.....39
X. CONCLUSIONS.....40
XI. APPENDIX.....43

I. INTRODUCTION

The cannabis industry continues to evolve and expand both in structure and in the number of states with legalized cannabis. The National Association of Insurance Commissioners (NAIC) Cannabis Insurance (C) Working Group's original white paper adopted in 2019, *Regulatory Guide Understanding the Market for Cannabis Insurance*, found there are substantial gaps in insurance coverage for the cannabis industry. While gaps remain, much has transpired since the writing of the original white paper. This white paper seeks to provide an update on activities and trends since the adoption of the previous white paper.

The original white paper focused on the cannabis industry's architecture, insurance needs and gaps, and insurance regulator best practices to encourage insurers to enter the market. The cannabis industry has become more sophisticated since the original white paper was published in 2019. It has also continued to rapidly expand. The maturation and expansion of the cannabis market are driving new product development, infrastructure changes, and the need for businesses to provide ancillary services. It is in these areas where insurance gaps most persist. As such, this white paper will include discussion on emerging insurance issues in these areas of the cannabis industry.

Additionally, the current state of cannabis regulation in the United States (U.S.) will be explored. States and U.S. jurisdictions continue to legalize cannabis, but it remains federally illegal under the Controlled Substances Act (CSA). This tension between federal and state law creates uncertainty about the insurability of cannabis and how policy language will be applied to coverages. Municipal bans on cannabis in states where cannabis has been legalized further complicate this issue. For these reasons, insurers remain reluctant to enter the cannabis space. Although capacity has improved since the first white paper's publishing, most of the commercial insurance for cannabis-related businesses is still found in the excess and surplus lines (also known as the non-admitted) market. Potential paths forward to these issues, including best regulatory practices and addressing the needs of states regulating insurance and cannabis operators under state law.

This white paper will outline the complexities of the cannabis industry, explaining the different designs of cannabis businesses, jurisdictional variations, current insurance types and offerings, potential future insurance products, differences presented by insuring hemp versus cannabis, and the importance of developing consistent regulatory practices for state cannabis insurance regulators. It will also cover cannabis history and terminology, cannabis policy trends at the state and national levels, current landscapes of cannabis regulation, licensing and education, cannabis business operating structures, and cannabis industry insurance market considerations. It will

conclude with a brief discussion on the future state of cannabis insurance, including possible next steps for all affected parties.

The need for accessible, affordable, and adequate insurance for the cannabis industry will only continue to increase. Therefore, it will be vitally important for state insurance regulators to fully comprehend and carefully consider the needs and risks of this industry. Regulators can play an important role in encouraging insurance participation in the new cannabis-related industry, which can help all affected parties achieve risk mitigation with proper financial management. This will lead to increases in consumer protections, as well as better functioning cannabis and insurance markets.

II. UNDERSTANDING CANNABIS CONCEPTS AND TERMS

Cannabis, also known as marijuana, is an annual herbaceous plant in the Cannabis genus under the Cannabaceae family.¹ Cannabis has been referred to as consisting of three species of plants: cannabis ruderalis, cannabis sativa, and cannabis indica. The properties of the plant depend on and are determined by the type of cannabis being produced. Each plant type differs in size, shape, and production yield. Many plants utilized in modern-day cannabis industries are hybrid species that have been selected for certain plant traits.²

Cannabis ruderalis has a naturally high composition of Cannabidiol (CBD), an anti-inflammatory non-psychoactive component, and low concentrations of delta-9 Tetrahydrocannabinol (THC) (the psychoactive substance associated with cannabis).³ This type of plant tends to be short and stalky and has the ability to begin the flowering cycle automatically at a certain point in the plant's lifespan, regardless of lighting.⁴ Cannabis ruderalis produces smaller yields when comparing it to the indica or sativa variants.⁵

¹ John M. McPartland, National Library of Medicine: National Center for Biotechnology Information – Cannabis Systematics at the Levels of Family, Genus, and Species (October 1, 2018) – <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6225593/>

² David Gloss, National Library of Medicine: National Center for Biotechnology Information – An Overview of Products and Bias in Research (July 23, 2015) – <https://pubmed.ncbi.nlm.nih.gov/26202343/>
<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4604179/#:~:text=Cannabis%20is%20often%20divided%20into,of%20the%20same%20parent%20species>

³ *Id.*

⁴ *Id.*

⁵ *Id.*

Cannabis sativa grows taller and more highly branched than the other two species.⁶ Cannabis sativa also grows narrow leaves and tends to produce higher yields than cannabis ruderalis.⁷ Additionally, it can produce high levels of THC composition.

Cannabis indica grows with short and dense branch structures.⁸ Cannabis indica generally has the shortest flowering period of the species.⁹ Cannabis indica also produces higher yields than cannabis ruderalis and can produce high levels of THC.¹⁰

Historically, the terms indica and sativa were introduced in the 18th Century to define different species of cannabis.¹¹ Sativa was used to describe cannabis hemp plants, which were cultivated for plant fibers and seeds.¹² Indica was used to describe intoxicating cannabis, which was harvested for seeds and hashish.¹³ The terms have been adapted to modern-day usage by allowing sativa to refer to cannabis with energizing properties and indica to be synonymous with cannabis that relaxes the consumer.

Recently, scientists have discovered that the effects of a cannabis plant on a consumer result from cannabinoids and terpenes. Cannabinoids are various naturally occurring, biologically active chemical constituents of cannabis, including some that possess psychoactive properties.¹⁴ Examples of cannabinoids include delta-9 THC, a chemical psychoactive component of cannabis, and CBD, a non-psychoactive and anti-inflammatory chemical component. THC is one of many chemical compounds found in the resin secreted by the glands of the cannabis plant. THC can stimulate cells in the brain to release dopamine, creating euphoria.¹⁵ CBD is non-impairing and non-euphoric, meaning it does not cause impairment or intoxication to the consumer.¹⁶

⁶ *Id.*

⁷ *Id.*

⁸ *Id.*

⁹ *Id.*

¹⁰ *Id.*

¹¹ Collective-Cannabis Education: Cannabis Strains: Indica, Sativa, & Hybrid (accessed June 27, 2022) – [https://collective-cannabis.com/cannabis-strains-indica-sativa-hybrid/#:~:text=Cannabis%20Indica%20was%20used%20to,high%20THC%20\(tetrahydrocannabinol\)%20content](https://collective-cannabis.com/cannabis-strains-indica-sativa-hybrid/#:~:text=Cannabis%20Indica%20was%20used%20to,high%20THC%20(tetrahydrocannabinol)%20content)

¹² *Id.*

¹³ *Id.*

¹⁴ Merriam-Webster: Defined Term Cannabinoid (December 13, 2021) – <https://www.merriam-webster.com/dictionary/cannabinoid>

¹⁵ Alina Bradford, Live Science: What is THC? (May 18, 2017) – <https://www.livescience.com/24553-what-is-thc.html>

¹⁶ Kimberly Holland, Healthline: Sativa vs Indica: What to Expect Across Cannabis Types and Strains (March 22, 2021) – <https://www.healthline.com/health/sativa-vs-indica>

Cannabis also contains terpenes, which are aromatic chemical compounds produced and commonly found in plants. Each cannabis plant has a different terpene profile, and the profile of each plant can cause varied effects on the consumer.¹⁷

Usable cannabis and hemp are derived from the same species of plant. However, hemp is defined as cannabis that has a THC concentration of no greater than .3% total, as measured in dry weight.¹⁸ Hemp is cultivated for use in the production of a various assortment of products, including foods and beverages, personal care products, nutritional supplements, fabrics and textiles, paper, construction materials, and other manufactured and industrial goods.¹⁹

Cannabis is produced in several different forms: seeds, clones, plant tissue, plants, harvested materials (i.e., leaves, flowers, stalks, stems, pollen, and concentrates), and consumer products (consumable flowers, concentrates (i.e., hash, kief, waxes, oils, and vapor), topical goods, and infused consumables). The main categories of consumer cannabis products include flowers; concentrates; and infused goods.²⁰

- Cannabis Flower – THC in cannabis plants is produced by resinous glands that tend to concentrate in the plant’s flowers or buds.²¹ Cannabis farmers harvest the flower from the plant (removing bulky leaves and stems with less THC concentration) and dry the plant material of any moisture so it is prepared for consumption. Generally, cannabis flower is often smoked in pipes or hand-rolled cigarettes called joints, pre-rolled joints, or pre-rolls. Cannabis flowers can also be smoked in a cigar or combined with tobacco and smoked as a cigarette.²²
- Cannabis Concentrates – Cannabis can be harvested and processed through methods that produce cannabis concentrates. These products have been grown, harvested, and processed in a way to maximize cannabinoid, THC, and terpene content. Cannabis concentrates can take the form of hash, kief, waxes, or oils. The cannabis in these products has been concentrated through different scientific extraction and processing methods, including but not limited to: screens, sifts, bags, mechanical separation,

¹⁷ Leafly: Indica vs Sativa: understanding the differences between weed types (June 9, 2022) -

<https://www.leafly.com/news/cannabis-101/sativa-indica-and-hybrid-differences-between-cannabis-types#:~:text=The%20common%20understanding%20of%20indicas,social%20gatherings%2C%20and%20creative%20projects>

¹⁸ Amy Abernethy, MD, PhD, U.S. Food & Drug Administration: Hemp Production and the 2018 Farm Bill (July 25, 2019) –

<https://www.fda.gov/news-events/congressional-testimony/hemp-production-and-2018-farm-bill-07252019>

¹⁹ Congressional Research Service: Defining Hemp: A Fact Sheet (March 22, 2019) – <https://sgp.fas.org/crs/misc/R44742.pdf>

²⁰ Weedmaps: A Guide to Cannabis Product Types (accessed June 27, 2022) – <https://weedmaps.com/learn/introduction/guide-cannabis-product-types>

²¹ *Id.*

²² *Id.*

chemical extractions, distillation, and pressurized heat applications. These methods employ different scientific strategies to extract, at highly concentrated ratios, THC from the cannabis plant. The final product of these extraction processes can result in a range of forms, from a dry and granular pollen powder similar to hash or kief to a sticky, resinous wax material, which can resemble plant sap, and is known as cannabis wax (i.e., budders, shatters, crumbles, sugars, distillates, or oils). These forms vary in properties, such as viscosity and density, and are named accordingly. For example, a cannabis concentrate wax marketed as a budder is likely to have the same consistency as household butter, being pliable and not too rigid. However, a cannabis concentrate wax marketed as shatter would have extremely rigid properties, and the wax could break into pieces or shatter if pulled or bent.²³

- **Infused Goods** – Cannabis can also be processed into topical products and infused consumables. Topical products are those that are placed directly on the consumer’s skin. Infused consumables include beverages, edibles, and suppository products that have been infused with cannabis, including cannabinoids such as THC or CBD. Topical products are not associated with impairment or intoxication to the consumer. However, infused consumable products will lead to intoxication or impairment of the consumer, as these products contain cannabis concentrates, including THC and CBD. Examples of infused consumable products include cannabis beverages and edibles.²⁴

III. THE EXPANSION OF STATES LEGALIZING CANNABIS

A. Medical-Use and Recreational-Use Legalization in States

California was the first state in the United States (U.S.) to legalize cannabis for medical use.²⁵ In 1996, California passed Proposition 215, allowing for the sale and medical use of cannabis for patients with AIDS, cancer, and other serious, painful diseases. Currently, as of February 3, 2022, 37 states, the District of Columbia (D.C), and three territories allow for the medical use of

²³ National Institute on Drug Abuse: Cannabis (Marijuana) Concentrates Drug Facts (accessed June 27, 2022) – <https://nida.nih.gov/publications/drugfacts/cannabis-marijuana-concentrates>

²⁴ Leafly: Cannabis Glossary – Topical (accessed June 27, 2022) – <https://www.leafly.com/learn/cannabis-glossary/topical>

²⁵ California Department of Cannabis Control: California’s Cannabis Laws (September 13, 2022) – [https://cannabis.ca.gov/cannabis-laws/laws-and-regulations/#:~:text=California%20became%20the%20first%20state,and%20adult%20\(recreational\)%20use](https://cannabis.ca.gov/cannabis-laws/laws-and-regulations/#:~:text=California%20became%20the%20first%20state,and%20adult%20(recreational)%20use)

cannabis.²⁶ In 2021, 25 years after California first authorized medical cannabis, the majority of states in the U.S. now allow the use of cannabis for medical purposes.

Colorado was the first state in the U.S. to legalize cannabis for recreational purposes in 2012.²⁷ Washington also passed marijuana reform legislation shortly after Colorado, in 2012, legalizing the recreational use of cannabis.²⁸ As of November 9, 2022, 21 states, two territories, and D.C. have enacted legislation to regulate cannabis for nonmedical or recreational use.²⁹ According to 2020 U.S. Census Bureau apportionment numbers, more than 145 million Americans now live in a state that has legalized cannabis.³⁰

The path toward legalization is not necessarily straight, nor is it quick. The following are examples of this experience.

Today, cannabis laws in Alaska allow adult use. The state first legalized medical marijuana in 1998, though for many years, there was no way for patients to legally purchase it.³¹ Alaska was the second state in the U.S. to decriminalize possession of up to one ounce and the third to legalize recreational marijuana.³² Residents over 21 years old with a valid state ID can legally grow up to six plants at home and purchase up to one ounce of marijuana or 7 grams of concentrates from regulated dispensaries.³³ Only cash is accepted.³⁴

²⁶ National Conference of State Legislators: State Cannabis Laws (September 12, 2022) –

<https://www.ncsl.org/research/health/state-medical-marijuana-laws.aspx>

²⁷ Claire Hansen, Horus Alas, and Elliott Davis Jr., US News: Where is Marijuana Legal? A Guide to Marijuana Legalization (October 14, 2021) – <https://www.usnews.com/news/best-states/articles/where-is-marijuana-legal-a-guide-to-marijuana-legalization>

²⁸ The Marijuana Policy Project - Colorado and Washington: Life After Legalization and Regulation (2023) –

<https://www.mpp.org/issues/legalization/colorado-and-washington-life-after-legalization-and-regulation/#:~:text=In%202012%2C%20Colorado%20and%20Washington,halfof%20the%20U.S.%20population>

²⁹ National Organization for the Reform of Marijuana Laws (NORML): Legalization and State Laws Website (November 28, 2022) – [Legalization - NORML](#); The Marijuana Policy Project: State Policy Website (November 28, 2022) –

<https://www.mpp.org/states/>

³⁰ United States Census Bureau: 2020 Census Apportionment Results (September 12, 2022) –

<https://www.census.gov/data/tables/2020/dec/2020-apportionment-data.html>

³¹ Alaska Medical Marijuana Act, Measure 8 (1998) (Accessed August 19, 2022) –

[https://ballotpedia.org/Alaska_Medical_Marijuana_Act,_Measure_8_\(1998\)#:~:text=The%20Alaska%20Medical%20Marijuana%20Initiative,marijuana%20for%20certain%20medical%20purposes.%22](https://ballotpedia.org/Alaska_Medical_Marijuana_Act,_Measure_8_(1998)#:~:text=The%20Alaska%20Medical%20Marijuana%20Initiative,marijuana%20for%20certain%20medical%20purposes.%22)

³² Alaska Marijuana Legalization, Ballot Measure 2 (2014) (Accessed August 19, 2022) –

[https://ballotpedia.org/Alaska_Marijuana_Legalization,_Ballot_Measure_2_\(2014\)](https://ballotpedia.org/Alaska_Marijuana_Legalization,_Ballot_Measure_2_(2014)), and Michael Hartman, National Conference of State Legislatures, Cannabis Overview, Alaska Legalization (May 31, 2022) – <https://www.ncsl.org/research/civil-and-criminal-justice/marijuana-overview.aspx>

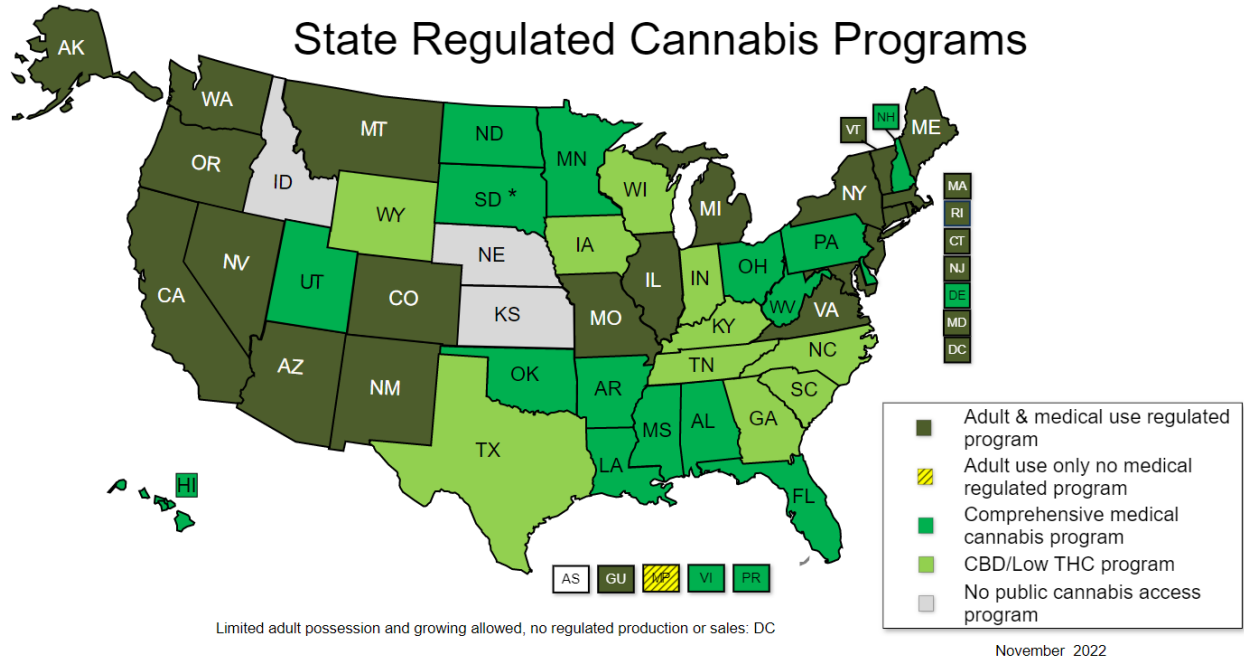
³³ Weedmaps: Alaska, Laws and Regulations (September 12, 2022) – <https://weedmaps.com/learn/laws-and-regulations/alaska>

³⁴ Laurel Andrews, Alaska Official Visitor's Guide, a Tourist's Guide to Legal Marijuana in Alaska (May 2, 2018) –

<https://www.adn.com/alaska-visitors-guide/2018/05/02/a-tourists-guide-to-legal-marijuana-in-alaska/>

Some states did not see cannabis legalized overnight. For example, Oregon’s Measure 80 (Oregon Cannabis Tax Act Initiative) in 2012 did not receive enough “yes” votes.³⁵ Measure 80 would have permitted cannabis to be sold at state-licensed stores and would have permitted adults to purchase cannabis at such stores without a license. Oregon did not legalize such recreational cannabis use until July 2016.³⁶ This is a consistent experience among the states where there is a majority support for legalization, but it may take multiple attempts.

The nature of cannabis being regulated on a state-by-state basis permits state systems on cannabis regulation to differ quite drastically. The below map outlines the different states and their varied approaches to cannabis regulation:



* National Conference of State Legislatures: State Cannabis Laws – Map of State Regulated Cannabis Programs (November 2022 - <https://www.ncsl.org/research/health/state-medical-marijuana-laws.aspx>)

B. Public Opinion Supports Legality Expansion

As discussed in the previous white paper, the majority of Americans now support legalized cannabis.³⁷ In fact, public support for legalizing cannabis is increasingly favorable. Over 90% of

³⁵ Ballotpedia: Oregon Cannabis Tax Act Initiative, Measure 80 (2012) (July 15, 2022) – [https://ballotpedia.org/Oregon_Cannabis_Tax_Act_Initiative,_Measure_80_\(2012\)](https://ballotpedia.org/Oregon_Cannabis_Tax_Act_Initiative,_Measure_80_(2012))

³⁶ Travel Portland Website: Legal Cannabis in Portland and Oregon (March 4, 2022) – <https://www.travelportland.com/culture/legal-marijuana-portland-oregon/>

³⁷ NAIC: Regulatory Guide – Understanding the Market for Cannabis Insurance (May 24, 2019) – https://content.naic.org/sites/default/files/inline-files/cmte_c_cannabis_wg_exposure_understanding_cannabis_marketplace_0.pdf

U.S. adults in 2021 believe cannabis should be legal for either medical or recreational purposes.³⁸ Here, 60% support the legalization of cannabis for medical and recreational use, and 31% support the legalization of cannabis for medical use only.³⁹ Public opinion on cannabis and cannabis legalization have changed significantly since President Richard Nixon signed the Controlled Substances Act (CSA) of 1970 into law. Once associated with the war on drugs, cannabis now presents business opportunities, with the state-legal cannabis markets expected to reach over \$40 billion in the U.S. by 2026.⁴⁰

Public opinions and perspectives on cannabis are shifting to a level of lower scrutiny than experienced under the previous zero-tolerance approach adopted by the federal government and individual states. For example, U.S. Congress has considered replacing the statutory term of reference from marijuana or marihuana to cannabis.⁴¹ The changing of terms from marijuana to cannabis is being pursued in part because there are potentially negative connotations associated with the history and origin of the term marihuana.⁴² States have also sought similar legislation for the switching of statutory references from marijuana to cannabis.⁴³ The increasing legislative reformation of cannabis at the federal and state levels, as well as less scrutiny from the public, combine to show that cannabis is likely trending toward regulation versus outright prohibition.

IV. FEDERAL LEGISLATION ACTIVITY INTENSIFIES

Conflicting individual state and federal laws on cannabis have largely discouraged insurers from participating in coverage of the market. To illustrate this conundrum, cannabis is an illegal substance under the Classified Substances Act (CSA).⁴⁴ The CSA classifies cannabis as a Schedule I drug that has no currently accepted medical use in the U.S.⁴⁵ A 2018 Farm Bill provision removed hemp from the list of Schedule I controlled substances.⁴⁶ Therefore, the U.S. Drug Enforcement Administration (DEA) will not consider hemp-derived cannabinoids as a controlled substance that

³⁸ Ted Van Green, PEW Research Center: Americans overwhelmingly say marijuana should be legal for recreational or medical use (November 15, 2021) – <https://www.pewresearch.org/fact-tank/2022/11/22/americans-overwhelmingly-say-marijuana-should-be-legal-for-medical-or-recreational-use/>

³⁹ *Id.*

⁴⁰ Alex Malyshev and Sarah Ganley, Reuters: Reading the tea leaves: What might federal legalization of marijuana look like? (November 15, 2021) – <https://www.reuters.com/legal/litigation/reading-tea-leaves-what-might-federal-legalization-marijuana-look-like-2021-11-15/2021> – <https://www.pewresearch.org/fact-tank/2021/04/16/americans-overwhelmingly-say-marijuana-should-be-legal-for-recreational-or-medical-use/>

⁴¹ Congress.Gov: H.R. 3617 – MORE Act of 2021 – <https://www.congress.gov/bill/117th-congress/house-bill/3617>

⁴² Matt Thompson, NPR: The Mysterious History of ‘Marijuana’, (July 22, 2021) – <https://www.npr.org/sections/codeswitch/2013/07/14/201981025/the-mysterious-history-of-marijuana>

⁴³ Washington State: Chapter 16, Laws of 2022 (67th Legislature, 2022 Regular Session) –

<https://lawfilesexxt.leg.wa.gov/biennium/2021-22/Pdf/Bills/Session%20Laws/House/1210-S2.SL.pdf>

⁴⁴ U.S. DEA Website, The Controlled Substances Act ([Title 21 United States Code \(USC\) Controlled Substances Act](https://www.dea.gov/drug-information/csa)) – <https://www.dea.gov/drug-information/csa>

⁴⁵ *Id.*

⁴⁶ U.S. Department of Agriculture Website, Farm Bill – <https://www.usda.gov/farmbill>

is subject to the CSA. However, cannabis and CBD (irrespective of being sourced from cannabis or hemp) are subject to Federal Drug Administration (FDA) approval under the federal Food, Drug, and Cosmetic Act (FD&C Act).⁴⁷ The FDA has not yet approved a cannabis drug for medical use or treatment. The FDA has approved CBD medicines for the treatment of epilepsy. Federal law currently prohibits CBD from being added to any food or drink product. On July 22, 2019, the FDA issued formal letters making the determination that certain CBD products were sold in violation of the FD&C Act.⁴⁸ Despite this prohibition, products containing CBD are generally widely available in the retail marketplace in formulations ranging from nutritional supplements to cosmetics and for both human and veterinary use.

Companies functioning within state-legal cannabis industries generally experience banking restrictions due to federal regulations.⁴⁹ This causes many cannabis businesses and cannabis-related businesses (CRBs) to function on a cash-only basis. Current estimates show that approximately 70% of CRBs operate solely as a cash-only business and have no formal relationship with a bank.⁵⁰ This causes CRBs to possess and process large amounts of money in cash form, which can create a higher risk of theft and additional liabilities.⁵¹ More on this and the federal authorities limiting the abilities of cannabis businesses to engage in financial transactions can be found in the NAIC's White Paper on *Understanding the Market for Cannabis Insurance (2019)*.

There is an ongoing concern about entities supporting cannabis businesses being charged with violation of the federal Racketeer Influenced and Corrupt Organizations (RICO) Act. In addition, the federal Internal Revenue Code 280E prevents cannabis businesses from taking advantage of tax deductions for actual economic expenses incurred in the ordinary course of business. This can prevent cannabis businesses from taking deductions related to insurance and premiums or costs, such as for workers' compensation and health insurance.

Recently, the federal government has been considering cannabis reform legislation at a record-setting pace. During the 117th Congress (in 2021 – 2022), at least five different pieces of national

⁴⁷ U.S. Food & Drug Administration Website (FD&C Act) – <https://www.fda.gov/regulatory-information/laws-enforced-fda/federal-food-drug-and-cosmetic-act-fdc-act>

⁴⁸ NAIC – CIPR Topics: Cannabis and Insurance (August 18, 2021) – https://content.naic.org/cipr_topics/topic_cannabis_and_insurance.htm

⁴⁹ NAIC: Regulatory Guide – Understanding the Market for Cannabis Insurance (May 24, 2019) – https://content.naic.org/sites/default/files/inline-files/cmte_c_cannabis_wg_exposure_understanding_cannabis_marketplace_0.pdf

⁵⁰ NAIC – CIPR Topics: Cannabis and Insurance (August 18, 2021) – https://content.naic.org/cipr_topics/topic_cannabis_and_insurance.htm

⁵¹ *Id.*

cannabis reform legislation were introduced.⁵² Each bill took a different approach to altering the federal government's position on cannabis. The bills include the federal Safe and Fair Enforcement (SAFE) Banking Act, the Clarifying Law Around Insurance of Marijuana (CLAIM) Act, the Marijuana Opportunity Reinvestment and Expungement (MORE) Act of 2021, the Cannabis Administration and Opportunity (CAOA) Act, and the States Reform Act of 2021.

The CLAIM Act would provide a safe harbor from penalties or other adverse agency action for insurance companies that provide services to cannabis-related legitimate businesses in jurisdictions where such activity is legal. The U.S. Government Accountability Office (GAO) must report on barriers to marketplace entry for minority-owned and women-owned cannabis-related businesses.⁵³

The NAIC submitted a letter in support of the CLAIM Act on June 17, 2021. The letter acknowledged the bill would provide a safe harbor from violations of federal law for those engaged in the business of insurance participating in cannabis industry activity that is permissible under state law. By removing barriers, the CLAIM Act would permit insurers to provide insurance coverage options for these commercial policyholders.⁵⁴

The SAFE Banking Act would remove constraints on depository institutions to provide banking services to a legitimate cannabis-related business. Under the SAFE Banking Act, proceeds would not be considered unlawful activity and not run afoul of anti-money laundering laws. Under this act, depository institutions would not be at risk of forfeiting financial assets for providing a loan or other financial services to a legitimate cannabis-related business. The NAIC also submitted a letter in support of the SAFE Banking Act on June 17, 2021.

The MORE Act would decriminalize cannabis. Specifically, it removes cannabis from the list of scheduled substances under the CSA and eliminates criminal penalties for an individual who manufactures, distributes, or possesses cannabis. The States Reform Act of 2021 would remove the legal obstacles preventing U.S. cannabis companies from accessing the financial system and allow for interstate commerce of cannabis. The bill also requests the release and expungement of people convicted of nonviolent cannabis-only crimes.⁵⁵

⁵² Julie Hyman, Yahoo! Finance: Weed is Likely to Remain Federally Illegal, but 'Cannabis Banking' Could Pass this Year (March 31, 2022) – <https://finance.yahoo.com/news/weed-is-likely-to-remain-federally-illegal-but-cannabis-banking-could-pass-this-year-132330251.html>

⁵³ Congress.Gov: H.R. 2068 – CLAIM Act – <https://www.congress.gov/bill/117th-congress/house-bill/2068>

⁵⁴ NAIC Support Letter – Claim Act 2021 (June 17, 2021) – <https://content.naic.org/sites/default/files/government-affairs-letter-support-claim-act-2021.pdf>

⁵⁵ Congress.Gov: H.R. 5977 – To amend the Controlled Substances Act regarding marihuana, and for other purposes. – <https://www.congress.gov/bill/117th-congress/house-bill/5977?s=1&r=5>

On July 21, 2022, Senate Majority Leader Chuck Schumer introduced the CAO Act.⁵⁶ The CAO Act attempts to accomplish significant reformation of federal cannabis policy, allowing states to lead on cannabis regulation and establishing a federal regulatory paradigm similar to that of alcohol and tobacco.⁵⁷ The CAO would expunge federal cannabis-related records and create funding for law enforcement departments to fight illegal cannabis cultivation.⁵⁸

On October 6, 2022, President Biden asked the Secretary of Health and Human Services and the Attorney General to review how marijuana is categorized under federal law.⁵⁹ President Biden also signed the Medical Marijuana and Cannabidiol Research Expansion Act (Statute at Large 136 Stat. 4178 - Public Law No. 117-215) in December 2022. This new law is anticipated to increase access to the scientific study of cannabis by streamlining the government issuance of permits to scientists who want to study the substance and expediting applications for cannabis producers (including universities) that grow the substance for research purposes.⁶⁰ None of these laws were passed in the previous Congress, but it is anticipated that discussion will continue on these issues.

V. CANNABIS BUSINESS REGULATORY, LICENSING, AND EDUCATION LANDSCAPE

A. States Legalize Cannabis Around the Cole Memorandum

Colorado and Washington were the first states to legalize cannabis for recreational use in 2012. At that time, 19 states had already legalized cannabis for medical use. To address the growing legalization of cannabis use by the states, the federal Department of Justice (DOJ) issued the Cole Memorandum in 2013. The Cole Memorandum provided states with the federal position on the enforcement of marijuana under the Classified Substances Act (CSA). Specifically, it provided that the federal government would not prioritize enforcement or interference with state implementation of regulated cannabis programs if states upheld the Department of Justice's (DOJ's) and federal government's priorities.⁶¹ These priorities included:

⁵⁶ Natalie Fertig, Politico: Schumer's Legal Weed Bill is Finally Here, (July 21, 2022) – <https://www.politico.com/news/2022/07/21/schumer-legal-weed-bill-00047058>

⁵⁷ John Schroyer and Jeff Smith, MJBizDaily: Schumer Marijuana Legalization Bill Finally Introduced in Senate, (July 22, 2022) – https://mjbizdaily.com/schumer-marijuana-legalization-bill-finally-introduced-in-senate/?utm_medium=email&utm_source=newsletter&utm_campaign=MJD_20220722_NEWS_Daily&nowprocket=1

⁵⁸ Natalie Fertig, Politico: Schumer's Legal Weed Bill is Finally Here, (July 21, 2022) – <https://www.politico.com/news/2022/07/21/schumer-legal-weed-bill-00047058>

⁵⁹ The White House: Briefing Room Website – Statement from President Biden on Marijuana Reform, (October 6, 2022) – <https://www.whitehouse.gov/briefing-room/statements-releases/2022/10/06/statement-from-president-biden-on-marijuana-reform/>

⁶⁰ Meredith Wadman, Science Insider: New U.S. Law Promises to Light Up Marijuana Research, (December 2, 2022) – <https://www.science.org/content/article/new-u-s-law-promises-light-marijuana-research>

⁶¹ *Id.*

- Preventing the distribution of marijuana to minors;
- Preventing revenue from the sale of marijuana from going to criminal enterprises, gangs, and cartels;
- Preventing the diversion of marijuana from states where it is legal under state law in some form to other states;
- Preventing state-authorized marijuana activity from being used as a cover or pretext for the trafficking of other illegal drugs or other illegal activity;
- Preventing violence and the use of firearms in the cultivation and distribution of marijuana;
- Preventing drugged driving and the exacerbation of other adverse public health consequences associated with marijuana use;
- Preventing the growing of marijuana on public lands and the attendant public safety and environmental dangers posed by marijuana production on public lands; and
- Preventing marijuana possession or use on federal property.

Many states that voted to legalize the sale and use of cannabis designed their regulated cannabis systems to carefully consider the DOJ and federal government priorities outlined in the Cole Memorandum. Each state took an individualized approach to implementing cannabis regulation. This has led to individual cannabis industries across the country that operate under separate and distinct authorities for their jurisdictions. The differences in state cannabis regulations are evident in the varied cannabis business licensing programs, regulation authorities, consumer experiences, and associated practices for CRBs. For example, Colorado has implemented a regulatory system where cannabis businesses can vertically integrate their businesses, including agriculture, retail sales, and manufacturing. Washington has implemented a prohibition on vertical integration, requiring licensed cannabis businesses to operate in their licensed business classification, such as a cannabis retailer, cannabis producer, or cannabis processor.

The Cole Memorandum was rescinded by the federal government in 2018.⁶² This created a gray area for states with legal cannabis operations. The United States Attorney General issued new guidance in 2018 under Attorney General Jefferson B. Sessions. The new guidance directed U.S. state attorneys to use their discretion, as well as well-established principles that govern all federal prosecutions, in cannabis enforcement.⁶³ The current administration has expressed views to return to a Cole-like environment but has not taken an official position.

⁶² Office of the Attorney General: Memorandum for All US Attorneys (January 4, 2018) – <https://www.justice.gov/opa/press-release/file/1022196/download>

⁶³ *Id.*

B. The Role of CANNRA

States have been striving to work toward best policies and practices in the cannabis and insurance industries by working through the Cannabis Regulators Association (CANNRA). CANNRA is a national not-for-profit organization of cannabis regulators that provides policymakers and regulatory agencies with the resources to make informed decisions when considering whether and how to legalize and regulate cannabis.⁶⁴ It is a support association for regulatory agencies, not a cannabis advocacy group. As such, it takes no formal position for or against cannabis legalization but rather seeks to provide government jurisdictions with unbiased information to help make informed decisions when considering whether or how to legalize or expand regulated cannabis.⁶⁵ Membership in CANNRA is limited to regulators and representatives from relevant government offices.⁶⁶ CANNRA is funded by member agencies and does not receive funding from industry or advocacy groups.⁶⁷

CANNRA strives to create and promote harmony and, where possible, standardization across jurisdictions that legalize and regulate cannabis.⁶⁸ CANNRA helps interested parties find objective data and evidence-based approaches to policymaking and implementation.⁶⁹ CANNRA also works to ensure federal officials benefit from the vast experiences of states across the nation so that any changes to federal law adequately address states' needs and priorities.⁷⁰

C. Cannabis Impairment and Insurance Considerations

Insurers rely on data to help them understand the risks they indemnify. However, there is still much to know about impairment and cannabis use. Cannabis shares the Schedule I classification along with some of the most serious drugs, including heroin, LSD, and meth. As such, cannabis used for studies must come from federally approved facilities. Historically, the University of Mississippi was recognized as the only institution federally approved to cultivate cannabis for research, with the license awarded in 1968.⁷¹ The cannabis that is produced in this facility does

⁶⁴ CANNRA: Home Website Page (accessed June 27, 2022) – <https://www.cann-ra.org/>

⁶⁵ *Id.*

⁶⁶ CANNRA: Membership Website Page (accessed June 27, 2022) – <https://www.cann-ra.org/leadership>

⁶⁷ CANNRA: News and Events Website Page (accessed June 27, 2022) – <https://www.cann-ra.org/news-events>

⁶⁸ *Id.*

⁶⁹ *Id.*

⁷⁰ *Id.*

⁷¹ Omar Sacirbey, MJ Biz Daily: DEA close to allowing companies to grow cannabis for scientific research (December 17, 2021) – <https://mjbizdaily.com/dea-preparing-to-ok-companies-to-grow-cannabis-for-scientific-research/#:~:text=Currently%2C%20the%20University%20of%20Mississippi,awarded%20its%20license%20in%201968.>

not resemble the cannabis in modern-day retailers. In fact, the cannabis produced in the federally approved facilities does not mimic the appearance nor potency of state-regulated cannabis.⁷²

Recently, the federal government, through the Drug Enforcement Administration (DEA), approved registrations for two other companies to produce cannabis for research purposes.⁷³ This is a historic development for the research of cannabis and allows the DEA to oversee the production of research-grade cannabis at a level not previously achieved by the University of Mississippi.⁷⁴ The two companies include Groff North America Hemplex and the Biopharmaceutical Research Company, which began harvesting their first crops by January 2022.⁷⁵

The limitations on human studies, with limited accessibility to cannabis that resembles that same substance in state-legal medical and retail markets, create substantial complications to the scientific research of cannabis, including long-term studies on the effects or dangers of impairment and usage. Thus, they provide limited information from which to develop policy or make informed decisions.

Testing for cannabis impairment is difficult due to the limits of drug testing technology, as well as the lack of a recognized limit to determine impairment. For example, the nationally recognized level of impairment for alcohol is set at .08 g/mL of blood alcohol concentration, which is well-founded in scientific research. However, there is no similar national standard set for driving under the influence of cannabis. Cannabis may not affect all people consistently. Cannabis may remain in a person's body for weeks after consumption, and may still appear in drug tests, even though it may no longer be causing impairment to the consumer. As a practical matter, because of these problems, drivers may be tested for high blood alcohol concentrations but may not be tested for other impairing substances.

The states of Illinois, Montana, Nevada, Ohio, and Washington have all adopted specific per se limits for THC present in a driver's body, with ranges between two nanograms and five nanograms per milliliter of blood.⁷⁶ These authorities provide that when a person has reached or

⁷² Christopher Ingraham and Tauhid Chappell, The Washington Post: Government marijuana looks nothing like the real stuff. See for yourself. (March 13, 2017) – <https://www.washingtonpost.com/news/wonk/wp/2017/03/13/government-marijuana-looks-nothing-like-the-real-stuff-see-for-yourself/>

⁷³ Kyle Jaeger, Marijuana Moment: Federal Marijuana Monopoly Finally Ends as Two Companies Harvest Cannabis Approved by DEA (January 4, 2022) – <https://www.marijuanamoment.net/dea-finally-breaks-federal-marijuana-grower-monopoly-with-two-new-companies-harvesting-cannabis-approved-by-agency/>

⁷⁴ *Id.*

⁷⁵ *Id.*

⁷⁶ National Conference of State Legislatures (NCSL): Drugged Driving | Marijuana-Impaired Driving (September 23, 2021) – <https://www.ncsl.org/research/transportation/drugged-driving-overview.aspx>

exceeded the legal threshold, that person is considered impaired under law. The state of Colorado has a reasonable inference law that outlines that in instances where THC is identified in a driver's blood, at quantities of 5ng/ml or more, it is assumed that the driver was under the influence.⁷⁷ The reasonable inference laws are different from the per se laws, as they allow drivers who are charged to raise an affirmative defense showing that despite having tested at or above the legal limit, they were not actually impaired. There are also 12 states that have zero-tolerance laws for THC, including Arizona, Delaware, Georgia, Indiana, Iowa, Michigan, Oklahoma, Pennsylvania, Rhode Island, South Dakota, Utah, and Wisconsin.⁷⁸

Complicating this issue is the lack of technologies, scientific methodologies, or accepted best practices in discovering or determining cannabis impairment. New technologies are being developed and generally involve biological screening or field sobriety tests. Here, examples of technologies used to detect cannabis impairment include saliva, urine, and blood testing machines. A few states, including Alabama and Michigan, have adopted active oral fluid roadside tests for drivers suspected to be impaired by cannabis use, among other drugs, which could negatively impact their driving.⁷⁹ Law enforcement officers in most states also generally possess discretion to determine whether an individual is impaired and presents a risk to themselves or others, whether using cannabis or other impairing substances in public, the workplace, or in driving situations. Many law enforcement agencies employ Drug Recognition Experts (DREs), who rely on professional experience and training to discover and determine whether an individual is impaired by cannabis usage. The use of new technology, scientific methodology, and best practices among law enforcement agencies will be critical in mitigating the risks of cannabis impairment in our workplaces and on our roadways.

1. Cannabis Driving Impairment – Cannabis DUI

Preventing cannabis users from driving while impaired was a top priority enumerated in the Cole Memorandum and an issue that each state with a regulated cannabis industry has considered. Cannabis is the second leading substance present in cases of driving under the influence, trailed only by alcohol.⁸⁰ Scientists and law enforcement are still seeking a reliable DUI test to identify impairment from cannabis use. While there are blood tests that can detect some of cannabis's components, such as THC, there is no scientifically accepted standardized method of testing or

⁷⁷ Colorado Department of Transportation: FAQs on Impaired Driving (September 13, 2022) – <https://www.codot.gov/safety/impaired-driving/druggeddriving/faqs>

⁷⁸ National Conference of State Legislatures (NCSL): Drugged Driving | Marijuana Impaired Driving (September 23, 2021) – <https://www.ncsl.org/research/transportation/drugged-driving-overview.aspx>

⁷⁹ *Id.*

⁸⁰ National Institute on Drug Abuse: Drugged Driving DrugFacts (September 13, 2022) – <https://nida.nih.gov/publications/drugfacts/drugged-driving>

determining the level of impairment from a cannabis user's blood or breath. Law enforcement officers may also have the discretion of completing a field sobriety test with any person they suspect is driving under the influence.

The National Association of Mutual Insurance Companies (NAMIC) analyzed this issue in 2021 with its research on the *Cannabis Conundrum: The Intersection of Property/Casualty Insurance and Cannabis-Impaired Driving*.⁸¹ NAMIC's research revealed that the states that have legalized cannabis for medical and recreational use will only continue to grow as ballot initiatives and legislation are codified. This places a focus on scientific research, funding, and technology development that will assist all parties in better understanding and ability to mitigate risks that cannabis-impaired driving may present. Educational campaigns to educate drivers of all ages and backgrounds on the potential risks associated with cannabis consumption will be needed.

Some studies, including studies associated with NAMIC and the American Property Casualty Insurance Association (APCIA), show a direct relation between cannabis regulation and increased auto accidents, as well as an associated increase in auto insurance premiums.^{82,83} Other studies focus on data that shows an increase in cannabis DUIs and related car accidents, whether related to recreational or medical cannabis legalization.^{84,85} Multiple insurance periodicals have recorded similar increases in car insurance claims and accident rates after states have regulated cannabis.^{86,87} Obviously, increased accident rates and claims have an effect on premiums; however, at this point, research is inconclusive on whether the relationship is a correlation or a direct causation.

Education for those outside of the cannabis industry can be conducted through public service announcements, government-sponsored education efforts, informative websites, and news media. For example, the U.S. Department of Transportation (DOT), the National Highway Traffic Safety Administration (NHTSA), and the Ad Council have recently started a campaign

⁸¹ Tony Cotto and Andrew Malin, NAMIC Advocacy: Cannabis Conundrum – The Intersection of Property/Casualty Insurance and Cannabis-Impaired Driving (May 10, 2021) – https://www.namic.org/pdf/publicpolicy/210510_cannibus_conundrum.pdf

⁸² Tony Cotto and Andrew Malin, NAMIC Advocacy: Cannabis Conundrum – The Intersection of Property/Casualty Insurance and Cannabis-Impaired Driving (May 10, 2021) – https://www.namic.org/pdf/publicpolicy/210510_cannibus_conundrum.pdf

⁸³ Stephanie Strategos Polis, American Property Casualty Insurance Association: Marijuana Legalization Reaffirms Auto Safety as Top Priority for Insurers (November 17, 2020) – <https://www.apci.org/media/news-releases/release/64148/>

⁸⁴ Angela Eichelberger, National Library of Medicine: Marijuana use and driving in Washington State: Risk perceptions and behaviors before and after implementation of retail sales (March 1, 2019) – <https://pubmed.ncbi.nlm.nih.gov/30822133/>

⁸⁵ The Highway Loss Data Institute: Recreational Marijuana and Collision Claim Frequency, Vol. 24, No. 14 (April 2017) – https://www.ihs.org/media/806f7c38-4594-4bbe-82ff-df4a749f5153/9fjfcw/HLDI%20Research/Bulletins/hldi_bulletin_34-14.pdf

⁸⁶ Insurance Journal: First States to Legalize Marijuana See Rise in Car Insurance Claims, Research Shows (January 7, 2019) – <https://www.insurancejournal.com/magazines/mag-features/2019/01/07/513762.htm>

⁸⁷ Jim Sams, Claims Journal: Insurance Group Says Data Suggests Cannabis is Increasing Accident Rates (March 14, 2019) – <https://www.claimsjournal.com/news/national/2019/03/14/289753.htm>

communicating the dangers of driving while under the influence of cannabis, called *Drug Impaired Driving: If You Feel Different, You Drive Different*.⁸⁸

2. Cannabis Workplace Impairment

Currently, two out of three Americans live in a state that has approved the sale and use of recreational cannabis.⁸⁹ Cannabis can appear in drug tests and remain in a consumer for 30 days or longer.⁹⁰ Therefore, cannabis users could lawfully consume the substance during their off-work hours but still be affected by cannabis or THC in their systems during work. Employers must assess if their staff present a risk of liability to themselves or others. Problems include issues with pre-employment drug testing, determining employee impairment, establishing reasonable accommodations, and maintaining medical privacy.

It should be noted that there is little data on the impact of legal market cannabis consumption on everyday life. There is a huge range of products available on the legal market that have never touched a research lab. Cannabis consists of a few primary cannabinoids and hundreds of minor cannabinoids and terpenes, and many are still being discovered. There is also a huge variation in potency across strains. Different products have different levels of major and minor cannabinoids, and each looks distinct. For these reasons, the study of cannabis is unlike the study of other drugs, where one is pretty much focused on a dose-dependent effect of a single pharmacological agent.⁹¹

Overlapping authorities and developments in case law on the topic have revealed that employers lack consistent and developed guidelines for cannabis drug testing in the workplace. Case law in several states, including California, Oregon, and Washington, has established that a private employer can terminate an employee for failing a company's drug test, even if that employee is authorized under state law to use cannabis as a medicine.⁹² Multiple states, including Arizona, Arkansas, Connecticut, Delaware, Maine, Minnesota, Oklahoma, Pennsylvania, Rhode Island, and

⁸⁸ U.S. Department of Transportation (NHTSA) (April 3, 2023) – <https://www.nhtsa.gov/campaign/if-you-feel-different-you-drive-different#:~:text=Several%20scientific%20studies%20show%20that,will%20be%20arrested%20for%20DUI>.

⁸⁹ Justin McCarthy, Gallup: Two in Three Americans Now Support Legalizing Marijuana (October 22, 2018) – <https://news.gallup.com/poll/243908/two-three-americans-support-legalizing-marijuana.aspx>

⁹⁰ Zawn Villines, Medical News Today: How long can you detect marijuana (cannabis) in the body (February 21, 2022) – <https://www.medicalnewstoday.com/articles/324315>

⁹¹ Cinnamon Bidwell, Presentation from the University of Colorado on Emerging Scientific Issues in the Cannabis Space (December 1, 2021)

⁹² Sachi Clements, Esq., NOLO Legal: State Laws on Off-Duty Marijuana Use (September 13, 2022) – <https://www.nolo.com/legal-encyclopedia/state-laws-on-off-duty-marijuana-use.html>

West Virginia, prohibit employers from refusing to employ an applicant or terminate an existing employee based only on a positive drug test for cannabis.⁹³

Recently, some employers in the private sector have been reducing the scrutiny placed on cannabis use and impairment in the workplace. In September 2021, Amazon made the corporate decision to no longer deny employment, or terminate employees, due to failed drug tests due to cannabis use.⁹⁴ Amazon even emphasized that the company would reinstate employment eligibility for previous applicants and staff who were terminated or deferred during random or pre-employment cannabis screenings.⁹⁵ However, this policy has exceptions, where employees involved in transportation may be required to prove they have not used and will not be impaired by cannabis.⁹⁶ The shift from a zero-tolerance policy on drug testing for cannabis use to one of acceptance is further evidenced by the developments in professional sports industries. Four of the biggest professional sports in America, including the NBA, NHL, MLB, and NFL, have all relaxed their drug testing policies as it pertains to cannabis.⁹⁷

3. Other Cannabis Impairment Considerations

Cannabis businesses are attempting to capitalize on the trend of increased usage by bringing ingenuity to their products and services.⁹⁸ While many consumers historically smoked the substance in private settings, there are now other innovative forms of cannabis in the regulated markets which allow consumers to eat or vaporize the substance discreetly in public environments.⁹⁹ These trends of increased exposure, additional usage, as well as ingenuity in the cannabis industry, combine to create complications with regulating and insuring the risks of cannabis impairment.

Prior to legalization, cannabis users would need to consume their cannabis products in private locations, out of view from the public and law enforcement. Cannabis users employed these strategies to secretly consume the illegal cannabis products for effect while also avoiding the risk of penalties from law enforcement. However, with the legalization of cannabis came the ability for consumers to use cannabis in different forms and settings. For example, a current medical

⁹³ *Id.*

⁹⁴ Janis I. Jeffreys, Cannabis Law PA: Why Amazon.com is no Longer Pre-employment Drug Testing for Marijuana (September 13, 2022) – <https://cannabislawpa.com/why-amazon-com-is-no-longer-pre-employment-drug-testing-for-marijuana/>

⁹⁵ *Id.*

⁹⁶ *Id.*

⁹⁷ Jeffrey Draluck, Athletes for Care: Which Major Sports Leagues Have Relaxed Their Cannabis Policies? (July 13, 2021) – <https://athletesforcare.org/news/573160/Which-Major-Sports-Leagues-Have-Relaxed-Their-Cannabis-Policies.htm>

⁹⁸ Heesun Wee, NBC News: Growing the Pot Industry: A Test of American Business Ingenuity (January 14, 2014) –

<https://www.nbcnews.com/business/business-news/growing-pot-industry-test-american-business-ingenuity-flna2d11923844>

⁹⁹ *Id.*

cannabis patient in Las Vegas can lawfully use a cannabis vaporizer at a cannabis consumption lounge to administer their prescribed medications.¹⁰⁰

Cannabis legalization and ingenuity possess potential to increase the frequency, exposure, and risks of cannabis impairment. Cannabis is now offered in newer and varied mediums, such as beverages and edibles, and can be created with concentrated forms of cannabis that are much more potent. Cannabis consumers run the risk of being uninformed on if the product has been scientifically researched or studied for long-term side effects and what level of impairment it is likely to produce.

The risks posed by cannabis impairment must be carefully considered in the underwriting process to ensure adequate coverage and appropriate premiums. Risk selection and risk classification play important roles in insurance underwriting systems. The current state of cannabis research may not provide the insurance industry with a sufficient understanding of cannabis impairment and how it can impact underwriting. An incomplete understanding of the increased risks associated with cannabis impairment could lead to circumstances of underinsured policyholders or a lack of sustainable insurer solvency.

D. Cannabis Education Landscape

Education could help address complications and gaps experienced in the cannabis and insurance industries caused by the recent and rapid rate of state regulation. Those needing to maintain currency include cannabis business owners, employees and licensees, regulators, and the insurance industry, such as insurers, claims adjusters, agents, and producers. Many involved in the cannabis industry and businesses would be better able to mitigate their risks with insurance by keeping current on applicable authorities and their requirements.

Regulators and other interested parties should enhance their knowledge by understanding industry trends, such as current and future state cannabis or insurance market conditions. For example, pre-license training for insurance producers does not touch on the topic of cannabis, but the insurance producers may be engaged in providing coverage to the cannabis industry. A producer of insurance should be well educated about the industry they provide coverage for in order to ensure the procured policy is appropriate, adequate, and lawful. Additionally, claims adjusters may need specialized training on cannabis-related claims.

¹⁰⁰ Patrick Maravelias, MJBizDaily: Las Vegas Cannabis Industry Preps for Launch of Consumption Lounges (August 8, 2022) – <https://mjbizdaily.com/las-vegas-cannabis-industry-preps-for-launch-of-consumption-lounges/>

E. Vaping Regulations and Their Impact on Cannabis

As cannabis is legalized and regulated in different states across the country, ingenuity in cannabis products and technologies continues to create complications for regulators, insurers, businesses, and consumer populations alike. An example of this is the increased use of and access to cannabis vaping or vaporization products.

Vaping technology was developed to provide a noncombustible nicotine delivery system to help cigarette and tobacco smokers. Vaping devices heat liquid into an aerosol that can be inhaled. This method of vaporization has now been adapted for cannabis use and is the method often used to consume cannabis products. Studies have shown that cannabis users believe vaping the substance is less harmful to their health than the consumption alternative of combustible smoking methods.¹⁰¹ This theory is based on the reduction of ingesting harmful contaminants present in cannabis smoke, which are less present in cannabis vapors.¹⁰² The significant increase in vaping has raised concern about the health and safety of this practice. Of particular concern is the increase in vaping among teenagers.

A large illicit cannabis market continues to exist without concern for product safety and exacerbates issues of product liability coverage. Illicit products containing substances not allowed in a regulated market are part of the challenge. Current scientific research provides inadequate information to understand the effects of acute and long-term inhalation of aerosols emitted by vaping devices. A lack of studies on the substance itself or the consumption methodologies means the consequences of vaping cannabis are largely unknown. While many choose to vape, believing it is a safer method of consumption, studies are needed to determine whether vaporizing cannabis truly offers a safer experience for the consumer.

Millions of Americans have consumed cannabis from vaporization devices over the past decade, and the possibly dangerous effects are now being observed.¹⁰³ In 2019, the U.S. experienced an outbreak of e-cigarette, or vaping, product use-associated lung injuries (EVALI).¹⁰⁴ The Centers for Disease Control and Prevention (CDC) established a link between EVALI and cannabis users, where a substance called Vitamin E Acetate was added to cannabis vaporization products, which

¹⁰¹ Dustin C. Lee, Benjamin S. Crosier, Jacob T. Borodovsky, James D. Sargent, and Alan J. Budney, National Center for Biotechnology Information, U.S. National Library of Medicine: Online Survey Characterizing Vaporizer Use among Cannabis Users (December 30, 2015) – <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4745650/>

¹⁰² *Id.*

¹⁰³ Centers for Disease Control and Prevention: Outbreak of Lung Injury Associated with the Use of E-Cigarette, or Vaping, Products (December 6, 2021) – https://www.cdc.gov/tobacco/basic_information/e-cigarettes/severe-lung-disease.html#what-we-know

¹⁰⁴ *Id.*

105

can interfere with normal lung functioning. Since this outbreak was the result of an additive, it does not speak to the impact of vaping itself but does speak to the need for regulation.

Governments in jurisdictions with regulated cannabis industries took alternative approaches to respond to the outbreak of EVALI cases in cannabis consumers. Washington and Oregon enacted emergency bans on cannabis vaping product additives, whereas Massachusetts temporarily stopped the sale of all vaping products.¹⁰⁶ While many jurisdictions were concerned about EVALI's association with consumers who vaporized cannabis, some states were confident in the safety of products being produced within their regulated systems. For example, Pennsylvania released a position in response to the EVALI outbreak, explaining that none of the EVALI cases experienced in the state were connected to the state's medical cannabis program.¹⁰⁷

F. Licensing Takes a Focus on Social and Economic Equality

The prohibition of cannabis in America has disproportionately and adversely impacted people of color.¹⁰⁸ Studies have shown that "... on average Black people are almost 4 times more likely to be arrested for pot than white people."¹⁰⁹ This racial disparity in law enforcement is present in all areas of the country, regardless of the demographics of the jurisdiction.¹¹⁰

State-legal cannabis industries are now estimated to be worth over \$18 billion and provide for hundreds of thousands of full-time jobs.¹¹¹ However, minority populations that were most adversely impacted by the war on drugs and the prohibition of cannabis are being excluded from

¹⁰⁵ Centers for Disease Control and Prevention: Severe Lung Disease FAQ (December 6, 2021) –

https://www.cdc.gov/tobacco/basic_information/e-cigarettes/severe-lung-disease/faq/index.html

¹⁰⁶ Will Stone, NPR: Some States with Legal Weed Embrace Vaping Bans, Warn of Black Market Risks (October 26, 2019) –

<https://www.npr.org/sections/health-shots/2019/10/26/770377080/some-states-with-legal-weed-embrace-vaping-bans-warn-of-black-market-risks>

¹⁰⁷ Tony Rhodin, Lehigh Valley Live The Express-Times: With 149 Illnesses in U.S. Linked to Vaping Pennsylvania Says its Medical

Marijuana Vape Products are Safe (August 23, 2019) – <https://www.lehighvalleylive.com/news/2019/08/with-153-illnesses-in-us-linked-to-vaping-pennsylvania-says-its-medical-marijuana-vape-products-are-safe.html>

¹⁰⁸ Robert Hoban, Forbes: The Critical Importance of Social Equity in the Cannabis Industry (August 31, 2020) –

<https://www.forbes.com/sites/roberthoban/2020/08/31/the-critical-importance-of-social-equity-in-the-cannabis-industry/?sh=41a7ba0d1a6d>

¹⁰⁹ Sagiv Galai, ACLU: Equity Must Be at the Heart of Marijuana Legalization (June 26, 2019) –

<https://www.aclu.org/blog/criminal-law-reform/drug-law-reform/equity-must-be-heart-marijuana-legalization>

¹¹⁰ ACLU: Report: The War on Marijuana in Black and White (published June 2013) – <https://www.aclu.org/report/report-war-marijuana-black-and-white?redirect=criminal-law-reform/war-marijuana-black-and-white>

¹¹¹ Alex Malyshev and Sarah Ganley, Reuters: The Challenges of Getting Social Equity Right in the State-Legal Cannabis Industry (July 22, 2021) – <https://www.reuters.com/legal/litigation/challenges-getting-social-equity-right-state-legal-cannabis-industry-2021-07-22/>

the industry. In 2021, African Americans represented roughly 13% of the U.S. population, yet only 1.2% to 1.7% were business owners in the cannabis industry.¹¹²

States legalizing cannabis have recently taken efforts to resolve the racial disparity in cannabis business ownership by employing social and economic equity provisions into their laws. Social and economic equity in cannabis licensing can vary by jurisdiction, but includes reducing barriers, improving access, and assisting cannabis business license applicants who are from certain communities that have been adversely and disproportionately impacted by cannabis prohibition. These groups can include but are not limited to women-owned businesses, minority-owned businesses, distressed farmers, and service-disabled veterans. The intended goal of social and economic equity provisions in cannabis business authorities is to achieve participation in the legalized industry for those who were most negatively affected by the war on drugs.

States that have experienced cannabis reform legislation, either recreationally or medically, have taken different approaches to implementing social and economic equity provisions in their regulated cannabis markets. For example, Michigan, in processing recreational cannabis business licenses, will reduce licensing fees for prospective business owners living in cities where residents were disproportionately impacted by the war on drugs.¹¹³ California offers a statewide program for recreational cannabis to assist local governments with equity provisions in providing loans, grants, and technical assistance to cannabis entrepreneurs and employers.¹¹⁴ It is too early to know the effect on the insurance market for cannabis businesses of these regulatory policies. However, there are efforts to address social and economic equity concerns in insurance generally.

VI. CANNABIS OPERATING AND ORGANIZATIONAL STRUCTURES EVOLVE

The industry's growing legitimization has intensified merger and acquisition activity to gain market share. The year 2021 is generally acknowledged in both the financial and cannabis

¹¹² *Id.*

¹¹³ MJBizDaily: MI Marijuana rules changes include new licenses, lower fees, social equity (September 1, 2021) – <https://mjbizdaily.com/michigan-marijuana-rules-changes-include-new-licenses-lower-fees-social-equity/>

¹¹⁴ Alex Malyshev and Sarah Ganley, Reuters: The Challenges of Getting Social Equity Right in the State-Legal Cannabis Industry (July 22, 2021) – <https://www.reuters.com/legal/litigation/challenges-getting-social-equity-right-state-legal-cannabis-industry-2021-07-22/>

industry press as one of overall sales growth marked by rising incidence of consolidation.¹¹⁵ The significant amount of consolidation in the industry continues to produce frequent ownership changes and business structure modifications.¹¹⁶ There are varying aspects through which this cannabis market evolution can be viewed, and each has implications for insurance coverage availability. As noted in his article “The Year of Cannabis Industry Consolidation,”¹¹⁷ Robert Hoban writes: “There are loosely four common phases of an industry’s life cycle –introduction, growth, maturity, and decline. The cannabis industry is not yet mature across the board but is largely stuck in the growth phase. The step between the later stages of the growth phase and the beginning of maturity comes down to one word: *consolidation*. That is the mantra for 2021.”

There are some indications that more vertically integrated—or common ownership along the supply chain—is occurring. It is viewed that larger-scale cultivation operations permit greater consistency in raw material availability. Some of this can be demonstrated by the increasing prevalence of indoor or greenhouse cultivation, which permits a more controlled growing environment and avoids some of the risks associated with traditional outdoor grow operations (e.g., use of clones rather than seed; environmental controls for light, heat, water, pest control; multiple harvests per year in a smaller footprint; more accessible warehousing/storage for processing; etc.). Such physical consolidation is much more friendly to vertical integration of ownership. This integration also permits more risk management along with scale to support the acquisition of insurance coverage. Greater scale and integration of cannabis businesses also allow the purchase of more comprehensive coverage through the excess and surplus lines market. The downside is that there are indications that the reinsurance market to cover such risks continues to be constrained, resulting in policy limits that may not reflect the scale or potential risk of the business.

Larger, and more vertically integrated, cannabis businesses are able to seek out and negotiate more comprehensive insurance packages and can pay higher premiums for tailored coverage. In contrast, cottage industry players (e.g., independent retailers) tend to look for more “off-the-

¹¹⁵ Ellen Chang, US News and World Report: Upcoming Mergers in the Cannabis Industry to Watch (March 8, 2021) – [Upcoming Mergers in the Cannabis Industry to Watch \(usnews.com\)](#); Robert Hoban, Forbes: The Year of Cannabis Industry Consolidation (March 22, 2021) – <https://www.forbes.com/sites/roberthoban/2021/03/22/the-year-of-cannabis-industry-consolidation/?sh=48d003db7715>; Michael Berger, Technical420.com: The Consolidation of the US Cannabis Market is About to Kick into High Gear (September 3, 2021) – [The Consolidation Of The U.S. Cannabis Market Is About To Kick Into High Gear - Technical420 | Technical420](#); and Tommy Wood, [Boulder, CO] Daily Camera: Robust sales, expanding legalization lead to increased mergers, acquisitions in Boulder County cannabis industry (Sept. 5, 2021) – <https://www.dailycamera.com/2021/09/05/robust-sales-expanding-legalization-lead-to-increased-mergers-acquisitions-in-boulder-county-cannabis-industry/>

¹¹⁶ Oregon Liquor Control Commission (OLCC): Update on Marijuana Licensing (August 30, 2018) – www.oregon.gov/olcc/marijuana/Documents/Bulletins/Licensing_Delay_DirectorsMessage.pdf

¹¹⁷ Robert Hoban, Forbes: The Year of Cannabis Industry Consolidation (March 22, 2021) – <https://www.forbes.com/sites/roberthoban/2021/03/22/the-year-of-cannabis-industry-consolidation/?sh=48d003db7715>

shelf” insurance solutions, as would typically be available in the admitted market (but appears to be not widely available). Some admitted insurance coverage is available for discrete types of insurance. A good example is workers’ compensation insurance, which is widely available for employers in the cannabis industry—but such niches are limited.

Another aspect of this consolidation is changes in the ownership and sophistication of the industry. In 2019, the Colorado legislature changed state law to allow people who live outside Colorado to own cannabis businesses in the state, and it permitted publicly traded companies and private capital funds to invest in Colorado cannabis businesses.¹¹⁸ This “opening” of the market for cannabis businesses was ostensibly premised on increased access to capital for cannabis businesses, but it also fueled merger and acquisitions (M&A) activity with concomitant insurance aspects. In particular, the availability of directors’ and officers’ liability coverage is often cited as a challenge for cannabis businesses.

VII. CANNABIS INSURANCE NEEDS AND COVERAGE AVAILABILITY

A. Admitted vs. Excess and Surplus Lines Market

While there are a few states with admitted carriers, most of the cannabis industry is purchasing insurance through the excess and surplus lines market. Some admitted carriers, mostly in specific lines, such as required workers’ compensation, will write coverage for cannabis businesses. However, for more comprehensive or package coverage, the substantial majority is written through excess and surplus carriers, which are generally exempt from state regulation, and in many to most cases, state laws. One result of this is that it is challenging, if not virtually impossible, for state regulators to assess the size and extent of insurance coverage, in both availability and affordability, along with coverage for cannabis businesses. Some admitted carriers do write coverage primarily in their domiciliary state or immediate region, or for a specific component of the marketplace (e.g., retail dispensaries) for general liability.

What state insurance regulators do know is that there is a burgeoning market for cannabis coverage in the excess and surplus lines and managing general agent/underwriter program arena. There are also a few other structures to provide coverages, such as captives and risk

¹¹⁸ Tommy Wood, [Boulder, CO] Daily Camera: Robust sales, expanding legalization lead to increased mergers, acquisitions in Boulder County cannabis industry (Sept. 5, 2021) – <https://www.dailycamera.com/2021/09/05/robust-sales-expanding-legalization-lead-to-increased-mergers-acquisitions-in-boulder-county-cannabis-industry/>

retention groups (RRGs) being explored.¹¹⁹ Estimates range from a handful to in excess of 30 insurers and managing general agents/underwriters are providing services in this area.¹²⁰ Nonetheless, a Google search of commercial insurance for cannabis business will yield several references to entities, primarily surplus lines brokers or managing general agents/underwriters, which “specialize” in writing coverage for cannabis businesses or have an insurance “program” for cannabis businesses. Review of some of these indicates the majority are surplus lines brokers who are providing excess and surplus lines coverage.

As more insurance companies feel comfortable writing insurance in this industry, it is anticipated the market will move from excess and surplus lines to the admitted market, similar to other products in the past.¹²¹ At one point, there were insurance companies that did not want anyone to know they were providing coverage for these exposures, and now they are openly providing this coverage.¹²² However, there is a chance that not all segments of the cannabis industry will move from the excess and surplus lines to the admitted market. We may see certain segments, like retail or dispensary, moving to the admitted market because the risks associated with those are less than with other segment areas.¹²³

B. Insurance Needs and Considerations from Seed-To-Market

Though most coverage is in the excess and surplus lines market, access to commercial insurance for cannabis businesses varies significantly by the market segment of the seed-to-sale continuum. For some market segments, there are an increasing number of options in areas such as general commercial liability or basic property coverage. In many cases, businesses in the cannabis space

¹¹⁹ According to IRMI.com an MGA is Managing General Agent (MGA) — a specialized type of insurance agent/broker that, unlike traditional agents/brokers, is vested with underwriting authority from an insurer. Accordingly, MGAs perform certain functions ordinarily handled only by insurers, such as binding coverage, underwriting and pricing, appointing retail agents within a particular area, and settling claims. Typically, MGAs are involved with unusual lines of coverage, such as professional liability and surplus lines of insurance, in which specialized expertise is required to underwrite the policies. However, MGAs also write some personal lines business, especially in geographically isolated Areas (e.g., western Oklahoma, North Dakota) where there are accessibility concerns. MGAs benefit insurers because the expertise they possess is not always available within the insurer's home or regional offices and would be more expensive to develop on an in-house basis. –

<https://www.irmi.com/term/insurance-definitions/managing-general-agent>

¹²⁰ Steve Hallo, National Underwriter Property and Casualty 360: Is cannabis the next insurance opportunity? (January 6, 2021) – <https://www.propertycasualty360.com/2021/01/06/is-cannabis-the-next-insurance-opportunity/>; and Alwyn Scott, Reuters: US cannabis insurers get ready to roll as federal legalization nears (August 19, 2021) – [U.S. cannabis insurers get ready to roll as federal legalization nears | Reuters](https://www.reuters.com/business/finance/us-cannabis-insurers-get-ready-to-roll-as-federal-legalization-nears-2021-08-19/); and New Dawn Risk, Broker at LLOYD: Understanding and opening up the US cannabis insurance market (accessed February 21, 2023) – https://www.newdawnrisk.com/wp-content/uploads/2020/05/Cannabis_report-FINAL.pdf

¹²¹ Alicja Grzadzowska, Insurance Business Canada (insurancebusinessmag.com): An insurance learning curve for all as cannabis legalization looms (March 2, 2018) – <https://www.insurancebusinessmag.com/ca/news/broker-perspective/an-insurance-learning-curve-for-all-as-cannabis-legalization-loom-93822.aspx>

¹²² Presentation Panel Discussion: Admitted and Nonadmitted Coverage Across the Cannabis Business Sectors (July 19, 2021) – [Webex Enterprise Site - Replay Recorded Meeting – https://naic.webex.com/webappng/sites/naic/recording/225c7bfecae91039aafd0050568f5657/playback](https://naic.webex.com/webappng/sites/naic/recording/225c7bfecae91039aafd0050568f5657/playback)

¹²³ *Id.*

are facing more expensive coverage than other similar businesses. While they can get some insurance, a common complaint is that the limits available are constrained, e.g., \$1 million per occurrence, \$2 million aggregate capped. A further challenge is the anticipated explosive business growth for established cannabis businesses year over year.¹²⁴

What follows is some discussion about the various cannabis business market segments, particular insurance needs and availability, and some of the particular risk considerations that make availability and affordability challenging.

1. Cultivation

Coverage for cannabis has several aspects. First, hemp was included as a “legal” crop in the 2018 Farm Bill.¹²⁵ As it currently stands, federal multi-peril crop insurance is available in certain states and communities with conditions. The cultivator must: 1) be licensed and meet all requirements of state, tribal, and federal authorities, 2) have at least one year of history producing the crop, and 3) have a contract for the purchase of the hemp crop at the policy inception.¹²⁶ Hemp has the additional risk of becoming “hot hemp” due to environmental causes (THC above the 0.3 compliance level). Additionally, hemp does not qualify for replant payments or prevented plant payments.¹²⁷

Second, for hemp that does not qualify and cannabis cultivation, the insurance coverage availability is much less clear. There appears to be a small market for private crop insurance, though reports are that it is prohibitively expensive until more data and experience is available to support underwriting. An option that is emerging is parametric coverage for outdoor cannabis crops with triggers including: recorded rainfall over a specified time, wind, early freeze, hail, and drought.¹²⁸

¹²⁴ Alexander T. Brown, see generally, Lathrop GPM: Five Insurance Considerations for Cannabis-Related Businesses (July 21, 2021) – [Five Insurance Considerations for Cannabis-Related Businesses: Lathrop GPM](https://www.lathropgpm.com/TheRoadToInsuranceRecovery/five-insurance-considerations-for-cannabis-related-businesses) –

<https://www.lathropgpm.com/TheRoadToInsuranceRecovery/five-insurance-considerations-for-cannabis-related-businesses>
¹²⁵ Amy Abernethy, MD, PhD, U.S. Food & Drug Administration: Hemp Production and the 2018 Farm Bill (July 25, 2019) – <https://www.fda.gov/news-events/congressional-testimony/hemp-production-and-2018-farm-bill-07252019>

¹²⁶ USDA, Risk Management Agency, A Hemp Q&A with Andrew Kowalski (accessed February 21, 2023) – <https://www.rma.usda.gov/en/News-Room/Digital/RMA-Stories/Ask-the-Expert---A-Hemp-Questions-and-Answers-with-Andrew-Kowalski>

¹²⁷ USDA Farmers: Hemp and Farm Programs (accessed February 21, 2023) – <https://www.farmers.gov/your-business/row-crops/hemp>

¹²⁸ Evan Stait, Cannabis Industry Journal: Why You Should Consider Parametric Insurance to Protect Your Outdoor Cannabis Crop, (Sept. 22, 2020) – <https://cannabisindustryjournal.com/column/why-you-should-consider-parametric-insurance-to-protect-your-outdoor-cannabis-crop/>

More broadly, a primary differentiator amongst cannabis cultivators is whether the grow is outdoor or indoor (greenhouse). The two methods have significantly different risk profiles, leading to differing accessibility and affordability. Outdoor cultivation brings not only the traditional multi-peril concerns of crop insurance for destructive weather (hail, frost, damaging wind), disease, drought, fire, flooding, and insect damage.¹²⁹ The more controlled environment of an indoor grow protects from some of the environmental risks but presents its own array of challenges, including electrical, plumbing, security, and contaminants, including but not limited to mold, mildew, and pesticides. Anecdotally, coverage is more available for indoor cannabis cultivation, though it is undeterminable whether this is because the grow environment can be more easily managed, or whether the scale of a greenhouse grow permits several “crops” per year with increased proceeds.

2. Processing and Manufacturing

Cannabis products are available in a rising number of derivations. Cannabis is commercially available in flower (similar to loose tobacco), pre-rolled joints, vapes, dabable concentrates (highly concentrated extracts aka wax, shatter, or other appellations), edibles (including gummies, chocolates, taffy, beverages, and more), tinctures, topical applications, and more. Usage and the reasons for usage likewise can vary greatly by product format. According to IRI, a data analytics firm focused on consumer-packaged goods (CPGs), 43% of adults in fully legal states are cannabis consumers. Of those, 72% consume inhalable products, and 62% of those inhalable users are consuming cannabis at least once daily. Topical cannabis is more associated with pain relief, as the top reported relief communicated by consumers of those products. Better sleep is the top reported relief communicated for consumers of edibles. Users of CBD cite a myriad of health-related reasons for their use, the top four being pain relief, better sleep, and management of anxiety and stress.¹³⁰

As the number and variety of products/uses grows, so do the processing and manufacturing systems to produce a retail product. Traditional cannabis consumption relies on “flower” or “bud,” which is ground and then packed into a pipe or rolled. To achieve this basic formulation, the cannabis plant must be harvested, dried, sorted, trimmed to remove the flower from leaves and stalks, and then cured. Obviously, premises for drying, sorting, trimming, and curing are required, and some portions of these processes may be supported by mechanization. Under the Colorado cannabis regulatory structure, the premises used must be licensed as a “Regulated

¹²⁹ Insurance Information Institute (III): Understanding Crop Insurance (accessed February 21, 2023) – <https://www.iii.org/article/understanding-crop-insurance>

¹³⁰ Jessica Lukas, BDSA, and Larry Levin, IRI, Blog on BDSA and IRI: The Rise of Legal Cannabis as a Consumer Packaged Good, (September 30, 2021) – <https://www.iriworldwide.com/en-us/insights/blog/rise-of-cannabis-as-a-consumer-packaged-good>

Marijuana Business Operation,” which carries extensive rules about possession and access to the premises, security and lock standards, signage, floor plans, shared facilities (medical and adult use), waste disposal, inventory tracking, health and safety measures, audits, and prohibited chemicals and practices.¹³¹

Insurance for cannabis manufacturing premises is reportedly becoming more widely available, but pricing can be more expensive than for other sectors. The extensive regulation of the premises must be balanced against the enhanced risks, including potentially high-value raw materials, inventory in-process, risks of fire, theft, contamination, etc., and the potential of mishandling waste in violation of state law. Against this higher base level of premises, coverage can be increased risks from processing to make cannabis derivative products such as edibles, topicals, and dabs. For many of these derivative products, the raw material (including cannabis or the <.3% THC hemp) must be processed using solvents, pressure, heat, distillation/crystallization, or combinations thereof. Each adds an aspect of risk that should be considered and accounted for in the underwriting process.

3. Testing

State-mandated testing schemes are substantial and detailed to ascertain if the regulated cannabis (as either raw material or finished product) is: 1) contaminated or mislabeled, 2) is in violation of any product safety, health or sanitary statute, rule, or regulation, or 3) whether the results of a test raise questions requiring further investigation. The most significant area of liability will be professional liability if someone suffers legal injury due to a negligently erroneous test result. As an erroneous test could require the destruction of an entire crop or product run, the economic injury is obvious. From a consumer perspective, a test result indicating safety when a product is contaminated or varies from potency standards could lead to substantial recovery for personal injury. Consequently, professional liability or errors and omissions coverage is an important part of a testing facility’s portfolio.¹³²

4. Distribution

There are effectively two levels of distribution concern. One is raw material transport between cultivator and manufacturer/processor (and testing labs), and the other is consumer delivery. However, at the base, in Colorado, both levels rely on a comprehensive seed-to-sale tracking

¹³¹ Code of Colorado Regulations, Department of Revenue, Marijuana Enforcement Division, 1 CCR 212-3, Part 3 - Regulated Marijuana Business Operations

¹³² See subsequent section under Products Liability for further discussion of aspects of liability for a defective product.

system, which can be used to provide manifests documenting the transport of cannabis products throughout the state. In Colorado, this requirement is stated in statute as:

“To ensure that no marijuana grown or processed by a retail marijuana establishment is sold or otherwise transferred except by a retail marijuana store or as authorized by law, the state licensing authority shall develop and maintain a seed-to-sale tracking system that tracks retail marijuana from either seed or immature plant stage until the marijuana or retail marijuana product is sold to a customer at a retail marijuana store[.] . . .”¹³³

The seed-to-sale tracking system in Colorado is based on a Radio Frequency Identification (RFID) tag, which is affixed to a plant and, with aggregation of the information on it, follows the plant through cultivation, harvest, manufacturing, and distribution. For licensed operators who are transporting legal product, this permits explicit manifests that can be reconciled with the cargo between cultivator and manufacturer/processor. Both medical and retail cannabis in Colorado require a transporter’s license, which is obtained from the state’s regulatory authority, the Marijuana Enforcement Division of the Colorado Department of Revenue.

Insurance concerns of transporters include cargo coverage for an often high-value commodity that can be subject to theft/hijacking and spoilage. As described in a Reuters article, “Low coverage limits on cargo insurance, for example, can force companies to split shipments up, said Gene Brown, an insurance agent in Carmel, California, who specializes in cannabis coverage.”¹³⁴ Similarly, the cash-based current consumer economics of the industry has substantial security needs and a high risk of theft.

Recently, delivery to consumers through purchase on an app has been authorized in Colorado and has generated significant interest. This interest was likely accelerated by the expansion of other delivery services, such as Uber Eats, and similar services during the COVID-19 pandemic. This direct-to-consumer delivery has similar liability concerns as other delivery services (e.g., damage to third-party vehicles and parties, and the potential for theft, misdirection, or deception).

5. Retailers

When someone says, “legal cannabis,” the mental picture most people have is of a local dispensary in a state where it is legalized. Certainly, for most people a dispensary or store is how

¹³³ §44-12-202(1), Colo. Rev. Stat. - Powers and duties of state licensing authority - rules. § (1). Note: an almost identical provision is located in Colorado’s medical marijuana code.

¹³⁴ Alwyn Scott, Reuters: U.S. cannabis insurers get ready to roll as federal legalization nears (August 19, 2021) – <https://www.reuters.com/article/us-usa-insurance-cannabis-focus-idCAKBN2FK1AO>

they experience the industry. As storefronts, retailers have many of the same business insurance needs as other commercial establishments (e.g., premises/property and general liability coverage, inventory, employee benefits and employment practices liability insurance, business income/interruption, umbrella, commercial auto, and cybersecurity). Generally, insurance coverage is increasingly becoming available for these risks, albeit often at higher rates than for other types of retailers.

Primary among the risks is those of theft – both cash and product. In 2020, one of Colorado’s largest cannabis retailers, with 21 locations, reported 15 burglary attempts in 90 days.¹³⁵ Because most cannabis outlets deal almost exclusively in cash, there is ample opportunity for burglaries and robberies. Also, because the product for sale is high value itself, criminals do not go for just the cash. It is common for retailers to have substantially increased security, including around-the-clock guards, video screening, and extensive training and monitoring of their staff, to mitigate their enhanced risk.¹³⁶

In addition to the risk of damage to premises from break-ins for theft, personal injury to employees, customers, and bystanders is also a concern. As noted previously, workers’ compensation coverage is more available for cannabis retailers since it is a state-mandated coverage. However, questions of consistent occupational subclassification and experience rating may develop and have premium impacts.¹³⁷ In Colorado, complaints or concerns are not generally received about employee benefit coverages (primarily health). This is likely due to the federal Affordable Care Act (ACA) and the expansion of guaranteed availability to the individual health insurance market. On the employment practices liability aspect, there are anecdotal reports of challenges in finding coverage. At this time, additional information is needed to ascertain whether there is out-of-the-ordinary employment practices liability that is not mitigated by state regulatory schemes. This includes requiring criminal background checks and licensure of all persons employed in a business that possesses, cultivates, dispenses, transfers, transports, offers to sell, manufactures, or tests regulated cannabis.

6. Products Liability

One of the thorniest insurance issues for cannabis businesses is that of products liability coverage. As products liability claims may be made against any, and potentially all, entities in the supply chain from retailer or distributor, manufacturer, tester, or cultivator. The costs of defense

¹³⁵ Thomas Mitchell, Westword: Colorado’s Largest Dispensary Chain: Fifteen Burglary Attempts in Ninety Days Last Year (October 28, 2021) – <https://www.westword.com/marijuana/colorado-livwell-burglary-cash-cannabis-banking-12660338>

¹³⁶ *Id.*

¹³⁷ Insurance Information Institute: Spotlight on: marijuana and employment (November 24, 2020) For discussion of other aspects of marijuana in the broader employment context – <https://www.iii.org/article/spotlight-on-marijuana-and-employment>

in a products liability action alone make this coverage “in demand.” Moreover, the breadth of circumstances that can lead to a products liability claim raises legitimate concerns for all parts of the industry. By way of refresher, there are three basic theories of product liability: 1) design defect, which could include pesticide, mold, or biological contamination; 2) manufacturing defect, which can include contamination introduced during processing, or by faulty testing and results; and 3) warning/instruction defect, including product labeling violations or omissions, advertising misrepresentation, and packaging defects (i.e., child-resistant packages). It is easy to imagine the potential liability concerns of an industry involving an intoxicant that, until relatively recently, was comprehensively banned throughout the United States.

Reliance on a standard policy for products liability coverage for CRBs may not provide the full protection a business would anticipate. Most standard policies contain broad exclusions for Schedule 1 federally prohibited substances or criminal/fraudulent or dishonest acts or claims arising from violation of statute, code, rule, regulation, procedure, or guidance. Most standard policies do not include products completed, operations, and health hazard exclusions for cannabis businesses. Coverage for defense costs in a products liability action against a cannabis business is particularly key. The experience in the vaping crisis, referred to as “Vape-Gate,” is instructive. While it was ultimately found that most of the vaping injuries involved illicit or black market vape products, the potential for substantial and broad liability led to tighter risk management in the cannabis supply chain, including identification of unapproved or potentially dangerous additives resulting in adulterated products.¹³⁸ It is recommended that cannabis businesses specifically discuss with their insurer about coverage for products liability to ensure they understand the coverage provided and any limitations on it.

VIII. MARKET CONSIDERATIONS FOR COMMERCIAL CANNABIS INSURANCE

As noted above, the availability of insurance coverage for cannabis businesses is overwhelmingly found in the excess and surplus lines market at present. In part, this is due to the evolving nature of the commercial cannabis industry, and the lack of generally agreed upon data, measurement, and experience to support insurance underwriting. It is anticipated that just as the cannabis commercial industry evolves, so will the associated commercial insurance options in the admitted market. This evolution is anticipated and may be driven by how the cannabis business market

¹³⁸ Steve Hallo, National Underwriter Property and Casualty 360 Market Insights: Vape Gate and today’s cannabis product liability market (December 16, 2020) – <https://www.propertycasualty360.com/2020/12/16/vape-gate-and-todays-cannabis-product-liability-market/>

develops (e.g., vertical integration and consolidation versus continuation of niche commercial entities in the cannabis supply and distribution market).

A. Cannabis as a Client (and Consumer Beliefs)

As more states legalize cannabis for either recreational use or medical use, more insurance companies may enter the market to write cannabis businesses. The cannabis industry is a new aspect for insurance companies. Thus, they will need to understand the risks and exposures, as well as the needs of cannabis businesses as clients.¹³⁹

It is also important for producers to be educated on the cannabis market to serve this demographic. For example, it would be beneficial for a producer to be educated on the risks and exposures at each segment from seed to sale so that they can explain to their client what would be best suited for their needs. They may also help explain the differences between legal requirements and best practices. A cannabis business may not purchase coverage because it is not legally required; however, it may be a good business practice.

The cannabis business as a client has a similar learning curve. The cannabis business owner must have done their due diligence to obtain a license, be educated on cannabis products and processes, and know the applicable laws surrounding cannabis. However, a cannabis business as an insurance client may need some help with insurance terms and coverage options as they may not know what options are suitable for their needs.¹⁴⁰ Vocabulary from region to region or state to state also differs. This can be challenging for an insurance company when trying to explain coverage options to a cannabis business as a client.

Misconceptions also play a part when cannabis businesses seek insurance. When cannabis businesses first opened (around 1996 in California) there was fear that due to the federal illegality, they could be subject to criminal charges at any moment.¹⁴¹ There are concerns from the cannabis industry that the information provided to insurers can be accessed by the federal

¹³⁹ Jason Howard, CRC Group Wholesale & Specialty: Understanding the Issues Around Insuring Cannabis-Related Businesses (accessed February 21, 2023) – [Understanding the Issues Around Insuring Cannabis-Related Businesses - News - Tools & Intel | CRC Group](https://www.crcgroup.com/Tools-Intel/post/understanding-the-issues-around-insuring-cannabis-related-businesses) – <https://www.crcgroup.com/Tools-Intel/post/understanding-the-issues-around-insuring-cannabis-related-businesses>

¹⁴⁰ Don Jergler, Insurance Journal: Insuring Cannabis Summit: Talking to Clients About Risk Starts with Education (December 28, 2020) – [Insuring Cannabis Summit: Talking to Clients About Risk Starts with Education \(insurancejournal.com\)](https://www.insurancejournal.com/news/north-carolina/2020/12/28/10398fd70050568f0567/)

¹⁴¹ Brenda Wells, Ph.D., Presentation on Balancing Actual and Perceived Risks (East Carolina University). (July 27, 2021). See: [Webex Enterprise Site - Replay Recorded Meeting](https://naic.webex.com/webappng/sites/naic/recording/fe42d865d13210398fd70050568f0567/playback) – <https://naic.webex.com/webappng/sites/naic/recording/fe42d865d13210398fd70050568f0567/playback>

government.¹⁴² Some businesses in the industry may believe that insurance is not worth the cost or that coverage is not available.¹⁴³ Such misconceptions fuel belief that coverage is not available but, more recently, the concerns have been about the cost and limitations of coverage. Among the inherent limitations of excess and surplus lines are the higher costs of coverage and restrictions on the coverage beyond cannabis licensure requirements.

B. The Role of Data

Cannabis businesses are just like any other business; however, they continue to pay several times more than what other industries pay for insurance.¹⁴⁴ For example, a small mercantile general liability policy might run about \$1,000, but for a cannabis business, that policy could run about \$10,000 without products liability.¹⁴⁵ A directors and officers policy (D&O) for \$1 million in coverage could cost a cannabis business well into the six-figure range.¹⁴⁶ The difference in pricing may largely be due to the federal versus state treatment and the concomitant risks involved with cannabis businesses.¹⁴⁷ One major issue that persists for cannabis businesses and insurance is the lack of consistent and verifiable market data across market segments to inform of potential risks.¹⁴⁸ Insurers know very little about the losses and expenses associated with this industry, and therefore, it is difficult to price. An insurer can acquire information from their potential customer, but there is not a public source of comparative data that insurers can use to evaluate risks.¹⁴⁹

The lack of data relating to losses and expenses is a major issue, but data from similarly situated businesses can be used to assist in the underwriting process. When looking at dispensaries, an insurer can look at a pharmacy for medical use cannabis and liquor stores or vape shops for recreational use of cannabis to learn about underwriting a cannabis business. Similarly, cannabis processors and growers can look to processors from other similarly situated industries. Cannabis businesses need insurance at every point from seed to sell. Although data is lacking, there is

¹⁴² Jason Howard, CRC Group Wholesale & Specialty: Understanding the Issues Around Insuring Cannabis-Related Businesses (accessed February 21, 2023) – [Understanding the Issues Around Insuring Cannabis-Related Businesses - News - Tools & Intel | CRC Group](https://www.crcgroup.com/Tools-Intel/post/understanding-the-issues-around-insuring-cannabis-related-businesses) – <https://www.crcgroup.com/Tools-Intel/post/understanding-the-issues-around-insuring-cannabis-related-businesses>

¹⁴³ Brenda Wells, Ph.D., Presentation on Balancing Actual and Perceived Risks (East Carolina University). (July 27, 2021) – [Webex Enterprise Site - Replay Recorded Meeting](https://naic.webex.com/webappng/sites/naic/recording/fe42d865d13210398fd70050568f0567/playback) –

<https://naic.webex.com/webappng/sites/naic/recording/fe42d865d13210398fd70050568f0567/playback>
¹⁴⁴ Wendel Rosen, Wendel Rosen: Cannabis Insurance Presents Tough Choices. (March 28, 2017) – <https://www.fennemorelaw.com/cannabis-insurance-presents-tough-choices/>

¹⁴⁵ Brenda Wells, Ph.D., Presentation on Balancing Actual and Perceived Risks. (East Carolina University). (July 27, 2021) – [Webex Enterprise Site - Replay Recorded Meeting](https://naic.webex.com/webappng/sites/naic/recording/fe42d865d13210398fd70050568f0567/playback) – <https://naic.webex.com/webappng/sites/naic/recording/fe42d865d13210398fd70050568f0567/playback>

¹⁴⁶ *Id.*

¹⁴⁷ *Id.*

¹⁴⁸ *Id.*

¹⁴⁹ *Id.*

information available to begin the underwriting process and to get a sense of what is needed by a cannabis-related business.

Insurers can also consider various factors during underwriting depending on the type of cannabis business. For processors, the results from a third-party inspection, the type of security system, and whether they are wired to outside monitoring stations, fire suppression systems, and the sufficiency of the electrical system with proper wattage and circuits all could be factors in the underwriting process. For retailers, the type of safe storing cash or product can also be considered when in the underwriting process, as there may be a regulatory requirement that a safe has to be so heavy as to not be easily moved, or the insurer may impose one. Overall, the insurer may want to know more about the owner/operator of the cannabis-related business. For instance, it may want to know if they are a member of a trade association or what education and training they have, and what they require of their staff. All this information can play a role in the risk involved with the cannabis-related business. What insurers would like to see is the risk be reduced. For example, the risk to insure someone who just decided to open a shop would be much higher than a person who took the time to get trained and educated in cannabis.

C. Developing Commercial Policy Forms

Most insurance policies, particularly those in the admitted market, are standardized. Advisory organizations help develop these forms that are used by property and casualty companies. The standardization of forms ensures: 1) the legal requirements from each state are taken into consideration; 2) premium rates are based on actuarial studies of insurable risks; and 3) case law is taken into consideration to prevent ambiguities in contract terms. Additionally, standardized forms using familiar terms and vocabulary may reduce the potential for disparate interpretations. Prior to legalization, insurance policies would typically exclude cannabis-related activities from a policy due to the illegality of the product as a federally listed Schedule 1 substance.¹⁵⁰ As states implement new cannabis laws, insurers will need to modify their contract forms to achieve compliance. Striving for consistent terminology and language is part of the normal work of advisory organizations.

¹⁵⁰ Heather Howell Wright, National Underwriter Property and Casualty 360: ISO Revises Policy Forms to Address Cannabis (November 1, 2019) – [ISO revises policy forms to address cannabis | PropertyCasualty360](https://www.propertycasualty360.com/2019/11/01/insurance-services-organization-revises-policy-forms-to-address-cannabis/) – <https://www.propertycasualty360.com/2019/11/01/insurance-services-organization-revises-policy-forms-to-address-cannabis/>

1. Insurance Services Office (ISO)

ISO is an insurance advisory organization that shares actuarial information with its customers, including insurance companies, actuaries, agents and brokers, and government entities.¹⁵¹ ISO gathers large amounts of loss data from various insurance companies to develop advisory prospective loss costs. Licensing carriers may use these loss costs to develop their ultimate insurance rates.¹⁵² ISO also creates insurance policy forms and endorsements often viewed by many as an industry standard.¹⁵³ ISO-created policy forms and endorsements often include policy language that has been tested in the courts, providing licensing carriers with potentially less volatility in interpretation than if an insurer creates its own form.¹⁵⁴

ISO insurance programs are available to provide insurance coverage to or exclude coverage with respect to cannabis-related businesses and exposures through policy endorsements.¹⁵⁵ An insurance endorsement can be used at policy inception or after a policy is issued to add, delete, exclude, or otherwise alter coverage.¹⁵⁶

Previously, neither the ISO Commercial General Liability (CGL), Commercial Property (Property), nor Commercial Auto (CA) forms expressly addressed cannabis. However, ISO developed several endorsements to specifically address the cannabis exposure in these and other insurance programs. The related endorsements can enhance an insurer's flexibility to tailor their product by expressly addressing coverage with respect to cannabis-related exposures.

If an insurance carrier prefers to avoid providing coverage with respect to cannabis-related exposures in any of the related insurance programs, ISO makes available several exclusionary endorsements to exclude coverage. However, if there is interest in providing coverage for a cannabis-related exposure, ISO has made available several endorsements for that purpose.

ISO's CGL and Property programs include options for the carrier to extend certain coverage with respect to the cannabis exposure. Carriers also have the option to extend limited coverage with respect to only the hemp exposure using a cannabis exclusion with an exception applying to

¹⁵¹ Marianne Bonner, The Balance: Insurance Services Office (ISO) (May 16, 2019) – [What Is the Insurance Services Office \(ISO\)? – thebalancesmb.com](https://thebalancesmb.com/insurance-services-office-iso/)

¹⁵² *Id.*

¹⁵³ *Id.*

¹⁵⁴ *Id.*

¹⁵⁵ Heather Howell Wright, National Underwriter Property and Casualty 360: ISO Revises Policy Forms to Address Cannabis (November 1, 2019) – [ISO revises policy forms to address cannabis | PropertyCasualty360 – https://www.propertycasualty360.com/2019/11/01/insurance-services-organization-revises-policy-forms-to-address-cannabis/](https://www.propertycasualty360.com/2019/11/01/insurance-services-organization-revises-policy-forms-to-address-cannabis/)

¹⁵⁶ Mila Araujo, The Balance: What Is an Insurance Endorsement (May 4, 2022) – [What Is an Insurance Endorsement? – thebalance.com](https://thebalance.com/insurance-endorsement/)

hemp. Additionally, the CGL program includes options for insurance carriers to exclude liability for specifically listed products.

Within the commercial general liability program, ISO developed liability coverage endorsements with an aggregate limit for cannabis, a cannabis exclusion with a hemp exception aggregate limit, and a cannabis liability exclusion with designated product or work exception subject to an aggregate limit.¹⁵⁷

Lastly, ISO developed the defense within limits endorsement specific to products liability coverage that allows the carrier to limit the cost of defense related to products covered by the coverage form. Similar options are available for ISO's Businessowners, Commercial Flood, and Commercial Inland Marine programs.

2. American Association of Insurance Services (AAIS)

AAIS, a not-for-profit advisory organization governed by its member insurance companies, provides insurance forms, rules, and loss costs to the property casualty insurance industry.¹⁵⁸ AAIS provides policy forms and manuals in commercial lines, inland marine, farm and agriculture business lines, as well as personal lines to more than 700 insurance carriers.¹⁵⁹ As a licensed statistical agent in 51 jurisdictions, AAIS collects data that helps members meet regulatory statistical reporting responsibilities, which also supports loss cost development and ratemaking activities.¹⁶⁰

AAIS' cannabis business owners' policy (CannaBOP) product was developed at the request of the California Department of Insurance (DOI) to strengthen carrier participation for coverage of commercial cannabis operations. The CannaBOP is a package policy that provides property and liability coverages for qualifying cannabis dispensaries, storage, distributors, processors, manufacturers, and private cannabis testing facilities and laboratories.¹⁶¹ Rather than providing coverage to legal cannabis businesses through an endorsement, AAIS advocates for cannabis-specific product development and cannabis-specific programs.¹⁶² The CannaBOP program also

¹⁵⁷ *Id.*

¹⁵⁸ AAIS: An Unwavering Commitment to our Members...and to the Success of the Insurance Industry (accessed February 21, 2023) – [Our Role in Insurance - AAIS Online](https://aaisonline.com/our-role-in-insurance) – <https://aaisonline.com/our-role-in-insurance>

¹⁵⁹ *Id.*

¹⁶⁰ *Id.*

¹⁶¹ AAIS Solutions Kit: CANNABOP: Cannabis - Businessowners (January 2020) – [30f1bcd6-6b5d-921f-ce64-654b16f08b88](https://aaisonline.com) – aaisonline.com

¹⁶² AAIS: Arizona Approves AAIS CannaBOP, Cannabis Business Owners Insurance Policy (March 9, 2021) – [Arizona Approves AAIS CannaBOP, Cannabis Business Owners Insurance Policy - AAIS Online](https://aaisonline.com/press-arizona-approves-aais-cannabop-cannabis-businessowners-insurance-policy) – <https://aaisonline.com/press-arizona-approves-aais-cannabop-cannabis-businessowners-insurance-policy>

includes the rules, loss costs, and a suite of optional endorsements to be used by an insurance company.¹⁶³ The program also offers technology support so that CannaBOP can be quickly distributed and AAIS dedicated personnel keeping a keen eye on the “legs & regs” to help carriers remain compliant within this space.¹⁶⁴

3. Filing Process and Adoption of ISO and AAIS Forms

AAIS and ISO are advisory organizations that submit advisory loss costs, rules, and forms to the respective regulating agency for review and approval. These advisory organizations have member or subscriber requirements to use their approved forms, rules, rates, or loss costs. Loss costs are the data on claims that have been paid out.

In some states, advisory organizations file on behalf of insurers that have given them authorization, and other states may have varying filing requirements, as in the case of California. In the absence of a filing made on behalf of an insurer, the insurance company submits a separate filing to adopt the product or endorsement before it can use what has been created by the advisory organization. For example, in California, insurer XYZ wanted to start writing a Cannabis Business Owners policy. As a member of an advisory organization, XYZ could use the advisory organization’s forms and data for what coverages to offer, forms to use, rules to apply, and rates (loss costs multiplied by a loss cost multiplier to account for the insurer expenses) to use. Insurer XYZ would submit a prior approval new program filing with the California DOI to adopt the portions of the advisory organization material they wanted to use. The filing would then be reviewed and approved before insurer XYZ could start writing cannabis business owners’ risks using the advisory organization’s filing as a foundation. So, two separate filing approvals are needed: first, the approval of the filing containing the advisory organization product; and then, after the advisory organization’s product is approved, the insurance company(s) filings requesting adoption of the already approved advisory organization’s product.

ISO’s Cannabis Endorsements were approved for use in a majority of the states in September 2019.¹⁶⁵ According to AAIS, CannaBOP was first filed and approved in California in 2018.¹⁶⁶ Since then, CannaBOP has been approved in Colorado, Nevada, Illinois, Michigan, and Washington.¹⁶⁷ In March 2021, CannaBOP was adopted by Golden Bear in Arizona.¹⁶⁸

¹⁶³ *Id.*

¹⁶⁴ AAIS: Introducing CannaBOP (accessed February 21, 2023) – <https://aaisonline.com/cannabopold#:~:text=Introducing%20CannaBOP%20The%20AAIS%20CannaBOP%20program%20is%20a%20of%20licensed%20cannabis%20dispensaries%2C%20distributors%20and%20testing%20labs.>

¹⁶⁵ Heather Howell Wright, National Underwriter Property and Casualty 360: ISO Revises Policy Forms to Address Cannabis (November 1, 2019) – <https://www.propertycasualty360.com/2019/11/01/insurance-services-organization-revises-policy-forms-to-address-cannabis/>

¹⁶⁶ AAIS: Arizona Approves AAIS CannaBOP, Cannabis Business Owners Insurance Policy (March 9, 2021) – [Arizona Approves AAIS CannaBOP, Cannabis Business Owners Insurance Policy - AAIS Online](https://aaisonline.com/press-arizona-approves-aais-cannabop-cannabis-businessowners-insurance-policy) – <https://aaisonline.com/press-arizona-approves-aais-cannabop-cannabis-businessowners-insurance-policy>

¹⁶⁷ *Id.*

¹⁶⁸ *Id.*

IX. RESPONDING TO EMERGING TRENDS

Emerging trends in the cannabis industry provide opportunities for next steps in policy, regulation, and insurance. Cannabis product innovation is expanding past edibles to infuse cannabis into beverages, baking staples, crafts, and luxury products. New formulas and strengths are also being introduced with these new products. Innovation brings both new insurance needs and risks. For instance, states issued recalls in 2022 for cannabis edibles for mislabeling and contamination, resulting in litigation.¹⁶⁹

Growing demand for ancillary services and infrastructure in the cannabis space will also likely impact cannabis-related insurance. Ancillary services include those that complement the cannabis industry and are often non-plant touching. This includes marketing, transportation and delivery, financing, breathalyzers, product packaging, accountants, landlords, staffing firms, nutrient suppliers, and equipment companies.

Insurance regulators should also be informed of the emergence of on-site social consumption lounges. A few states have started issuing licenses for these establishments. On-site social cannabis lounge sites may operate similarly to bars, where consumers would gather to socially consume cannabis at a place of business. These businesses will face liability and insurance issues akin to businesses serving alcohol, like bars, breweries, and wineries.

X. CONCLUSIONS

A major aspect of obtaining insurance coverage for cannabis-related businesses is the complexity of limitations to interstate commerce hampering multi-state expansion. The current cannabis marketplaces are contained in individualized state jurisdictions without competition from other state marketplaces.¹⁷⁰ There have been state legislative authorizations in California (2022) and Oregon (2019) to create legal cannabis interstate commerce through trade pacts with other states. However, these laws require Congressional authorization or a memorandum from the DOJ allowing for interstate transfers of cannabis products. Federal legislation was introduced in 2021 with the States Reform Act (SRA). The SRA would decriminalize cannabis at the federal level while deferring to state powers over prohibition and commercial regulation.

¹⁶⁹ Jay Viridi, Cannabis Industry Journal: Challenges Abound for Cannabis Industry Growth in 2023 (November 30, 2022) – https://cannabisindustryjournal.com/feature_article/challenges-abound-for-cannabis-industry-growth-in-2023/

¹⁷⁰ Tommy Tobin and Andrew Kline, Yale Law & Policy Review: A sleeping Giant: How the Dormant Commerce Clause Looms Over the Cannabis Marketplace (January 3, 2022) – https://ylpr.yale.edu/inter_alia/sleeping-giant-how-dormant-commerce-clause-looms-over-cannabis-marketplace

Insurers are likely to continue to be cautious about entering the cannabis space in the absence of federal safe harbor provisions, legalization, decriminalization, or rescheduling. The federal prohibition has the effect of inhibiting access to vital ancillary services, such as banking with financial institutions and mitigating risk through insurance. States may look to add safe harbor laws into their authorities to ensure vital ancillary businesses can legally service the cannabis industry within state laws. The goal of safe harbor authorities is to seek and grant protections from liabilities or penalties, so long as certain conditions are met. For example, California recently passed a bill that states an individual or firm providing insurance or related services to a state legal cannabis business does not commit a crime under California law solely for providing that insurance or related service.¹⁷¹ The NAIC has supported federal legislation to provide a safe harbor for financial institutions and insurers serving cannabis-related businesses operating in states that have legalized cannabis.

Currently, most commercial insurance coverage for cannabis-related businesses is in the excess and surplus market. There is, however, growing interest among admitted carriers in entering this area. Among the potential structures to facilitate cannabis-related business coverage are: the use of state-based commercial insurance programs, risk retention groups (RRGs), captives, and joint underwriting associations (JUAs). States may want to look at their state laws to identify and remediate any restrictions in use of such programs for cannabis-related businesses.

Fair Access to Insurance Requirements (FAIR) plan programs afford opportunities for difficult risks to be underwritten by certain insurers when other insurance is not feasible. Sometimes known as insurers of last resort, the availability of these plans varies by jurisdiction. While commonly limited to personal lines, some states include commercial coverage. Generally, these programs help to provide insurance for those unable to acquire it from the admitted or excess and surplus insurance markets. FAIR plans are shared market plans, where several insurance companies provide coverage for the property, limiting the amount of risk that any one company assumes.

Risk retention groups and captive insurers also provide additional options for cannabis-related business insurance coverage. Governed by state law, there are many nuances that a state must consider. For example, Washington identified 17 businesses using captive insurance but not

¹⁷¹ Assembly Member Cooley, AB 2568 (Chapter 393, Statutes of 2022).

paying premium taxes to the state the captive was operating in. This was due to legal framework for captive registration and taxation had not yet been established.¹⁷²

Joint underwriting associations (JUAs) could be created to alleviate the lack of availability and affordability for state mandated cannabis-related commercial insurance coverage. A joint underwriting association is a nonprofit risk-pooling association established by a state legislature in response to availability crises in respect to certain kinds of insurance coverage. For example, a number of states have established JUAs to provide medical malpractice insurance for physicians who are unable to obtain affordably priced insurance coverage in the standard marketplace.

Addressing black-market cannabis operations could also help support capacity for cannabis-related commercial insurance. Black-market operations can take the form of illegal grows, unlicensed production and processing facilities, and criminal retailers. Black-market operations compete with the regulated markets and remove revenue that would be taxed and generated with the legal retailers. Black-market products are also not subject to any regulations for advertising, marketing, retail sales, or consumer safety. This creates risk that can spill over into the state-legal cannabis market. For example, during Vape Gate, insurers increased pricing and added product liability exclusions for unapproved additives. Many of the vape issues were found to be due to black market products. However, insurers' apprehension on writing vape-related risks lingered for a few years following the event.¹⁷³

Some states are already taking steps to address black market operations. For example, Oregon and Washington each involve their law enforcement agencies in a collaborative effort with their cannabis regulatory bodies to seek and enforce against illegal cannabis operations. Oregon even coordinates its enforcement efforts in collaboration with California agencies in these efforts. Colorado coordinates between law enforcement and the cannabis regulatory agencies. In Washington, state tax revenue generated at regulated cannabis retailers is also distributed to local law enforcement agencies, which can help fund their enforcement efforts against black-market operations. The cannabis and insurance industries, as well as consumers, benefit from these enforcement activities, as well as the removal of the unregulated black-market.

As the number of states legalizing cannabis continues to grow, so will the need for cannabis-related commercial insurance. Insurance regulators must stay current with the rapidly changing landscape. There has been a rapid introduction of new cannabis products whose product liability

¹⁷² Joel S. Chansky, FCAS, MAAA Craig R. Brophy, FCAS, MAAA David R. Kennerud, FCAS, MAAA Joseph T. Holahan, JD, Milliman Report: Captive Insurance Study (January 18, 2021) – <https://www.insurance.wa.gov/sites/default/files/documents/captive-insurance-study.pdf>

¹⁷³ Steve Hallo, Market Insights: Vape Gate and today's cannabis product liability market (December 16, 2020) – <https://www.propertycasualty360.com/2020/12/16/vape-gate-and-todays-cannabis-product-liability-market/>

needs and risks are still unknown. The insurance needs of ancillary businesses will also need to be understood. Finally, insurance regulators will need to access the capacity for new business models, such as on-site consumption lounges, to find insurance coverage and address associated educational needs.

XI. APPENDIX:

ADDITIONAL CANNABIS INFORMATIONAL RESOURCES

- **Americans for Safe Access:** <https://www.safeaccessnow.org/>
- **Cannabis Business Times:** <https://www.cannabisbusinesstimes.com/>
- **Cannabis Now:** <https://cannabisnow.com/>
- **Cannabis Regulators Association:** <https://www.cann-ra.org/>
- **Drug Policy Alliance:** <http://www.drugpolicy.org/>
- **Global Commission on Drug Policy:** <http://www.globalcommissionondrugs.org/>
- **Insurance Journal: Attaining Compliance in the Cannabis Universe:**
<https://www.insurancejournal.com/research/research/attaining-compliance-in-the-cannabis-universe/>
- **Law Enforcement Action Partnership:** <https://lawenforcementactionpartnership.org/>
- **Marijuana Policy Project (MPP):** <https://www.mpp.org/>
- **MJ Business Daily:** <https://mjbizdaily.com/>
- **NAIC - Cannabis Insurance Hearings:**
 - Hearing 1:
<https://naic.webex.com/webappng/sites/naic/recording/225c7bfecae91039aafd0050568f5657/playback>
 - Hearing 2:
<https://naic.webex.com/webappng/sites/naic/recording/fe42d865d13210398fd70050568f0567/playback>
- **NAIC: Regulatory Guide – Understanding the Market for Cannabis Insurance:**
https://content.naic.org/sites/default/files/inline-files/cmte_c_cannabis_wg_exposure_understanding_cannabis_marketplace_0.pdf

- **National Cannabis Industry Association:** <https://thecannabisindustry.org/>
- **National Conference of State Legislatures:** <https://www.ncsl.org/research/civil-and-criminal-justice/marijuana-overview.aspx>
- **National Highway Traffic Safety Administration:** <https://www.nhtsa.gov/drug-impaired-driving/understanding-how-marijuana-affects-driving#:~:text=Though%2033%20states%20have%20changed,the%20wheel%20of%20a%20vehicle>
- **National Organization for the Reform of Marijuana Laws:** <https://norml.org/>
- **Patients out of Time:** <https://www.medicalcannabis.com/>
- **Smart Approaches to Marijuana:** <https://learnaboutsam.org/>
- **Students for Sensible Drug Policy:** <https://ssdp.org/>
- **Transform Drug Policy Foundation:** <https://transformdrugs.org/>
- **United States Department of Agriculture – Hemp:** <https://www.ams.usda.gov/rules-regulations/hemp>
- **United States Drug Enforcement Administration – Marijuana:** <https://www.dea.gov/factsheets/marijuana>
- **Veterans for Cannabis:** <https://www.vetscp.org/>
- **White House, Office of National Drug Control Policy:** <https://www.whitehouse.gov/ondcp>

PROJECT HISTORY**REGULATORY GUIDE TO UNDERSTANDING THE MARKET FOR CANNABIS INSURANCE: 2023 UPDATE
WHITE PAPER****1. Description of the Project, Issues Addressed, etc.**

The *Regulatory Guide to Understanding the Market for Cannabis Insurance: 2023 Update* white paper explores emerging insurance issues in the cannabis industry and the current state of cannabis regulation in the United States (U.S.).

2. Name of Group Responsible for Drafting the Model and States Participating

The Cannabis Insurance (C) Working Group drafted the white paper. The following states are on the Working Group: California, Colorado, Alaska, Arkansas, Delaware, District of Columbia, Illinois, New Mexico, Mississippi, Oklahoma, Oregon, Pennsylvania, Puerto Rico, Rhode Island, Nevada, Vermont, New Jersey, and Washington.

3. Project Authorized by What Charge and Date First Given to the Group

The white paper was authorized through the Property and Casualty (C) Insurance Committee's addition of a charge to the Cannabis Insurance Working Group's 2022 charges. Specifically, the charge asked the Working Group to use information gained through exploring potential sources of constraint to coverage limits and availability of cannabis insurance products in the P/C insurance lines to develop an updated white paper.

An updated white paper was needed because the cannabis industry has become more sophisticated since the original white paper was published in 2019. It has also continued to rapidly expand, driving new product development, infrastructure changes, and the need for businesses to provide ancillary services. The state of cannabis regulation, specifically at the state and local levels, has also evolved significantly since the last white paper.

4. A General Description of the Drafting Process (e.g., drafted by a subgroup, interested parties, the full group, etc). Include any parties outside the members that participated

The Cannabis Insurance (C) Working Group designated a drafting group to develop the white paper after it reviewed and approved an outline. The drafting group met in drafting sessions approximately bi-weekly until completion. Drafting group member states included California, Colorado, Illinois, Oregon, Vermont, and Washington. The Insurance Services Office (ISO) and American Association of Insurance Services (AAIS) contributed educational materials and revisions to the sections of the white paper that discuss their products and services. The Working Group was presented with updates on the working drafts so they could provide feedback.

5. A General Description of the Due Process (e.g., exposure periods, public hearings, or any other means by which widespread input from industry, consumers and legislators was solicited)

The white paper was exposed on April 11, 2023, for a 45-day public comment period ending May 26, 2023. Notification of the exposure was redistributed on June 6, 2023, to include the Property and Casualty Insurance (C) Committee's distribution list and the comment period was extended to July 7.

6. A Discussion of the Significant Issues (items of some controversy raised during the due process and the group's response)

The white paper focuses on issues impacting affordability and availability of insurance for cannabis-related risks in states that have legalized its use. It avoids advocacy-oriented discussion. As such, no controversy occurred during its drafting or exposure period.

7. List the key provisions of the model (sections considered most essential to state adoption)

While this is a white paper, not a model, state insurance regulators will find the Conclusions section helpful in understanding the unique activities states are taking or contemplating to address the need for cannabis-related insurance.

8. Any Other Important Information (e.g., amending an accreditation standard)

Capital Adequacy (E) Task Force RBC Proposal Form

- | | | |
|---|--|--|
| <input type="checkbox"/> Capital Adequacy (E) Task Force | <input type="checkbox"/> Health RBC (E) Working Group | <input type="checkbox"/> Life RBC (E) Working Group |
| <input type="checkbox"/> Catastrophe Risk (E) Subgroup | <input type="checkbox"/> P/C RBC (E) Working Group | <input type="checkbox"/> Longevity Risk (A/E) Subgroup |
| <input type="checkbox"/> Variable Annuities Capital. & Reserve (E/A) Subgroup | <input type="checkbox"/> Economic Scenarios (E/A) Subgroup | <input checked="" type="checkbox"/> RBC Investment Risk & Evaluation (E) Working Group |

<p style="text-align: right;">DATE: <u>4/20/23</u></p> <p>CONTACT PERSON: <u>Dave Fleming</u></p> <p>TELEPHONE: <u>816-783-8121</u></p> <p>EMAIL ADDRESS: <u>dfleming@naic.org</u></p> <p>ON BEHALF OF: <u>RBC Inv. Risk & Eval. (E) Working Group</u></p> <p>NAME: <u>Philip Barlow</u></p> <p>TITLE: <u>Associate Commissioner for Insurance</u></p> <p>AFFILIATION: <u>District of Columbia</u></p> <p>ADDRESS: <u>1050 First Street, NE Suite 801</u> <u>Washington, DC 20002</u></p>	<p style="text-align: center;">FOR NAIC USE ONLY</p> <hr/> <p>Agenda Item # <u>2023-09-IRE</u> Year <u>2023</u></p> <hr/> <p style="text-align: center;">DISPOSITION</p> <p>ADOPTED:</p> <p><input checked="" type="checkbox"/> TASK FORCE (TF) <u>6/30</u></p> <p><input checked="" type="checkbox"/> WORKING GROUP (WG) <u>6/14</u></p> <p><input type="checkbox"/> SUBGROUP (SG) _____</p> <p>EXPOSED:</p> <p><input type="checkbox"/> TASK FORCE (TF) _____</p> <p><input checked="" type="checkbox"/> WORKING GROUP (WG) _____</p> <p><input type="checkbox"/> SUBGROUP (SG) _____</p> <p>REJECTED:</p> <p><input type="checkbox"/> TF <input type="checkbox"/> WG <input type="checkbox"/> SG _____</p> <p>OTHER:</p> <p><input type="checkbox"/> DEFERRED TO _____</p> <p><input type="checkbox"/> REFERRED TO OTHER NAIC GROUP _____</p> <p><input type="checkbox"/> (SPECIFY) _____</p>
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IDENTIFICATION OF SOURCE AND FORM(S)/INSTRUCTIONS TO BE CHANGED

- | | | |
|--|---|---|
| <input type="checkbox"/> Health RBC Blanks | <input type="checkbox"/> Property/Casualty RBC Blanks | <input checked="" type="checkbox"/> Life and Fraternal RBC Blanks |
| <input type="checkbox"/> Health RBC Instructions | <input type="checkbox"/> Property/Casualty RBC Instructions | <input type="checkbox"/> Life and Fraternal RBC Instructions |
| <input type="checkbox"/> Health RBC Formula | <input type="checkbox"/> Property/Casualty RBC Formula | <input type="checkbox"/> Life and Fraternal RBC Formula |
| <input type="checkbox"/> OTHER _____ | | |

DESCRIPTION/REASON OR JUSTIFICATION OF CHANGE(S)

This proposal applies a .45 base RBC factor in the life RBC formula for residual tranches.

Additional Staff Comments:

DF – The Working Group adopted a factor of .30 for yearend 2023 to be replaced by .45 beginning with yearend 2024 with consideration of positive or negative adjustment based on additional information.

EY- The Task Force adopted this proposal and 2023-10-IRE together during June 30 meeting.

**** This section must be completed on all forms.**

Revised 2-2023

Attachment Four
Executive (EX) Committee and Plenary
8/16/23

OTHER LONG-TERM ASSETS (CONTINUED)

	Annual Statement Source	(1) Book / Adjusted Carrying Value	(2) Unrated Items †	(3) RBC Subtotal †	(4) Factor	(5) RBC Requirement
Schedule BA - Unaffiliated Common Stock						
(42)	Schedule BA Unaffiliated Common Stock-Public	AVR Equity Component Column 1 Line 65			X	§ =
(43)	Schedule BA Unaffiliated Common Stock-Private	AVR Equity Component Column 1 Line 66			X	0.3000 =
(44)	Total Schedule BA Unaffiliated Common Stock (pre-MODCO/Funds Withheld)	Line (42) + (43)				
(45)	Reduction in RBC for MODCO/Funds Withheld Reinsurance Ceded Agreements	Company Records (enter a pre-tax amount)				
(46)	Increase in RBC for MODCO/Funds Withheld Reinsurance Assumed Agreements	Company Records (enter a pre-tax amount)				
(47)	Total Schedule BA Unaffiliated Common Stock (including MODCO/Funds Withheld.)	Lines (44) - (45) + (46)				
Schedule BA - All Other						
(48.1)	BA Affiliated Common Stock - Life with AVR	AVR Equity Component Column 1 Line 67				
(48.2)	BA Affiliated Common Stock - Certain Other	AVR Equity Component Column 1 Line 68				
(48.3)	Total Schedule BA Affiliated Common Stock - C-1o	Line (48.1) + (48.2)			X	0.3000 =
(49.1)	BA Affiliated Common Stock - All Other	AVR Equity Component Column 1 Line 69			X	0.0680 =
(49.2)	Total Sch. BA Affiliated Common Stock - C-1cs	Line (49.1) + AVR Equity Component Column 1 Line 93			X	0.3000 =
(50)	Schedule BA Collateral Loans	Schedule BA Part 1 Column 12 Line 29999999 + Line 30999999			X	0.0680 =
(51)	Total Residual Tranches or Interests	AVR Equity Component Column 1 Line 93			X	0.3000 =
(52.1)	NAIC 01 Working Capital Finance Notes	AVR Equity Component Column 1 Line 94			X	0.0050 =
(52.2)	NAIC 02 Working Capital Finance Notes	AVR Equity Component Column 1 Line 95			X	0.0163 =
(52.3)	Total Admitted Working Capital Finance Notes	Line (52.1) + (52.2)				
(53.1)	Other Schedule BA Assets	AVR Equity Component Column 1 Line 96				
(53.2)	Less NAIC 2 thru 6 Rated/Designated Surplus Notes and Capital Notes	Column (1) Lines (23) through (27) + Column (1) Lines (33) through (37)				
(53.3)	Net Other Schedule BA Assets	Line (53.1) less (53.2)			X	0.3000 =
(54)	Total Schedule BA Assets C-1o (pre-MODCO/Funds Withheld)	Lines (11) + (21) + (31) + (41) + (48.3) + (50) + (52.3) + (53.3)			X	0.3000 =
(55)	Reduction in RBC for MODCO/Funds Withheld Reinsurance Ceded Agreements	Company Records (enter a pre-tax amount)				
(56)	Increase in RBC for MODCO/Funds Withheld Reinsurance Assumed Agreements	Company Records (enter a pre-tax amount)				
(57)	Total Schedule BA Assets C-1o (including MODCO/Funds Withheld.)	Lines (54) - (55) + (56)				
(58)	Total Schedule BA Assets Excluding Mortgages and Real Estate	Line (47) + (49.2) + (51) + (57)				

† Fixed income instruments and surplus notes designated by the NAIC Capital Markets and Investment Analysis Office or considered exempt from filing as specified in the *Purposes and Procedures Manual of the NAIC Investment Analysis Office* should be reported in Column (3).

‡ Column (2) is calculated as Column (1) less Column (3) for Lines (1) through (17). Column (2) equals Column (3) - Column (1) for Line (53.3).

§ The factor for Schedule BA publicly traded common stock should equal 30 percent adjusted up or down by the weighted average beta for the Schedule BA publicly traded common stock portfolio subject to a minimum of 22.5 percent and a maximum of 45 percent in the same manner that the similar 15.8 percent factor for Schedule BA publicly traded common stock in the Asset Valuation Reserve (AVR) calculation is adjusted up or down. The rules for calculating the beta adjustment are set forth in the AVR section of the annual statement instructions.

Denotes items that must be manually entered on the filing software.

Capital Adequacy (E) Task Force RBC Proposal Form

- | | | |
|---|--|--|
| <input type="checkbox"/> Capital Adequacy (E) Task Force | <input type="checkbox"/> Health RBC (E) Working Group | <input type="checkbox"/> Life RBC (E) Working Group |
| <input type="checkbox"/> Catastrophe Risk (E) Subgroup | <input type="checkbox"/> P/C RBC (E) Working Group | <input type="checkbox"/> Longevity Risk (A/E) Subgroup |
| <input type="checkbox"/> Variable Annuities Capital. & Reserve (E/A) Subgroup | <input type="checkbox"/> Economic Scenarios (E/A) Subgroup | <input checked="" type="checkbox"/> RBC Investment Risk & Evaluation (E) Working Group |

<p style="text-align: right;">DATE: <u>4/20/23</u></p> <p>CONTACT PERSON: <u>Steve Clayburn</u></p> <p>TELEPHONE: <u>(202)624-2197</u></p> <p>EMAIL ADDRESS: <u>steveclayburn@acli.com</u></p> <p>ON BEHALF OF: <u>American Council of Life Insurers (ACLI)</u></p> <p>NAME: <u>Steve Clayburn</u></p> <p>TITLE: _____</p> <p>AFFILIATION: _____</p> <p>ADDRESS: _____</p>	<p style="text-align: center;">FOR NAIC USE ONLY</p> <hr/> <p>Agenda Item # <u>2023-10-IRE</u> Year <u>2023</u></p> <hr/> <p style="text-align: center;">DISPOSITION</p> <p>ADOPTED:</p> <p><input checked="" type="checkbox"/> TASK FORCE (TF) <u>6/30</u></p> <p><input checked="" type="checkbox"/> WORKING GROUP (WG) <u>6/14</u></p> <p><input type="checkbox"/> SUBGROUP (SG) _____</p> <p>EXPOSED:</p> <p><input type="checkbox"/> TASK FORCE (TF) _____</p> <p><input checked="" type="checkbox"/> WORKING GROUP (WG) _____</p> <p><input type="checkbox"/> SUBGROUP (SG) _____</p> <p>REJECTED:</p> <p><input type="checkbox"/> TF <input type="checkbox"/> WG <input type="checkbox"/> SG _____</p> <p>OTHER:</p> <p><input type="checkbox"/> DEFERRED TO _____</p> <p><input type="checkbox"/> REFERRED TO OTHER NAIC GROUP _____</p> <p><input type="checkbox"/> (SPECIFY) _____</p>
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IDENTIFICATION OF SOURCE AND FORM(S)/INSTRUCTIONS TO BE CHANGED

- | | | |
|--|---|---|
| <input type="checkbox"/> Health RBC Blanks | <input type="checkbox"/> Property/Casualty RBC Blanks | <input checked="" type="checkbox"/> Life and Fraternal RBC Blanks |
| <input type="checkbox"/> Health RBC Instructions | <input type="checkbox"/> Property/Casualty RBC Instructions | <input type="checkbox"/> Life and Fraternal RBC Instructions |
| <input type="checkbox"/> Health RBC Formula | <input type="checkbox"/> Property/Casualty RBC Formula | <input type="checkbox"/> Life and Fraternal RBC Formula |
| <input type="checkbox"/> OTHER _____ | | |

DESCRIPTION/REASON OR JUSTIFICATION OF CHANGE(S)

The adoption by the Working Group of proposal 2023-04-IRE provides the structure for this sensitivity test. This proposal is to address the factor to be applied in that test.

Additional Staff Comments:

DF – The Working Group adopted a factor of .15 for yearend 2023.
EY- The Task Force adopted this proposal and 2023-09-IRE together during June 30 meeting.

SENSITIVITY TESTS - AUTHORIZED CONTROL LEVEL

Sensitivity Tests Affecting Authorized Control Level Risk-Based Capital		(1)	(2)	(3)	(4)	
	Source	Statement Value	Additional Sensitivity Factor	Additional RBC	Authorized Control Level Before Test	Authorized Control Level After Test
(1.1) Other Affiliates: Company	LR042 Summary for Affiliated Investments Column (1) Line (13)		0.700			
(1.2) Other Affiliates: Subsidiaries	LR038 Additional Information Required Column (1) Line (1.2)		0.700			
(1.99) Total Other Affiliates			0.700			
(2.1) Noncontrolled Assets - Company	LR017 Off-Balance Sheet and Other Items Column (1) Line (15)		0.020			
(2.2) Noncontrolled Assets - Subsidiaries	LR038 Additional Information Required Column (1) Line (2.2)		0.020			
(2.99) Total Noncontrolled Assets			0.020			
(3.1) Guarantees for Affiliates: Company	LR017 Off-Balance Sheet and Other Items Column (1) Line (24)		0.020			
(3.2) Guarantees for Affiliates: Subsidiaries	LR038 Additional Information Required Column (1) Line (3.2)		0.020			
(3.99) Total Guarantees for Affiliates			0.020			
(4.1) Contingent Liabilities: Company	LR017 Off-Balance Sheet and Other Items Column (1) Line (25)		0.020			
(4.2) Contingent Liabilities: Subsidiaries	LR038 Additional Information Required Column (1) Line (4.2)		0.020			
(4.99) Total Contingent Liabilities			0.020			
(5.1) Long-Term Leases: Company	LR017 Off-Balance Sheet and Other Items Column (1) Line (26)		0.030			
(5.2) Long-Term Leases: Subsidiaries	LR038 Additional Information Required Column (1) Line (5.2)		0.030			
(5.99) Total Long-Term Leases			0.030			
(7.1) Affiliated Investments†: Company	LR038 Additional Information Required Column (1) Line (7.14)		0.100			
(7.2) Affiliated Investments†: Subsidiaries	LR038 Additional Information Required Column (1) Line (7.2)		0.100			
(7.99) Total Affiliated Investments			0.100			
(8.1) Total Residual Tranches or Interests	LR038 Additional Information Required Column (1) Line (11.1)		0.150			

† Excluding affiliated preferred and common stock

Denotes items that must be manually entered on the filing software.

REQUEST FOR MODEL LAW DEVELOPMENT

This form is intended to gather information to support the development of a new model law or amendment to an existing model law. Prior to development of a new or amended model law, approval of the respective Parent Committee and the NAIC's Executive Committee is required. The NAIC's Executive Committee will consider whether the request fits the criteria for model law development. Please complete all questions and provide as much detail as necessary to help in this determination.

Please check whether this is: New Model Law or Amendment to Existing Model

1. Name of group to be responsible for drafting the model:

Mortgage Guaranty Insurance Working Group

2. NAIC staff support contact information:

Dan Daveline, (816)783-8134, ddaveline@naic.org
Andy Daleo, (816)783-8141, adaleo@naic.org

3. Please provide a description and proposed title of the new model law. If an existing law, please provide the title, attach a current version to this form and reference the section(s) proposed to be amended.

Mortgage Guaranty Insurance Model Act (#630)

Amendments will be made to the following sections, but not limited to:

- Section 3 - Capital Requirements – Paid-in Capital
- Section 5 - Geographic Concentration
- Section 7 - Investment Limitations
- Section 8 - Reinsurance and the Use of Captive Reinsurance
- Section 12 - Modifications to Risk-to-Capital and Minimum Policyholders Position
- Section 16 - Contingency Reserves

4. Does the model law meet the Model Law Criteria? Yes or No (Check one)

(If answering no to any of these questions, please reevaluate charge and proceed accordingly to address issues).

a. Does the subject of the model law necessitate a national standard and require uniformity amongst all states? Yes or No (Check one)

If yes, please explain why

Due to the recent mortgage crisis spanning globally, the Working Group desires to proceed with the development of a Model. While there could be modest variations, substantial agreement is desirable.

b. Does Committee believe NAIC members should devote significant regulator and Association resources to educate, communicate and support this model law?

Yes or No (Check one)

5. **What is the likelihood that your Committee will be able to draft and adopt the model law within one year from the date of Executive Committee approval?**

1 2 3 4 5 (Check one)

High Likelihood

Low Likelihood

Explanation, if necessary: May require an extension to 18 months total, due to possible need for outside expertise.

6. **What is the likelihood that a minimum two-thirds majority of NAIC members would ultimately vote to adopt the proposed model law?**

1 2 3 4 5 (Check one)

High Likelihood

Low Likelihood

Explanation, if necessary:

7. **What is the likelihood that state legislature will adopt the model law in a uniform manner within three years of adoption by the NAIC?**

1 2 3 4 5 (Check one)

High Likelihood

Low Likelihood

Explanation, if necessary: Primarily the key regulating mortgage guaranty states or the 15 states that are currently regulating mortgage guaranty insurers will adopt this Model or something substantially similar. It less likely for a state that does not have a domiciled mortgage guaranty insurer to adopt this Model.

8. **Is this model law referenced in the Accreditation Standards? If so, does the standard require the model law to be adopted in a substantially similar manner?**

No

9. **Is this model law in response to or impacted by federal laws or regulations? If yes, please explain.**

Not in response to Federal law, but it could be impacted by by Federal laws or GSE guidelines currently being developed.

Draft: 5/11/23

Adopted by Mortgage Guaranty Insurance (E) Working Group—7/13/23

Adopted by Financial Condition (E) Committee—7/19/23

MORTGAGE GUARANTY INSURANCE MODEL ACT

Table of Contents

Section 1.	Title
Section 2.	Definitions
Section 3.	Capital and Surplus Insurer's Authority to Transact Business
Section 4.	Insurer's Authority to Transact Business Mortgage Guaranty Insurance as Monoline
Section 5.	Risk Concentration
Section 6.	Capital and Surplus
Section 7.	Geographic Concentration
Section 8.	Section 6. Advertising
Section 9.	Section 7. Investment Limitation
Section 8.	Coverage Limitation
Section 9.	Mortgage Guaranty Insurance as Monoline
Section 10.	Reserve Requirements
Section 11.	Reinsurance
Section 12.	Sound Underwriting Discrimination Practices
Section 13.	Quality Assurance
Section 14.	Section 11. Policy Forms and Premium Rates Filed
Section 15.	Risk in Force and Waivers
Section 16.	Conflict of Interest
Section 17.	Section 12. Outstanding Total Liability
Section 13.	Rebates, Commissions and Charges
Section 14.	Compensating Balances Prohibited
Section 18.	Limitations on Rebates, Commissions, Charges and Contractual Preferences
Section 19.	Rescission
Section 20.	Records Retention
Section 21.	Section 15. Conflict of Interest
Section 16.	Reserves
Section 17.	Regulations

Section 1. Title

This Act may be cited as the Mortgage Guaranty Insurance Act.

Section 2. Definitions

The definitions set forth in this Act shall govern the construction of the terms used in this Act but shall not affect any other provisions of the code.

~~A.~~ A. "Authorized ~~real estate security,~~ for the purpose of this Act, Real Estate Security" means ~~an:~~

- (1) An amortized note, bond or other ~~evidence~~ instrument of indebtedness, except for reverse mortgage loans made pursuant to [insert citation of state law that authorizes reverse mortgages] of the real property law, evidencing a loan, not exceeding ~~ninety five~~ one hundred three percent (~~95~~103%) of the fair market value of the real estate, secured by a mortgage, deed of trust, or other instrument that constitutes, or is equivalent to, a first lien or ~~charge on real estate~~ junior lien or charge on real estate, with any percentage in excess of one hundred percent (100%) being used to finance the fees and closing costs on such indebtedness; provided:

~~(a) (1) The real estate loan secured in this manner is one of a type that a bank, savings and loan association, or an insurance company creditor, which is supervised and regulated by a department of this any state or territory of the U.S. or an agency of the federal government, is authorized to make, or would be authorized to make, disregarding any requirement applicable to such an institution that the amount of the loan not exceed a certain percentage of the value of the real estate;~~

~~(2b) The improvement on loan is to finance the acquisition, initial construction or refinancing of real estate that is a:~~

~~(i) Residential building designed for occupancy by not more than four families, a one-family residential condominium or unit in a planned unit development, or any other one-family residential unit as to which title may be conveyed freely; or~~

~~(ii) Mixed-use building with only one non-residential use and one one-family dwelling unit; or~~

~~(iii) Building or buildings designed for occupancy as specified by Subsections A(1) and A(2) of this section; and by five (5) or more families or designed to be occupied for industrial or commercial purposes.~~

~~(3c) The lien on the real estate may be subject to and subordinate to the following:~~

~~(a) The lien of any public bond, assessment or tax, when no installment, call or payment of or under the bond, assessment or tax is delinquent; and~~

~~(b) Outstanding mineral, oil, water or timber other liens, leases, rights, rights of way, easements or rights of way of support, sewer rights, building restrictions or other restrictions or, easements, covenants, conditions or regulations of use, or outstanding leases upon the real property under which rents or profits are reserved to the owner thereof that do not impair the use of the real estate for its intended purpose.~~

~~(2) Notwithstanding the foregoing, a loan referenced in Section 2A(1) of this Act may exceed 103% of the fair market value of the real estate in the event that the mortgage guaranty insurance company has approved for loss mitigation purposes a request to refinance a loan that constitutes an existing risk in force for the company.~~

~~(3) An amortized note, bond or other instrument of indebtedness evidencing a loan secured by an ownership interest in, and a proprietary lease from, a corporation or partnership formed for the purpose of the cooperative ownership of real estate and at the time the loan does not exceed one hundred three percent (103%) of the fair market value of the ownership interest and proprietary lease, if the loan is one of a type that meets the requirements of Section 2A(1)(a), unless the context clearly requires otherwise, any reference to a mortgagor shall include an owner of such an ownership interest as described in this paragraph and any reference to a lien or mortgage shall include the security interest held by a lender in such an ownership interest.~~

~~B. "Bulk Mortgage Guaranty Insurance" means mortgage guaranty insurance that provides coverage under a single transaction on each mortgage loan included in a defined portfolio of loans that have already been originated.~~

~~C. "Certificate of Insurance" means a document issued by a mortgage guaranty insurance company to the initial insured to evidence that it has insured a particular authorized real estate security under a master policy, identifying the terms, conditions and representations, in addition to those contained in the master policy and endorsements, applicable to such coverage.~~

~~D. "Commissioner" means [insert the title of the principal insurance supervisory official] of this state, or the [insert the title of the principal insurance supervisory official]'s deputies or assistants, or any employee of~~

~~the [insert name of the principal insurance regulatory agency] of this state acting in the [insert the title of the principal insurance supervisory official]'s name and by the [insert the title of the principal insurance supervisory official]'s delegated authority. "Commissioner." The term "commissioner" shall mean the insurance commissioner, the commissioner's deputies, or the Insurance Department, as appropriate.~~

Drafting Note: Insert the title of the chief insurance regulatory official wherever the word "commissioner" appears.

E.

~~B.~~ "Contingency reserve" "Contingency Reserve" means an additional premium reserve established to protect policyholders against the effect of adverse economic cycles.

~~C.~~ "Mortgage guaranty insurance" is F. "Domiciliary Commissioner" means the principal insurance supervisory official of the jurisdiction in which a mortgage guaranty insurance company is domiciled, ~~or that principal insurance supervisory official's deputies or assistants, or any employee of the regulatory agency of which that principal insurance supervisory official is the head acting in that principal insurance supervisory official's name and by that principal insurance supervisory official's delegated authority.~~

G. "Effective Guaranty" refers to the assumed backing of existing or future holders of securities by virtue of their issuer's conservatorship or perceived access to credit from the U.S. Treasury, as opposed to the direct full faith and credit guarantee provided by the U.S. government.

H. "Loss" refers to losses and loss adjustment expenses.

I. "Master Policy" means a document issued by a mortgage guaranty insurance company that establishes the terms and conditions of mortgage guaranty insurance coverage provided thereunder, including any endorsements thereto.

J. "Mortgage Guaranty +

~~(1)~~ Insurance" is insurance against financial loss by reason of nonpayment of principal, interest or other sums agreed to be paid under the terms of any ~~note or bond or other evidence of indebtedness secured by a mortgage, deed of trust, or other instrument constituting a lien or charge on real estate, provided the improvement on the real estate is a residential building or a condominium unit or buildings designed for occupancy by not more than four families;~~ authorized real estate security.

~~(2)~~ Insurance against financial loss by reason of nonpayment of principal, interest or other sums agreed to be paid under the terms of any note or bond or other evidence of indebtedness secured by a mortgage, deed of trust, or other instrument constituting a lien or charge on real estate, providing the improvement on the real estate is a building or buildings designed for occupancy by five (5) or more families or designed to be occupied for industrial or commercial purposes; and

~~(3)~~ Insurance against financial loss by reason of nonpayment of rent or other sums agreed to be paid under the terms of a written lease for the possession, use or occupancy of real estate, provided the improvement on the real estate is a building or buildings designed to be occupied for industrial or commercial purposes.

K. "Mortgage Guaranty Quality Assurance Program" means an early detection warning system for potential underwriting compliance issues which could potentially impact solvency or operational risk within a mortgage guaranty insurance company.

L. "NAIC" means the National Association of Insurance Commissioners.

M. "Pool Mortgage Guaranty Insurance" means mortgage guaranty insurance that provides coverage under a single transaction or a defined series of transactions on a defined portfolio of loans for losses up to an aggregate limit.

- N. “Right of Rescission” represents a remedy available to a mortgage guaranty insurance company to void a certificate and restore parties to their original position, based on inaccurate, incomplete or misleading information provided to, or information omitted or concealed from, the mortgage guaranty insurance company in connection with the insurance application, resulting in an insured loan that did not meet the mortgage guaranty insurance company’s eligibility requirements in effect on the date of submission of the insurance application.
- O. “Risk in Force” means the mortgage guaranty insurance coverage percentage applied to the unpaid principal balance.

Section 3. Insurer’s Authority to Transact Business

A company may not transact the business of mortgage guaranty insurance until it has obtained a certificate of authority from the commissioner.

Section 4. Mortgage Guaranty Insurance as Monoline

A mortgage guaranty insurance company that anywhere transacts any class of insurance other than mortgage guaranty insurance is not eligible for the issuance of a certificate of authority to transact mortgage guaranty insurance in this state nor for the renewal thereof.

Section 5. Risk Concentration

A mortgage guaranty insurance company shall not expose itself to any loss on any one authorized real estate security risk in an amount exceeding ten percent (10%) of its surplus to policyholders. Any risk or portion of risk which has been reinsured shall be deducted in determining the limitation of risk.

Section 6. Capital and Surplus

- A. **Initial and Minimum Capital and Surplus Requirements.** A mortgage guaranty insurance company shall not transact the business of mortgage guaranty insurance unless, if a stock insurance company, it has paid-in capital of at least \$~~10~~10,000,000 and paid-in surplus of at least \$~~15~~15,000,000, or if a mutual insurance company, a minimum initial surplus of \$~~225~~225,000,000. A stock insurance company or a mutual insurance company shall at all times thereafter maintain a minimum policyholders’ surplus of at least \$~~1,500~~20,000,000.

Section 4. Insurer’s Authority to Transact Business

~~No mortgage guaranty insurance company may issue policies until it has obtained from the commissioner of insurance a certificate setting forth that fact and authorizing it to issue policies.~~

- B. **Section 5. Minimum Capital Requirements Applicability.** A mortgage guaranty insurance company formed prior to the passage of this Act may maintain the amount of capital and surplus or minimum policyholders’ surplus previously required by statute or administrative order for a period not to exceed twelve months following the effective date of the adoption of this Act.
- C. **Minimum Capital Requirements Adjustments.** The domiciliary commissioner may by order reduce the minimum amount of capital and surplus or minimum policyholders’ surplus required under Section 6A under the following circumstances:
- (1) For an affiliated reinsurer that is a mortgage guaranty insurance company and that is or will be engaged solely in the assumption of risks from affiliated mortgage guaranty insurance companies, provided that the affiliated reinsurer is in run-off and, in the domiciliary commissioner’s opinion,

the business plan and other relevant circumstances of the affiliated reinsurer justify the proposed reduction in requirements.

(2) For mortgage guaranty insurance companies that are in run-off and not writing new business that is justified in a business plan, in the domiciliary commissioner's opinion.

Section 7. Geographic Concentration

- A. A mortgage guaranty insurance company shall not insure loans secured by a single risk in excess of ten percent (10%) of the company's aggregate capital, surplus and contingency reserve.
- B. No mortgage guaranty insurance company shall have more than twenty percent (20%) of its total insurance in force in any one Standard Metropolitan Statistical Area (SMSA), as defined by the ~~United States~~U.S. Department of Commerce.
- C. The provisions of this section shall not apply to a mortgage guaranty insurance company until it has possessed a certificate of authority in this state for three (3) years.

Section 68. Advertising

No mortgage guaranty insurance company or an agent or representative of a mortgage guaranty insurance company shall prepare or distribute or assist in preparing or distributing any ~~brochure, pamphlet, report or any form of~~ advertising media or communication to the effect that the real estate investments of any financial institution are "insured investments," unless the ~~brochure, pamphlet, report or~~ advertising media or communication clearly states that the loans are insured by mortgage guaranty insurance companies possessing a certificate of authority to transact mortgage guaranty insurance in this state or are insured by an agency of the federal government, ~~as the case may be.~~

Section 79. Investment Limitation

~~A mortgage guaranty insurance company shall not invest~~Investments in notes or other evidences of indebtedness secured by a mortgage or other liens upon residential real property ~~shall not be allowed as assets in any determination of the financial condition of a mortgage guaranty insurer.~~ This section shall not apply to obligations secured by real property, or contracts for the sale of real property, which obligations or contracts of sale are acquired in the course of ~~the~~ good faith settlement of claims under policies of insurance issued by the mortgage guaranty insurance company, or in the good faith disposition of real property so acquired. This section shall not apply to investments backed by the full faith and credit of the U.S. Government or investments with the effective guaranty of the U.S. Government. This section shall not apply to investments held by a mortgage guaranty insurance company prior to the passage of this Act.

Section 8. ~~Coverage Limitation~~10. Reserve Requirements

- A. Unearned premium Reserves, Loss Reserves, and Premium Deficiency Reserves. Financial reporting will be prepared in accordance with the Accounting Practices and Procedures Manual and Annual Financial Statement Instructions of the NAIC.
- B. Contingency Reserve. Each mortgage guaranty insurance company shall establish a contingency reserve subject to the following provisions:
 - (1) The mortgage guaranty insurance company shall make an annual contribution to the contingency reserve which in the aggregate shall be equal to fifty percent (50%) of the direct earned premiums reported in the annual statement or net earned premiums reported if the reinsurer maintains the contingency reserve.
 - (2) Except as provided within this Act, a mortgage guaranty insurance company's contributions to the contingency reserve made during each calendar year shall be maintained for a period of 120 months, to provide for reserve buildup. The portion of the contingency reserve established and maintained

for more than 120 months shall be released and shall no longer constitute part of the contingency reserve.

(3) Withdrawals may be made from the contingency reserve on a first-in, first-out basis or such other basis, with the prior written approval of the domiciliary commissioner, based on the amount by which:

(a) Incurred losses and loss adjustment expenses exceed 35% of the direct earned premium in any year. Provisional withdrawals may be made from the contingency reserve on a quarterly basis in an amount not to exceed 75% of the withdrawal as adjusted for the quarterly nature of the withdrawal; or

(b) Upon the approval of the domiciliary commissioner and 30-day prior notification to non-domiciliary commissioners, a mortgage guaranty insurer may withdraw from the contingency reserve any amounts which are in excess of the requirements of Section 15 as required in [insert section of the mortgage guaranty Insurance model law requiring minimum policyholder's position] as filed with the most recently filed annual statement.

(i) The mortgage guaranty insurance company's domiciliary commissioner may consider loss developments and trends in reviewing a request for withdrawal. If any portion of the contingency reserve for which withdrawal is requested is maintained by a reinsurer or in a segregated account or trust of a reinsurer, the domiciliary commissioner may also consider the financial condition of the reinsurer.

C. **Miscellaneous.** Unearned premium reserves and contingency reserves on risks insured before the effective date of this Act may be computed and maintained as required previously.

Section 11. Reinsurance

A. **Prohibition of Captive Reinsurance.** A mortgage guaranty insurance company shall not enter into captive reinsurance arrangements which involve the direct or indirect ceding of any portion of its insurance risks or obligations to a reinsurer owned or controlled by an insured; any subsidiary or affiliate of an insured; an officer, director or employee of an insured or any member of their immediate family; a corporation, partnership, trust, trade association in which an insured is a member, or other entity owned or controlled by an insured or an insured's officer, director or employee or any member of their immediate family that has a financial interest; or any designee, trustee, nominee or other agent or representative of any of the foregoing.

B. **Reinsurance Cessions.** A mortgage guaranty insurer may, by written contract, reinsure any insurance that it transacts, except that no mortgage guaranty insurer may enter into reinsurance arrangements designed to circumvent the compensating control provisions of Section 17 or the contingency reserve requirement of Section 10. The unearned premium reserve and the loss reserves required by Section 10 shall be established and maintained by the direct insurer or by the assuming reinsurer so that the aggregate reserves shall be equal to or greater than the reserves required by direct writer. The cession shall be accounted for as provided in the accounting practices and procedures prescribed or permitted by the applicable Accounting Practices and Procedures Manual of the NAIC.

Section 12. Sound Underwriting Practices

A. **Underwriting Review and Approval Required.** All certificates of mortgage guaranty insurance, excluding policies of reinsurance, shall be written based on an assessment of evidence that prudent underwriting standards have been met by the originator of the mortgage. Delegated underwriting decisions shall be reviewed based on a reasonable method of sampling of post-closing loan documentation to ensure compliance with the mortgage guaranty insurance company's underwriting standards.

B. **Quality Control Reviews.** Quality control reviews for bulk mortgage guaranty insurance and pool mortgage guaranty insurance shall be based on a reasonable method of sampling of post-closing loan documentation

for delegated underwriting decisions to ensure compliance with the representations and warranties of the creditors or creditors originating the loans and with the mortgage guaranty insurance company's underwriting standards.

C. **Minimum Underwriting Standards.** Mortgage guaranty insurance companies shall establish formal underwriting standards which set forth the basis for concluding that prudent underwriting standards have been met.

D. **Underwriting Review and Approval.** A mortgage guaranty insurance company's underwriting standards shall be:

(1) A mortgage guaranty insurance company shall limit its coverage net of reinsurance ceded to a reinsurer in which the company has no interest to a maximum of twenty five percent (25%) of the entire indebtedness to the insured or in lieu thereof, a mortgage guaranty insurance company may elect to pay the entire indebtedness to the insured and acquire title to the authorized real estate security.

Section 9.—Reviewed and approved by executive management, including, but not limited to the highest-ranking executive officer and financial officer; and

(2) Communicated across the organization to promote consistent business practices with respect to underwriting.

E. **Notification of Changes in Underwriting Standards.** On or before March 1 of each year, a mortgage guaranty insurance company shall file with the domiciliary commissioner changes to its underwriting standards and an analysis of the changes implemented during the course of the immediately preceding year. The annual summary of material underwriting standards changes should include any change associated with loan to value ratios, debt to income ratios, borrower credit standing or maximum loan amount which has resulted in a material impact on net premium written of +/- 5% from prior year to date.

Nondiscrimination. In extending or issuing mortgage guaranty insurance, a mortgage guaranty insurance company

A. A mortgage guaranty insurance company that anywhere transacts any class of insurance other than mortgage guaranty insurance is not eligible for the issuance of a certificate of authority to transact mortgage guaranty insurance in this state nor for the renewal thereof.

B. A mortgage guaranty insurance that anywhere transacts the classes of insurance defined in Section 2A(2) or 2A(3) is not eligible for a certificate of authority to transact in this state the class of mortgage guaranty insurance defined in Section 2A(1). However, a mortgage guarantee insurance company that transacts a class of insurance defined in Section 2A may write up to five percent (5%) of its insurance in force on residential property designed for occupancy by five (5) or more families.

Section 10.—**Underwriting Discrimination**

A. Nothing in this chapter shall be construed as limiting the right of a mortgage guaranty insurance company to impose reasonable requirements upon the lender with regard to the terms of a note or bond or other evidence of indebtedness secured by a mortgage or deed of trust, such as requiring a stipulated down payment by the borrower may not =

~~B.~~ No mortgage guaranty insurance company may discriminate in the issuance or extension of mortgage guaranty insurance on the on the basis of the applicant's sex, marital status, race, color, creed or national origin, national origin, disability, or age or solely on the basis of the geographic location of the property to be insured unless the discrimination related to geographic location is for a business purpose that is not a mere pretext for unfair discrimination; or the refusal, cancellation, or limitation of the insurance is required by law or regulatory mandate.

C. ~~No policy~~**Drafting Note:** States and jurisdictions should consult their constitution or comparable governance documents and applicable civil rights legislation to determine if broader protections against unacceptable forms of discrimination should be included in Section 12F.

Section 13. ~~mortgage guaranty insurance~~**Quality Assurance**

A. **Quality Assurance Program.** A mortgage guaranty insurance company shall establish a formal internal mortgage guaranty quality assurance program, which provides an early detection warning system as it relates to potential underwriting compliance issues which could potentially impact solvency or operational risk. This mortgage guaranty quality assurance program shall provide for the documentation, monitoring, evaluation and reporting on the integrity of the ongoing loan origination process based on indicators of potential underwriting inadequacies or non-compliance. This shall include, but not limited to:

- (1) **Segregation of Duties.** Administration of the quality assurance program shall be delegated to designated risk management, quality assurance or internal audit personnel, who are technically trained and independent from underwriting activities that they audit.
- (2) **Senior Management Oversight.** Quality assurance personnel shall provide periodic quality assurance reports to an enterprise risk management committee or other equivalent senior management level oversight body.
- (3) **Board of Director Oversight.** Quality assurance personnel shall provide periodic quality assurance reports to the board of directors or a designated committee of directors established to facilitate board of director oversight.
- (4) **Policy and Procedures Documentation.** Mortgage guaranty quality assurance program, excluding policies and procedures of reinsurance, shall be formally established and documented to define scope, roles and responsibilities.
- (5) **Underwriting Risk Review.** Quality assurance review shall include an examination of underwriting risks including classification of risk and compliance with risk tolerance levels.
- (6) **Lender Performance Reviews.** Quality assurance monitoring provisions shall include an assessment of lender performance.
- (7) **Underwriting Performance Reviews.** Quality assurance monitoring provisions shall assess compliance with underwriting standard.
- (8) **Problem Loan Trend Reviews.** Quality assurance monitoring provisions shall assess prospective risks associated with timely loan payment including delinquency, default inventory, foreclosure and persistency trends.
- (9) **Underwriting System Change Oversight.** Underwriting system program changes shall be monitored to ensure the integrity of underwriting and pricing programs, which impact automated underwriting system decision making.
- (10) **Pricing and Performance Oversight.** Pricing controls shall be monitored to ensure that business segment pricing supports applicable performance goals.

(11) Internal Audit Validation. Periodic internal audits shall be conducted to validate compliance with the mortgage guaranty quality assurance program.

B. Regulator Access and Review of Quality Assurance Program. The commissioner shall be provided access to an insurer's mortgage guaranty quality assurance program for review at any reasonable and thorough examination of the evidence supporting credit worthiness of the borrower and the appraisal report reflecting market evaluation of the property and has determined that prudent underwriting standards have been met time upon request and during any financial regulatory examination. Nothing herein shall be construed to limit a regulator's right to access any and all of the records of an insurer in an examination or as otherwise necessary to meet regulatory responsibilities.

Section ~~14~~14. Policy Forms and Premium Rates Filed

A. Policy Forms. All ~~policy forms and~~ endorsements, ~~and modifications (excluding bulk mortgage guaranty insurance and pool mortgage guaranty insurance)~~ shall be filed with and be subject to the approval of the commissioner. With respect to owner-occupied, single-family dwellings, ~~the mortgage guaranty insurance policy shall provide that or a mixed-use building described in Section 2A(1)(b), which is owner-occupied at the time of loan origination and for at least 50% of the days within the twelve (12) consecutive months prior to borrower default,~~ the borrower shall not be liable to the insurance company for any deficiency arising from a foreclosure sale.

B. ~~In addition, each mortgage guaranty insurance~~ Premium Rates. Each mortgage guaranty insurance company ~~(excluding bulk mortgage guaranty insurance and pool mortgage guaranty insurance)~~ shall file with the ~~department~~ commissioner the rate to be charged ~~and the premium~~ including all modifications ~~of rates and premiums to be paid by the policyholder.~~

C. Premium Charges. Every mortgage guaranty insurance company shall ~~adopt, print and~~ make available a ~~schedule of to insureds the~~ premium charges for mortgage guaranty insurance policies. ~~Premium charges made in conformity via a company website or an integration with the provisions of this Act shall not be deemed to be interest or other charges under any other provision of law limiting interest or other charges in connection with mortgage loans. a third-party system.~~ The ~~schedule~~ premium rate provided shall show the entire amount of premium charge for ~~each~~ the type of mortgage guaranty insurance policy to be issued by the insurance company.

Drafting Note: Open rating states may delete a portion or all of ~~this provision~~ Section 14 and insert their own rating law.

Section ~~12.~~ ~~Outstanding Total Liability~~ 15. Risk in Force and Waivers

A. ~~A mortgage guaranty insurance~~ Risk in Force. A mortgage guaranty insurance company shall not at any time have outstanding a ~~total liability~~ risk in force, net of reinsurance, under its aggregate mortgage guaranty insurance policies exceeding twenty-five (25) times its capital, surplus and contingency reserve. In the event that any mortgage guaranty insurance company has outstanding total ~~liability~~ risk in force exceeding twenty-five (25) times its capital, surplus and contingency reserve, it shall cease transacting new mortgage guaranty business until such time as its total ~~liability~~ risk in force no longer exceeds twenty-five (25) times its capital, surplus and contingency reserve. Total ~~outstanding liability~~ risk in force shall be calculated on a ~~consolidated~~ an individual entity basis ~~for all mortgage guarantee insurance companies.~~

B. Waiver. The commissioner may waive the requirement found in Section 15A at the written request of a mortgage guaranty insurer upon a finding that ~~are part of a holding company system~~ the mortgage guaranty insurer's policyholders position is reasonable in relationship to the mortgage guaranty insurer's aggregate insured risk in force and adequate to its financial needs. The request must be made in writing at least 90 days in advance of the date that the mortgage guaranty insurer expects to exceed the requirement of Section 15A and shall, at a minimum, address the factors specified in Section 15C.

C. **Waiver Criteria.** In determining whether a mortgage guaranty insurer's policyholders position is reasonable in relation to the mortgage guaranty insurer's aggregate insured risk in force and adequate to its financial needs, all of the following factors, among others, may be considered:

- (1) The size of the mortgage guaranty insurer as measured by its assets, capital and surplus, reserves, premium writings, insurance in force, and other appropriate criteria.
- (2) The extent to which the mortgage guaranty insurer's business is diversified across time, geography, credit quality, origination, and distribution channels.
- (3) The nature and extent of the mortgage guaranty insurer's reinsurance program.

The quality, diversification, and liquidity of the

- (4) mortgage guaranty insurer's assets and its investment portfolio.
- (5) The historical and forecasted trend in the size of the mortgage guaranty insurer's policyholders position.
- (6) The policyholders position maintained by other comparable mortgage guaranty insurers in relation to the nature of their respective insured risks.
- (7) The adequacy of the mortgage guaranty insurer's reserves.
- (8) The quality and liquidity of investments in affiliates. The commissioner may treat any such investment as a nonadmitted asset for purposes of determining the adequacy of surplus as regards policyholders.
- (9) The quality of the mortgage guaranty insurer's earnings and the extent to which the reported earnings of the mortgage guaranty insurer include extraordinary items.
- (10) An independent actuary's opinion as to the reasonableness and adequacy of the mortgage guaranty insurer's historical and projected policyholders position.
- (11) The capital contributions which have been infused or are available for future infusion into the mortgage guaranty insurer.
- (12) The historical and projected trends in the components of the mortgage guaranty insurer's aggregate insured risk, including, but not limited to, the quality and type of the risks included in the aggregate insured risk.

D. **Authority to Retain Experts.** The commissioner may retain accountants, actuaries, or other experts to assist in the review of the mortgage guaranty insurer's request submitted pursuant to Section 15B. The mortgage guaranty insurer shall bear the commissioner's cost of retaining those persons.

E. **Specified Duration.** Any waiver shall be:

- (1) For a specified period of time not to exceed two years; and
- (2) Subject to any terms and conditions that the commissioner shall deem best suited to restoring the mortgage guaranty insurer's minimum policyholders position required by Section 15A.

Section 16. **Conflict of Interest**

A mortgage guaranty insurer may underwrite mortgage guaranty insurance on mortgages originated by the holding company

system or affiliate or on mortgages originated by any mortgage lender to which credit is extended, directly or indirectly by the holding company system or affiliate only if the insurance is underwritten on the same basis, for the same consideration and subject to the same insurability requirements as insurance provided to nonaffiliated lenders. Mortgage guaranty insurance underwritten on mortgages originated by the holding company system or affiliate or on mortgages originated by any mortgage lender to which credit is extended, directly or indirectly by the holding company system or affiliate shall be limited to 50% of the insurer's direct premium written in any calendar year, or such higher percentage established in writing for the insurer in the domiciliary commissioner's discretion, based on the domiciliary commissioner's determination that a higher percentage is not likely to adversely affect the financial condition of the insurer.

Section 17. Compensating Balances Prohibited

Except for commercial checking accounts and normal deposits in support of an active bank line of credit, a mortgage guaranty insurance company, holding company or any affiliate thereof is prohibited from maintaining funds on deposit with the lender for which the mortgage guaranty insurance company has insured loans. Any deposit account bearing interest at rates less than what is currently being paid other depositors on similar deposits or any deposit in excess of amounts insured by an agency of the federal government shall be presumed to be an account in violation of this section. Furthermore, a mortgage guaranty insurance company shall not use compensating balances, special deposit accounts or engage in any practice that unduly delays its receipt of monies due or that involves the use of its financial resources for the benefit of any owner, mortgagee of the real property or any interest therein or any person who is acting as agent, representative, attorney or employee of the owner, purchaser or mortgagee as a means of circumventing any part of this section.

Section 18. Limitations on Rebates, Commissions, Charges and Contractual Preferences

- A. ~~insurance~~ **Inducements.** A mortgage guaranty insurance company shall not pay or cause to be paid either directly or indirectly, to any owner, purchaser, lessor, lessee, mortgagee or prospective mortgagee of the real property that secures the authorized real estate security or that is the fee of an insured lease, or any interest therein, or to any person who is acting as an agent, representative, attorney or employee of such owner, purchaser, ~~lessor, lessee~~ or mortgagee, any commission, or any part of its premium charges or any other consideration as an inducement for or as compensation on any mortgage guaranty insurance business.
- B. Compensation for Placement.** In connection with the placement of any mortgage guaranty insurance, a mortgage guaranty insurance company shall not cause or permit the conveyance of anything of value, including but not limited to any commission, fee, premium adjustment, remuneration or other form of compensation of any kind whatsoever to be paid to, or received by an insured lender or lessor; any subsidiary or affiliate of an insured; an officer, director or employee of an insured or any member of their immediate family; a corporation, partnership, trust, trade association in which an insured is a member, or other entity in which an insured or an officer, director or employee or any member of their immediate family has a financial interest; or any designee, trustee, nominee or other agent or representative of any of the foregoing, except for the value of the insurance itself or claim payments thereon as provided by contract or settlement.
- C. ~~No mortgage guaranty insurance~~ **Rebates.** A mortgage guaranty insurance company shall not make a rebate of any portion of the premium charge, as shown by the schedule required by Section ~~14C. No mortgage guaranty insurance~~ 14C. No mortgage guaranty insurance company shall not quote any rate or premium charge to a person that is different than that currently available to others for the same type of coverage. The amount by which a premium charge is less than that called for by the current schedule of premium charges is an unlawful rebate.
- D. Undue Contractual Preferences.**
- (1) Any contract, letter agreement, or other arrangement used to clarify any terms, conditions, or interpretations of a master policy or certificate shall be documented in writing.
 - (2) Any contractual or letter agreements used to modify or clarify general business practices and administrative, underwriting, claim submission or other information exchange processes shall not contain provisions which override or significantly undermine the intent of key provisions of the

mortgage guaranty insurance model act, including mortgage insurer discretion, rights and responsibilities related to:

(a) Underwriting standards.

(b) Quality assurance.

(c) Rescission.

- E. **Sanctions.** The commissioner may, after notice and hearing, suspend or revoke the certificate of authority of a mortgage guaranty insurance company, or in his or her discretion, issue a cease and desist order to a mortgage guaranty insurance company that pays a commission, rebate, or makes any unlawful rebate conveyance of value under this section in willful violation of the provisions of this Act. In the event of the issuance of a cease and desist order, the commissioner may, after notice and hearing, suspend or revoke the certificate of authority of a mortgage guaranty insurance company that does not comply with the terms thereof.

Section 14. — **Compensating Balances Prohibited**

- F. ~~Except for commercial checking accounts and normal deposits in support of an active bank line of credit, a mortgage guaranty insurance company, holding company or any affiliate thereof is prohibited from maintaining funds on deposit with the lender for which the mortgage guaranty insurance company has insured loans. Any deposit account bearing interest at rates less than what is currently being paid other depositors on similar deposits or any deposit in excess of amounts insured by an agency of the federal government shall be presumed to be an account in violation of this section.~~ **Educational Efforts and Promotional Materials Permitted.** A mortgage guaranty insurance company may engage in any educational effort with borrowers, members of the general public, and officers, directors, employees, contractors and agents of insured lenders that may reasonably be expected to reduce its risk of Loss or promote its operational efficiency and may distribute promotional materials of minor value.

Section 19. — **Rescission**

All mortgage guaranty insurance company master policies shall include a detailed description of provisions governing rescissions, re-pricing, and cancellations, which specify the insurer's and insured's rights, obligations and eligibility terms under which those actions may occur to ensure transparency.

Section 20. — **Records Retention**

- A. **Record Files.** A licensed mortgage guaranty insurance company shall maintain its records in a manner which allows the commissioner to readily ascertain the insurer's compliance with state insurance laws and rules during an examination including, but not limited to, records regarding the insurer's management, operations, policy issuance and servicing, marketing, underwriting, rating and claims practices.

B. ~~Furthermore, a mortgage guaranty insurance company shall not use compensating balances, special deposit accounts or engage in any practice that unduly delays its receipt of monies due or that involves the use of its financial resources for the benefit of any owner, mortgagee of the real property or any interest therein or any person who is acting as agent, representative, attorney or employee of the owner, purchaser or mortgagee as a means of circumventing any part of this section.~~

- Section 15. — **Retention Period.** Policy and claim records shall be retained for the period during which the certificate or claim is active plus five (5) years, unless otherwise specified by the insurance commissioner. Recordkeeping requirements shall relate to:

- (1) Records to clearly document the application, underwriting, and issuance of each master policy and certificate of insurance; and
- (2) Claim records to clearly document the inception, handling, and disposition.

C. **Record Format.** Any record required to be maintained by a mortgage insurer may be created and stored in the form of paper, photograph, magnetic, mechanical or electronic medium.

D. **Record Maintenance.** Record maintenance under this Act shall comply with the following requirements:

- (1) Insurer maintenance responsibilities shall provide for record storage in a location that will allow the records to be reasonably produced for examination within the time period required.
- (2) Third-Party maintenance related responsibilities shall be set forth in a written agreement, a copy of which shall be maintained by the insurer and available for purposes of examination.

Conflict of Interest

~~A. If a member of a holding company system, a mortgage guaranty insurance company licensed to transact business in this state shall not, as a condition of its certificate of authority, knowingly underwrite mortgage guaranty insurance on mortgages originated by the holding company system or an affiliate or on mortgages originated by any mortgage lender to which credit is extended, directly or indirectly, by the holding company system or an affiliate.~~

~~A. B. A mortgage guaranty insurance company, the holding company system of which it is a part, or any affiliate shall not as a condition of the mortgage guaranty insurance company's certificate of authority, pay any commissions, remuneration, rebates or engage in activities proscribed in Sections 13 and 14.~~

~~Section 16. Reserves~~

~~A. Unearned Premium Reserves~~

~~A mortgage guaranty insurance company shall compute and maintain an unearned premium reserve as set forth by regulation adopted by the commissioner of insurance.~~

~~B. Loss Reserve~~

~~A mortgage guaranty insurance company shall compute and maintain adequate case basis and other loss reserves that accurately reflect loss frequency and loss severity and shall include components for claims reported and for claims incurred but not reported, including estimated losses on:~~

- ~~(1) Insured loans that have resulted in the conveyance of property that remains unsold;~~
- ~~(2) Insured loans in the process of foreclosure;~~
- ~~(3) Insured loans in default for four (4) months or for any lesser period that is defined as default for such purposes in the policy provisions; and~~
- ~~(4) Insured leases in default for four (4) months or for any lesser period that is defined as default for such purposes in policy provisions.~~

~~C. Contingency Reserve~~

~~Each mortgage guaranty insurance company shall establish a contingency reserve out of net premium remaining (gross premiums less premiums returned to policyholders net of reinsurance) after establishment of the unearned premium reserve. The mortgage guaranty insurance company shall contribute to the contingency reserve an amount equal to fifty percent (50%) of the remaining unearned premiums. Contributions to the contingency reserve made during each calendar year shall be maintained for a period of 120 months, except that withdrawals may be made by the company in any year in which the actual incurred losses exceed thirty five percent (35%) of the corresponding earned premiums, and no releases shall be made without prior approval by the commissioner of insurance of the insurance company's state of domicile.~~

~~If the coverage provided in this Act exceeds the limitations set forth herein, the commissioner of insurance shall establish a rate formula factor that will produce a contingency reserve adequate for the added risk assumed. The face amount of an insured mortgage shall be computed before any reduction by the mortgage guaranty insurance company's election to limit its coverage to a portion of the entire indebtedness.~~

~~D. Reinsurance~~

~~Whenever a mortgage guaranty insurance company obtains reinsurance from an insurance company that is properly licensed to provide reinsurance or from an appropriate governmental agency, the mortgage guaranty insurer and the reinsurer shall establish and maintain the reserves required in this Act in appropriate proportions in relation to the risk retained by the original insurer and ceded to the assuming reinsurer so that the total reserves established shall not be less than the reserves required by this Act.~~

~~E. Miscellaneous~~

- ~~(1) Whenever the laws of any other jurisdiction in which a mortgage guaranty insurance company subject to the requirement of this Act is also licensed to transact mortgage guaranty insurance require a larger unearned premium reserve or contingency reserve in the aggregate than that set forth herein, the establishment of the larger unearned premium reserve or contingency reserve in the aggregate shall be deemed to be in compliance with this Act.~~
- ~~(2) Unearned premium reserves and contingency reserves shall be computed and maintained on risks insured after the effective date of this Act as required by Subsections A and C. Unearned premium reserves and contingency reserves on risks insured before the effective date of this Act may be computed and maintained as required previously.~~

Section ~~1721~~. Regulations

The commissioner shall have the authority to promulgate rules and regulations deemed necessary to effectively implement the requirements of this Act.

Chronological Summary of Actions (all references are to the Proceedings of the NAIC).

1976 Proc. II 15, 17, 647, 686, 747-753 (adopted).

1979 Proc. I 44, 47-48, 49, 719, 968-969 (corrected).

PROJECT HISTORY – 2023**MORTGAGE GUARANTY INSURANCE MODEL ACT (#630)****1. Description of the Project, Issues Addressed, etc.**

The current NAIC *Mortgage Guaranty Insurance Model Act* (#630) was first adopted in 1976 and amended in 1979. Model #630 was created to provide effective regulation and supervision of mortgage guaranty insurers. Model #630 defines mortgage guaranty insurance as insurance against financial loss by reason of nonpayment of principal, interest, or other sums agreed to be paid on any note secured by a mortgage, deed of trust, or other instrument constituting a lien or charge on real estate. Mortgage guaranty insurance may also cover against financial loss by reason of nonpayment of rent under the terms of a written lease. As of April 2012, eight states had adopted the most recent version of the model in a substantially similar manner. An additional 12 states have adopted an older version of the model, legislation, or regulation derived from other sources such as bulletins and administrative rulings.

The Mortgage Guaranty Insurance (E) Working Group was formed in November 2012. By early 2013, the Working Group developed a list of potential regulatory changes to Model #630 to address changes in mortgage lending and mortgage finance since the model's original approval in the 1970s and to respond to the lessons learned during the 2008 national recession and housing market downturn. As a result, a Request for NAIC Model Law Development was made and approved by the Executive (EX) Committee at the 2013 Summer National Meeting.

Development of the modernized model has a long history dating back to the fall of 2012. At that time, development of a capital model to accompany Model #630 was the key focus of attention. During 2013, mortgage guaranty insurers engaged Oliver Wyman to begin working on a Mortgage Guaranty Capital Model. Over the next several years, the Mortgage Guaranty Capital Model was developed. It was determined in December 2016 that a secondary contractor would need to be hired to further assess the reliability of the Mortgage Guaranty Capital Model. In September 2017, Milliman began its work to review and validate the Mortgage Guaranty Capital Model.

In March 2018, Milliman provided its assessment of the capital model to the Working Group. It indicated that inconsistencies and errors were found in the data preparation steps used to: 1) estimate the capital model coefficients and the application of the same capital model coefficients; and 2) forecast future loan performance. Milliman stated that these inconsistencies and errors were material to the capital model and would need to be addressed before the Mortgage Guaranty Capital Model could be implemented.

As a result, Milliman continued its work on the Mortgage Guaranty Capital Model, and in December 2019, it was exposed for public comment. The comments regarding the exposure were expected to be discussed during the 2020 Spring National Meeting. However, due to the COVID-19 pandemic, this meeting was cancelled. The Working Group also began working on an annual statement exhibit to begin collecting data for the capital model. In April 2021, the Mortgage Guaranty Insurance (E) Working Group referred the exhibit proposal to the Blanks (E) Working Group. The exhibit was finalized and implemented into the blank effective year-end 2021. In May 2022, the Mortgage Guaranty Insurance (E) Working Group decided to pause the development of the capital model and continue collecting data for further analysis in the future. As a result, the Working Group focused on finalizing the model.

2. Name of Group Responsible for Drafting the Model and States Participating

The Mortgage Guaranty Insurance (E) Working Group comprised the drafting Group and consisted of the following states during 2023: North Carolina (chair); Arizona; California; Florida, Missouri, New York, Pennsylvania; Texas; and Wisconsin.

3. Project Authorized by What Charge and Date First Given to the Group

The Executive (EX) Committee approved the Request for NAIC Model Law Development during the 2013 Summer National Meeting. Throughout the course of model development, the Financial Condition (E) Committee chair approved extensions due to extenuating circumstances.

4. A General Description of the Drafting Process (e.g., drafted by a subgroup, interested parties, the full group, etc). Include any parties outside the members that participated.

The Working Group formed a drafting group, which consisted of: Jackie Obusek (NC–Chair); Kurt Regner (AZ); Monica Macaluso (CA); Robert Ballard (FL); John Rehagen (MO); Margot Small (NY); Melissa Greiner (PA); Amy Garcia (TX); and Amy Malm (WI). Following the lengthy hiatus from the development of the model, due to work being completed on the Mortgage Guaranty Capital Model, the drafting group began finalization of model in May 2022 without consideration of the capital model. During its May meeting, the drafting group discussed the overall approach to finalizing the model and a rather aggressive timeline for completion.

5. A General Description of the Due Process (e.g., exposure periods, public hearings, or any other means by which widespread input from industry, consumers and legislators was solicited)

The Working Group met in open session on Oct. 6 and Dec. 13, 2022, and March 22, 2023. During these sessions, interested regulators and parties submitted comment letters to the Working Group. The drafting group held nine regulator-only discussion and planning calls between May 2022 and March 2023. The Working Group exposed the model for public comment on Oct. 7, 2022, and again on Feb. 27, 2023, and May 11, 2023. Comments were received from: the California Department of Insurance (DOI); the Center for Economic Justice (CEJ); and the Mortgage Guaranty Consortium (Arch Mortgage Insurance Company, Enact Mortgage Insurance Corporation, Essent Guaranty Inc., Mortgage Guaranty Insurance Corporation, National Mortgage Insurance Corporation, and Radian Guaranty Inc).

6. A Discussion of the Significant Issues (items of some controversy raised during the due process and the group’s response)

Section 10, Reserve Requirements – Contingency Reserve

The most significant issue raised during development was related to the recording of the contingency reserves when reinsurance is used. The specific provision is: “The Mortgage Guaranty Insurance company shall make an annual contribution to the Contingency Reserve which in the aggregate shall be equal to fifty percent (50%) of the direct earned premiums reported in the annual statement or net earned premiums reported if the reinsurer maintains the contingency reserve.” The mortgage insurers indicated that many reinsurers do not complete a statutory financial statement and would not have the ability to record the contingency reserve. The drafting group members discussed the topic and agreed to leave the provision as stated.

Section 21, No Private Right of Action Provision

The mortgage guaranty insurers proposed the following provision for inclusion in the model: “No Private Right of Action. Nothing in this Act is intended to, or does, create a private right of action based upon compliance or noncompliance with any of the Act’s provisions. Authority to enforce compliance with this Act is vested exclusively in the Commissioner.” Following discussion by the drafting group, the provision was added to the model and included in the Feb. 27, 2023, exposure. The drafting group received several comments on the provision. Following discussion, Section 21 was removed from the model.

7. List the Key Provisions of the Model (sections considered most essential to state adoption)

Section 10. Reserve Requirements

- A. **Unearned Premium Reserves, Loss Reserves, and Premium Deficiency Reserves.** Financial reporting will be prepared in accordance with the *Accounting Practices and Procedures Manual* (AP&P Manual) and Annual Financial Statement Instructions of the NAIC.
- B. **Contingency Reserve.** Each mortgage guaranty insurance company shall establish a contingency reserve subject to the following provisions:
 - (1) The mortgage guaranty insurance company shall make an annual contribution to the contingency reserve, which, in the aggregate, shall be equal to 50% of the direct earned premiums reported in the annual statement or net earned premiums reported if the reinsurer maintains the contingency reserve.

- (2) Except as provided within this act, a mortgage guaranty insurance company's contributions to the contingency reserve made during each calendar year shall be maintained for a period of 120 months to provide for reserve buildup. The portion of the contingency reserve established and maintained for more than 120 months shall be released and shall no longer constitute part of the contingency reserve.
- (3) Withdrawals may be made from the contingency reserve on a first-in, first-out basis or such other basis, with the prior written approval of the domiciliary commissioner, based on the amount by which:
- (a) Incurred losses and loss adjustment expenses exceed 35% of the direct earned premium in any year. Provisional withdrawals may be made from the contingency reserve on a quarterly basis in an amount not to exceed 75% of the withdrawal as adjusted for the quarterly nature of the withdrawal; or
- (b) Upon the approval of the domiciliary commissioner and 30-day prior notification to non-domiciliary commissioners, a mortgage guaranty insurer may withdraw from the contingency reserve any amounts that are in excess of the requirements of Section 15 as required in (insert section of the mortgage guaranty insurance model law requiring minimum policyholder's position) as filed with the most recently filed annual statement.
- (i) The mortgage guaranty insurance company's domiciliary commissioner may consider loss developments and trends in reviewing a request for withdrawal. If any portion of the contingency reserve for which withdrawal is requested is maintained by a reinsurer or in a segregated account or trust of a reinsurer, the domiciliary commissioner may also consider the financial condition of the reinsurer.
- C. **Miscellaneous.** Unearned premium reserves and contingency reserves on risks insured before the effective date of this act may be computed and maintained as required previously.

Section 15. Risk in Force and Waivers

- A. **Risk in Force.** A mortgage guaranty insurance company shall not at any time have outstanding risk in force, net of reinsurance, under its aggregate mortgage guaranty insurance policies exceeding 25 times its capital, surplus, and contingency reserve. In the event that any mortgage guaranty insurance company has outstanding total risk in force exceeding 25 times its capital, surplus, and contingency reserve, it shall cease transacting new mortgage guaranty business until such time as its total risk in force no longer exceeds 25 times its capital, surplus, and contingency reserve. Total risk in force shall be calculated on an individual entity basis.
- B. **Waiver.** The commissioner may waive the requirement found in subsection (a) of this section at the written request of a mortgage guaranty insurer upon a finding that the mortgage guaranty insurer's policyholders position is reasonable in relationship to the mortgage guaranty insurer's aggregate insured risk in force and adequate to its financial needs. The request must be made in writing at least 90 days in advance of the date that the mortgage guaranty insurer expects to exceed the requirement of subsection (a) of this section and shall, at a minimum, address the factors specified in subsection (j) of this section.
- C. **Waiver Criteria.** In determining whether a mortgage guaranty insurer's policyholders position is reasonable in relation to the mortgage guaranty insurer's aggregate insured risk in force and adequate to its financial needs, all of the following factors, among others, may be considered:
- (1) The size of the mortgage guaranty insurer as measured by its assets, capital and surplus, reserves, premium writings, insurance in force, and other appropriate criteria.
- (2) The extent to which the mortgage guaranty insurer's business is diversified across time, geography, credit quality, origination, and distribution channels.

- (3) The nature and extent of the mortgage guaranty insurer's reinsurance program.
- (4) The quality, diversification, and liquidity of the mortgage guaranty insurer's assets and its investment portfolio.
- (5) The historical and forecasted trend in the size of the mortgage guaranty insurer's policyholders position.
- (6) The policyholders position maintained by other comparable mortgage guaranty insurers in relation to the nature of their respective insured risks.
- (7) The adequacy of the mortgage guaranty insurer's reserves.
- (8) The quality and liquidity of investments in affiliates. The commissioner may treat any such investment as a nonadmitted asset for purposes of determining the adequacy of surplus as regards policyholders.
- (9) The quality of the mortgage guaranty insurer's earnings and the extent to which the reported earnings of the mortgage guaranty insurer include extraordinary items.
- (10) An independent actuary's opinion as to the reasonableness and adequacy of the mortgage guaranty insurer's historical and projected policyholders position.
- (11) The capital contributions that have been infused or are available for future infusion into the mortgage guaranty insurer.
- (12) The historical and projected trends in the components of the mortgage guaranty insurer's aggregate insured risk, including the quality and type of the risks included in the aggregate insured risk.

D. Authority to Retain Experts. The commissioner may retain accountants, actuaries, or other experts to assist the commissioner in the review of the mortgage guaranty insurer's request submitted pursuant to subsection (i) of this section. The mortgage guaranty insurer shall bear the commissioner's cost of retaining those persons.

E. Specified Duration. Any waiver shall be (i) for a specified period of time not to exceed two years and (ii) subject to any terms and conditions that the commissioner shall deem best suited to restoring the mortgage guaranty insurer's minimum policyholders position required by subsection (a) of this section.

8. Any Other Important Information (e.g., amending an accreditation standard)

None. It is not an accreditation standard, and the Working Group is not making a recommendation that it be considered as an accreditation standard.



State Implementation Reporting of NAIC-Adopted Model Laws and Regulations

Executive (EX) Committee

- Amendments to the ***Unfair Trade Practices Act (#880)***—These revisions were adopted by the Executive (EX) Committee and Plenary at the 2021 Spring National Meeting. Fourteen jurisdictions have adopted revisions to this model.

Life Insurance and Annuities (A) Committee

- Amendments to the ***Annuity Disclosure Model Regulation (#245)***—These revisions were adopted by the Executive (EX) Committee and Plenary at the 2021 Summer National Meeting. Four jurisdictions have adopted revisions to this model.
- Amendments to the ***Standard Nonforfeiture Law for Individual Deferred Annuities (#805)***—These revisions were adopted by the Executive (EX) Committee and Plenary at the 2020 Fall National Meeting. Twenty-four jurisdictions have adopted revisions to this model.

Health Insurance and Managed Care (B) Committee

- Amendments to the ***Health Maintenance Organization Model Act (#430)***—These revisions were adopted by the Executive (EX) Committee and Plenary at the 2020 Fall National Meeting. One jurisdiction has adopted revisions to this model.
- Amendments to the ***Insurance Holding Company System Regulatory Act (#440)***—These revisions were adopted by the Executive (EX) Committee and Plenary at the 2020 Fall National Meeting. Twenty-six jurisdictions have adopted revisions to this model.
- Amendments to the ***Insurance Holding Company System Model Regulation with Reporting Forms and Instructions (#450)***—These revisions were adopted by the Executive (EX) Committee and Plenary at the 2020 Fall National Meeting. Thirteen jurisdictions have adopted revisions to this model.

Property and Casualty Insurance (C) Committee

- Adoption of the ***Real Property Lender-Placed Insurance Model Act (#631)***—This model was adopted by the Executive (EX) Committee and Plenary at the 2021 Spring National Meeting. One jurisdiction has adopted this model.
- Adoption of the ***Pet Insurance Model Act (#633)***—This model was adopted by the Executive (EX) Committee and Plenary at the 2022 Summer National Meeting. Three jurisdictions have adopted this model.

EXECUTIVE (EX) COMMITTEE

Executive (EX) Committee, Aug. 14, 2023, Minutes.....	4-2
Executive (EX) Committee Interim Meeting Report (Attachment One)	4-6
Executive (EX) Committee Task Force Reports (Attachment Two).....	4-7
Report of Model Law Development Requests (Attachment Three).....	4-9

Draft: 8/28/23

Executive (EX) Committee
Seattle, Washington
August 14, 2023

The Executive (EX) Committee met in Seattle, WA, Aug. 14, 2023. The following Committee members participated: Chlora Lindley-Myers, Chair (MO); Andrew N. Mais, Vice Chair (CT); Jon Godfread, Vice President (ND); Scott A. White, Secretary-Treasurer (VA); Dean L. Cameron, Most Recent Past President (ID); Lori K. Wing-Heier (AK); Michael Conway (CO); Trinidad Navarro (DE); Doug Ommen (IA); Sharon P. Clark (KY); James J. Donelon (LA); Kathleen A. Birrane (MD); Anita G. Fox (MI); Andrew R. Stolfi (OR); Carter Lawrence (TN); and Kevin Gaffney (VT).

1. Adopted the Aug. 13 Report of the Executive (EX) Committee and the Internal Administration (EX1) Subcommittee

Director Lindley-Myers reported that the Executive (EX) Committee and Internal Administration (EX1) Subcommittee met Aug. 13, 2023, in regulator-to-regulator session, pursuant to paragraph 4 (internal or administrative matters of the NAIC) and paragraph 6 (consultations with NAIC staff members related to NAIC technical guidance) of the NAIC Policy Statement on Open Meetings.

During this meeting, the Committee and Subcommittee adopted its July 11, March 25, and March 22 minutes, which included the following action: 1) approved the termination of the defined benefit pension plan; 2) approved the fiscal for an additional full-time employee in Regulatory Services; 3) approved a second round of grant funding from the Robert Wood Johnson Foundation (RWJF); 4) approved changing the dates of the 2024 Summer National Meeting in Chicago, IL; 5) received a May year-to-date (YTD) financial update and overview of the preliminary 2024 budget; 6) approved the release of a request for proposal (RFP) to hire an executive search firm; 7) heard an update on the *State Connected* strategic plan; and 8) approved the Succession Planning and Organization Design fiscal.

The Committee and Subcommittee adopted the Executive (EX) Committee's May 23 and March 31 minutes, which included the following action: 1) approved Commissioner White to serve on the International Association of Insurance Supervisors (IAIS) Executive Committee; and 2) approved the following 2027 National Meeting locations: a) the 2027 Spring National Meeting will be in Kansas City, MO; b) the 2027 Summer National Meeting will be in New York City, NY; and c) the 2027 Fall National Meeting will be in Nashville, TN.

The Committee and Subcommittee adopted the report of the Audit Committee, including its Aug. 3 and May 24 minutes. During these meetings, the Committee took the following action: 1) received the June 30 financial update; 2) heard an overview of proposed 2024 revenues; 3) reappointed RubinBrown as the financial audit firm to conduct the 2023 audit; 4) affirmed the 2024 Audit Committee charter; 5) discussed Grant and Zone financials, including the following potential changes: a) allowing a one-time allocation of up to \$75,000 from technical training funds to general use; and b) allowing allocations from general funds to the New Avenues to Insurance Careers (N.A.I.C.) Foundation, pending funds balance; 6) heard an update on the Enterprise Resource Planning (ERP) project; 7) heard an update on the 2024 budget calendar; 8) received the 2022/2023 Service Organization Control (SOC) 1 and SOC 2 Audit reports; and 9) heard a presentation on the 2023 operating reserve analysis.

The Committee and Subcommittee adopted the report of the Internal Administration (EX1) Subcommittee, including its June 6 minutes. During this meeting, the Subcommittee took the following action: 1) received the March 31 Long-Term Investment Portfolio report; and 2) received the March 31 Defined Benefit Portfolio report.

The Committee and Subcommittee also: 1) heard a Cybersecurity report; and 2) heard the Acting Chief Executive Officer (CEO) report.

Director Wing-Heier made a motion, seconded by Commissioner Godfread, to adopt the Aug. 13 report of the joint meeting of the Executive (EX) Committee and the Internal Administration (EX1) Subcommittee. The motion passed unanimously.

2. Adopted its May 23 and March 31 Interim Meeting Report

Commissioner Godfread made a motion, seconded by Commissioner Mais, to adopt the Executive (EX) Committee's May 23 and March 31 interim meeting report (Attachment One). The motion passed unanimously.

3. Adopted the Reports of its Task Forces

Director Wing-Heier made a motion, seconded by Director Fox, to adopt the reports of the: 1) Climate and Resiliency (EX) Task Force; 2) Government Relations (EX) Leadership Council; 3) Long-Term Care Insurance (EX) Task Force; and 4) Special (EX) Committee on Race and Insurance (Attachment Two). The motion passed unanimously.

4. Received a Status Report on the Implementation of *State Connected*

Director Lindley-Myers provided an update on *State Connected* implementation efforts. The NAIC unveiled its strategic plan, *State Connected*, during the Spring National Meeting. The strategic focus areas are Member Connectivity; Training, Expertise, and Technology; Data and Analytics; Consumer Education, Outreach, and Advocacy; Committee Governance and Management; and NAIC Operations. The NAIC management team is diligently working on plans for implementation, including budget and resource issues. The Executive (EX) Committee will meet to discuss implementation plans in the coming months.

5. Received a Report on Model Law Development Efforts

Director Lindley-Myers presented a written report on the progress of ongoing model law development efforts (Attachment Three).

6. Heard a Report from the NIPR Board of Directors

Director Deiter reported that the National Insurance Producer Registry (NIPR) Board of Directors met Aug. 12 to discuss strategic planning for 2024 through 2026. The final strategic plan is expected to be adopted at the end of the year.

NIPR's revenues through the end of June remain strong. Total revenues are \$1.9 million, 5.7% above budget through June and 10% above the prior year. Most credentialing and reporting products exceeded budget. On a YTD basis, net assets have increased by \$6.9 million, which is \$5.1 million above budget.

NIPR is continuing to work with New York and Washington to implement those states on all remaining NIPR major products. Once complete, all states will be fully utilizing NIPR for major lines, products, and services.

NIPR continues to implement the Contact Change Request (CCR) application for business entities. The CCR allows business entities the ability to change their contact information easily through *NIPR.com*. The CCR for Business Entities is available in 34 states. NIPR will continue expanding its services to allow electronic solutions for states and industry to process additional licensee updates, including name changes and designated responsible licensed

producer (DRLP) changes. NIPR is now offering electronic “Name Change” for the following states: Connecticut, Missouri, North Dakota, Rhode Island, and Vermont. During the first week of August, NIPR released Connecticut as the pilot state for the DRLP changes.

Due to the volume of NIPR transactions and expected increases once New York and Washington are complete, the NIPR Board recently approved adding additional team members to NIPR’s customer service center. These NIPR team members provide a valuable service to state insurance regulators by answering producer licensing-related questions for all states and territories, helping to reduce the administrative burden on individual state insurance departments.

7. Heard a Report from the Compact

Commissioner Birrane reported that the Interstate Insurance Product Regulation Commission (Compact) will meet Aug. 15. During this meeting, the Compact will welcome Commissioner Godfreed and North Dakota as the newest member of the Compact. Gov. Doug Burgum (R-ND) signed U.S. Senate Bill 2172 on April 6, and the law took effect Aug. 1. North Dakota brings the membership in the Compact up to 47, which includes Washington, DC and Puerto Rico.

The Compact will receive a briefing on *Actuarial Guideline LIV—Nonforfeiture Requirements for Index-Linked Variable Annuity Products* (AG 54), which puts parameters around certain values in index-linked variable annuities (ILVAs). ILVAs have only been in the marketplace since 2010 and do not cleanly fit as a variable or non-variable annuity under the statutory framework. AG 54 attempts to address the calculation of the interim value when a withdrawal, surrender, or death occurs. A subgroup of the Compact’s Product Standards Committee is working on new uniform standards for ILVAs. Applying AG 54 is likely to be a public policy issue for members.

The Compact will discuss planning and releasing an Accomplishments Report of its current strategic plan. It will also get consensus on whether to continue with the three existing strategic priorities: 1) the Uniform Standards States Support and Companies Willingly Use; 2) the Nationally Recognized Regulatory Review Process; and 3) the resource for Compacting States, Regulated Entities, and Consumers.

The Compact will hear reports from its committees, including the Adjunct Services Committee. The Committee is chaired by Commissioner Barbara D. Richardson (AZ) and vice chaired by Commissioner Michael Humphreys (PA). The goal of the Committee is to take feedback from Compact Roundtables and consider proposals for what Compact 2.0 should look like in terms of providing adjunct services to members.

The Compact conducted three Roundtables in 2023, including the most recent one on May 17 in Washington, DC. Discussion at the Roundtables included a variety of topics ranging from speeding up the standards development process to positioning the Compact to provide advisory services. A Compact Roundtable will be held in Omaha, NE, Oct. 25, immediately following InsurTech on the Silicon Prairie.

The Compact will receive two recommendations for public rulemaking: 1) Uniform Standards for a new product line—group whole life insurance for employer groups; and 2) an amendment to the Rulemaking Rule to address incorporation by reference, especially when the incorporated material is amended, so there is a period for input before the amendment becomes effective.

The Compact will recognize Don Beatty (VA), who will retire Dec. 1. Mr. Beatty is the most recent recipient of the Dineen Award, and he has given his time and expertise to building the foundations of the Compact, as well as supporting its ongoing development.

The Compact is in a healthy cash position of just under \$1.5 million. Through the end of June, the Compact is within 3% of budgeted revenues, with actual revenues being a little over \$2.4 million. Expenses are well managed and under budget by 10%, with the actual being \$1.45 million.

The Compact is seeing strong annual registration revenue, which means more companies than anticipated are using the Compact platform as of the end of June. So far this year, the Compact has collected and remitted more than \$1.4 million in state filing fees to its members.

The Compact has made another payment to the NAIC in the amount of \$275,000 in service of the debt to the NAIC for its line of credit during the Compact's early years. To date, the Compact has made four annual payments totaling \$1.1 million dollars, and it has six annual payments remaining.

Having no further business, the Executive (EX) Committee adjourned.

SharePoint/NAIC Support Staff Hub/Committees



Virtual Meetings

EXECUTIVE (EX) COMMITTEE

May 23, 2023 / March 31, 2023

Summary Report

The Executive (EX) Committee met May 23 and March 31, 2023, in regulator-to-regulator session, pursuant to paragraph 4 (internal or administrative matters of the NAIC or any NAIC member) of the NAIC Policy Statement on Open Meetings. During these meetings, the Committee:

1. Appointed Commissioner Scott A. White (VA) to serve on the International Association of Insurance Supervisors (IAIS) Executive Committee.
2. Approved the 2027 national meeting site locations: Spring National Meeting, Kansas City, MO; Summer National Meeting, New York, NY; and Fall National Meeting, Nashville, TN.



Draft: 8/10/23

REPORT OF THE EXECUTIVE (EX) COMMITTEE TASK FORCES

Climate and Resiliency (EX) Task Force—The Climate and Resiliency (EX) Task Force will meet Aug. 15 and anticipates the following action: 1) adopting its Spring National Meeting minutes; 2) hearing an update from the Solvency Workstream; 3) hearing a presentation from the Bermuda Institute for Ocean Sciences (BIOS) on rising sea levels; 4) hearing from Ceres on inclusive insurance; 5) hearing from Munich Re on coral reef insurance; and 6) hearing from California on atmospheric rivers.

Government Relations (EX) Leadership Council—The Government Relations (EX) Leadership Council did not meet at the Summer National Meeting. The Leadership Council meets weekly in regulator-to-regulator session, pursuant to paragraph 8 (consideration of strategic planning issues) of the NAIC Policy Statement on Open Meetings, to discuss federal legislative and regulatory developments affecting insurance regulation.

Long-Term Care Insurance (EX) Task Force—The Long-Term Care Insurance (EX) Task Force conducted an e-vote that concluded Aug. 9, in lieu of the Summer National Meeting, and took the following action: 1) adopted its Spring National Meeting minutes. The Task Force also met May 16 in regulator-to-regulator session, pursuant to paragraph 3 (specific companies, entities, or individuals) of the NAIC Policy Statement on Open Meetings, to continue work on its goals.

Special (EX) Committee on Race and Insurance—The Special (EX) Committee on Race and Insurance will meet Aug. 14 and anticipates the following action: 1) adopting its Spring National Meeting minutes; 2) hearing an update on health equity; 3) hearing an update on the Member Diversity Leadership Forum; and 4) receiving a status report from its workstreams. At the end of last year, the Special Committee voted to disband Workstream One and Workstream Two (focused on diversity within the insurance industry, the insurance regulatory community, and the NAIC) and rename its remaining workstreams by product line—property/casualty (P/C), life, and health.

- **Property/Casualty (P/C) Workstream**—The P/C Workstream of the Special Committee has been looking at potential bias in marketing, access to insurance, underwriting, rating, and claims handling. The Workstream recently met with industry representatives to focus on underwriting and rating, having previously met to focus on marketing issues. These discussions help to inform the workstream as it looks at potential algorithmic bias and explores industry best practices.
- **Life Workstream**—The Life Workstream of the Special Committee met July 20 to discuss its next steps. The Workstream plans to continue its focus on “marketing, distribution, and access to life insurance products in minority communities, including the role that financial literacy plays” by developing a resource guide for regulators. The guide is intended to be a resource for information helpful to all insurance departments looking to take action to improve access and understanding in underserved communities. The Workstream plans to work in cooperation with the NAIC Diversity, Equity, and Inclusion (DE&I) Division and the State Diversity Leaders. A list of questions was distributed during the State Diversity Leaders Forum on July 24 to start to catalog state activity. The Workstream also plans to hear additional presentations. There are stakeholders interested in sharing resources and information for possible inclusion in the resource guide. The Workstream anticipates hearing a presentation from Colorado, as well as hearing presentations from consumer representatives and industry stakeholders that expressed an interest in presenting.

- **Health Workstream**—The Health Workstream of the Special Committee met in regulator-to-regulator session after the Spring National Meeting to consider its activities and initiatives for 2023. During that meeting, the Workstream decided to hold at least three meetings to continue its education on benefit design relating to preventive care and mental health coverage (beyond pure parity). The Health Workstream also plans to meet about the evolution of the federal Affordable Care Act (ACA) Section 1332 waivers. Additionally, it is considering additional meetings to hear about innovative programs and initiatives that states are doing that are designed to promote health equity. The Workstream is also working to finalize a collaborative space on NAIC Connect to provide a platform in which Workstream members can share with other NAIC members the information it has captured during its meetings on removing barriers to health insurance for historically disadvantaged communities. The thought is that the Workstream’s NAIC Connect page would be a living resource for the NAIC membership, and the Workstream can continue to build content and other tools for the states on this site. In addition, the Workstream hopes that this site could also serve as a platform for discussion and conversations related to health equity and other related topics.



Draft: 8/9/23

Model Law Development Report

Amendments to the *Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act (#171)*—Amendments to Model #171 are required for consistency with the federal Affordable Care Act (ACA) and the revisions to its companion model act, the *Supplementary and Short-Term Health Insurance Minimum Standards Model Act (#170)*. The Accident and Sickness Insurance Minimum Standards (B) Subgroup completed the revisions to Model #170 in late 2018, which the Executive (EX) Committee and Plenary adopted in February 2019. Therefore, they did not require approval of a Request for NAIC Model Law Development by the Executive (EX) Committee.

Soon after completing its work on Model #170, the Subgroup began considering revisions to Model #171. The Subgroup met every two weeks until it lost one of its co-chairs in December 2019. After a long hiatus since late 2019 because of the loss of a co-chair and the COVID-19 pandemic, as well as other resource issues, the Subgroup resumed its meetings in June 2021. The Subgroup has been meeting on a regular basis to discuss the comments received on Model #171. During the last few months of 2022, the Subgroup’s discussions focused on Section 8—Supplementary and Short-Term Health Minimum Standards for Benefits. This section establishes minimum standards for benefits for the products subject to the model, including accident-only coverage, hospital indemnity or other fixed indemnity coverage, and disability income protection coverage. The revisions also include a new section establishing minimum benefits for short-term, limited-duration (STLD) plans. The Subgroup completed its discussions of Section 8 in December 2022, including developing a new subsection establishing minimum benefit standards for STLD plans.

The Subgroup resumed its meetings in February 2023 and plans to continue meeting on a regular basis to continue its discussions and plans to work on the following Model #171 sections in this order: 1) the remainder of Section 8, including revisiting the proposed new subsection on STLD plans to discuss the Feb. 24 comments received on that section; 2) Section 7—Prohibited Policy Provisions; 3) revisit Section 5—Definitions and Section 6—Policy Definitions to reconcile any inconsistencies that may have arisen after the Subgroup’s review of the substantive provisions of Model #171; and 4) Section 9—Required Disclosure Provisions. The Subgroup is completing work on Section 9—Required Disclosure Provisions. The Subgroup hopes to finish its work to develop an initial draft of comments on Model #171 for public comment by the end of the year.

Amendments to the *Property and Casualty Insurance Guaranty Association Model Act (#540)*—The Executive (EX) Committee approved a Request for NAIC Model Law Development for amendments to Model #540 during the 2022 Summer National Meeting. The amendments will address the continuity of guaranty fund coverage when a policy is transferred from one insurer to another. The Executive (EX) Committee also approved a Request for NAIC Model Law Development for additional amendments to Model #540 during the 2023 Spring National Meeting. The amendments will address guaranty association coverage of cybersecurity insurance. The Receivership Law (E) Working Group adopted draft revisions on July 24 that address both requests. On Aug. 14, the Receivership and Insolvency (E) Task Force exposed the draft revisions and a few edits subsequent to the Working Group’s adoption for a 30-day public comment period ending Sept. 14.

Amendments to the *Mortgage Guaranty Insurance Model Act (#630)*—The Executive (EX) Committee approved a Request for NAIC Model Law Development for amendments to Model #630 during the 2013 Summer National Meeting. The Mortgage Guaranty Insurance (E) Working Group has developed proposed changes to the model, which the Financial Condition (E) Committee adopted on July 19, 2023. The full membership will consider adoption of the revised model during the Summer National Meeting.

Amendments to the *Nonadmitted Insurance Model Act (#870)*—The Executive (EX) Committee approved a Request for NAIC Model Law Development for amendments to Model #870 during the 2021 Spring National Meeting. The amendments will modernize the model and bring it into alignment with the federal Nonadmitted and Reinsurance Reform Act (NRRRA). The Surplus Lines (C) Task Force met May 23, 2022, to discuss amendments to Model #870 and expose Model #870 for a 60-day public comment period ending July 21, 2022. It met Oct. 17, 2022, to hear a summary of comments received on the draft exposure and actions taken by the drafting group to address the comments. The Task Force exposed Model #870 for a 30-day public comment period ending Nov. 17, 2022. It discussed the comments received on the draft exposure during an open meeting on Dec. 12, 2022. On Jan. 23, 2023, the Task Force exposed a draft of Model #870 for a 14-day public comment period. The Task Force and the Property and Casualty Insurance (C) Committee adopted Model #870 during the Spring National Meeting. The Executive (EX) Committee and Plenary will consider adoption of the model during the Summer National Meeting.

Amendments to the *Unfair Trade Practices Act (#880)*—The Executive (EX) Committee approved a Request for NAIC Model Law Development for amendments to Model #880 during the 2023 Spring National Meeting. The amendments will address the use of lead generators for sales of health insurance products and identify models and guidelines that need to be updated or developed to address current marketplace activities. The Improper Marketing of Health Insurance (D) Working Group distributed the initial draft on Aug. 31, 2022, for a public comment period ending Sept. 30, 2022. The Working Group met Nov. 3, 2022, to hear a summary of comments received on the draft exposure and actions taken by the Working Group to address the comments. The Working Group exposed revised amendments to Model #880 for a public comment period ending Nov. 18, 2022. The Working Group discussed the draft exposure and comments received during an open meeting on Dec. 3, 2022, during the Fall National Meeting. The Working group extended the review period for draft amendments to Model #880.

The Working Group met March 23, 2023, during the Spring National Meeting to hear a summary of comments on the draft exposure and actions the Working Group took to address the comments. The Working Group created a subject matter expert (SME) group to meet and finalize the draft amendments to Model #880. On July 10, the Working Group distributed the revised draft amendments for a public comment period ending July 21. The Working Group met July 27 to hear a summary of comments received on the draft exposure and action the Working Group took to address comments. The Working Group distributed revised amendments on Aug. 9, to be discussed at the Summer National Meeting for consideration of adoption.

New Model: *Insurance Consumer Privacy Protection Model Law*—During the 2022 Summer National Meeting, the Executive (EX) Committee approved a Request for NAIC Model Law Development for a new model that would replace existing models in order to enhance consumer protections and corresponding obligations of entities licensed by insurance departments to reflect the extensive innovations that have been made in communications and technology. The Privacy Protections (H) Working Group approved this request on Aug. 2. The drafting group met in regulator-to-regulator session Aug. 31, Sept. 15, Sept. 29, Oct. 4, Oct. 13, Dec. 1, and Dec. 5. The drafting group also met with companies privately to discuss current consumer data practices on Nov. 17, Nov. 29, Nov. 30, Dec. 5, Dec. 6, and Dec. 8. The Working Group met in open session Dec. 12 to hear presentations from an industry and a consumer perspective on general market practices regarding the use of personal information during the insurance process followed by an open discussion of these insights.

The Working Group exposed its initial draft of the new model (Model #674) Feb. 1, 2023, for a 60-day public comment period ending April 3. The drafting group met in regulator-to-regulator session Jan. 23 and March 15. The drafting group continued its meetings with companies privately to discuss current consumer data practices

on Feb. 16, March 1, March 2, March 7, March 8, March 9, March 14, April 5, April 12, and April 13. The Working Group discussed comments received and engaged with the public to continue to revise the privacy model law's language at the Spring National Meeting; during open Working Group meetings April 18, May 2, and May 16; and during the in-person, two-day interim meeting in Kansas City, MO, June 5–6.

The Working Group exposed the second draft of the new model (Model #674, version 1.2) July 11 for a public comment period ending July 28 because the new version was based on changes that were discussed at the interim meeting. The drafting group met in regulator-to-regulator session June 22, June 23, June 26, June 29, June 30, July 7, July 10, and July 20. The drafting group continued its meetings with companies privately to discuss current consumer data practices on July 28 with additional meetings scheduled for Aug. 2, Aug. 7, and Aug. 9. The Working Group met in open session July 25 to discuss comments received and to engage with the public to continue to revise the privacy model law's language. It will also meet in regulator-to-regulator and open sessions at the Summer National Meeting to discuss key topics noted in the comments received and to discuss an extension to continue to engage with interested parties in improving the model law's language, as appropriate to the model law's purpose.

CLIMATE AND RESILIENCY (EX) TASK FORCE

Climate and Resiliency (EX) Task Force Aug. 15, 2023, Minutes..... 4-13

Climate and Resiliency (EX) Task Force
Seattle, Washington
August 15, 2023

The Climate and Resiliency (EX) Task Force met Aug. 15, 2023. The following Task Force members participated: Lori K. Wing-Heier, Co-Chair (AK); Ricardo Lara, Co-Chair (CA), James J. Donelon, Co-Vice Chair (LA); Mike Kreidler, Co-Vice Chair (WA); Mark Fowler (AL); Alan McClain (AR); Barbara D. Richardson (AZ); Michael Conway represented by Peg Brown (CO); Andrew N. Mais (CT); Karima M. Woods (DC); Trinidad Navarro represented by Stephen C. Taylor and Susan Jennette (DE); Michael Yaworsky represented by Virginia Christy (FL); Gordon I. Ito represented by Jerry Bump (HI); Doug Ommen (IA); Dana Popish Severinghaus (IL); Amy L. Beard represented by Patrick O'Connor (IN); Sharon P. Clark (KY); Gary D. Anderson (MA); Kathleen A. Birrane (MD); Timothy N. Schott (ME); Anita G. Fox represented by Steve Mayhew (MI); Grace Arnold represented by Peter Brickwedde (MN); Chlora Lindley-Myers represented by Cynthia Amann (MO); Mike Chaney (MS); Troy Downing (MT); Mike Causey represented by Angela Hatchell (NC); Jon Godfread (ND); Eric Dunning (NE); D.J. Bettencourt represented by Christian Citarella (NH); Alice T. Kane represented by Leatrice Geckler (NM); Scott Kipper represented by Nick Stosic (NV); Adrienne A. Harris represented by Bob Kasinow (NY); Judith L. French represented by Tom Botsko (OH); Andrew R. Stolfi represented by TK Keen (OR); Elizabeth Kelleher Dwyer (RI); Michael Wise represented by Will Davis (SC); Tregenza A. Roach (VI); Kevin Gaffney (VT); Nathan Houdek (WI); and Jeff Rude (WY). Also participating were: Michael Peterson (CA); and Wanchin Chou (CT).

1. Adopted its Spring National Meeting Minutes

The Task Force also met Aug. 2 in regulator-to-regulator session, pursuant to paragraph 6 (consultations with NAIC staff members related to NAIC technical guidance) of the NAIC Policy Statement on Open Meetings, to preview the NAIC Climate Risk Dashboard.

Commissioner Kreidler made a motion, seconded by Commissioner Clark, to adopt the Task Force's March 24 minutes (see *NAIC Proceedings – Spring 2023, Climate and Resiliency (EX) Task Force*). The motion passed unanimously.

2. Heard a Presentation from the ASU Global Futures Laboratory on Global Temperature Rise

Commissioner Lara said sea level rise is an issue that presents insurance challenges, most notably when intense coastal storms are combined with high tides and storm surge. He said that leads to additional consequences for residential and commercial insurance markets.

Peter Schlosser (Arizona State University—ASU) said society has reached a new geological age in which humankind has touched every part of the planet, and this is highlighted through climate effects because they are visible to us. He said more extreme events are occurring at a higher frequency, and the challenge facing society is the short amount of time there is to respond.

Schlosser said while use of renewable energy is increasing, it cannot make up for the amount of energy from coal, oil, and gas that is being consumed. He said scientific data shows carbon emissions and an increased carbon dioxide concentration are heating the atmosphere. He said there is a global demand for more energy, but society is not at a point where it is using the kind of energy that does not lead to global warming. Schlosser said during the last decade, the warmest eight years on the planet were recorded.

Schlosser said extreme weather events, including wildfires, drought, and flooding, will continue to increase in frequency.

Schlosser said the melting of ice sheets in the Arctic and Antarctic regions has increased. He said the main contributor to sea level rise is the increase in melt days that cover large areas of Greenland and Antarctica. He said projections show a rise in sea level of 1 to 3 meters by the end of the current century. He said this would affect the seaports that ship 90% of globally exchanged goods.

Schlosser said the goal to cut emissions in half by 2030 is falling behind and that more carbon dioxide would have to be taken out of the atmosphere to make up for the lack of emissions reduction. He said the U.S. Department of Energy has made available \$3.5 billion to advance technology that can remove carbon from the atmosphere.

Schlosser said the work of the Global Futures Laboratory at ASU includes monitoring the health of critical ecosystems, such as coral reefs; innovating ethical energy system transformation; providing advanced decision support; and engaging stakeholder dialogues to support areas under pressure from climate risks. He said the decisions made in the next 10 years will likely shape the climate and how society is able to deal with it for the upcoming century.

Commissioner Lara said the Task Force will be hearing a presentation on parametric insurance products related to coral reefs.

Chou asked if nuclear fusion has been considered a solution for moving away from fossil fuels. Schlosser said nuclear energy, which is mainly based on nuclear fission instead of fusion, will not play a dominant role in solving the problem. He said smaller reactors conducting nuclear fission still involve the problem of nuclear waste.

Commissioner Kreidler asked if there is any message that could assist state insurance regulators in playing a more active role with insurance companies in recognizing the volatility of climate risks. Schlosser said the data over the last 10 years would show the evolution of the indicators of extreme events, such as wildfires and drought. He said this data would give enough information to conclude that now is the time to look at what role insurance can play in climate solutions. He said it is known that some areas prone to catastrophic events should not be rebuilt, and other areas should look at increasing resilience measures.

Commissioner Lara asked what happens to the Pacific Islands if sea level rise continues at the projected rate. Schlosser said coast lines are already eroding, and some islands will be completely underwater within a few decades. He said the 1.5-degree Celsius target set at the 2011 United Nations (UN) Climate Change Conference (COP17) would have allowed a good fraction of the islands to survive with adaptation.

3. Heard a Presentation from Ceres on an Inclusive Insurance Study and a Climate Risk Disclosure Study

Commissioner Lara said for communities faced with climate risk, insurance is critical to their overall resilience, yet increasing climate risks are causing challenges for insurance affordability and availability. He said pre-disaster mitigation is going to help communities avoid impacts and access insurance, and new approaches are needed so that some communities are not left behind.

Steven M. Rothstein (Ceres) said disaster insurance is critical for recovery. He said too many people are underinsured for disasters, are unable to afford coverage, or are unable to find coverage that meets their needs. He said there are new policies, regulatory changes, and innovative insurance products that can improve inclusivity in disaster insurance.

Rothstein said through conversations with state insurance regulators, insurers, and community groups, Ceres found five principles of inclusive insurance: 1) affordable; 2) accessible; 3) transparent and understandable; 4) people-centered; and 5) just.

Rothstein said its *Inclusive Insurance for Climate-Related Disasters* report included 14 recommendations for actions under federal and state policy, regulatory reform, local government programs, and private sector offerings. He said one example of this work is the roof fortifying programs being offered in several states. He said one way to fill the gaps in insurance inclusivity is with new products like microinsurance and parametric insurance.

Rothstein said Ceres and the California Department of Insurance (DOI) recently completed an analysis of the Task Force on Climate-Related Financial Disclosures (TCFD) reports. He said this analysis did not suggest that all insurers should answer the questions presented in the TCFD the same way, but they looked at the amount of information provided by the companies for each of the 11 recommendations. He said they used a machine learning (ML) analysis and rules-based text mining to review 480 unique TCFD reports. He said based on their review, 95% of reports provided information on risk management and strategy, and 39% of reports provided information on metrics and targets. He said 78% of reports provided information on six or more of the TCFD recommendations.

Rothstein said the completed analysis report includes a deeper analysis of 15 companies, reviewed against 200 TCFD-aligned data points to assess decision utility.

Rothstein said Ceres has released a report on an analysis of more than 400 insurance companies' investment portfolios. He said the 2019 data was provided by the California DOI. He said the analysis looked at both property/casualty (P/C) and life insurance companies, and reviewed how much companies invested in electric utilities, fossil fuels, and green bonds, among other categories.

Commissioner Downing asked if any research has been done on the risks of certain vulnerable communities if the transition away from fossil fuels is done too quickly. Rothstein said some of that research is available in the *Inclusive Insurance for Climate-Related Disasters* report. He said these economic problems are affecting communities of color disproportionately, and these problems are not specific to just coastal regions. Commissioner Roach said it is important to think about the theoretical questions of how ceasing the use of fossil fuels could have economic impacts on certain communities, but the climate data shows there are areas, particularly island communities, that will completely cease to exist due to the realities of climate impacts.

4. Heard a Presentation on Atmospheric River Storms

Director Wing-Heier said the Task Force continues its yearlong emphasis on the peril of flooding. She said the Task Force heard from two Canadian organizations at the Spring National Meeting, and the NAIC has maintained an emphasis on flood insurance data collection. She said there are certain types of storms where the impact is high rainfall in a specific location, causing substantial damage. She said many western states have areas that are not adjacent to large rivers but still have major flood events, and that is due to atmospheric rivers. She said the impacts seen in Alaska can be particularly damaging if an atmospheric river occurs on snow and ice. She said as state insurance regulators determine how to better mitigate the damage at the state and local level and how to advocate for federal risk mitigation, they need to understand what makes these storms different and so damaging.

Peterson said when looking at mitigating flood risk in individual communities, there is research that shows how specific types of flood events are going to cause an impact. He said all jurisdictions face flood risk and have had issues with flood insurance uptake, and more that is known about a specific flood event will help inform the advice for mitigation efforts.

Peterson said the first documented use of the term “atmospheric river” was in 1994, but data from the National Oceanic and Atmospheric Administration (NOAA) shows that there were major flooding events in the past that were caused by atmospheric rivers.

Peterson said atmospheric rivers tend to affect western states, although they do occur in the Northeast states but are less common. He said atmospheric rivers are long, narrow streams of water vapor that originate in the tropics. He said these storms will drop a month’s worth of precipitation in just a couple of days. He said California gets 50% of its water supply from atmospheric rivers, but they also account for 90% of flooding events.

Peterson said in Alaska, winds, flooding, and landslides from an atmospheric river caused an estimated \$29 million in damage to public infrastructure in 2020, not including private property losses. He said this year in California, an atmospheric river caused an estimated \$5 billion to \$7 billion in economic losses, with less than one-third of those losses being insured. He said in western states, 85% of flood losses are due to atmospheric rivers, and 95% of flood losses in coastal areas are due to atmospheric rivers. Peterson said these areas are also affected by storm surge. He said climate change is predicted to increase the temperature of these storms, which will increase intensity.

Peterson said scientists and policymakers are beginning to build a vocabulary around high-intensity rainfall. He said there is a proposed ranking system for severity of atmospheric river storms. He said in ranking zones 1, 2, and 3, atmospheric rivers are primarily beneficial to areas in need of the water supply. He said zones 4 and 5 are more hazardous and produce significant damage. He said this ranking system will help advise the type of mitigation needed for these storms.

Peterson said western states are at a high risk for intense atmospheric rivers and low insurance uptake, creating a protection gap challenge. He said these storms are a growing source of insured and uninsured losses. He said although these storms are specialized to certain areas of the country, they will have very high severity of losses. He said there is an opportunity for better risk communication and risk mitigation to reduce future losses.

5. Received an Update from its Solvency Workstream

Commissioner Birrane said at the 2022 Summer National Meeting, the Task Force accepted the recommendations of the Solvency Workstream to make referrals to three Financial Condition (E) Committee working groups to strengthen the oversight of the climate change impact on the financial condition of U.S. insurers. She said those referrals were made to the Financial Examiners Handbook (E) Technical Group, the Financial Analysis Solvency Tools (E) Working Group, and the Own Risk and Solvency Assessment (ORSA) Implementation (E) Subgroup. She said the Financial Examiners Handbook (E) Technical Group and the Financial Analysis Solvency Tools (E) Working Group have taken up those referrals, and each group is meeting in August to consider detailed guidance that NAIC staff have drafted to address those referrals. She said both groups expect to finalize their guidance by the end of 2023 for inclusion in the year-end 2023 handbooks. She said the Own Risk and Solvency Assessment (ORSA) Implementation (E) Subgroup has not yet taken up the referral and is waiting for the completion of the *Financial Examiners Handbook* and the *Financial Analysis Handbook* work. She said the Workstream has been focused on the evaluation and development of a U.S. regulatory approach to climate scenario analysis. She said the Workstream has been meeting in regulator-only session to do a deeper dive into the approaches and is working with NAIC staff to consider what methods will provide valuable information to state insurance regulators. She said the Workstream has reached directional consensus and is now working to build out a draft referral that is expected to be exposed for a public comment period in September.

Having no further business, the Climate and Resiliency (EX) Task Force adjourned.

SharePoint/NAIC Support Staff Hub/Committees/EX CMTE/CRTF/2023_Summer/CRTF_0815_Minutes

GOVERNMENT RELATIONS (EX) LEADERSHIP COUNCIL

The Government Relations (EX) Leadership Council did not meet at the Summer National Meeting.

LONG-TERM CARE INSURANCE (EX) TASK FORCE

Long-Term Care Insurance (EX) Task Force Aug. 9, 2023, Minutes..... 4-19
Revised March 13, 2023, Minutes (Attachment One) 4-20

Draft: 8/10/23

Long-Term Care Insurance (EX) Task Force
E-Vote *(in lieu of meeting at the 2023 Summer National meeting)*
August 9, 2023

The Long-Term Care Insurance (EX) Task Force conducted an e-vote that concluded Aug. 9, 2023. The following Task Force members participated: Michael Conway, Chair, (CO); Andrew R. Stolfi, Vice Chair, (OR); Lori K. Wing-Heier represented by Sarah Bailey (AK); Mark Fowler (AL); Alan McClain (AR); Barbara D. Richardson represented by Erin Klug (AZ); Andrew N. Mais represented by Paul Lombardo (CT); Karima M. Woods represented by Philip Barlow (DC); Trinidad Navarro represented by Sally Frechette (DE); Michael Yaworsky represented by Christina Huff (FL); Dean L. Cameron (ID); Vicki Schmidt represented by Mandy Roe (KS); Sharon P. Clark (KY); Jim J. Donelon (LA); Kathleen A. Birrane represented by Brad Boban (MD); Timothy N. Schott (ME); Grace Arnold represented by Fred Andersen (MN); Chlora Lindley-Myers (MO); Troy Downing represented by Bob Biskupiak (MT); Mike Causey represented by Ted Hamby (NC); Eric Dunning (NE); D.J. Bettencourt represented by Jennifer Li (NH); Alice Kane (NM); Scott Kipper (NV); Judith L. French represented by Laura Miller (OH); Michael Humphreys (PA); Elizabeth Kelleher Dwyer (RI); Larry D. Deiter (SD); Cassie Brown represented by R. Michael Markham (TX); Scott A. White represented by Doug Stolte (VA); Kevin Gaffney represented by Anna Van Fleet (VT); Mike Kreidler (WA); Nathan Houdek (WI); and Allan L. McVey (WV).

1. Adopted its Spring National Meeting Minutes

The Task Force conducted an e-vote to consider adoption of its Spring National Meeting minutes, including edits from Michigan and Minnesota (Attachment One). The motion passed with a majority of the members voting in favor.

Having no further business, the Long-Term Care Insurance (EX) Task Force adjourned.

SharePoint/NAIC Support Staff Hub/Member Meetings/EX CMTE/LTCITF/2023 Summer NM/minutes/LTCI(EX)TaskForce_080923_Minutes.docx

Draft: 8/9/23

Long-Term Care Insurance (EX) Task Force
Virtual Meeting (*in lieu of meeting at the 2023 Spring National Meeting*)
March 13, 2023

The Long-Term Care Insurance (EX) Task Force met March 13, 2023. The following Task Force members participated: Michael Conway, Chair (CO); Andrew R. Stolfi, Vice Chair, represented by TK Keen (OR); Lori K. Wing-Heier represented by Sarah Bailey (AK); Mark Fowler (AL); Alan McClain represented by Jimmy Harris (AR); Barbara D. Richardson represented by Erin Klug (AZ); Ricardo Lara represented by Tyler McKinney (CA); Andrew N. Mais represented by Paul Lombardo (CT); Karima M. Woods represented by Philip Barlow (DC); Trinidad Navarro (DE); Michael Yaworsky represented by Lilyan Zhang (FL); Gordon I. Ito (HI); Doug Ommen represented by Klete Geren (IA); Dean L. Cameron (ID); Amy L. Beard represented by Scott Shover (IN); Vicki Schmidt (KS); Sharon P. Clark (KY); James J. Donelon represented by Tom Travis (LA); Gary D. Anderson represented by Rachel M. Davison (MA); Timothy N. Schott (ME); Anita G. Fox represented by ~~Karen Dennis Rachel Davison~~ (MI); Grace Arnold represented by Fred Andersen (MN); Chlora Lindley-Myers (MO); Troy Downing represented by Mari Kindberg (MT); Mike Causey represented by Ted Hamby (NC); Jon Godfread represented by Chrystal Bartuska (ND); Eric Dunning (NE); Jennifer Catechis represented by Anna Krylova (NM); Scott Kipper (NV); Judith L. French (OH); Michael Humphreys (PA); Elizabeth Kelleher Dwyer represented by Megan Mihara (RI); Larry D. Deiter (SD); Cassie Brown represented by R. Michael Markham (TX); Kevin Gaffney (VT); Scott A. White (VA); Mike Kreidler (WA); Nathan Houdek represented by Diane Dambach (WI); Allan L. McVey (WV); and Jeff Rude (WY).

1. Adopted its 2022 Fall National Meeting Minutes

Keen made a motion, seconded by Commissioner Clark, to adopt the Task Force's Nov. 30, 2022, minutes (*see NAIC Proceedings – Fall 2022, Long-Term Care Insurance (EX) Task Force*). The motion passed unanimously.

2. Heard a Report on Industry Trends and Other Updates

Andersen said coordinated efforts between states have resulted in the completion of targeted reviews of year ending 2021 reserve adequacy filings. Review of the 2022 annual filings will begin soon. The following are key industry trends that have been seen and that will be monitored going forward:

- Cost-of-care inflation trends lead to more maximum daily benefit being used than originally expected. There is consensus among companies selling long-term care insurance (LTCI) that home care costs have increased over the past five to six years. There will likely be long-term impacts from this issue.
- There was a shift in situs of care from facilities to home care. Varying reports indicate the reversal of that trend back to facilities.
- Home care daily costs are starting to catch up with the cost of facility care.
- There is an increase in ~~incidents~~incidence and the length of claims. COVID-19 had caused lower ~~incidents~~incidence and shorter claims. So far, the impact of COVID-19 is short-term. COVID-19 is not seen as having a long-term impact on the finances of the blocks of business.
- Pre-claim wellness initiatives have had some impact on claims. Wellness initiatives may involve being proactive or preventing falls, providing early cognitive tests, and providing care for the family caregiver. It is still uncertain if the investments in these wellness initiatives will be more than offset by cost reductions.
- Improvements in technology and medical and drug advancements have potential impacts on claim costs.

Andersen said the Long-Term Care Actuarial (B) Working Group met Feb. 17 and exposed: 1) the information checklist submitted with rate increase filings; and 2) the actuarial methodologies used to review older blocks of

business. Comments on both exposures are due April 24. If any changes are made to the checklist or the methodologies, similar changes will be proposed to the Long-Term Care Insurance Multistate Rate Review Framework (LTCI MSA Framework). Review of the checklist is likely to be completed in 2023. Review of the methodologies will likely conclude in 2024.

3. Adopted Proposed Edits to the Checklist for Premium Increase Communications

Commissioner Conway said proposed edits to the *Checklist for Premium Increase Communications* were exposed for a 30-day public comment period ending Feb. 3. Five comment letters were received. A drafting group of consumer representatives and regulators from California, Pennsylvania, Vermont, and Virginia reviewed the comments and recommended a few edits in response to the comments.

Jane Koenigsman (NAIC) summarized the comments and the drafting group's responses (Attachment One). Comments were received from Wayne Enstice (University of Cincinnati), Patrick Cantilo (Cantilo & Bennett), Robert Wake (ME), Jan Andrews (NC), and Molly Nollette (WA).

Koenigsman said the comments from Enstice did not appear to be related to consumer communication but rather the review of rate increases and reduced benefit options (RBOs). She said the drafting group recommended referring those comments to the Long-Term Care Actuarial (B) Working Group.

Commissioner Kreidler made a motion, seconded by Superintendent Schott, to refer the comments received from Enstice to the Long-Term Care Actuarial (B) Working Group. The motion passed unanimously.

Koenigsman said the drafting group proposed additional edits to address certain comments, including duplicative checklist items, the use of references to "example" RBOs in the revisions, rate guarantees, default options, and other clarifying changes.

Hamby made a motion, seconded by Commissioner Kreidler, to adopt the revised *Checklist for Premium Increase Communications* (Attachment Two). The motion passed unanimously.

Having no further business, the Long-Term Care Insurance (EX) Task Force adjourned.

SharePoint/NAIC Support Staff Hub/Member Meetings/EX CMTE/LTCITF/2023 Spring
NM/minutes/LTCI(EX)TaskForce_031323_Minutes.docx

SPECIAL (EX) COMMITTEE ON RACE AND INSURANCE

Special (EX) Committee on Race and Insurance Aug. 14, 2023, Minutes 4-23

Draft: 8/29/23

Special (EX) Committee on Race and Insurance
Seattle, Washington
August 14, 2023

The Special (EX) Committee on Race and Insurance met in Seattle, WA, Aug. 14, 2023. The following Special Committee members participated: Andrew N. Mais, Co-Chair (CT); Chlora Lindley-Myers, Co-Chair (MO); Jon Godfread, Co-Vice Chair (ND); Scott A. White, Co-Vice Chair (VA); Lori K. Wing-Heier (AK); Mark Fowler (AL); Alan McClain (AR); Michael Conway (CO); Michael Yaworsky (FL); Doug Ommen (IA); Dean L. Cameron (ID); Dana Popish Severinghaus (IL); Amy L. Beard (IN); Sharon P. Clark (KY); James J. Donelon (LA); Judith L. French (OH); Glen Mulready (OK); Gary D. Anderson (MA); Kathleen A. Birrane (MD); Timothy N. Schott (ME); Anita G. Fox (MI); Grace Arnold (MN); Troy Downing (MT); Mike Causey (NC); Eric Dunning (NE); Scott Kipper (NV); Andrew R. Stolfi (OR); Michael Humphreys (PA); Alexander S. Adams Vega (PR); Elizabeth Kelleher Dwyer (RI); Larry D. Deiter (SD); Jon Pike (UT); Kevin Gaffney (VT); Mike Kreidler (WA); Nathan Houdek (WI); and Jeff Rude (WY).

1. Adopted its Spring National Meeting Minutes

Commissioner Pike made a motion, seconded by Director Cameron, to adopt the Special Committee's March 23 minutes (*see NAIC Proceedings – Spring 2023, Special (EX) Committee on Race and Insurance*). The motion passed unanimously.

2. Heard an Update from AHIP on Health Equity

Dr. LaShawn McIver (America's Health Insurance Plans—AHIP) noted, as the Chief Health Equity Officer, she will lead AHIP's health equity initiatives, setting and driving strategies to improve health equity for underrepresented and medically underserved communities. She will also provide strategic leadership to drive an overall industry-wide health equity strategic road map for AHIP as a member-driven organization.

Commissioner Mais asked Dr. McIver what she anticipates will be her greatest opportunities and greatest challenge to advance health equity in this new role.

Dr. McIver responded that she anticipates coming from the federal Centers for Medicare & Medicaid Services (CMS) during a historic time shaping the future of a more equitable health care system to an organization that represents the other important part of the health care system, which is the private insurers and how they are helping to drive equity, there is opportunity to build a bridge across the entire health care system working towards a healthier nation through a more equitable quality health care system. In terms of challenges, there are differences in understanding what this means and what will be needed to get there as a collective, and understanding where, as a member-driven organization, AHIP members are and how they can coalesce around key priorities to help shift the health care system towards greater equity. Dr. McIver also noted that no one entity can do this work alone and that true health equity can only be achieved when working together. She said she looks forward to working with the NAIC to continue this important work.

Dr. McIver asked that as AHIP incorporates this new level of strategic leadership to advance health equity in the health care ecosystem, whether there is current work the NAIC would like to share.

Commissioner Arnold reported the Health Workstream has been focusing on preventive care and mental health care. The Workstream has discussed mental health care in particular from a parity perspective, but not from a disparity perspective. Anything AHIP can add to the conversation about what plans are doing to address those issues will be of value to the NAIC Membership.

Commissioner Birrane reported that the Special Committee is tracking artificial intelligence (AI) usage by health insurers and for a variety of purposes. One of the areas where health insurers in particular, along with health providers, look at demographic information and use AI for that purpose is to address health equity. Commissioner Birrane noted she would be interested in Dr. McIver's views of the right balance of what kind of information is sought and what kind of AI applications used to gather data and information are useful to get equitable outcomes.

Director Cameron asked how the NAIC can help support AHIP's efforts to promote greater equity in the health care system.

Dr. McIver responded that the NAIC has done incredible work. She said she believes that to develop the best solution, it is helpful to understand what is working from the NAIC perspective, where there are areas for improvement through the lens of equity, and what are the greatest opportunities for this collective to achieve all of those.

Director Cameron said he would have liked to have made more progress during his time as NAIC President with financial literacy and increasing consumer knowledge of the importance and benefits of having insurance coverage. He asked Dr. McIver if there is a way AHIP can help foster that discussion.

Dr. McIver said health and financial literacy are important parts of helping individuals understand health care coverage and navigate the health care system. She directed NAIC Members to a readily available tool that exists within the CMS Office of Minority Health (OMH) called From Coverage to Care, which is a suite of resources available on the internet allowing an individual to navigate the health care system.

3. Received an Update on the Member Diversity Leadership Forum

Chandara Phanachone (CA) provided an update on the Member Diversity Leadership Forum, highlighting the regulator diversity training coursework that has been launched titled Foundations of Diversity, Equity & Inclusion for Regulators. She said the coursework is designed to develop a common foundation for understanding the purpose and value of diversity, equity, and inclusion (DE&I). The coursework consists of three sections 1) understanding DE&I; 2) cultural proficiency: understanding, awareness, and competency; and 3) DE&I in the workplace. :

Gary Jones (PA) stated since its rollout in February 2023, 678 regulators have taken the Foundations of Diversity, Equity & Inclusion for Regulators course and the course rating, as of August 2023, is 4.2 out of 5.0. He said the purpose of this coursework is to come together and understand each other to make the community and workplace better.

Evelyn Boswell (NAIC) noted Ms. Phanachone and Mr. Jones are currently leading the Member Diversity Leadership Forum. Ms. Boswell said the Forum will continue hosting book clubs, attending recruiting fairs, and promoting regulator coursework. She said she is looking to connect department recruiters to Morgan State University, a historically Black college and university (HBCU), to assist insurance departments in finding actuarial science interns.

Director Cameron asked for a Foundation update. Kay Noonan (NAIC) said the Foundation is finalizing the arrangements for the first planned internship and scholarship program.

4. Received a Status Report on the Property/Casualty (P/C) Workstream

Commissioner Gaffney reported that the Property/Casualty (P/C) Workstream continues to focus on engaging with the Collaboration Forum activities related to algorithmic bias. He said the work is best conducted in a collaborative manner, not only through the Collaboration Forum but with the Life Workstream and Health Workstream, as well as the Big Data and Artificial Intelligence (H) Working Group.

Commissioner Gaffney said the Workstream is building on this fundamental work by looking at potential bias in marketing, access to insurance, underwriting, rating, and claims handling, including fraud detection. The Workstream is looking at the product life cycle, starting with marketing and access and moving to underwriting and rating. The Workstream has met with several insurers to focus on marketing and advertising activities. Commissioner Gaffney said that more recently, the Workstream has met with insurers to discuss underwriting and rating. These discussions help to inform the Workstream's work looking at potential algorithmic bias and exploring industry best practices. The Workstream will continue to investigate additional areas of the product life cycle, likely at the Fall National Meeting.

Commissioner Gaffney concluded by saying the Workstream is also looking at recent studies and reports concerning the possibility of unfair bias within underwriting and rating in ongoing research and conversations with additional parties.

5. Received a Status Report on the Life Workstream

Director French reported that the Life Workstream met July 20 to discuss next steps as the Workstream continues to focus on marketing, distribution, and access to life insurance products in minority communities, including the role that financial literacy plays.

Director French said the Workstream is moving forward with the development of a "resource guide" to be developed in cooperation with the NAIC DE&I Division and State Diversity Leaders. The Workstream envisions developing a resource guide that includes information helpful to state insurance departments looking to take action to improve access and understanding in underserved communities. As a first step, a list of questions was distributed during the State Diversity Leaders Forum on July 24 to catalog state activity. Director French noted the Workstream plans to hold additional meetings, first hearing from Colorado in October and, during the same meeting, a presentation from another state.

Director French concluded by sharing about the Workstream's July 20 meeting, during which it heard from stakeholders interested in sharing resources and information for possible inclusion in the resource guide. She said the Workstream anticipates holding an additional meeting to hear from consumer representatives and industry stakeholders who expressed an interest in also sharing resources and information.

6. Received a Status Report on the Health Workstream

Commissioner Arnold reported that the Workstream met at the Spring National Meeting in regulator-to-regulator session to consider its activities and meetings for 2023. During that meeting, the Workstream decided to: 1) continue its education on benefit design relating to preventative care and mental health coverage and disparities; 2) explore the evolution of the federal Affordable Care Act (ACA) Section 1332 waivers and the innovative uses of them that can be implemented to lower uninsured rates and reduce disparities in states; and 3) continue to provide a forum for sharing innovative programs and initiatives that states and companies are doing to promote health equity.

Commissioner Arnold said during the Workstream's July 24 meeting, it heard presentations focusing on preventative care and lowering barriers to such care, particularly with respect to chronic diseases. The presentations discussed the impact of lowering barriers to care that will increase health equity and reduce disparities. The Workstream is planning to hold a follow-up meeting on this topic in October or early November.

The Workstream plans to meet in late September or early October to hear presentations from a variety of stakeholders, including industry and consumers, on initiatives and programs to reduce mental health disparities.

Commissioner Birrane reported that the Workstream also is scheduled to meet Sept. 19 to hear presentations on the evolution of Section 1332 waivers and other market reforms aimed at lowering state uninsured rates. Additionally, the discussion will explore success in states that have amended their benchmark plans and other market reforms in states to make health insurance more accessible.

Commissioner Arnold noted that the Workstream is also working to create a collaborative workspace on the NAIC Connect platform to provide a forum for Workstream members to share with each other and other NAIC members the information the Workstream has captured during its past and future meetings on removing barriers to health insurance for historically disadvantaged communities. Due to the hard work of the NAIC Member Services & Engagement Division, the Workstream's NAIC Connect platform page is scheduled to go live within the next few weeks as part of the initial pilot rollout, along with the Innovation, Cybersecurity, and Technology (H) Committee. The Workstream plans to meet Sept. 21 to walk members through the features and content on the page.

Having no further business, the Special (EX) Committee on Race and Insurance adjourned.

SharePoint/NAIC Support Staff Hub/Committees/EX CMTE/SCORI/2023_Summer/_Final Minutes & Summary/08-RaceIns Minutes.docx

LIFE INSURANCE AND ANNUITIES (A) COMMITTEE

Life Insurance and Annuities (A) Committee Aug. 15, 2023, Minutes 5-2
Life Insurance and Annuities (A) Committee July 19, 2023, Minutes (Attachment One)..... 5-8

Draft: 8/29/23

Life Insurance and Annuities (A) Committee
Seattle, Washington
August 15, 2023

The Life Insurance and Annuities (A) Committee met in Seattle, WA, Aug. 15, 2023. The following Committee members participated: Judith L. French, Chair (OH); Carter Lawrence, Vice Chair, represented by Bill Huddleston and Toby Compton (TN); Mark Fowler (AL); Barbara D. Richardson (AZ); Philip Barlow (DC); Doug Ommen (IA); Justin McFarland (KS); James J. Donelon (LA); Eric Dunning (NE); Justin Zimmerman (NJ); Scott Kipper (NV); Adrienne A. Harris represented by John Finston (NY); Glen Mulready (OK); Scott A. White represented by Craig Chupp (VA); and Nathan Houdek (WI). Also participating were: Cynthia Amann (MO); Mike Chaney (MS); and Rachel Hemphill (TX).

1. Adopted its July 19 Minutes

Director French said the Committee met July 19. During this meeting, the Committee took the following action: 1) adopted its Spring National Meeting minutes; 2) adopted revisions to the *Valuation Manual*; and 3) adopted revised charges for the Life Actuarial (A) Task Force.

Commissioner Mulready made a motion, seconded by Huddleston, to adopt the Committee's July 19 minutes. (Attachment One). The motion passed unanimously.

2. Adopted the Report of the Life Actuarial (A) Task Force

Director French explained that the Accelerated Underwriting (A) Working Group has not met since the Spring National Meeting. She said a draft guidance document was exposed for public comment at the beginning of the year; however, to avoid potential conflicts and the duplication of efforts, the Working Group is on hold pending the completion of work underway under the Innovation, Cybersecurity, and Technology (H) Committee.

Director French said the Annuity Suitability (A) Working Group also has not met since the Spring National Meeting. She explained that the Working Group has plans to meet after the Summer National Meeting to continue its discussion of potential questions to add to the current frequently asked questions (FAQ) document related to the safe harbor/comparable standards provision in the revised *Suitability in Annuity Transactions Model Regulation* (#275). She said the Working Group did not meet while additional information was being gathered on how stakeholders are implementing the safe harbor/comparable standards provision to determine what additional questions should be added to the FAQ document.

Hemphill said the Life Actuarial (A) Task Force met Aug. 11–12, 2023. She said the Task Force received a presentation on state insurance regulator reviews of company filings for *Actuarial Guideline LIII—Application of the Valuation Manual for Testing the Adequacy of Life Insurer Reserves* (AG 53). She said the Valuation Analysis (E) Working Group is performing reviews of AG 53 filings and coordinating with domestic regulators where outliers are identified. She said the Task Force will continue to coordinate with the Working Group to support the effectiveness of AG 53.

Hemphill said the Task Force exposed an amendment proposal form (APF) to allow for the listing of specific considerations (e.g., COVID-19) that companies must reflect in the companies' historical mortality improvement (HMI) rates. She said this change will promote greater consistency in how HMI rates are developed and thus allow greater flexibility for the Society of Actuaries (SOA) in the development of the future mortality improvement (FMI) rates.

Hemphill said the Task Force continued discussion on the work to develop a replacement generator of economic scenarios (GOES), including hearing an update from the American Academy of Actuaries (Academy) on interest rate acceptance criteria and a presentation by NAIC staff on additional quantitative results from the Economic Scenario Generator Field Test. She said the Task Force discussed a focus on increasing efficiency as it moves forward, including relying on model office testing whenever possible, which is more timely and flexible than full field testing. She said the Task Force continues to be actively engaged with industry on this technical topic.

Hemphill said the Task Force received an update from the SOA on a planned educational redesign that seeks to increase international relevancy and add flexibility for candidates. She said several state insurance regulators expressed serious concern with one aspect of the planned redesign. The SOA described a plan to remove U.S. regulatory material from the required materials and move it to an optional regulatory certificate. Hemphill said the Task Force expressed that an understanding of U.S. laws and regulatory materials should be required for all actuaries practicing in the U.S., not just appointed actuaries. She said if the SOA were to remove this material, it is likely that the Fellow of the Society of Actuaries (FSA) designation would no longer be adequate for actuaries to be qualified to practice in the U.S. without first completing a supplemental regulatory course. She said the SOA was open to feedback, and the Task Force will be sending a written response reiterating these concerns and will continue engaging with the SOA.

Chupp made a motion, seconded by Acting Commissioner Zimmerman, to adopt the report of the Life Actuarial (A) Task Force. The motion passed unanimously.

3. Heard a Presentation on Risks Facing the Life Insurance and Annuities Industry

Steve Hazelbaker (Noble Consulting Services Inc.) gave a presentation on the risks and challenges facing the life and annuities industry. He said he would discuss some of the recognized risks to the industry, including: 1) the risks posed by InsurTech; 2) federal and international regulatory developments; 3) private equity (PE) firm relationships with insurers; and 4) inflation.

Hazelbaker said InsurTech offers a lot of opportunities, but it presents risks and challenges. He said InsurTech may affect company distribution, internal processes, company strategies, and maybe even the group organization structure. He said the use of artificial intelligence (AI) and its governance also presents potential risks and challenges with respect to data security and unintended consequences.

Hazelbaker said federal and international regulatory developments may affect life and annuity insurers, as well as PE firm relationships with insurers, particularly as money managers for annuity carriers, or their involvement with ownership interests.

Hazelbaker said another risk factor that affects life and annuity carriers is inflation. He said growth in the annuity market is a particular concern. He discussed two factors contributing to annuity growth: 1) pension risk transfers; and 2) multi-year guaranteed annuities (MYGAs). He said pension buyouts are happening more frequently, and people turn to life and annuity carriers because they understand the mortality and liquidity risks that are involved with pensions. Annuities are also able to match asset and liability durations. He said about 20 companies currently dominate the market in this area, but sales were up 42% in 2022. He said MYGA sales also contributed to growth in annuities. He said sales of MYGAs doubled in 2022. Not only is there market risk in meeting the guarantees associated with MYGAs, but they also present liquidity risk, particularly at the end of the guaranteed terms.

Hazelbaker said annuity growth continued in the first quarter of 2023, largely fueled by the increase in interest rates. A lot of people in the 55–70 age group that are typically interested in buying annuities, as well as equity volatility, contributed to annuity growth. Equity volatility also contributed to annuity growth; i.e., the value of existing bond holdings at lower interest rates declines as interest rates rise. Hazelbaker said disintermediation risk

may come into play in the fixed annuity market when there are higher than expected surrenders and withdrawals from people seeking to get out of lower interest rate investments and buy higher yield investments. He said that introduces liquidity risk and market risk, and it emphasizes the importance of asset adequacy testing (AAT) by actuaries.

Hazelbaker discussed insurance investments. He said inflation and interest rate hikes can stress the banking sector, which indirectly affects life and annuity carriers. He said it may lead to the deterioration of corporate credit quality, which can lead to investment defaults. He said that can indirectly have an impact on equity valuations. He said people may be altering their investment strategies, which could lead to investments that are less liquid, more complex, have greater market volatility, have greater cash flow variability, and may involve affiliated investments to a greater extent. He said regulating investments is not getting any easier, and investments seem to evolve to meet guidelines but may be carrying more risks associated with those investments. He said some companies may be involved in selecting certain investments because of risk-based capital (RBC) arbitrage. He said the NAIC Capital Markets Bureau (CMB) recently put out a special report that addressed the impact of rising interest rates on U.S. insurer investments. He said there are several positive implications, like supporting investment income and benefitting life and annuity insurers' spread business. He said there also may be less pressure to invest in riskier assets to get the kind of yields that companies are seeking. He said life and annuity companies can also reinvest proceeds of maturing investments into investments that provide greater yields. He said the negative implications are that a company may have realized or unrealized losses due to the decline in the market value of fixed maturity investments. He also said existing mortgage loans at lesser rates could decline in market value, resulting in higher loan-to-value ratios.

Hazelbaker listed some additional risks and challenges to the industry that he puts on his personal list. He said he considers commercial real estate in the list of risk considerations that affect life and annuity insurers. He said the Mackenzie Consulting Group recently came out with a study indicating that commercial real estate may lose \$800 billion in value by 2030 based on a study involving nine major cities. He said reinsurance is complicated, but state insurance regulators need to be aware of the ceding and assuming activities of insurers and the related implications of inter-company reinsurance on life and annuity carriers. He said the retention of talent and intellectual capital is an ongoing challenge that successful companies will have to continue to meet. He said he also includes climate and other environmental factors on his list of challenges. He said climate and other environmental factors may affect the investments of life and annuity carriers, like fossil fuel holdings, mortgage loans depending on the location of the properties, and even the effect of mortality from a long-term perspective.

4. Heard a Presentation on the Unique Life Insurance Needs of the Military

Shawn Loftus (United Services Automobile Association—USAA) gave a presentation on the unique life insurance needs of the military and veterans. He said the USAA is focused on meeting the unique needs of this population. The USAA was founded in 1922 by 25 army officers. They decided to pool their money together to insure each other's vehicles because they were not able to get auto insurance. More than 100 years later, the USAA has grown to be a fully integrated financial services company. The USAA life insurance company was founded in 1963, and the Federal Savings Bank opened in 1983. Loftus said there are 37,000 employees across the U.S. and three overseas locations. He said the USAA is proud to provide exceptions, products, and services to the military community, including active duty service members, veterans, and their families.

Loftus explained that the military is a diverse community with unique needs. He said they are highly mobile. He said they move around frequently and can be deployed with very little notice, so accessibility and speed are important to them. He said they are also price-conscious. He said affordability is important, especially for enlisted members with limited discretionary income. He said they have dangerous and stressful jobs. He said they need products, services, and advice tailored to their needs, and they deserve the very best service levels. He said to serve these unique needs, the USAA has developed products and services tailored to fit the military community.

For example, the USAA offers no charge riders to currently serving military members to address severe injuries and military separation. Loftus said USAA partners with other carriers to offer products customized to the veteran community. He said the underwriting programs and guidelines are tailored to the unique jobs and needs of the military. He said they offer advice for unique circumstances like deployment. He said a deployment call can take a couple of hours, and members are walked through a lengthy checklist to help them get their accounts in order before they leave. He said the USAA survivor relations team is a specially trained group that compassionately helps surviving family members settle all their accounts across life insurance, property/casualty (P/C) insurance, and banking when there is a loss of a loved one. He said too often, the cause of the loss is suicide.

Loftus said mental health and suicide prevention are top issues of concern for the USAA. He said since the start of this century, more than 120,000 veterans have died by suicide. He said the veteran suicide rate is currently 1.5 times that of the general population. In June, the USAA announced the launch of a national campaign and coalition to address this national crisis. It is called “Face the Fight.” He said “Face the Fight” is a coalition of foundations, nonprofits, and veteran-focused organizations that have joined together to raise awareness and support for veteran suicide prevention. He said the aspiration is to cut the suicide rate in half by 2030. He said the mission of the initiative is to: 1) break the stigma of seeking help; 2) increase the conversation about the problem; and 3) complement the efforts of the U.S. Department of Veterans Affairs (VA), the U.S. Department of Defense, and many others to stop veteran suicide. More information can be found at facethefight.org or by emailing USAA@ElizabethDoleFoundation.org.

Loftus said the USAA recognizes that there is no simple solution to this complex problem. He said there are many organizations and public agencies that are leading impactful efforts to help decrease veteran suicide, and “Face the Fight” wants to add its support and amplify what others are already doing. He said as part of “Face the Fight,” individuals and groups of people are being asked to stand together and be a supportive network to our veterans. He said veteran suicide is not inevitable. When people face this fight together, there is hope. Loftus said veterans have long served this country with great dignity, honor, and duty, and it is our collective responsibility to help protect, support, and honor those who dedicated their lives to protect us. In response to a question by Director Richardson, Loftus further discussed the relationship between mental illness and suicide and how quickly suicidal ideations can occur. Commissioner Chaney mentioned that during the COVID-19 crisis, the Mississippi Insurance Department issued a telemedicine bulletin allowing access to mental health services remotely that saved over 50 suicide lives.

5. Heard an Update on the Life Workstream of the Special (EX) Committee on Race and Insurance

Director French said the Life Workstream of the Special (EX) Committee on Race and Insurance met July 20. She said the Workstream discussed its next steps as it continues to focus on its charge to consider “marketing, distribution and access to life insurance products in minority communities, including the role that financial literacy plays.” She said the Workstream is planning to move ahead and create a “resource guide” to be developed in cooperation with the NAIC Diversity, Equity, and Inclusion (DE&I) Division and the State Diversity Leaders.

Director French explained that the Workstream envisions developing a guide that includes information helpful to all insurance departments looking to take action to improve access and understanding in underserved communities. She said a list of questions was distributed during the State Diversity Leaders Forum on July 24 to start to catalog state activity.

Director French said the Workstream also plans to hold meetings to hear some additional presentations. She said the Workstream plans to hear a presentation from Colorado, as well as a presentation from another state on a call in early October.

Director French said several stakeholders expressed an interest in sharing resources and information for possible inclusion in the resource guide. The Workstream anticipates holding an additional call to hear from consumer representatives and industry stakeholders that expressed an interest in sharing.

Brenda J. Cude (University of Georgia) offered her assistance on the resource guide. Jennifer Cook (NAIC) said she would be working on the resource guide and reach out to Dr. Cude.

6. Discussed Other Matters

Director French said Tennessee organized the presentations for this meeting, and she welcomes other states similarly organizing future presentations to bring information to the Life Insurance and Annuities (A) Committee. Also, if there are other groups out there with information to share, she said they should reach out to Cook.

Birny Birnbaum (Center for Economic Justice—CEJ) expressed several concerns with the work of the Committee. He said he was unclear as to why the work of the Accelerated Underwriting (A) Working Group has been put on hold. He said efforts to address accelerated underwriting have been underway at the NAIC for seven years. He said it is unclear what efforts at the Innovation, Cybersecurity, and Technology (H) Committee are needed for the Working Group to offer guidance on (e.g., the use of consumer credit information and biometrics, both of which have been shown to be problematic). He said the NAIC had a session two years ago on bias in facial recognition.

Birnbaum asked whether there was a time frame for the receipt of the guidance from the Innovation, Cybersecurity, and Technology (H) Committee such that the Working Group can continue its work. He said the draft governance model that was developed by the Committee does not overlap with the specific consumer protection risks and regulatory guidance associated with accelerated underwriting.

Birnbaum said the NAIC completed the AI Principles three years ago. He said the AI Principles were intended to guide the work of NAIC committees and working groups regarding specific applications of AI, such as accelerated underwriting. He said instead of using that guidance, all the AI work of NAIC committees and working groups has gone to the Innovation, Cybersecurity, and Technology (H) Committee, where the issue appears to disappear.

Peter Kochenburger (Southern University School of Law) expressed his support for the concerns raised by Birnbaum regarding waiting until the Innovation, Cybersecurity, and Technology (H) Committee finishes its work on the bulletin. He said waiting for another high-level document that will not advance the discussion of the tougher issues facing accelerated underwriting simply delays for another year the substantive guidance and consumer protections that were promised in the AI Principles adopted three years ago. He said it seems like an unnecessary delay.

Commissioner Houdek provided an update about the work of the Accelerated Underwriting (A) Working Group and coordination with the Innovation, Cybersecurity, and Technology (H) Committee. He explained that the Committee is working on a model governance bulletin that has a broader scope than the accelerated underwriting guidance document, and it makes sense to pause the work of the Working Group until after the bulletin is completed to ensure the work products are aligned. He said once the bulletin is adopted, the Working Group will assess next steps and determine whether any adjustments are needed to the accelerated underwriting regulatory guidance document in light of the model governance bulletin.

Amann explained that the work of the Working Group began many years ago and started with the development of an informational paper, but the technology advanced ahead of the Working Group. She explained that the educational paper developed by the Working Group was a precursor to best practices or a model, and now that there are other groups like the Innovation, Cybersecurity, and Technology (H) Committee focusing on issues such

as AI, machine learning (ML), and other issues that affect the conclusions the Working Group may come to, there needs to be coordination.

Birnbaum expressed concern about the lack of progress by the Annuity Suitability (A) Working Group on the FAQ document addressing the safe harbor/comparable standards provision in the revised Model #275. He said the question of how to interpret and enforce the safe harbor provision has been a contentious question for a while. He said the Market Conduct Examination Guidelines (D) Working Group has been attempting to develop exam guidance related to the updated Model #275, but that effort has been stymied by the lack of clarity regarding the safe harbor provision from the Annuity Suitability (A) Working Group.

Commissioner Ommen provided an update about the progress of the Annuity Suitability Working Group. He explained that Model #275 has been adopted in over 40 states, and while he cannot speak to all the states, in Iowa they are undertaking reviews of the implementation by insurance companies, paying close attention to the use of the safe harbor principles. He said he appreciated Birnbaum's interest in more public discussion about the application of the safe harbor, and he anticipates that states will at some point have best practices with respect to the safe harbor to ensure that there is consistency and uniformity in the marketplace.

Birnbaum reiterated his longstanding concerns regarding illustrations. He said the Life Actuarial (A) Task Force proposed and the Life Insurance and Annuities (A) Committee adopted AG 49-B as a short-term fix to deceptive indexed universal life (IUL) illustrations. He said the Task Force and the Committee acknowledged that illustrations suffered from other problems. He said the illustration model was developed and adopted before indexed products appeared in the marketplace. He asked why there has not been any activity on life insurance and annuity illustrations.

Birnbaum asked why the Life Workstream of the Special (EX) Committee on Race and Insurance is focusing on financial literacy. He said he did not understand how financial literacy addresses the availability and affordability of life insurance in underserved communities or the design of products that address the needs of underserved communities. He said the focus on financial literacy suggests that the problem is with buyers and not sellers.

Director French explained that the Life Workstream of the Special Committee had a number of charges, but it had been and continues to be focused on its charge to consider "marketing, distribution and access to life insurance products in minority communities, including the role that financial literacy plays."

Having no further business, the Life Insurance and Annuities (A) Committee adjourned.

SharePoint/NAIC Support Staff Hub/A Cmte/2023 Summer/A_mtgmin final_rev

Draft: 7/20/23

Life Insurance and Annuities (A) Committee
Virtual Meeting
July 19, 2023

The Life Insurance and Annuities (A) Committee met July 19, 2023. The following Committee members participated: Judith L. French, Chair (OH); Carter Lawrence, Vice Chair (TN); Barbara D. Richardson (AZ); Karima M. Woods represented by Phillip Barlow (DC); Doug Ommen (IA); Vicki Schmidt (KS); James J. Donelon (LA); Eric Dunning (NE); Justin Zimmerman (NJ); Adrienne A. Harris represented by Bill Carmello (NY); Scott A. White represented by Craig Chupp (VA) and Nathan Houdek (WI). Also participating was: Rachel Hemphill (TX).

1. Adopted its Spring National Meeting Minutes

Commissioner Lawrence made a motion, seconded by Commissioner Ommen, to adopt the Committee's March 23 minutes (*see NAIC Proceedings – Spring 2023, Life Insurance and Annuities (A) Committee*). The motion passed unanimously.

2. Adopted 2024 Valuation Manual Amendments

Hemphill said the Life Actuarial (A) Task Force adopted 12 amendment proposal forms (APFs) to be effective for the 2024 *Valuation Manual*. She said the APFs fall into three categories: 1) APFs primarily adding documentation in reporting (2022-06, 2022-09, 2023-02, and 2023-04); 2) APFs primarily clarifying requirements or correcting typos (2022-07, 2022-10, 2023-01, and 2023-03); and 3) APFs making more substantive changes to requirements (2021-08, 2022-08, 2023-05, and 2023-07). Hemphill summarized the substance of this third category of APFs.

Hemphill said that APF 2021-08 reduces the reporting lag for VM-51, Experience Reporting Formats, from two years to one year to gather more timely industry mortality data and thus allow more timely creation of mortality tables. She said that APF 2022-08 makes variable annuities that are exempt from complex modeling have reduced VM-G, Appendix G – Corporate Governance Guidance for Principle-Based Reserves, governance requirements, analogous to the treatment already in place for life principle-based reserving. She said APF 2023-05 allows alternate hedge modeling and hedge error reflection for variable annuities indexed credit hedging programs, reflecting the distinct nature of these hedging programs. She said APF 2023-07 removes one of two methods available to companies for calculating part of VM-21, Requirements for Principle-Based Reserves for Variable Annuities, reserve requirements, effective in 2025, due to this method being rarely used. She said only two companies are affected by this change. One company is immediately able to use the more common method, and the other will be able to use the other method by 2025 and is directly working with its domestic regulator to effectuate the change.

Director Richardson made a motion, seconded by Commissioner Lawrence, to adopt the 2024 *Valuation Manual* amendments. (*see NAIC Proceedings – Summer 2023, Plenary, Attachment ?*). The motion passed unanimously.

3. Adopted Amended Life Actuarial (A) Task Force Charges.

Hemphill explained that on June 15, the Life Actuarial (A) Task Force voted to adopt its updated charges, which include: 1) the removal of the Indexed-Linked Variable Annuities (ILVA) Subgroup. Hemphill said the Subgroup completed its charges when the Task Force adopted Actuarial Guideline LIV—Nonforfeiture Requirements for Index-Linked Variable Annuity Products (AG 54); and 2) the addition of the Generator of Economic Scenarios (E/A)

Subgroup and its charges. Hemphill explained that state insurance regulators and interested parties agreed that a formal subgroup was needed to have a robust and proactive approach to future economic scenario generator (ESG) maintenance and updates, including to: a) oversee the ESG governance framework; b) review material generator updates; c) monitor economic conditions for any signal that there is a need for additional generator updates; d) support generator implementation; and e) maintain generator acceptance criteria. Mike Yanacheak (IA) and Pete Weber (OH) have agreed to serve as Subgroup chair and vice chair, respectively.

Carmello made a motion, seconded by Director Dunning, to adopt the amended Life Actuarial (A) Task Force charges. The motion passed unanimously.

4. Discussed Other Matters

Jennifer Cook (NAIC) said that the agenda for the Special (EX) Committee on Race and Insurance Life workstream meeting on July 20 has changed. The Colorado presentation has been postponed to a future meeting. The workstream will still meet to discuss its next steps.

Having no further business, the Life Insurance and Annuities (A) Committee adjourned.

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LIFE ACTUARIAL (A) TASK FORCE

Life Actuarial (A) Task Force Aug. 11–12, 2023, Minutes	5-12
Life Actuarial (A) Task Force July 20, 2023, Minutes (Attachment One)	5-18
Mortality Improvements Life Working Group 2023 Recommendation Presentation (Attachment One-A)	5-19
Life Actuarial (A) Task Force June 15, 2023, Minutes (Attachment Two)	5-34
Proposed Charges for the Life Actuarial (A) Task Force (Attachment Two-A)	5-36
Hemphill Comment Letter (Attachment Two-B)	5-38
Interest Maintenance Reserve (IMR) Template (Attachment Two-C)	5-40
Life Actuarial (A) Task Force June 1, 2023, Minutes (Attachment Three)	5-41
Virginia Comment Letter (Attachment Three-A)	5-43
Amendment Proposal Form (APF) 2023-05 (Attachment Three-B)	5-44
American Council of Life Insurers (ACLI) Comment Letter (Attachment Three-C)	5-50
APF 2023-07 (Attachment Three-D)	5-51
IMR Guidance (Attachment Three-E)	5-53
APF 2023-08 (Attachment Three-F)	5-68
Life Actuarial (A) Task Force May 18, 2023, Minutes (Attachment Four)	5-70
Generator of Economic Scenarios (GOES) Presentation Results (Attachment Four-A)	5-71
Life Actuarial (A) Task Force May 11, 2023, Minutes (Attachment Five)	5-91
ACLI Comment Letter (Attachment Five-A)	5-93
APF 2021-08 (Attachment Five-B)	5-95
ACLI Comment Letter (Attachment Five-C)	5-97
ACLI Comment Letter (Attachment Five-D)	5-99
American Academy of Actuaries (Academy) Comment Letter (Attachment Five-E)	5-101
Risk & Regulatory Consulting (RRC) Comment Letter (Attachment Five-F)	5-103
APF 2023-05 (Attachment Five-G)	5-104
Life Actuarial (A) Task Force May 4, 2023, Minutes (Attachment Six)	5-110
Life Actuarial (A) Task Force Response to Valuation of Securities (E) Task Force Referral (Attachment Six-A)	5-111
APF 2023-07 (Attachment Six-B)	5-112
Life Actuarial (A) Task Force April 27, 2023, Minutes (Attachment Seven)	5-114
ACLI Comment Letter (Attachment Seven-A)	5-116
APF 2021-08 (Attachment Seven-B)	5-118
Statutory Accounting Practices (E) Working Group Referral (Attachment Seven-C)	5-120
Life Actuarial (A) Task Force April 20, 2023, Minutes (Attachment Eight)	5-121
APF 2023-04 (Attachment Eight-A)	5-124
Academy Comment Letter (Attachment Eight-B)	5-126
ACLI Comment Letter (Attachment Eight-C)	5-128
APF 2023-06 (Attachment Eight-D)	5-130
Valuation of Securities (E) Task Force Bond Risk Measures Referral (Attachment Eight-E)	5-132
Academy Comment Letter (Attachment Eight-F)	5-144
ACLI Comment Letter (Attachment Eight-G)	5-146
Valuation of Securities (E) Task Force Structured Equity and Funds Referral (Attachment Eight-H)	5-159
ACLI Comment Letter (Attachment Eight-I)	5-162
Life Actuarial (A) Task Force and Life Risk-Based Capital (E) Working Group April 13, 2023, Minutes (Attachment Nine)	5-172

Economic Scenarios (E/A) Subgroup Charges (Attachment Nine-A).....	5-174
Mathematical Finance Company Comment on Generator of Economic Scenarios (GOES) (E/A) Subgroup Draft Changes (Attachment Nine-B).....	5-175
GOES Technical Drafting Group Topics (Attachment Nine-C)	5-177
Report of the Experience Reporting (A) Subgroup (Attachment Ten).....	5-185
Report of the Indexed Universal Life (IUL) Illustration (A) Subgroup (Attachment Eleven)	5-186
Report of the Longevity Risk (E/A) Subgroup (Attachment Twelve)	5-187
Report of the Variable Annuities Capital and Reserve (E/A) Subgroup (Attachment Thirteen).....	5-188
Report of the VM-22 (A) Subgroup (Attachment Fourteen).....	5-189
VM-22 (A) Subgroup July 26, 2023, Minutes (Attachment Fifteen)	5-190
VM-22 SPA Draft (Attachment Fifteen-A)	5-191
VM-22 (A) Subgroup June 13, 2023, Minutes (Attachment Sixteen)	5-206
VM-22 (A) Subgroup May 24, 2023, Minutes (Attachment Seventeen).....	5-207
VM-22 (A) Subgroup May 10, 2023, Minutes (Attachment Eighteen)	5-209
VM-22 (A) Subgroup April 26, 2023, Minutes (Attachment Nineteen)	5-210
VM-22 (A) Subgroup April 19, 2023, Minutes (Attachment Twenty)	5-212
VM-22 (A) Subgroup April 12, 2023, Minutes (Attachment Twenty-One)	5-214
Latest Exposed Draft of VM-22 PBR: Requirements for Principle-Based Reserves for Non-Variable Annuities (Attachment Twenty-One-A)	5-216
<i>Actuarial Guideline LIII—Application of the Valuation Manual for Testing the Adequacy of Life Insurer Reserves (AG 53) Presentation (Attachment Twenty-Two)</i>	5-300
2023 HMI and FMI Scale Update (Attachment Twenty-Three)	5-312
NAIC Model Office Considerations (Attachment Twenty-Four)	5-320
APF 2023-09 (Attachment Twenty-Five).....	5-323
Update on Proposed GOES Interest Rate Acceptance Criteria (Attachment Twenty-Six).....	5-325
GOES C3 Phase I Field Test Results (Attachment Twenty-Seven).....	5-357
Society of Actuaries (SOA) Research Update to the Life Actuarial (A) Task Force (Attachment Twenty-Eight)	5-369
SOA Presentation on the Evolution of the FSA Pathway (Attachment Twenty-Nine).....	5-378
Academy Life Practice Council Update (Attachment Thirty)	5-381
2024 Generally Recognized Expense Table (GRET) Recommendation Presentation (Attachment Thirty-One)	5-384
2024 GRET Recommendation Letter (Attachment Thirty-Two)	5-390
NAIC Staff IMR Memorandum (Attachment Thirty-Three).....	5-395
APF 2023-08 IMR Allocation (Attachment Thirty-Four).....	5-410
IMR Template (Attachment Thirty-Five)	5-412
ACLI Comments on IMR Template (Attachment Thirty-Six)	5-417
ACLI Comments on APF 2023-08 (Attachment Thirty-Seven).....	5-420

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Life Actuarial (A) Task Force
Seattle, Washington
August 11–12, 2023

The Life Actuarial (A) Task Force met in Seattle, WA, Aug. 11–12, 2023. The following Task Force members participated: Cassie Brown, Chair, represented by Rachel Hemphill (TX); Scott A. White, Vice Chair, represented by Craig Chupp (VA); Lori K. Wing-Heier represented by Sharon Comstock (AK); Mark Fowler represented by Sanjeev Chaudhuri (AL); Ricardo Lara represented by Thomas Reedy (CA); Andrew N. Mais represented by Wanchin Chou (CT); Doug Ommen represented by Mike Yanacheak (IA); Dana Popish Severinghaus represented by Vincent Tsang and Bruce Sartain (IL); Amy L. Beard represented by Scott Shover (IN); Vicki Schmidt represented by Nicole Boyd (KS); Grace Arnold represented by Fred Andersen and Ben Slutsker (MN); Chlora Lindley-Myers represented by William Leung (MO); Eric Dunning represented by Michael Muldoon (NE); D.J. Bettencourt represented by Jennifer Li (NH); Justin Zimmerman represented by Seong-min Eom (NJ); Adrienne A. Harris represented by Amanda Fenwick and Michael Cebula (NY); Judith L. French represented by Peter Weber (OH); Glen Mulready represented by Andrew Schallhorn (OK); Michael Humphreys represented by Steve Boston (PA); Jon Pike represented by Tomasz Serbinowski (UT); and Allan L. McVey represented by Tim Sigman (WV).

1. Adopted its July 20, June 15, June 1, May 18, May 11, May 4, April 27, April 20, and April 13 Minutes and the Reports of the Experience Reporting (A) Subgroup, the IUL Illustration (A) Subgroup, the Longevity Risk (E/A) Subgroup, and the Variable Annuities Capital and Reserve (E/A) Subgroup

The Task Force met July 20, June 15, June 1, May 18, May 11, May 4, April 27, April 20, and April 13. During these meetings, the Task Force took the following action: 1) adopted its Spring National Meeting minutes; 2) exposed the recommendation on Valuation Manual (VM)-20, Requirements for Principle-Based Reserves for Life Products, historical mortality improvement (HMI) and future mortality improvement (FMI) rates; 3) adopted amended charges to remove the Index-Linked Variable Annuity (A) Subgroup and add the Generator of Economic Scenarios (GOES) (E/A) Subgroup; 4) responded to a referral from the Statutory Accounting Principles (E) Working Group (SAPWG) regarding negative interest maintenance reserves (IMRs); 5) exposed a template with additional disclosures related to company IMR; 6) adopted amendment proposal form (APF) 2023-07, which removes the company-specific market path (CSMP) method from VM-21, Requirements for Principle-Based Reserves for Variable Annuities; 7) adopted APF 2023-05, which revises hedge modeling in VM-21 to address index credit hedging; 8) exposed APF 2023-08, which clarifies the treatment of negative IMR; 9) discussed the GOES field test results in joint session with the Life Risk-Based Capital (E) Working Group; 10) adopted APF 2021-08, which removes the one-year lag in mortality experience reporting in VM-51, Experience Reporting Formats; 11) responded to a referral from the Valuation of Securities (E) Task Force regarding bond risk measures; 12) adopted APF 2023-04, which clarifies company mortality experience disclosures in VM-31, PBR Actuarial Report Requirements for Business Subject to a Principle-Based Valuation; and 13) exposed APF 2023-06, which would add a cash surrender value floor to the VM-20 stochastic reserve calculation and change the VM-20 net premium reserve calculation for universal life with secondary guarantees (ULSG) products.

The Task Force reviewed the reports of the Experience Reporting (A) Subgroup, the Indexed Universal Life (IUL) Illustration (A) Subgroup, the Longevity Risk (E/A) Subgroup, and the Variable Annuities Capital and Reserve (E/A) Subgroup.

Chupp made a motion, seconded by Yanacheak, to adopt the Task Force's July 20 (Attachment One), June 15 (Attachment Two), June 1 (Attachment Three), May 18 (Attachment Four), May 11 (Attachment Five), May 4 (Attachment Six), April 27 (Attachment Seven), April 20 (Attachment Eight), and April 13 minutes (Attachment Nine) and the reports of the Experience Reporting (A) Subgroup (Attachment Ten), the IUL Illustration (A)

Subgroup (Attachment Eleven), the Longevity Risk (E/A) Subgroup (Attachment Twelve), and Variable Annuities Capital and Reserve (E/A) Subgroup (Attachment Thirteen). The motion passed unanimously.

2. Adopted the Report of the VM-22 (A) Subgroup

Slutsker delivered the report of the VM-22 (A) Subgroup.

Slutsker made a motion, seconded by Chupp, to adopt the report of the VM-22 (A) Subgroup (Attachment Fourteen), including its July 26 (Attachment Fifteen), June 13 (Attachment Sixteen), May 24 (Attachment Seventeen), May 10 (Attachment Eighteen), April 26 (Attachment Nineteen), April 19 (Attachment Twenty), and April 12 (Attachment Twenty-One) minutes. The motion passed unanimously.

3. Heard a Presentation on Findings from State Insurance Regulator Reviews of AG 53 Company Filings

Andersen walked through a presentation (Attachment Twenty-Two) on findings from the state insurance regulator reviews of company filings for *Actuarial Guideline LIII—Application of the Valuation Manual for Testing the Adequacy of Life Insurer Reserves* (AG 53). Regarding the 7% net yield threshold, Sartain asked how materiality was brought into the analysis. Andersen said a chart later in the presentation plotted the net yield assumptions of companies compared to their percentage allocation of high-net-yielding assets, and a greater focus was placed on the companies with higher net yields and high-yielding asset allocations. On slide 12 of the presentation, Hemphill asked for clarification on what the corridor lines on the scatterplot illustrated. Andersen replied that companies above the top line are a definite concern, those inside the corridor are a moderate concern, and companies below the corridor either have very low exposure or relatively low net yield assumptions and would not be a concern for this analysis.

Muldoon asked why the 7% net yield threshold was used for all assets, and he suggested varying the threshold by asset class. Andersen responded that the current analysis does not recognize a risk-adjusted variance between asset classes, and the approach aligned with language in VM-21. Eom said he wants clarification on the range of the asset allocations for companies reporting extreme net yields. Andersen replied that state insurance regulators did not receive that information, but it would be included in a proposed guidance document that could be used for second-year AG 53 reports. Serbinowski inquired as to how the asset allocations of companies may change in later durations of their cash flow testing models. Again, Andersen noted that they did not have this information, but it was being considered to be requested in the proposed guidance document.

Leonard Mangini (Mangini Actuarial and Risk Advisory LLC) proposed that a cap on the net asset earned rate (NAER) could be implemented in asset adequacy testing (AAT) in a similar fashion to VM-21, and also noted that Canada had instituted a similar requirement. Andersen noted that although that option was not currently being considered by the Task Force, it could be a possible consideration in the future. Regarding difficult-to-value and/or illiquid assets, Serbinowski asked how state insurance regulators could be comfortable with high net yields for these assets. Andersen noted that this issue was contemplated in the language of AG 53, and it is acceptable for companies to: 1) add more complexity to their modeling to properly quantify the risks associated with these assets; or 2) add additional conservatism. However, Andersen noted that it was not appropriate for companies to simply exclude these assets from their analysis due to the challenges of valuing them.

4. Heard a Presentation on the VM-20 HMI and FMI Factors

Marianne Purushotham (Society of Actuaries—SOA) walked through a presentation (Attachment Twenty-Three) on the American Academy of Actuaries (Academy) Mortality Improvements Life Working Group (MILWG) 2023 recommendation for VM-20 HMI and FMI rates. Hemphill asked whether mortality deterioration due to the opioid epidemic was being graded off in later durations as the rates transitioned into the long-term FMI

assumption. Purushotham confirmed that some of the effects of the opioid epidemic were being graded off consistent with the U.S. Social Security Administration (SSA) intermediate mortality projection data, but the SSA was including more of this data in its projections over time. Slutsker asked how frequently the long-term rate was updated. Purushotham said the long-term rate is reset whenever the scale resets. Brian Bayerle (American Council of Life Insurers—ACLI) asked how more mortality experience from insured lives would be incorporated into the analysis in future years, along with the timing. Purushotham replied that work had been done on comparing the life insurance experience data that the NAIC has collected to the different deciles of the general population data ahead of coming up with a recommendation potentially for discussions in 2024 and implementation in 2025.

Scott O’Neal (NAIC) then went over a presentation (Attachment Twenty-Four) that highlighted the NAIC’s plan to perform a model office analysis of the impact of the new set of HMI and FMI rates. Bayerle asked whether the NAIC had the capability to change the weighting of the population in the model office to be more representative of industry life insurance populations. O’Neal said the model office population could be modified, but the plan for this year was to illustrate the impacts separately for 30- and 50-year-olds from the current model population.

5. Exposed APF 2023-09

Hemphill discussed APF 2023-09, which adds guidance on the application of HMI and FMI factors in VM-20. Bayerle asked how the reflection of mortality improvement considerations “identified by the SOA” would work in practice and whether that language needed to be included in the *Valuation Manual*. Hemphill suggested striking the “identified by the SOA” language from APF 2023-09, along with an additional editorial change for the exposed version.

Chupp made a motion, seconded by Reedy, to expose APF 2023-09 (Attachment Twenty-Five) with the edits described above for a 45-day public comment period ending Sept. 27. The motion passed unanimously.

6. Heard a Presentation from the Academy on Interest Rate Acceptance Criteria for the GOES

Jason Kehrberg (American Academy of Actuaries—Academy) and Link Richardson (Academy) went over a presentation (Attachment Twenty-Six) on the interest rate acceptance criteria for the GOES. After Kehrberg noted that the interest rate level criteria for the 30th and 70th percentiles had been removed, Hemphill noted concern that a large portion of scenarios included in the determination of the conditional tail expectancy (CTE)-70 reserve calculation would not be included in the criteria. Kehrberg replied that with any additional criteria that are added, there is a balancing act between meeting the additional criteria and the other criteria that have been prioritized. Weber asked how the buffers that are included in the acceptance criteria were developed. Kehrberg noted that the setting of the buffers was an iterative approach that utilized testing using a reference model and expert judgment.

O’Neal stated that recent United States Treasury (UST) rate experience had included large inversions for a prolonged period, and he asked how this recent experience would look compared to the acceptance criteria. Kehrberg replied that the Academy could take a look at the question and consider whether to add the most recent experience to the acceptance criteria to see how much the criteria would change. Yanacheak noted that the frequency of worse-than-history events was based on judgment, but he asked why historical data could not also be utilized. He further stated that perhaps different periods of time could be looked at, and a frequency of breakout events could be determined. Kehrberg noted that a lack of data could be a problem, as history is just a single scenario, and up to 10,000 scenarios would be produced from the GOES. However, Kehrberg noted that it is something that could be looked at and added to the analysis. After Kehrberg introduced the “sojourn” acceptance criteria where UST rates would need to stay within a corridor for a predefined period of time, Yanacheak questioned whether the currently proposed model would be able to meet this acceptance criteria and how it would fit with the state insurance regulator geometric average-based low-for-long acceptance criteria.

Kehrberg replied that the sojourn acceptance criteria were not intended to replace the geometric average-based low-for-long acceptance criteria but instead were meant to be complementary and capture product-specific risks that may not be addressed by the geometric average-based low-for-long criteria.

7. Heard a Presentation on the GOES Field Test C-3 Phase I Results

O’Neal went over a presentation (Attachment Twenty-Seven) of the GOES Field Test C3 Phase I results. Slutsker asked if O’Neal incorporated the factor-based floor into his analysis. O’Neal responded that he did make some limited comparisons of the floor, but more work would be needed to understand the model-based results’ relationship to the floor. However, he stated that comparing the range of factors from the factor-based calculation to the average factor from the model-based calculation for each of the baseline and field test runs, it looked like many participants would likely hold the factor-based floor.

Slutsker observed that for the baseline field test run, approximately half of the participants did not hold a positive capital requirement using their cash flow models for C3 Phase I, and he asked O’Neal if he found that to be surprising. O’Neal stated that he did find it surprising, and although additional analysis could be performed, it seemed that there were limited situations where the model-based calculation would dominate over the factor-based calculation. Hemphill said although the comparison to the factor-based floor would be interesting, the fact that some of the model-based calculations were coming in so low needs to be looked into further. Reedy asked whether with more volatile scenario sets and the limited number of scenarios currently used in C3 Phase I, more period-to-period variation in results would be expected. Hemphill responded that the smaller subsets could have had a material effect on the results and muddied the potential impact of the different field test scenario sets. Richardson noted that during an analysis they also looked at the impact of the present value of ending surplus to understand the impact of different scenario sets, and the results could be masked when just looking at a present value of accumulated deficiencies.

8. Heard an Update from the Compact

Katie Campbell (Interstate Insurance Product Regulation Commission—Compact) delivered an update on the activities of the Compact. Serbinowski noted the work that the Compact is doing to develop filing standards for ILVA products and encouraged state insurance regulators to: 1) get involved in the activities of the Product Standards Committee; and 2) try and understand why a company would file a product with their state instead of the Compact. Serbinowski concluded his comments by stating that the Compact does a tremendous job at reviewing product filings.

9. Heard an Update from the Academy on Pre-Tax Versus Post-Tax IMR

Linda Lankowski (Academy) from the Academy’s Life Valuation Committee noted that she would be discussing considerations around using pre-tax versus post-tax IMR in reserve calculations and presenting with Sheldon Summers (Academy), Dave Neve (Academy), Bruce Friedland (Academy), and Maambo Mujala (Academy). Lankowski stated that the committee has recently published a paper called “Pre-Tax vs. Post-Tax Interest Maintenance Reserves in Stochastic Principle-Based Reserves.” She added that in 2021, a comment letter on the VM-22 draft noted that pre-tax IMR in the reserve calculation could mean that reserves posted to the balance sheet might not be sufficient. After discussion of the comment letter at the VM-22 (A) Subgroup, Lankowski said the Academy Life Valuation Committee was asked to investigate.

Friedland provided background on the IMR, noting that formulaic reserves were in place when the IMR was adopted. He stated that the aim of the IMR was to keep consistency between the assets and liabilities when assets are sold in dynamic interest rate environments. Without IMR, he stated that there is a potential inconsistency in which the asset side of the balance sheet would be unlocked, but the liability side would not. He stated that as a

result, the IMR was introduced to set aside gains and losses arising from asset sales and prevent them from having an immediate impact. He noted, however, that principle-based reserves (PBR) are different from formulaic reserves in that they are effectively unlocked and reset on each valuation date.

Mujala outlined three options for the treatment of IMR in reserving: 1) allocating pre-tax IMR; 2) allocating post-tax IMR; and 3) no IMR used in the determination of reserves. She spoke in favor of allocating pre-tax IMR, noting that using pre-tax IMR in the determination of the reserves allows for a neutral balance sheet impact. Lankowski noted that some view allocating post-tax IMR as more appropriate on a theoretical basis and as more tax efficient. Finally, she noted that some support the removal of IMR from the determination of the reserve, as the deterministic and stochastic reserve calculations are based on future cash flows, which are not affected by IMR. However, she noted that the removal of IMR may be inappropriate for products that use formulaic reserves.

Neve summarized the discussion by noting that there is no recommendation from the Academy on any approach, as there is no perfect answer from an actuarial perspective. He additionally stated that IMR is not expected to be material; although, dropping the IMR completely from the PBR calculation may be material for some companies. However, he stated that this materiality issue probably needs more research and discussion for VM-21.

10. Heard an Update from the SOA on Research and Education

Cindy MacDonald (SOA) delivered a presentation (Attachment Twenty-Eight) on the SOA's research initiatives. Regarding the SOA's lapse study for fixed annuities, Tsang asked if the study included partial withdrawals in addition to full surrenders. MacDonald noted that the study only currently includes full surrenders, to which Tsang responded that he would also like to receive information on partial withdrawals from the study. She also asked state insurance regulators if they would be willing to help solicit participants for experience studies for areas where state insurance regulators want to see more data, and Hemphill and other state insurance regulators noted a willingness to do so.

Stuart Klugman (SOA) then provided a presentation (Attachment Twenty-Nine) on the SOA's planned changes to the SOA's Fellowship Pathway. Hemphill noted several concerns she had with the proposed changes to the Fellowship Pathway, including: 1) more actuaries than just the appointed actuary are involved in the work that supports the actuarial opinion and memorandum, and all of those actuaries need regulatory information; 2) the removal of the regulatory content could cause an actuary not to meet the U.S. Qualification Standards; and 3) a lack of regulatory knowledge could reduce compliance with statutory regulations. Andersen, Reedy, Yanacheak, and Cebula all noted support for Hemphill's comments. Hemphill noted that as a next step, a letter would be drafted noting the concerns with the proposed changes to the Fellowship Pathway for consideration by the Task Force.

11. Heard an Update from the Academy Council on Professionalism and Education

Ken Kent (Academy) introduced Laura Hanson (Actuarial Standards Board—ASB) and Shawna Ackerman (Actuarial Board for Counseling and Discipline—ABCD), who would be jointly delivering the Academy Council on Professionalism and Education's update. Hanson discussed Actuarial Standards of Practice (ASOPs) 24, 40, and 46–47, which are currently exposed to public comment. She additionally noted that ASOPs 7, 12, and 41 are expected to be exposed for comments in the next three to six months, and ASOP 10 and 57 have recently been adopted.

Ackerman said the ABCD received about 100 requests for guidance over the past year. About 20 of those requests, she noted, were in the life practice area.

12. Heard an Update from the Academy Life Practice Council

Slutsker and Amanda Barry-Moilanen (Academy) delivered a presentation (Attachment Thirty) on the activities of the Academy Life Practice Council.

13. Exposed the GRET

MacDonald walked through a presentation on the 2023 Generally Recognized Expense Table (GRET) recommendation. Chou asked why the direct market and niche marketing expense trends were so different compared to the prior year. MacDonald noted that volatility in the companies participating in the GRET from year to year could cause opposing changes in the trend rather than any underlying expense relationship.

Slutsker made a motion, seconded by Yanacheak, to expose the GRET presentation and recommendation (Attachments Thirty-One and Thirty-Two, respectively) for a 30-day public comment period ending Sept. 12. The motion passed unanimously.

14. Discussed IMR Guidance, APF 2023-08, and the IMR Template

Hemphill led the discussion on IMR guidance (Attachment Thirty-Three), APF 2023-08 (Attachment Thirty-Four), and the IMR template (Attachment Thirty-Five). Bayerle spoke to the ACLI's comment letters (Attachments Thirty-Six and Thirty-Seven), noting concerns including that: 1) the timing of the request for the template could come before it would be able to be reviewed by an external auditor; and 2) some of the items addressed by APF 2023-08, the IMR guidance, and the IMR template would need to be updated depending on the action of the SAPWG. Hemphill responded that she expected that the delivery of the IMR template would be consistent with the April 1 date for PBR actuarial reports and the timing for the asset adequacy memoranda, and she also noted that the Task Force expected to update APF 2023-08, the IMR guidance, and the IMR template to be consistent with the action the Working Group takes on IMR.

Having no further business, the Life Actuarial (A) Task Force adjourned.

SharePoint/NAIC Support Staff Hub/Committees/Member Meetings/A CMTE/LATF/2023-2-Summer/Summer National Meeting/LATF Minutes Packet/LATF Summer National Meeting Minutes

Draft: 8/2/23

Life Actuarial (A) Task Force
Virtual Meeting
July 20, 2023

The Life Actuarial (A) Task Force met July 20, 2023. The following Task Force members participated: Cassie Brown, Chair, represented by Rachel Hemphill; Scott A. White, Vice Chair, represented by Craig Chupp (VA); Lori K. Wing-Heier represented by Sharon Comstock (AK); Ricardo Lara represented by Ahmad Kamil (CA); Andrew N. Mais represented by Wanchin Chou (CT); Doug Ommen represented by Mike Yanacheak (IA); Dana Popish Severinghaus represented by Vincent Tsang (IL); Amy L. Beard represented by Scott Shover (IN); Vicki Schmidt represented by Nicole Boyd (KS); Timothy N. Schott represented by Marti Hooper (ME); Grace Arnold represented by Fred Andersen and Ben Slutsker (MN); Chlora Lindley-Myers represented by William Leung (MO); Eric Dunning represented by Michael Muldoon (NE); D.J. Bettencourt represented by Jennifer Li (NH); Justin Zimmerman represented by Seong-min Eom (NJ); Adrienne A. Harris represented by Bill Carmello (NY); Judith L. French represented by Peter Weber (OH); Glen Mulready represented by Andrew Schallhorn (OK); and Michael Humphreys represented by Steve Boston (PA).

1. Adopted its Spring National Meeting Minutes

Hemphill noted that the Task Force would be considering whether to adopt its Spring National Meeting minutes. Chupp noted two error corrections to the table of contents in the Spring National Meeting minutes packet.

Yanacheak made a motion, seconded by Chupp, to adopt the Task Force's March 20–21 minutes with the error corrections mentioned by Chupp (*see NAIC Proceedings – Spring 2023, Life Actuarial (A) Task Force*). The motion passed unanimously.

2. Exposed the 2023 VM-20 HMI and FMI Recommendation

Marianne Purushotham (Society of Actuaries—SOA) walked through a presentation on the Mortality Improvements Life Working Group (MILWG) 2023 recommendation (Attachment One-A) for the VM-20, Requirements for Principle-Based Reserves for Life Products, historical mortality improvement (HMI) and future mortality improvement (FMI) rates. Chou asked why there was a big difference in the youngest attained ages between the smoothed and unsmoothed rates. Purushotham said that there was a lack of data at those ages and that she would provide additional information on the proportion of data at those ages. Chou then asked about the variation in the COVID-19 shock impact between the attained ages in the FMI rates. Purushotham noted that the data the SOA used to determine the impact showed a lot of variation by age. Chupp asked why the 2026 projection year FMI rate was not zero across all ages, given the earlier description of the methodology. Purushotham stated that she would follow up on that question.

Chupp made a motion, seconded by Chou, to expose the 2023 VM-20 HMI and FMI recommendation for a 30-day public comment period ending Aug 23, 2023. The motion passed unanimously.

Having no further business, the Life Actuarial (A) Task Force adjourned.

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Mortality Improvements Life Working Group (MILWG): 2023 HMI and FMI Scale Update



Academy Mortality Improvements Life Work Group (MILWG)
SOA Mortality and Longevity Oversight Advisory Council (MLOAC)

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Life Actuarial Task Force (LATF)—7/20/23

DB1

2023 Plan

Presented at 2023 NAIC Spring Meeting

- Revisit historical HMI methodology in light of recent and expected experience - completed DB0
- Revisit smoothing approach for HMI and FMI—completed
- Approach to COVID-19 impact for 2023—FMI (future mortality improvement) and HMI (historical mortality improvement)—completed
- Insured vs. general population HMI and FMI recommendations (begin work in 2023)
- Revisit FMI margin structure
- Review recommendation for MI with 2008 VBT Limited Underwriting (LU) table

2



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Agenda

- Provide an update on work completed:
 - ▣ Revisit historical HMI methodology in light of recent and expected
 - ▣ Revisit smoothing approach for HMI and FMI
 - ▣ Approach to COVID-19 impact for 2023—FMI (future mortality improvement) and HMI (historical mortality improvement)
- Present recommendation for 2023 HMI and FMI scales
- Provide an update on next steps for remaining 2023 work plan

3



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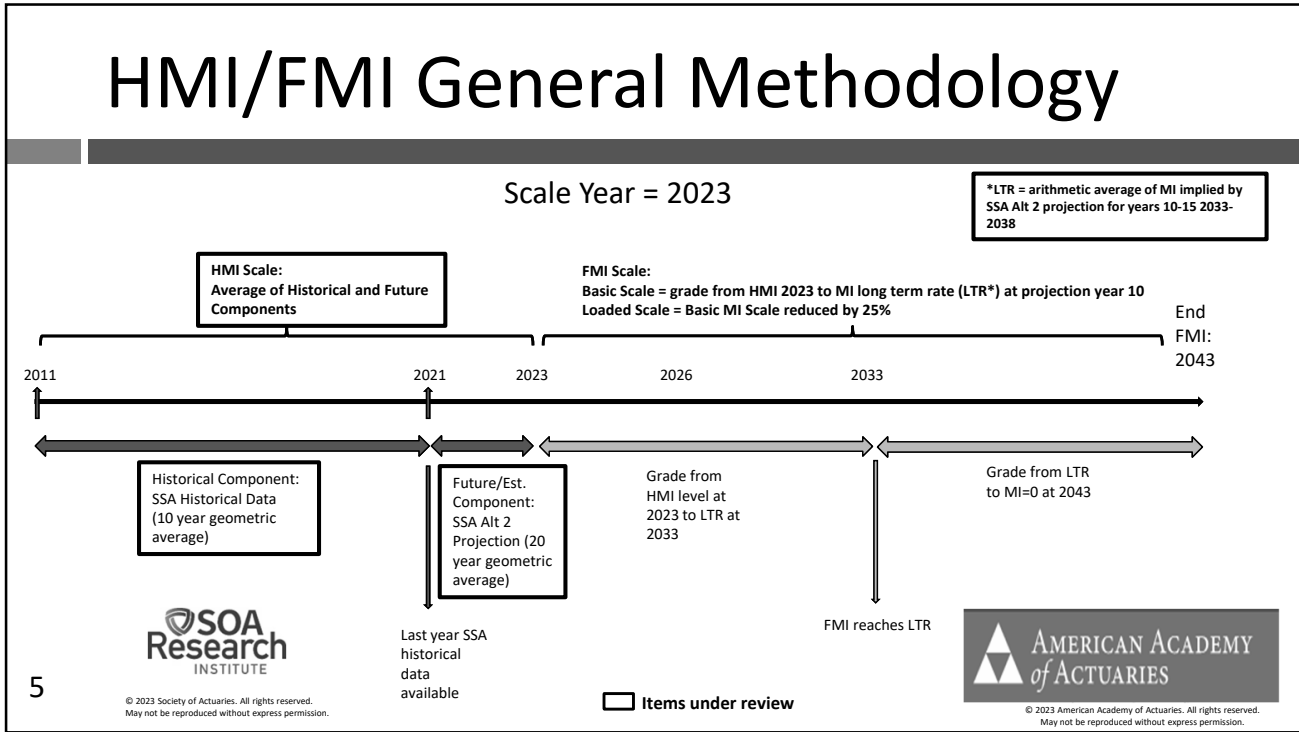
Revisit HMI Methodology



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- # HMI Methodology Review Items
1. **Historical averaging period (10 years)**
 - ▣ Mortality improvement between 2011-2021 (last year through which SSA historical data has been compiled and published)
 2. **Future averaging period (20 years)**
 - ▣ From last year of historical data available
 3. **Averaging method**
 - ▣ Calculation of historical and future averages
 - ▣ Weighting of historical and future
- SOA Research INSTITUTE
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- 6
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HMI Methodology Review Items Recommendation: Historical Averaging Period (currently 10 years)

Recommendation: remain at 10 years

- Recent experience (2011-2021)
- Reduces year-to-year potential volatility of shorter periods but experience is relevant

7



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HMI Methodology Review Items Recommendation: Future Averaging Period (currently 20 years)

Recommendation: remain at 20 years

- Smooths out potential SSA Alt 2 early projection year bumps

8



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HMI Methodology Review Items Recommendation: Averaging Method

Averaging method: currently use geometric average over historical and future periods

Recommendation: continue to use geometric approach for 2023

Consider moving to arithmetic average rather than geometric for both historical and future components (will re-examine for 2024 scale work)

- ❑ Relies less on only the beginning and ending year experience
- ❑ Not much difference between arithmetic and geometric average results for years since we implemented the annual life MI scale updates
- ❑ Consistent with the FMI LTR determination

9



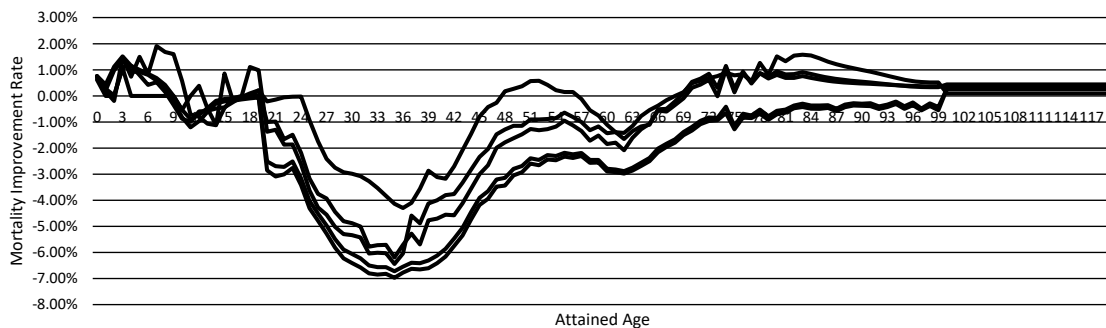
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Calculation of Historical Averages

Male Historical Component—10 year average, Full COVID Impact



— Geometric Mean — Arithmetic Mean — Median — Trimmed Mean — Winsorization

10



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HMI Methodology Review Items Recommendation: Weighting of Historical and Future Components of HMI

Recommendation:

Keep 50/50 weighting on averaging

- No data-focused basis for changing at this point

11



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Revisit Smoothing Process



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Review Smoothing Approach

	Current Method	Recommendation
1. Ages 0-15 (juvenile)	Use adult average (18-84) x 1.5	Use 0-20 average
2. Ages 16-20	Linear interpolation from juvenile rate to adult rate at age 21	Use 0-20 average
3. Ages 21-84	Use Adult Average 18-84	Break into more detailed age groups: 0-20 25-40 45-60 65-85 Linear interpolation between groups.
4. Ages 85-94	Linear interpolation from adult rate to .0025 per year ultimate level at age 95	Linear interpolation from 65-85 average to .001 per year ultimate level at age 95 (use .001 due to COVID considerations)
5. Ages 95 and later	Use constant .0025 (used .001 for 2022 due to COVID impact considerations)	Use constant .001 due to COVID considerations

13

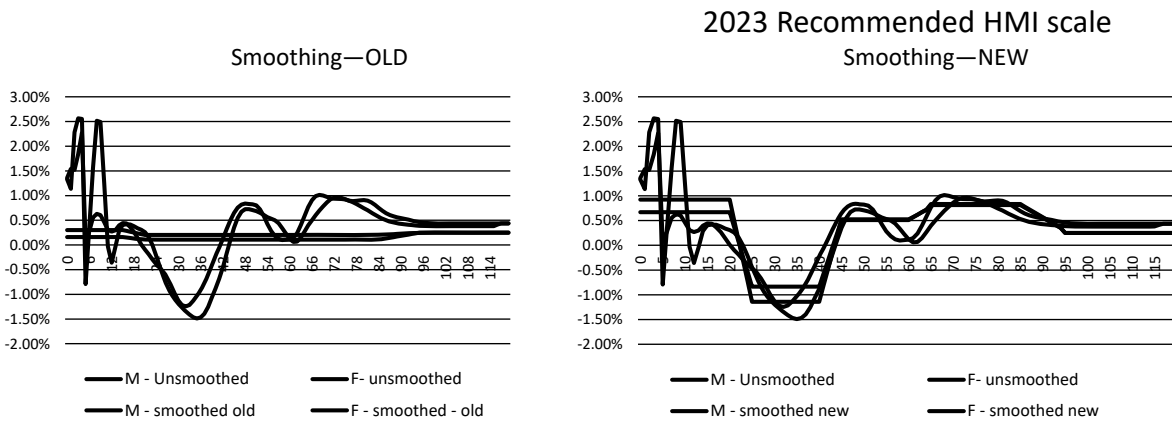


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Comparison of Smoothing Approaches



14



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COVID-19 Impact—2023 Approach



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COVID-19 Impact

COVID-19 DJNO impact considerations

- Ensuring COVID-19 impact is considered
- Some companies with high credibility will use their best estimate mortality (including implied historical improvement) for long periods before grading to industry
 - Creates potential disconnect between HMI and the recommended industry FMI scale

Recommendation: COVID impact will be included in the first few years of the FMI scale for 2023 (similar to approach for 2022 scale work)

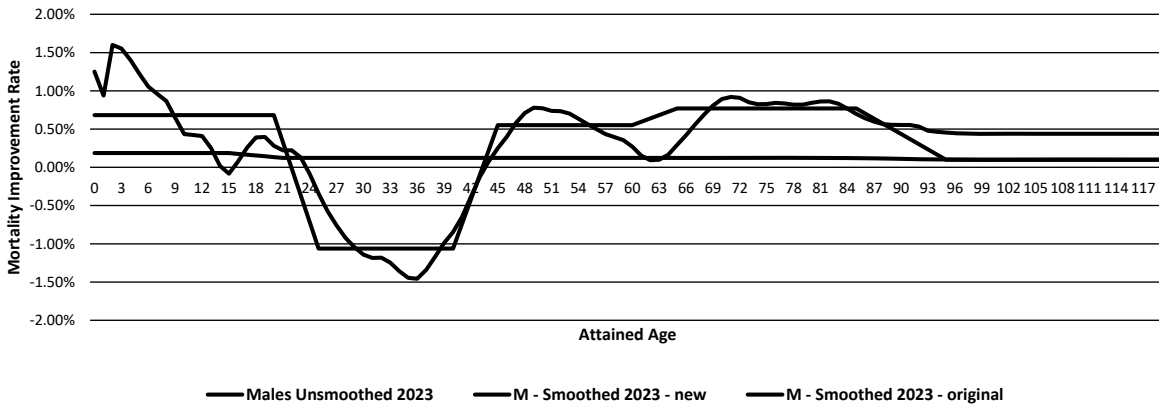


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HMI 2023 Recommendation Male, Mortality Improvement Rates



17

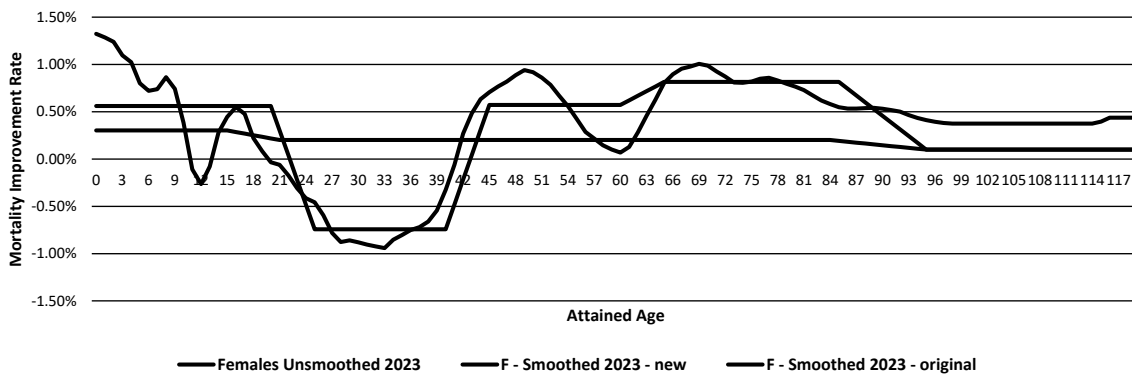


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HMI 2023 Recommendation Female, Mortality Improvement Rates



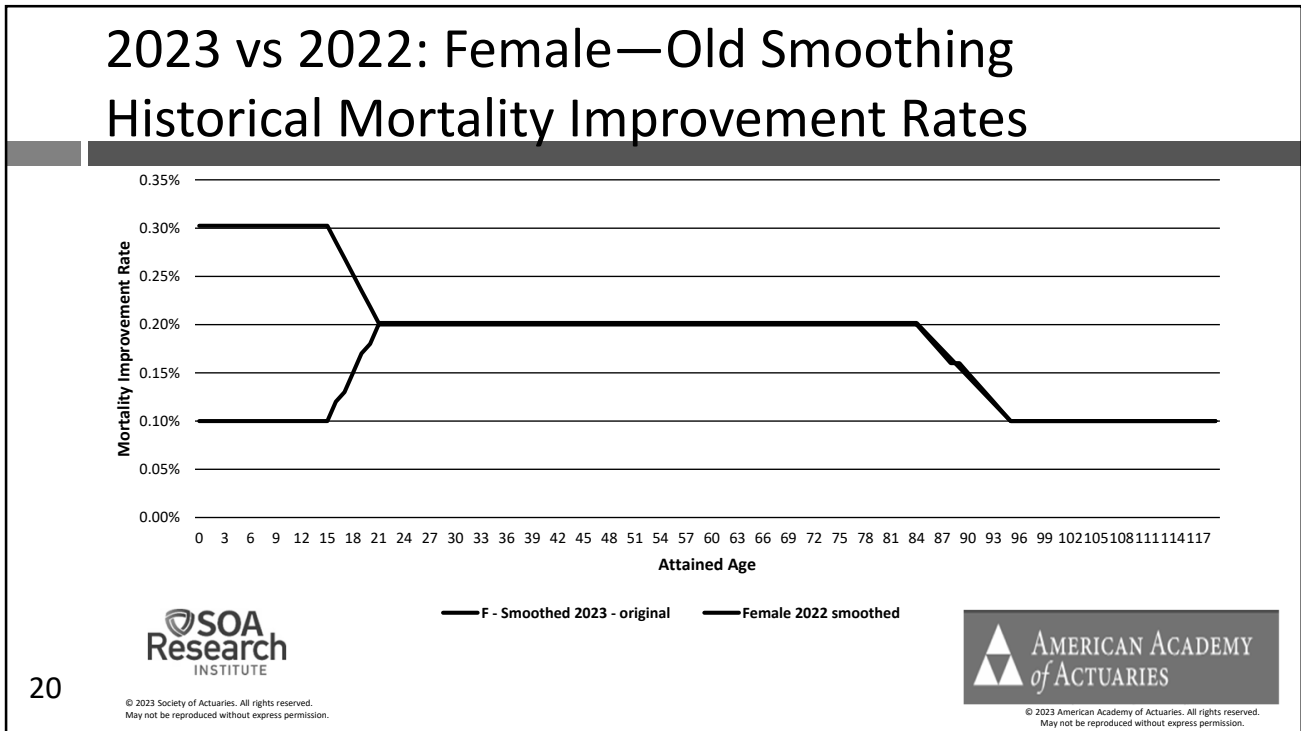
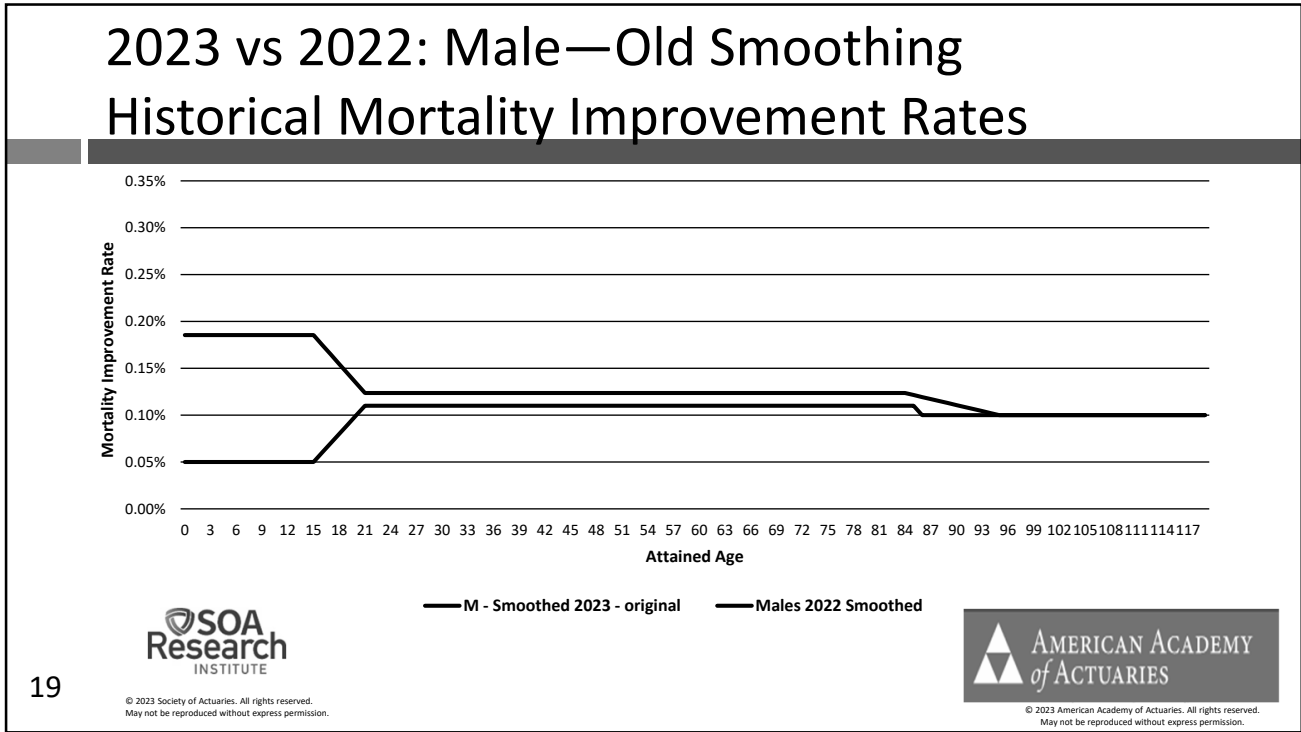
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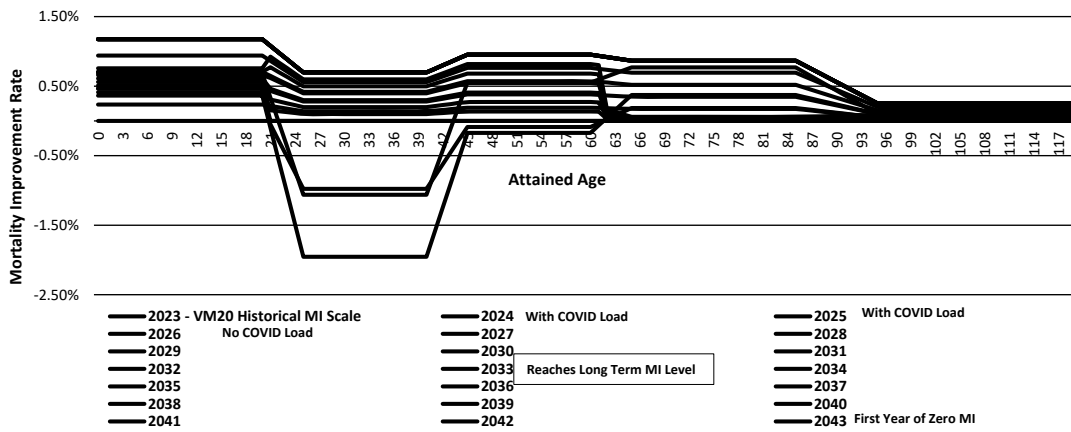
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FMI 2023 Recommendation—Basic Scale Male, Future Mortality Improvement Rates



21

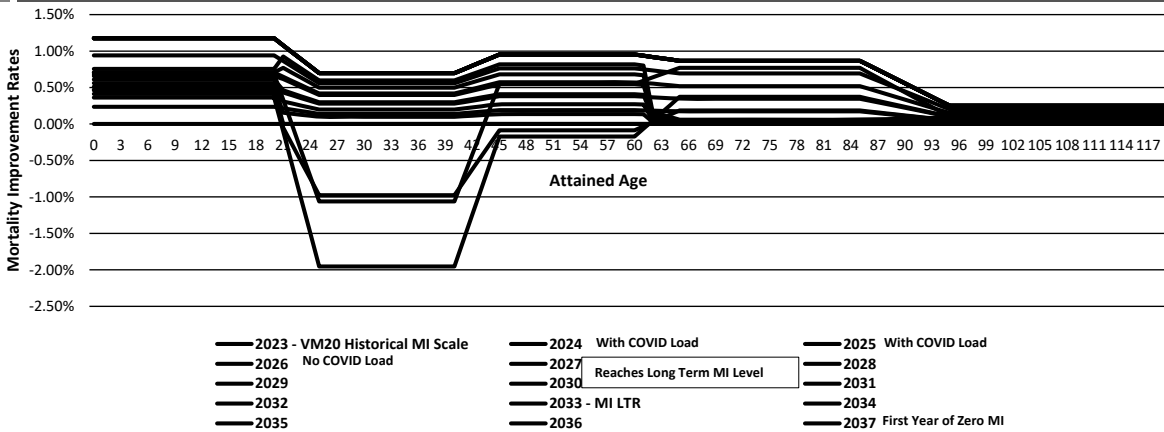


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FMI 2023 Recommendation—Basic Scale Female, Future Mortality Improvement Rates



22

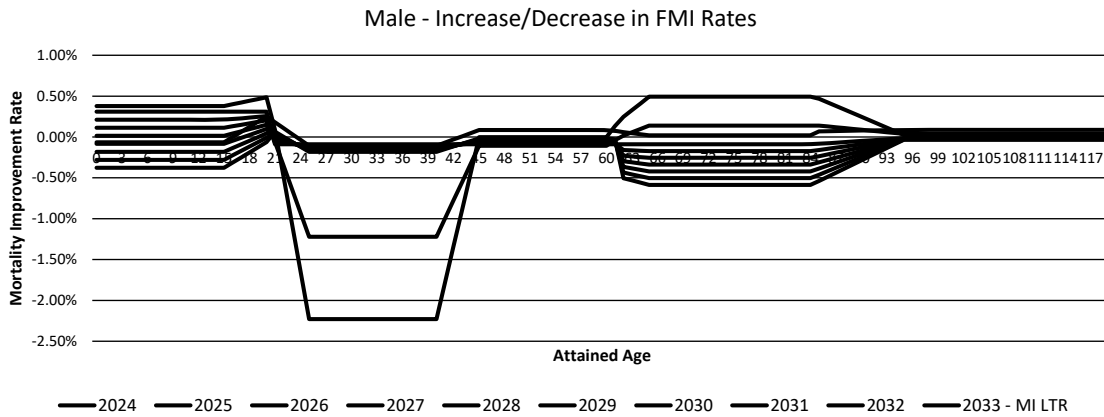


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2023 vs 2022—Male Future Mortality Improvement Rates



23

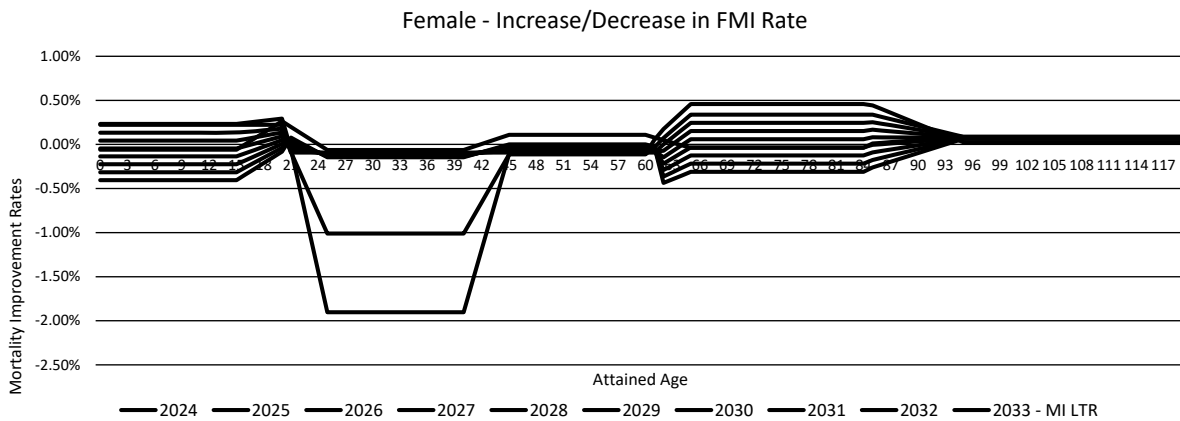


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2023 vs 2022—Female Future Mortality Improvement Rates



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Update on Next Steps for 2023

- ▣ Insured vs. general population HMI and FMI recommendations (work continues)
- ▣ Revisit FMI margin structure
- ▣ Review recommendation for MI with 2008 VBT Limited Underwriting (LU) table
 - Keep the HMI and FMI scales at 0 MI for all ages
 - Look at additional data sources to support this

25



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Questions?

26



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Life MI Subgroup Members

Marianne Purushotham, FSA, MAAA (Chair)
Cynthia Edwalds, FSA, MAAA
Sam Gutterman, FSA, MAAA
Tim Hoxha, FSA, MAAA
Mary Simmons, FSA, MAAA
Jean-Marc Fix, FSA, MAAA
Larry Stern, FSA, MAAA
Mark Rosa, FSA, MAAA
Cynthia MacDonald, FSA, MAAA

Members available to provide supplementary information and explanation as needed.



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Appendix



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HMI/FMI General Methodology

HMI Scale Year	Historical Component: <i>Historical Data (10 yrs)</i> SSA Data = General Population Mean	Estimated/Future Component: <i>SSA (Social Security Administration)</i> <i>Alt2 Projection (20 yr average)</i>
2023	Averaging Period: 2011-2021	Averaging Period: 2023-2043
FMI Scale Year	Process	Long-Term Rate (LTR)
2023	Basic Scale: <ul style="list-style-type: none"> • Grades to LTR at projection yr 10 (2033) • Remains at LTR for projection yrs 10-15 • Grades to no additional MI at projection yr 20 (2043) • Margin for uncertainty included to develop “Loaded Scale” – 25% flat reduction in MI 	Average of SSA Alt 2 MI for projection years 10-15



30

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Draft: 7/17/23

Life Actuarial (A) Task Force
Virtual Meeting
June 15, 2023

The Life Actuarial (A) Task Force met June 15, 2023. The following Task Force members participated: Cassie Brown, Chair, represented by Rachel Hemphill (TX); Scott A. White, Vice Chair, represented by Craig Chupp (VA); Lori K. Wing-Heier represented by Sharon Comstock (AK); Ricardo Lara represented by Ahmad Kamil (CA); Andrew N. Mais represented by Wanchin Chou (CT); Dana Popish Severinghaus represented by Vincent Tsang (IL); Amy L. Beard represented by Scott Shover (IN); Vicki Schmidt represented by Nicole Boyd (KS); Timothy N. Schott represented by Marti Hooper (ME); Grace Arnold represented by Fred Andersen and Ben Slutsker (MN); Chlora Lindley-Myers represented by William Leung (MO); Eric Dunning represented by Michael Muldoon (NE); Adrienne A. Harris represented by Bill Carmello (NY); Judith L. French represented by Peter Weber (OH); Michael Humphreys represented by Steve Boston (PA); and Jon Pike represented by Tomasz Serbinowski (UT).

1. Adopted its Amended Charges

Hemphill walked through the Task Force's amended charges, noting that the changes reflect the removal of the Index-Linked Variable Annuity (A) Subgroup and the addition of the Generator of Economic Scenarios (GOES) (E/A) Subgroup.

Leung made a motion, seconded by Slutsker, to adopt the amended charges (Attachment Two-A), noting that the charges of the ILVA (A) Subgroup had been met and that the GOES (E/A) Subgroup would have Mike Yanacheak (IA) as Chair and Weber as Vice-Chair. The motion passed unanimously.

2. Considered its Response to the Statutory Accounting Principles (E) Working Group Referral on Negative IMR

Hemphill walked through a written response (Attachment Two-B) to the Statutory Accounting Principles (E) Working Group referral on negative interest maintenance reserve (IMR). Carmello suggested that the impetus for the request from the Working Group to build an IMR reporting template was that the template could then be used to justify admitting negative IMR. Hemphill responded that the Task Force's response would indicate that asset adequacy testing (AAT), given the lack of prescription, was not an effective guardrail to justify admitting negative IMR. Carmello further inquired if part of the functionality of the template would track whether the proceeds from the sales of bonds that drove negative IMR balances were used to reinvest in new bonds. Hemphill noted that the next agenda item would be to discuss the potential exposure of the IMR template and that the purpose of the template was to contain additional disclosures that would allow a reviewing actuary to understand how negative IMR is being handled, regardless of whether the Working Group decides to allow negative IMR to be admitted.

Hearing no objection from Task Force members, Hemphill said that the written response would be referred to the Working Group.

3. Exposed the IMR Template

Hemphill discussed the IMR template (Attachment Two-C) that would be a component of the Task Force's work product related to the negative IMR referral from the Working Group. Leung asked if the template would apply to both companies that have negative total IMR balances and those that have positive overall IMR balances. Hemphill noted that: 1) the focus would be on companies that have total company negative IMR balances but could also be useful for companies with positive total company IMR balances; and 2) initially, the template would be optional

and filled out at the request of regulators. Leung then noted some editorial and error corrections to the template, which Hemphill agreed to change. Brian Bayerle (American Council of Life Insurers—ACLI) requested that the length of the exposure period be the maximum number of days that would still allow for discussion at the Summer National Meeting.

Chupp made a motion, seconded by Leung, to expose the IMR template with the editorial and error corrections that were discussed for a 44-day public comment period ending July 28. The motion passed unanimously.

Having no further business, the Task Force adjourned.

SharePoint/NAIC Support Staff Hub/Member Meetings/A CMTE/LATF/2023-2-Summer/LATF Calls/06 15/June 15 Minutes.docx

Draft: 5/23/23

Adopted by the Life Actuarial (A) Task Force, TBD

2023 Proposed Charges

LIFE ACTUARIAL (A) TASK FORCE

The mission of the Life Actuarial (A) Task Force is to identify, investigate, and develop solutions to actuarial problems in the life insurance industry.

Ongoing Support of NAIC Programs, Products, or Services

1. The **Life Actuarial (A) Task Force** will:

- A. Work to keep reserve, reporting, and other actuarial-related requirements current. This includes principle-based reserving (PBR) and other requirements in the *Valuation Manual*, actuarial guidelines, and recommendations for appropriate actuarial reporting in blanks. Respond to charges from the Life Insurance and Annuities (A) Committee and referrals from other groups or committees, as appropriate.
- B. Report progress on all work to the Life Insurance and Annuities (A) Committee and provide updates to the Financial Condition (E) Committee on matters related to life insurance company solvency. This work includes the following:
 - i. Work with the American Academy of Actuaries (Academy) and the Society of Actuaries (SOA) to develop new mortality tables for valuation and minimum nonforfeiture requirements, as appropriate, for life insurance and annuities.
 - ii. Provide recommendations for guidance and requirements for accelerated underwriting (AU) and other emerging underwriting practices, as needed.
 - iii. Evaluate and provide recommendations regarding the VM-21, Requirements for Principle-Based Reserves for Variable Annuities/*Actuarial Guideline XLIII—CARVM for Variable Annuities* (AG 43) standard projection amount (SPA), which may include continuing as a required floor or providing as disclosure. This evaluation is to be completed prior to year-end 2023.
 - iv. Work with the SOA on the annual development of the Generally Recognized Expense Table (GRET) factors.
 - v. Provide recommendations and changes, as appropriate, to other reserve and nonforfeiture requirements to address issues, and provide actuarial assistance and commentary to other NAIC committees relative to their work on actuarial matters.
 - vi. Work with the selected vendor to develop and implement the new economic scenario generator (ESG) for use in regulatory reserve and capital calculations.
 - vii. Monitor international developments regarding life and health insurance reserving, capital, and related topics. Compare and benchmark these with PBR requirements.

2. The **Experience Reporting (A) Subgroup** will:

- A. Continue the development of the experience reporting requirements within the *Valuation Manual*. Provide input, as appropriate, for the process regarding the experience reporting agent, data collection, and subsequent analysis and use of experience submitted.

LIFE ACTUARIAL (A) TASK FORCE (continued)

3. The **Generator of Economic Scenarios (GOES) (E/A) Subgroup** of the Life Risk-Based Capital (E) Working Group and the Life Actuarial (A) Task Force will:

- A. Monitor that the economic scenario governance framework is being appropriately followed by all relevant stakeholders involved in scenario delivery.
- B. Review material economic scenario generator updates, either driven by periodic model maintenance or changes to the economic environment and provide recommendations.
- C. Regularly review key economic conditions and metrics to evaluate the need for off-cycle or significant economic scenario generator updates and maintain a public timeline for economic scenario generator updates.
- D. Support the implementation of an economic scenario generator for use in statutory reserve and capital calculations.
- E. Develop and maintain acceptance criteria that reflect history as well as plausibly more extreme scenarios.

~~3.4.~~ The **Indexed Universal Life (IUL) Illustration (A) Subgroup** will:

- A. Consider changes to *Actuarial Guideline XLIX-A—The Application of the Life Illustrations Model Regulation to Policies with Index-Based Interest to Policies Sold On or After December 14, 2020* (AG 49-A), as needed. Provide recommendations for the consideration of changes to the *Life Insurance Illustrations Model Regulation* (#582) to the Task Force, as needed.

~~4.~~ The **Index Linked Variable Annuity (A) Subgroup** will:

- A. ~~Provide recommendations and changes, as appropriate, to nonforfeiture, or interim, value requirements related to index-linked variable annuities (ILVAs).~~

5. The **Longevity Risk (E/A) Subgroup** of the Life Actuarial (A) Task Force and the Life Risk-Based Capital (E) Working Group will:

- A. Provide recommendations for recognizing longevity risk in statutory reserves and/or risk-based capital (RBC), as appropriate.

6. The **Variable Annuities Capital and Reserve (E/A) Subgroup** of the Life Risk-Based Capital (E) Working Group and the Life Actuarial (A) Task Force will:

- A. Monitor the impact of the changes to the variable annuities (VA) reserve framework and RBC calculation and determine if additional revisions need to be made.
- B. Develop and recommend appropriate changes, including those to improve accuracy and clarity of VA capital and reserve requirements.

7. The **Valuation Manual (VM)-22 (A) Subgroup** will:

- A. Recommend requirements, as appropriate, for non-variable (fixed) annuities in the accumulation and payout phases for consideration by the Task Force. Continue working with the Academy on a PBR methodology for non-variable annuities.

NAIC Support Staff: Scott O’Neal/Jennifer Frasier

[SharePoint/NAIC Support Staff Hub/Committee Charges/2023/01_Draft Charges](#)



MEMORANDUM

TO: Dale Bruggeman, Chair of the Statutory Accounting Principles (E) Working Group
Kevin Clark, Vice-Chair of the Statutory Accounting Principles (E) Working Group

FROM: Rachel Hemphill, Chair, Life Actuarial (A) Task Force
Craig Chupp, Vice-Chair, Life Actuarial (A) Task Force

RE: Life Actuarial (A) Task Force Response on Negative IMR

DATE: June 15, 2023

Background

On March 27, 2023 a memorandum from the Statutory Accounting Principles (E) Working Group (SAPWG) was received by the Life Actuarial (A) Task Force (LATF) with a referral for consideration of the Asset Adequacy Testing (AAT) implications of negative IMR. Specifically, the Working Group recommended a referral to the Task Force to consider the following:

1. Development of a template summarizing how IMR (positive and negative) is reflected within AAT.
2. Consideration of the actual amount of negative IMR that is to be used in AAT, noting that as negative IMR is included, there is a greater potential for an AAT liability.
3. Better consideration and documentation of cash flows within AAT, as well as any liquidity stress test considerations.
4. Ensuring that excessive withdrawal considerations are consistent with actual data. (Insurers selling bonds because of excess withdrawals should not use the IMR process.)
5. Ensuring that any guardrails for assumptions in AAT are reasonable and consistent with other financial statement / reserving assumptions.

Recommendation

On its April 27th call, LATF discussed the referral from SAPWG. LATF agreed on the following actions:

Develop IMR Template

LATF is drafting a template with additional disclosures on the reflection of IMR in Principle-Based Reserving (PBR) and AAT. We have requested input from the American Academy of Actuaries and the American Council of Life Insurers on a

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Kansas City 1100 Walnut Street NW, Suite 1500, Kansas City, MO 64106-2197	p 816 842 3600	f 816 783 8175
New York One New York Plaza, Suite 4210, New York, NY 20004	p 212 398 9000	f 212 382 4207

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potential template. The template's disclosures would aim to support verification of the requirements SAPWG is considering for potential admittance of negative IMR, including confirming:

1. That IMR is appropriately allocated for PBR and AAT,
2. That any negative IMR amounts reflected in starting assets do not generate income and so increase reserves in PBR and/or decrease reserve sufficiency in AAT,
3. That admitted negative IMR does not reflect bonds sold due to historical or anticipated future excess withdrawals, and
4. That admitted negative IMR only reflects bonds sold and replaced with similar bonds.

For items three and four above, we note that while LATF can request verification and justification from companies, this may be difficult for companies to demonstrate. For item three, we can require additional disclosures including actual to expected experience for withdrawals. For item four, it is not yet clear what verification companies could provide.

This template would be optional but recommended starting with 2023 reporting and could be required starting in 2025. Individual regulators could request this information during reviews if warranted before 2025.

Issue Guidance on Consistency

LATF is drafting guidance for year-end 2023 and 2024, consistent with the guidance LATF issued for year-end 2022 but updated for SAPWG's potential admittance of some portion of aggregate negative IMR. That is, LATF continues to affirm that a principle-based, reasonable, and appropriate allocation of IMR for PBR and AAT would be consistent with handling of the IMR asset for statutory reporting. LATF will also consider an Amendment Proposal Form to make changes directly in the Valuation Manual to clarify the treatment of negative IMR starting with the 2025 Valuation Manual. This work continues to address the concern raised that there would be a "double hit" if negative IMR were not admitted while being required to be reflected in PBR and/or AAT.

Recommendation to SAPWG Regarding AAT

LATF recommends to SAPWG that any decision to admit or not admit aggregate negative IMR should not rely on AAT at this time. We wish to clarify that AAT is not formulaic, is heavily judgment-based, and generally does not contain prescriptive guardrails on that judgment, such as the reinvestment guardrail and other guardrails that apply in PBR. In response to specific concerns around a lack of consistency in AAT asset assumptions, Actuarial Guideline (AG) 53 was developed to provide regulators with additional disclosures, but again does not contain guardrails. AG 53 review work is currently under way. Moreover, this is not the only area where concerns could arise regarding the reliability of specific AAT results. We do not believe it would be appropriate to admit negative IMR if doing so was depending on AAT as the sole or primary safeguard for any related solvency concerns.

**Optional AOM and PBR Actuarial Report Template IMR
 Supplemental IMR Reporting**
 (All dollar amounts in thousands.)

Company Name:
 NAIC Company Code:
 Valuation Year:

IMR and Relevant Annual Statement Reporting

1 General Account IMR	2 Separate Account IMR	3 RBC	4 General Account Capital and Surplus	5 Admitted negative (disallowed) IMR	6 Comments
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

RBC Flag: Ok
 Capital and Surplus Flag: Ok

IMR and Relevant 9/30 Statement Reporting (to be completed if 9/30 data is used for AAT)

1 General Account IMR	2 Separate Account IMR	3 RBC	4 General Account Capital and Surplus	5 Admitted negative (disallowed) IMR	6 Comments
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

RBC Flag: Ok
 Capital and Surplus Flag: Ok

Reflection of IMR in Asset Adequacy Testing and Principle-Based Reserving

1 Reporting Basis	2 As of Quarter	3 Amount of IMR Allocated	4 Amount of negative (disallowed) IMR Allocated	5 IMR Allocation Basis	6 Included in Starting Assets? (Y/N)	7 Allocated IMR generates future income? (Y/N)	8 Comments
VM-30 (AAT)							
VM-21							
VM-20: Term Reserving Category							
VM-20: ULSG Reserving Category							
VM-20: All Other Reserving Category							

Automatic Verification

AAT IMR Flag: Ok

Admitted negative (disallowed) IMR should not reflect asset sales due to excess withdrawals, either historical excess withdrawals or anticipated future excess withdrawals (where the company anticipates future withdrawals that are "excess" as defined by IMR instructions - above 150% of the prior two years). First, discuss and support with Actual to Expected analysis the level of historical excess withdrawals and anticipated future excess withdrawals. This discussion may be supplemented by other analysis and A/E's, such as for lapse data. Second, please confirm and support that any admitted net negative IMR is not due to asset sales related to excess withdrawals. Note that if the company cannot provide strong support, then the Admitted Negative (disallowed) IMR shall be 0.

(Enter summary here, and attach additional documentation as necessary.)

Admitted negative (disallowed) IMR is limited to IMR generated from losses incurred from the sale of bonds, or other qualifying fixed income investments, that were reported at amortized cost prior to the sale, and for which the proceeds of the sale were immediately used to acquire bonds, or other qualifying fixed income investments, that will be reported at amortized cost. Please confirm and support that any admitted net negative IMR is generated by losses that satisfy that requirement. Note that if the company cannot provide strong support, then the Admitted Negative (disallowed) IMR shall be 0.

(Enter summary here, and attach additional documentation as necessary.)

Draft: 6/28/23

Life Actuarial (A) Task Force
Virtual Meeting
June 1, 2023

The Life Actuarial (A) Task Force met June 1, 2023. The following Task Force members participated: Cassie Brown, Chair, represented by Rachel Hemphill; Scott A. White, Vice Chair, represented by Craig Chupp (VA); Lori K. Wing-Heier represented by Sharon Comstock (AK); Mark Fowler represented by Sanjeev Chaudhuri (AL); Ricardo Lara represented by Ahmad Kamil and Thomas Reedy (CA); Andrew N. Mais represented by Wanchin Chou (CT); Doug Ommen represented by Mike Yanacheak (IA); Dana Popish Severinghaus represented by Vincent Tsang (IL); Amy L. Beard represented by Scott Shover (IN); Vicki Schmidt represented by Nicole Boyd (KS); Grace Arnold represented by Fred Andersen and Ben Slutsker (MN); Chlora Lindley-Myers represented by William Leung (MO); Eric Dunning represented by Michael Muldoon (NE); Marlene Caride represented by Seong-min Eom (NJ); Adrienne A. Harris represented by Bill Carmello (NY); Judith L. French represented by Peter Weber (OH); Glen Mulready represented by Andrew Schallhorn (OK); Michael Humphreys represented by Steve Boston (PA); and Jon Pike represented by Tomasz Serbinowski (UT); Allan L. McVey represented by Tim Sigman (WV).

1. Adopted APF 2023-05

Chupp walked through a series of editorial changes that had been made to amendment proposal form (APF) 2023-05 in response to his comment letter (Attachment A). Hemphill noted that the Task Force still needed to decide on the final minimum index credit hedging error. Brian Bayerle (American Council of Life Insurers – ACLI) noted a preference for a 1% minimum hedging error, further stating that a higher minimum error could penalize companies with a very tight hedging strategy. Weber stated that from his experience reviewing Ohio domiciled companies, he has seen hedging errors very close to zero, making the 1% minimum hedging error a reasonable guardrail. Reedy noted a preference for a 2% minimum guardrail and noted it could be revisited at a later date if warranted. Given the disagreement, Hemphill asked Jennifer Frasier (NAIC) to conduct a straw poll. Frasier conducted the poll, then noted that there was a fairly even mix between members supporting a one percent guardrail and members supporting a two percent guardrail.

Weber made a motion, seconded by Tsang, to adopt APF 2023-05 (Attachment B) with a minimum index credit hedging error of 1.5%. The motion passed unanimously.

2. Adopted 2023-07

Bayerle spoke the ACLI's comment letter (Attachment C) regarding APF 2023-07, noting that the ACLI requests that regulators work closely with any companies that would be impacted by the removal of the Company-Specific Market Path (CSMP) method from VM-21, Requirements for Principle-Based Reserves for Variable Annuities. Hemphill noted that the CSMP method was very infrequently used and that outreach to the affected companies had already begun.

Slutsker made a motion, seconded by Reedy, to adopt APF 2023-07 (Attachment D). During discussion of the motion, Reedy asked to make an editorial adjustment to make the effective date "on or after" January 1st rather than simply "after". Slutsker agreed to modify the motion for the editorial adjustment suggested by Reedy. The motion passed unanimously.

3. Exposed IMR Guidance and APF 2023-08

Hemphill said given that the Statutory Accounting Principles (E) Working Group is considering admitting some portion of negative interest maintenance reserves (IMRs), the Task Force would consider issuing additional temporary guidance effective starting year-end 2023 to ensure that the NAIC's reserve and capital standards are consistent with the IMR accounting treatment. Hemphill also noted that APF 2023-08 had been developed to clarify the IMR treatment consistent with the guidance but could only be effective for the 2025 Valuation Manual at the earliest. Bayerle requested a 45-day exposure period for the IMR guidance and APF 2023-08.

Leung made a motion, seconded by Chou, to expose the IMR Guidance (Attachment Three-E) and APF 2023-08 (Attachment Three-F) for 45-day public comment period. The motion passed unanimously.

4. Heard Update on VM-20 HMI and FMI Rate Development

Marianne Purushotham (Society of Actuaries – SOA) noted that she intended to present a recommended set of historical and future mortality improvement (HMI and FMI) rates for use in VM-20, Requirements for Principle-Based Reserves for Life Products at the June 29th meeting of the Task Force. Purushotham noted that given the continued impacts of the COVID-19 virus and the VM-20 requirements related to HMI and FMI, the group would recommend continuing with the approach that was used last year where the mortality deterioration resulting from COVID-19 would be included in the FMI rates in the initial projection years. Hemphill noted that the Task Force would consider amendments to the Valuation Manual in the future to allow for potential methodology improvements, but that the approach Purushotham laid out made sense. As no Task Force members objected to the approach, Purushotham said that her group would move forward with developing the recommendation.

5. Heard Update on IMR Template Development

Hemphill noted that a template to gather additional information on how companies report IMR was being developed to help address concerns with total company negative IMR balances. Hemphill further stated that the template had been shared with the American Academy of Actuaries (Academy) to receive feedback and would be exposed on an upcoming call.

Having no other business, the Task Force adjourned.

SharePoint/NAIC Support Staff Hub/Member Meetings/A CMTE/LATF/2023-2-Summer/LATF Calls/06 01/June 01 Minutes.docx

Date: May 15, 2023

Virginia is submitting comments regarding the following exposure:

APF 2023-05 (Index Credit Hedging)

Comments:

1. The language should be consistent with the new definition of “index crediting strategies”. The phrase “indexed interest strategies” is used in two places (VM-21 Section 4.A.4.b.i and VM-31 Section 3.F.8.d.x) and should be replaced with “index crediting strategies”.
2. The capitalization should be consistent with VM-01, in that defined terms are not capitalized unless they are proper nouns. Therefore, the three defined terms should not be capitalized in VM-01 or anywhere else in the document.

Thank you for your consideration of these comments.

Craig Chupp, FSA, MAAA
Life and Health Insurance Actuary
Virginia Bureau of Insurance
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Phone: (804) 382-3196

Dates: Received	Reviewed by Staff	Distributed	Considered
3/7/23, 5/5/23, 5/10/23, 5/15/23, 6/1/23	SO		
Notes: APF 2023-05			

**Life Actuarial (A) Task Force/ Health Actuarial (B) Task Force
 Amendment Proposal Form***

1. Identify yourself, your affiliation and a very brief description (title) of the issue.

Identification:

Brian Bayerle, ACLI

Title of the Issue:

Revise hedge modeling language to address index credit hedging.

2. Identify the document, including the date if the document is “released for comment,” and the location in the document where the amendment is proposed:

VM-01, VM-21 Section 4.A.4, VM-21 Section 6.B.3, VM-21 Section 9, VM-21 Section 9.C.2, VM-21 Section 9.E.7, VM-31 Section 3.F.8.d

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January 1, 2023 NAIC Valuation Manual, APF 2020-12

3. Show what changes are needed by providing a red-line version of the original verbiage with deletions and identify the verbiage to be deleted, inserted or changed by providing a red-line (turn on “track changes” in Word®) version of the verbiage. (You may do this through an attachment.)

See attached.

4. State the reason for the proposed amendment? (You may do this through an attachment.)

Index credit hedging is fundamentally different than the dynamic GMxB hedging which formed the conceptual underpinnings for VM-21. For example, the relatively fixed parameters of traditional GMxBs drive the hedging approach. In contrast, indexed products (including RILAs) have flexible crediting parameters which are continually reset based on hedge availability and costs, as well as current market conditions. In short, GMxB contract features drive hedging, while index product hedging drives contract features.

Since the reforms of VM-21 and C3P2, ILVA products have experienced major market growth. Several carriers, with the agreement of regulators and auditors, have interpreted the current VM-21 guidance as permitting the effects of index credit hedging to be reflected in product cash flows instead of within the “best efforts” and “adjusted” scenarios. Both regulators and industry would benefit from the codification of this approach within VM-21.

ACLI’s proposal borrows heavily from the Academy’s draft VM-22. The “error” for index credit hedging is describes as a percentage reduction to hedge payoffs. The percentage reduction must be supported by relevant, credible, and documented experience. A minimum of [1%/2%] is proposed as a regulatory guardrail.

The ACLI proposal would subject index credit hedging to the “clearly defined” documentation requirements of VM-21. Substantively, the change would (a) include index credit hedge purchases with the VM-21 “adjusted” run, and (b) permit index credit hedging to reflect a different, and potentially lower, level of ineffectiveness.

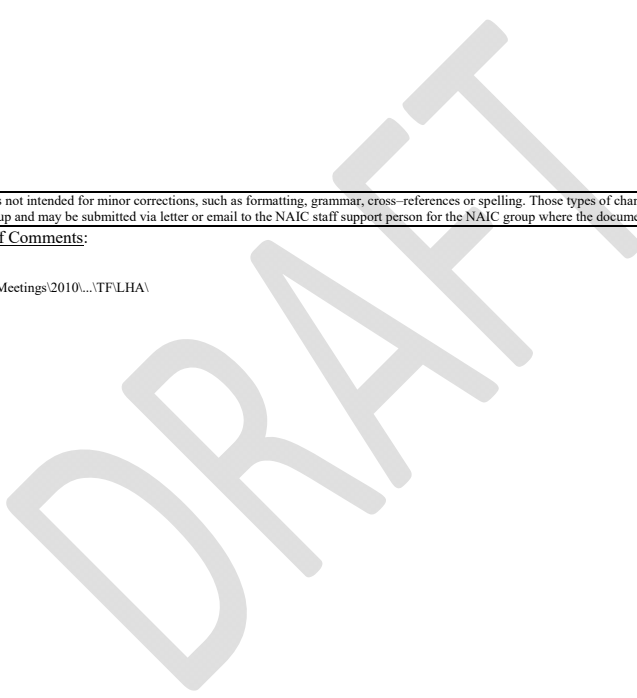
Dates: Received	Reviewed by Staff	Distributed	Considered
3/7/23, 5/5/23, 5/10/23, 5/15/23, 6/1/23	SO		
Notes: APF 2023-05			

ACLI supports aligning the index credit hedging guidance between VM-21 and VM-22. We started with draft VM-22 verbiage in creating this APF. In a few areas, our members have suggested technical improvements to the draft VM-22 definitions. It may be appropriate to carry these over to VM-22.

* This form is not intended for minor corrections, such as formatting, grammar, cross-references or spelling. Those types of changes do not require action by the entire group and may be submitted via letter or email to the NAIC staff support person for the NAIC group where the document originated.

NAIC Staff Comments:

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Dates: Received	Reviewed by Staff	Distributed	Considered
3/7/23, 5/5/23, 5/10/23, 5/15/23, 6/1/23	SO		
Notes: APF 2023-05			

VM-01

The term “iIndex cCredit hHedge mMargin” means a margin capturing the risk of inefficiencies in the company’s hedging program supporting index credits. This includes basis risk, persistency risk, and the risk associated with modeling decisions and simplifications. It also includes any uncertainty of costs associated with managing the hedging program and changes due to investment and management decisions.

The term “iIndex cCredit” means any interest credit, multiplier, factor, bonus, charge reduction, or other enhancement to policy or contract values that is directly linked to one or more indices. Amounts credited to the policy or contract resulting from a floor on an index account are included. An iIndex cCredit may be positive or negative.

The term “iIndex cCrediting sStrategies” means the strategies defined in a contract to determine index credits for a contract. For example, this may refer to underlying index, index parameters, date, timing, performance triggers, and other elements of the crediting method.

VM-21 Section 4.A.4

4. Modeling of Hedges

- a. For a company that does not have a future hedging strategy supporting the contracts:
 - i. The company shall not consider the cash flows from any future hedge purchases or any rebalancing of existing hedge assets in its modeling, since they are not included in the company’s investment strategy supporting the contracts.
 - ii. Existing hedging instruments that are currently held by the company in support of the contracts falling under the scope of these requirements shall be included in the starting assets.
- b. For a company with one or more future hedging strategies supporting the contracts:
 - i. For a future hedging strategy with hedge payoffs that solely offset ~~interest-index~~ credits associated with ~~indexed interest strategies~~index crediting strategies (~~indexed interest~~ credits):
 - a) In modeling cash flows, the company shall include the cash flows from future hedge purchases or any rebalancing of existing hedge assets that are intended solely to offset ~~interest-index~~ credits to contract holders.
 - b) Existing hedging instruments that are currently held by the company for offsetting the ~~indexed~~ credits in support of the contracts falling under the scope of these requirements shall be included in the starting assets.
 - c) An iIndex cCredit hHedge mMargin for these hedge instruments shall be reflected in both the “best efforts” and the “adjusted” runs, as applicable, by reducing index ~~interest credit~~ hedge payoffs by a margin multiple that shall be justified by sufficient and credible company experience and account for model error. It shall be no less than ~~[1%/2%]~~1.5% multiplicatively of the portion of the ~~interest-index~~ credited that is hedged. In the absence of sufficient and credible company experience, a margin of at least 20% shall be assumed. There is no cap on the index credit hedge margin if company experience indicates actual error is greater than ~~these minimums~~[20%].

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Commented [A1]: Replace with "these minimums" as rereading this applies to either 2% or 20% scenarios. Not strictly needed if we are trying to be minimal with edits.

Dates: Received	Reviewed by Staff	Distributed	Considered
3/7/23, 5/5/23, 5/10/23, 5/15/23, 6/1/23	SO		
Notes: APF 2023-05			

- ii. For a company with one or more future hedging strategies supporting the contracts that do not solely offset indexed interest credits, the detailed requirements for the modeling of the hedges are defined in Section 9. The following requirements do not supersede the detailed requirements.
- a) The appropriate costs and benefits of hedging instruments that are currently held by the company in support of the contracts falling under the scope of these requirements shall be included in the projections used in the determination of the SR.
 - b) The projections shall take into account the appropriate costs and benefits of hedge positions expected to be held in the future through the execution of the future hedging strategies supporting the contracts. Because models do not always accurately portray the results of hedge programs, the company shall, through back-testing and other means, assess the accuracy of the hedge modeling. The company shall determine a SR as the weighted average of two CTE values: first, a CTE70 (“best efforts”) representing the company’s projection of all of the hedge cash flows, including future hedge purchases, and a second CTE70 (“adjusted”) which shall use only hedge assets held by the company on the valuation date and only future hedge purchases associated solely with indexed interest credits. These are discussed in greater detail in Section 9. The SR shall be the weighted average of the two CTE70 values, where the weights reflect the error factor determined following the guidance of Section 9.C.4.
 - c) The company is responsible for verifying compliance with all requirements in Section 9 for all hedging instruments included in the projections.
 - d) The use of products not falling under the scope of these requirements (e.g., equity-indexed annuities) as a hedge shall not be recognized in the determination of accumulated deficiencies.
- iii. If a company has a more comprehensive hedge strategy combining index credits with guaranteed benefit and/or other risks (e.g., full fair value or economic hedging), no portion of this hedge strategy is eligible for the treatment described in section 4.A.4.b.ian appropriate and documented bifurcation method should be used in the application of sections 4.A.4.b.i and 4.A.4.b.ii above for the hedge modeling and justification. Such bifurcation methods may quantify the specific risk exposure attributable to index credit liabilities versus other liabilities such as guaranteed living benefits, and apply such for the basis for allocation.

Commented [A2]: Until industry can provide quantitative evidence on historical hedging errors as a percent of interest credited, suggest no allowing bifurcation.

VM-21 Section 6.B.3 Footnote

¹ Throughout this Section 6, references to CTE70 (adjusted) shall also mean the SR for a company that does not have a future hedging strategy supporting the contracts that does not solely offset index credits as discussed in Section 4.A.4.a.

Dates: Received	Reviewed by Staff	Distributed	Considered
3/7/23, 5/5/23, 5/10/23, 5/15/23, 6/1/23	SO		
Notes: APF 2023-05			

VM-21 Section 9

Section 9: Modeling Hedges under a Future Non-Index Credit Hedging Strategy

A. Initial Considerations

1. ~~This section applies to modeling of hedges other than situations where the company only hedges index credits. If the company clearly separates index credit hedging from other hedging, then this section only applies to the other hedging if the index hedging follows the requirements in Section 4.A.4.b.i. If the company does not clearly separate index credit hedging from other hedging, then this section is applicable for modeling of all hedges.~~

Commented [A3]: Delete

2. Subject to Section 9.C.2, the appropriate costs and benefits of hedging instruments that are currently held by the company in support of the contracts falling under the scope of these requirements shall be included in the calculation of the SR, determined in accordance with Section 3.D and Section 4.D.

(Subsequent sections to be renumbered)

VM-21 Section 9.C.2

2. The company shall calculate a CTE70 (adjusted) by recalculating the CTE70 assuming the company has no future hedging strategies supporting the contracts except hedge purchases solely related to strategies to hedge index credits, therefore following the requirements of Section 4.A.4.a and 4.A.4.b.i.

However, for a company with a future hedging strategy supporting the contracts, existing hedging instruments, except hedging instruments solely related to strategies to hedge index credits, that are currently held by the company in support of the contracts falling under the scope of these requirements may be considered in one of two ways for the CTE70 (adjusted):

- a) Include the asset cash flows from any contractual payments and maturity values in the projection model.
- b) No hedge positions, in which case, the hedge positions held on the valuation date are replaced with cash and/or other general account assets in an amount equal to the aggregate market value of these hedge positions.

VM-21 Section 9.E.7

7. The company may also consider historical experience for similar current or past hedging programs on similar products to support the error factor or Index Credit Hedge Margin determined for the projection.

Commented [A4]: Expanding provision for index credit hedging, noting that the index credit adjustment is described as the Index Credit Hedge Margin, not the error factor.

Dates: Received	Reviewed by Staff	Distributed	Considered
3/7/23, 5/5/23, 5/10/23, 5/15/23, 6/1/23	SO		
Notes: APF 2023-05			

VM-31 Section 3.F.8.d.x (new subsection)

- x. Justification for the margin for any future hedging strategy that offsets ~~interest index credits~~ associated with ~~indexed interest strategies~~ index crediting strategies (indexed interest credits), including relevant experience, other relevant analysis, and an assessment of potential model error

Commented [A5]: Modify to "index credits" to be consistent throughout the draft and the additional definition.
- xi. ~~Ten~~ years of historical experience on hedge gains/losses as a percent of index credited for hedge programs supporting index credits.

Commented [A6]: VM-31 requirement for historical experience to support error factor.
- xii. ~~If there is less than five years of historical experience of this hedging program or a hedging program on similar products, an explanation of how the company considered increases in the error factor to account for limited historical experience.~~

Commented [A7]: Explanation for how margin was increased if there was less than 5 years of experience.
- ~~x. The method used to bifurcate comprehensive hedge strategies (i.e., strategies combining index credits, guaranteed benefit, and other risks (e.g., full fair value or economic hedging), per section 4.A.4.b.iii.~~

Commented [A8]: Only include if bifurcation is allowed

DRAFT



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May 24, 2023

Rachel Hemphill
Chair, NAIC Life Actuarial (A) Task Force (LATF)

Re: APF 2023-07 (CSMP Removal)

Dear Chair Hemphill:

The American Council of Life Insurers (ACLI) appreciates the opportunity to comment on APF 2023-07 on the removal of the Company-Specific Market Path (CSMP) approach for calculating standard projection amount in VM-21.

This APF may have a significant impact on the companies considering or using the CSMP methodology. To mitigate any problems that may arise, we ask that regulators work directly with the impacted companies throughout this process and give them adequate time to make the necessary changes to their systems and processes.

Thank you very much for your consideration of our comments and we are looking forward to continued engagement with regulators on this topic.

Sincerely,

A handwritten signature in dark ink, appearing to read 'B Bayerle', written in a cursive style.

A handwritten signature in dark ink, appearing to read 'Colin Masterson', written in a cursive style.

cc: Scott O'Neal, NAIC

American Council of Life Insurers | 101 Constitution Ave, NW, Suite 700 | Washington, DC 20001-2133

The American Council of Life Insurers (ACLI) is the leading trade association driving public policy and advocacy on behalf of the life insurance industry. 90 million American families rely on the life insurance industry for financial protection and retirement security. ACLI's member companies are dedicated to protecting consumers' financial wellbeing through life insurance, annuities, retirement plans, long-term care insurance, disability income insurance, reinsurance, and dental, vision and other supplemental benefits. ACLI's 280 member companies represent 94 percent of industry assets in the United States.

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**Life Actuarial (A) Task Force/ Health Actuarial (B) Task Force
Amendment Proposal Form***

1. Identify yourself, your affiliation and a very brief description (title) of the issue.

Identification:

California Office of Principles-Based Reserving and Minnesota Department of Commerce

Title of the Issue:

Company-Specific Market Path (CSMP) Removal

2. Identify the document, including the date if the document is “released for comment,” and the location in the document where the amendment is proposed:

VM-21 Section 6.A.1

January 1, 2024 NAIC *Valuation Manual*

3. Show what changes are needed by providing a red-line version of the original verbiage with deletions and identify the verbiage to be deleted, inserted or changed by providing a red-line (turn on “track changes” in Word®) version of the verbiage. (You may do this through an attachment.)

See attached.

4. State the reason for the proposed amendment? (You may do this through an attachment.)

The standard projection amount drafting group found that there is very little use of the CSMP method for the VM-21 standard projection amount. Therefore, we recommend removing this method from VM-21 starting in 2025, which gives time to transition to the CTEPA method for the few companies that currently employ the CSMP method.

* This form is not intended for minor corrections, such as formatting, grammar, cross-references or spelling. Those types of changes do not require action by the entire group and may be submitted via letter or email to the NAIC staff support person for the NAIC group where the document originated.

NAIC Staff Comments:

Dates: Received	Reviewed by Staff	Distributed	Considered
5/1/2023, 6/1/2023	SO		
Notes: APF 2023-07			

VM-21 Section 6: Requirements for the Additional Standard Projection Amount

A. Overview

1. Determining the Additional Standard Projection Amount

- a. For valuation dates before January 1, 2025, the additional standard projection amount shall be the larger of zero and an amount determined in aggregate for all contracts falling under the scope of these requirements, excluding those contracts to which the Alternative Methodology is applied, by calculating the Prescribed Projections Amount by one of two methods, the Company-Specific Market Path (CSMP) method or the CTE with Prescribed Assumptions (CTEPA) method. The company shall assess the impact of aggregation on the additional standard projection amount.
- ~~a.~~ b. For valuation dates on or after January 1, 2025, the additional standard projection amount shall be the larger of zero and an amount determined in aggregate for all contracts falling under the scope of these requirements, excluding those contracts to which the Alternative Methodology is applied, by calculating the Prescribed Projections Amount by the CTEPA method. The company shall assess the impact of aggregation on the additional standard projection amount.
- ~~b.~~ c. The additional standard projection amount shall be calculated based on the scenario reserves, as discussed in Section 4.B, with certain prescribed assumptions replacing the company prudent estimate assumptions. As is the case in the projection of a scenario in the calculation of the SR, the scenario reserves used to calculate the additional standard projection amount are based on an analysis of asset and liability cash flows produced along certain equity and interest rate scenario paths.

August XX, 2023

To: Members of the Life Actuarial (A) Task Force

From: NAIC Staff

RE: Guidance on Allocating Negative IMR (PIMR) In VM-20, VM-21, and VM-30

Executive Summary

While the potential admittance of some portion of negative Interest Maintenance Reserve (IMR) is being considered by the Statutory Accounting Practices (E) Working Group (SAPWG), continued guidance on the proper practice for allocating IMR for principles-based reserving (PBR) and asset adequacy testing purposes may be helpful for companies in the near term.

Background

LATF issued guidance on November 17, 2022 (Attachment A) on allocating negative IMR (PIMR) in VM-20, VM-30, VM-31. Since then, SAPWG has continued to discuss the potential admittance of some portion of negative IMR. In light of these ongoing discussions, continued guidance is needed to ensure consistent treatment for negative IMR in PBR and asset adequacy testing. Due to the timing of Valuation Manual updates, the earliest that such guidance can practically be added to the Valuation Manual is for year-end 2025. Therefore, LATF is issuing additional guidance for 2023 and 2024.

Recommendation

In order to assist state regulators and companies in achieving uniform outcomes for year-end 2023 and 2024, we have the following recommendation: the allocation of IMR in VM-20, VM-21, and VM-30 should be principle-based, “appropriate”, and “reasonable”. Companies are not required to allocate any non-admitted portion of IMR (or PIMR, as applicable) for purposes of VM-20, VM-21, and VM-30, as being consistent with the asset handling for the non-admitted portion of IMR would be part of a principle-based, reasonable and appropriate allocation. However, any portion of negative IMR that is an admitted asset, should be allocated for purposes of VM-20, VM-21, and VM-30, as again a principle-based, reasonable and appropriate IMR allocation would be consistent with the handling of the IMR asset.

This recommended guidance is for year-end 2023 and 2024, to address the current uncertainty and concerns with the “double-counting” of losses. This recommended guidance will help ensure consistency between states and between life insurers in this volatile rate environment. This guidance is expected to be incorporated in the 2025 Valuation Manual.

Attachment A

November 17, 2022

To: Members of the Life Actuarial (A) Task Force

From: NAIC Staff

RE: Guidance on Allocating Negative IMR (PIMR) In VM-20, VM-21, and VM-30

Executive Summary

With the rapidly rising interest rate environment, companies selling fixed income assets for a loss are seeing their Interest Maintenance Reserve (IMR) balances decrease or even become negative. Current statutory accounting treatment makes negative IMR a non-admitted asset. While a longer-term evaluation of IMR is being considered by the Statutory Accounting Practices (E) Working Group (SAPWG), additional guidance on the proper practice for allocating IMR for Asset Adequacy Testing and Principle-based Reserving purposes may be helpful for companies in the near term.

Background

The letter to SAPWG from the American Council of Life Insurers (ACLI) (Attachment 1) notes that "...with the inclusion of a negative IMR balance in asset adequacy testing, the disallowance of a negative IMR can result in double counting of losses (i.e., through the disallowance on the balance sheet and the potential AAT-related reserve deficiency)." There are several sections of the Valuation Manual and RBC instructions where IMR is referenced in the letter. Some of these references contemplate allocating negative IMR (or pre-tax IMR (PIMR), as applicable) at the level of business that is being analyzed/reserved for. However, these references do not detail what to do when the total company IMR balance is negative – and therefore a non-admitted asset under current statutory guidance.

Other references do provide additional insight as to the allocation of IMR when the total company balance is negative/disallowable. VM-20 Section 7.D.7.b notes that "...the company shall use a reasonable approach to allocate any portion of the total company balance that is disallowable under statutory accounting procedures (i.e., when the total company balance is an asset rather than a liability)." Question 22 of the AAA's Asset Adequacy Practice Note (Attachment 2) states that "... a negative IMR is not an admitted asset in the annual statement. So, some actuaries do not reflect a negative value of IMR in the liabilities used for asset adequacy analysis." However, Question 22 also notes a 2012 survey data that showed varying practices across companies, including some companies that allocated negative IMR.

Recommendation

In order to assist state regulators and companies in achieving uniform outcomes for year-end 2022, we have the following recommendation: the allocation of IMR in VM-20, VM-21, and VM-30 should be principle-based, "appropriate", and "reasonable". Companies are not required to allocate any non-admitted portion of IMR (or PIMR, as applicable) for purposes of VM-20, VM-21, and VM-30, as being consistent with the asset handling for the non-admitted portion of IMR would be part of a principle-based, reasonable and appropriate allocation. However, if a company was granted a permitted practice to admit negative IMR as an asset, the company should allocate the formerly non-admitted portion of negative IMR, as again a principle-based, reasonable and appropriate IMR allocation would be consistent with the handling of the IMR asset. This recommended guidance is for year-end 2022, to address the current uncertainty and concerns with the "double-counting" of losses. This recommended guidance will help ensure consistency between states and between life insurers in this volatile rate environment. Refinement of this guidance may be considered beyond year-end 2022.

Attachment 1

**Mike Monahan**

Senior Director, Accounting Policy

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Senior Vice President, Chief Actuary

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October 31, 2022

Mr. Dale Bruggeman, Chairman
Statutory Accounting Principles Working Group
National Association of Insurance Commissioners
1100 Walnut Street, Suite 1500
Kansas City, MO 64106-2197

Dear Mr. Bruggeman:

Re: Proposal for the NAIC to Fulfill the Original Intent of the Interest Maintenance Reserve

The American Council of Life Insurers (ACLI) would like to request urgent action on an issue that was never fully resolved by the NAIC and has become a pressing matter for the industry due to the rapid rise in interest rates—the allowance of a net negative Interest Maintenance Reserve (IMR) balance.

The ACLI proposes the allowance of a negative IMR balance in statutory accounting. Negative IMR balances are expected to become more prevalent in a higher interest rate environment and their continued disallowance will only serve to project misleading optics on insurers' financial strength (e.g. inappropriate perception of decreased financial strength through lower surplus and risk-based capital even though higher rates are favorable to an insurer's financial health) while creating uneconomic incentives for asset-liability management (e.g. discourage prudent investment transactions that are necessary to avoid mismatches between assets and liabilities just to avoid negative IMR).

ACLI believes the necessary changes can be implemented quickly and with minimal changes to the annual statement reporting instructions.

American Council of Life Insurers | 101 Constitution Ave, NW, Suite 700 | Washington, DC 20001-2133

The American Council of Life Insurers (ACLI) is the leading trade association driving public policy and advocacy on behalf of the life insurance industry. 90 million American families rely on the life insurance industry for financial protection and retirement security. ACLI's member companies are dedicated to protecting consumers' financial wellbeing through life insurance, annuities, retirement plans, long-term care insurance, disability income insurance, reinsurance, and dental, vision and other supplemental benefits. ACLI's 280 member companies represent 94 percent of industry assets in the United States.

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The remainder of this letter expands upon these points.

Historical Context and Background

The IMR, first effective in statutory accounting in 1992, requires that a realized fixed income gain or loss, attributable to changes in interest rates (but not gains or losses that are credit related), be amortized into income over the remaining term to maturity of the fixed income investments (and related hedging programs) sold rather than being reflected in income immediately.

Since statutory accounting practices for life insurance companies are the primary determinant of obtaining an accurate picture for assessing solvency, it was imperative that the accounting practices be consistent for assets, liabilities, and income and that they be reported on a financially consistent basis. If assets and liabilities were not reported on a financially consistent basis, then the financial statements would not be useful in determining an accurate assessment of solvency or whether there were sufficient assets to pay contractual obligations when they become due.

Amortized cost valuation of fixed income investments reflects the outlook at the time of purchase and amortization reflects the yields available at time of purchase. Policy reserve liabilities are established at the same time, and the interest rate assumptions are consistent with the yields at that time. But if fixed income investments are sold, with the proceeds reinvested in new fixed income investments, a new amortization schedule is established which may be based on an entirely different yield environment, which may be inconsistent with the reserve liabilities when they were established.

IMR was created to prevent the timing of the realization of gains or losses on fixed income investments, related to interest rates changes, to affect the immediate financial performance of the insurance company. This recognized that the gains and losses were transitory without any true economic substance since the proceeds would be reinvested at offsetting lower or higher interest rates.

For example, without the IMR, if a company sold all bonds in a declining interest environment (e.g., from 4% to 2%), and reinvested in new bonds, surplus would increase through significant realized gains. The increased surplus would inappropriately reflect increased financial strength that is illusory, due to a now lower yielding portfolio, as there would be no change to the income needed to support the liabilities.

Likewise, if a company sold all bonds in an increasing interest rate environment (e.g., from 2% to 4%), and reinvested in new bonds, surplus would decrease through significant realized losses. The decreased surplus would inappropriately reflect decreased financial strength that is similarly illusory due to the reinvestment at higher yields relative to when the bonds were originally purchased.

A net negative IMR is currently disallowed in statutory accounting. This handling is contrary to its original intent which recognized that interest related gains and losses are both transitory without any true economic substance since the proceeds would be reinvested at offsetting lower or higher interest rates, respectively. See attachment I to this letter that illustrates the financially consistent

treatment of assets, liabilities, and income and how IMR is needed to achieve that objective for both realized gains and losses.

That IMR should conceptually apply to both realized gains and losses was recognized by the NAIC during and after IMR development. The below is a quote from a 2002 report by the NAIC AVR/IMR Working Group to the E-Committee:

*“The basic rationale for the IMR would conclude that neither a maximum nor a minimum is appropriate. If the liability values are based on the assumption that the assets were purchased at about the same time as the liabilities were established, then there should be no bounds to the reserve which corrects for departures from that assumption; **if a company has to set up a large reserve because of trading gains, it is in no worse position that if it had held the original assets. As for negative values of the IMR, the same rationale applies. However, the concept of a negative reserve in the aggregate has not been adopted.**”*

While realized losses can offset realized gains in IMR, the IMR instructions require the disallowance of a net negative IMR balance (e.g., as noted in the last sentence of the aforementioned quote). See attachment II to this letter, which includes the pertinent IMR instructions where negative IMR balances are currently disallowed and in need of amendment.

When IMR was originally developed, it was intended to achieve its purpose in both a declining and rising interest rate environment. The originally adopted disallowed status of a negative IMR was expected to be addressed in subsequent years. However, over time with the persistent declining interest rates, the issue lost urgency since a negative IMR would not have been a significant issue for any company. The NAIC AVR/IMR Working Group ultimately disbanded without ever addressing this longstanding item on their agenda.

With a rising interest rate environment, it is important that the allowance of a negative IMR be addressed to fulfill its original purpose. In general, rising interest rates are favorable to the financial health of the insurance industry as well as for policyowners.

Without a change, the rising interest rate environment will give the inappropriate perception of decreased financial strength through lower surplus and risk-based capital and worse, create incentives for insurance companies to take action, or not take actions, to prevent uneconomic surplus impacts where the actions (or lack thereof) themselves may be economically detrimental.

Symmetrical treatment of a negative IMR (i.e., the allowance of a negative IMR balance) would appropriately not change surplus as a sale and reinvestment would not affect the underlying insurance company liquidity, solvency, or claims paying ability, just like with a positive IMR. See attachment III to this letter that illustrates that the sale of a fixed income investment, and reinvestment in a new fixed income investment, has no bearing on a life insurance company's liquidity, solvency, or claims paying ability.

As it was initially recognized by the NAIC that IMR should apply to both gains and losses, adequate safeguards were already built into the IMR instructions for asset adequacy, risk-based capital, and troubled companies.

Negative IMR – Reserve Adequacy and Risk-Based Capital

When IMR was developed, it was anticipated that a negative IMR balance would be reflected in asset adequacy analysis. This inclusion ensures that the assets, with the appropriate allocation from the IMR (whether negative or positive), would be adequate to fund future benefit obligations and related expenses of the company.

From the standpoint of reserve adequacy, the inclusion of a negative IMR balance appropriately reduces the investment income in asset adequacy testing. Without the inclusion of negative IMR, reserve inadequacies would potentially not be recognized.

Further, with the inclusion of a negative IMR balance in asset adequacy testing, the disallowance of a negative IMR can result in double counting of losses (i.e., through the disallowance on the balance sheet and the potential AAT-related reserve deficiency). The Actuarial Opinion that covers asset adequacy analysis requires the appropriate assessment of negative IMR in its analysis.

If a negative IMR balance is used in the asset adequacy analysis, its allowance is appropriate. Likewise, if only a portion of a company's negative IMR balance is reflected in the asset adequacy analysis, only the allowance for that portion of the negative IMR balance reflected is appropriate. If a negative IMR balance is disallowed, it would be inappropriate to include in asset adequacy analysis. It is imperative there is symmetry between both reserving and accounting considerations, and there is already precedent in the asset adequacy analyses for inclusion of IMR.

Below are the current references to IMR in the valuation manual and risk-based capital calculations.

Regulation	Use	IMR references
Actuarial Opinion and Memorandum Regulation (VM-30)	Asset adequacy analysis for annual reserve opinion	An appropriate allocation of assets in the amount of the IMR, whether positive or negative, shall be used in any asset adequacy analysis.
Life principle-based reserves (VM-20)	Calculation of deterministic reserve	Calculate the deterministic reserve equal to the actuarial present value of benefits, expenses, and related amounts less the actuarial present value of premiums and related amounts, less the positive or negative pre-tax IMR balance at the valuation date allocated to the group of one or more policies being modeled
Life principle-based reserves (VM-20)	Calculation of stochastic reserve	Add the CTE amount (D) plus any additional amount (E) less the positive or negative pre-tax IMR balance allocated to the group of one or more policies being modeled
Variable annuities principle-based reserves (VM-21)	Reserving for variable annuities	The IMR shall be handled consistently with the treatment in the company's cash-flow testing, and the amounts should be adjusted to a pre-tax basis.
C3 Phase 1 (Interest rate risk capital)	RBC for fixed annuities and single premium life	IMR assets should be used for C3 modeling.

Additional IMR Safeguards

The IMR instructions do provide additional safeguards in situations where it would be appropriate to recognize interest-rate related gains and losses immediately rather than be included in the IMR.

They were established to prevent situations where the liability the IMR supports, no longer exists. Examples noted in the annual statement instructions include:

- Major book-value withdrawals or increases in policy loans occurring at a time of elevated interest rates.
- Major book value withdrawals resulting from a “run on the bank” due to adverse publicity.

As a result, the IMR instructions include an IMR Exclusion whereby all gains or losses which arise from the sale of investments related to “Excess Withdrawal Activity” are to be excluded from IMR and reflected in net income. In short, Excess Withdrawal Activity is defined as 150% of the product of the lower of the withdrawal rate in the preceding or in the next preceding year calendar year times the withdrawal reserves at the beginning of the year.

Summary

With a rising interest rate environment, it is important that the allowance of a negative IMR be addressed to fulfill its original purpose. In general, rising interest rates are favorable to the financial health of the insurance industry as well as for policyowners. Without a change, the rising interest rate environment will give the inappropriate perception of decreased financial strength through lower surplus and risk-based capital.

The inability to recognize negative IMR could also impact the rating agency view of the industry, or worse, incentivize companies to avoid prudent investment transactions that are necessary to avoid mismatches between assets and liabilities. Furthermore, there are adequate safeguards in place to ensure that allowing a negative IMR does not cause any unrecognized reserve or capital inadequacies or any overstatement of claims paying ability.

Current statutory accounting guidance creates two equally objectionable alternatives for insurers and their policyowners. Following the current statutory guidance will improperly reflect financial strength through understating surplus, so additional surplus may need to be retained. Alternatively, one could take steps to manage the current situation by limiting trading of fixed income investments and related hedging programs, which would diminish significant economic value for policyowners, as well as create a mismatch between assets and liabilities.

Both scenarios encourage short-term non-economic activity not in the best long-term interest of the insurance company’s financial health or its policyowners. For insurers with diminishing IMR balances due to the rapid increase in interest rates, this dilemma is either here or fast approaching and can only be resolved now with certainty of the appropriate treatment of IMR by the NAIC.

The ACLI looks forward to urgently working with the NAIC toward fulfilling the original intent of IMR. It is imperative that insurers receive relief for year-end 2022.

If you have any questions regarding this letter, please do not hesitate to contact us.

Sincerely,

A handwritten signature in cursive script that reads "Monahan".

Mike Monahan
Senior Director, Accounting Policy

A handwritten signature in cursive script that reads "Paul A. Dunham" followed by a stylized monogram.

Paul Graham
Senior Vice President, Chief Actuary

Attachment I

Simplified Example – Need for Reporting Assets, Liabilities, and Income on a Consistent Basis:

- This example shows the appropriate interrelationship of IMR on assets, reserve liabilities, and income.
- Assume a bond is held with the following characteristics:
 - Par Value: \$1,000
 - Coupon: 3%
 - Term-to-maturity: 10 years
- Assume the bond is then sold at “time zero” and the proceeds are immediately reinvested in a bond with the same characteristics (e.g., term-to maturity, credit quality, coupon equivalent to market rate, etc.).
- Assume a simplified example with no existing IMR balance, where the bond supports a fixed insurance liability with the same duration as the original bond, as well as a present value of \$1,000.

Table 1: Market Interest Rate Scenario			
	Same	Lower	Higher
Market interest rate	3%	2%	4%
Bond’s market value	\$1,000	\$1,090	\$919
Realized gain/(loss) if sold	\$0	\$90	(\$81)*

Realized gain/(loss) deferred to balance sheet IMR and amortized into income over remaining life of bond sold (i.e., 10 years).

Table 2: Statutory Investment Income			
IMR amortization	\$0	\$9	(\$8)
Interest income on new bond	\$30	\$21	\$38
Total annual stat income	\$30	\$30	\$30

On average, future income is approximately the same in each interest rate scenario as the IMR gets reduced through amortization to income.

Table 3: Statutory Balance Sheet			
Balance Sheet Bonds	\$1,000	\$1,090	\$919
IMR	\$0	(\$90)	\$0*
Stat assets net of IMR	\$1,000	\$1,000	\$919*
Reserves	\$1,000	\$1,000	\$1,000
Surplus	\$0	\$0	(\$81)*

Even though the sale of the bond (and subsequent reinvestment) is non-economic, and the same income is being produced to support the liability, a negative surplus position makes it appear there is now a deficiency. Allowing the negative IMR appropriately would show no surplus impact, as is shown when a gain occurs, as there is no change in reported reserve liabilities. Appropriately consistent financial results require the allowance of negative IMR

***The negative IMR balance is currently disallowed and directly reduces surplus. This treatment is not supported by theoretical rationale and gives a distorted view of solvency.**

Attachment II

Pertinent Annual Statement Instructions

Line 6 – Reserve as of December 31, Current Year

Record any positive or allowable negative balance in the liability line captioned “Interest Maintenance Reserve” on Page 3, Line 9.4 of the General Account Statement and Line 3 of the Separate Accounts Statement. A negative IMR balance may be recorded as a negative liability in either the General Account or the Separate Accounts Statement of a company only to the extent that it is covered or offset by a positive IMR liability in the other statement.

If there is any disallowed negative IMR balance in the General Account Statement, include the change in the disallowed portion in Page 4, Line 41 so that the change will be appropriately charged or credited to the Capital and Surplus Account on Page 4. If there is any disallowed negative IMR balance in the Separate Accounts Statement, determine the change in the disallowed portion (prior year less current year disallowed portions), and make a direct charge or credit to the surplus account for the “Change in Disallowed Interest Maintenance Reserve” in the write -in line, in the Surplus Account on Page 4 of the Separate Accounts Statement.

The following information is presented to assist in determining the proper accounting:

General Account IMR Balance	Separate Account IMR Balance	Net IMR Balance
Positive	Positive	Positive (see rule a)
Negative	Negative	Negative (see rule b)
Positive	Negative	Positive (see rule c)
Positive	Negative	Negative (see rule d)
Negative	Positive	Positive (see rule e)
Negative	Positive	Negative (see rule f)

Rules:

- a. If both balances are positive, then report each as a liability in its respective statement.
- b. If both balances are negative, then no portion of the negative balances is allowable as a negative liability in either statement. Report a zero for the IMR liability in each statement and follow the above instructions for handling disallowed negative IMR balances in each statement.
- c. If the general account balance is positive, the separate accounts balance is negative and the combined net balance is positive, then all of the negative IMR balance is allowable as a negative liability in the Separate Accounts Statement.
- d. If the general account balance is positive, the separate account balance is negative, and the combined net balance is negative, then the negative amount not covered by the positive amount is not allowable. Report only the allowable portion as a negative liability in the Separate Accounts Statement and follow the above instructions for handling the disallowed portion of negative IMR balances in the Separate Accounts Statement.
- e. If the general account balance is negative, the separate account balance is positive, and the combined net balance is positive, then all of the negative IMR balance is allowable as a negative liability in the General Account Statement.
- f. If the general account balance is negative, the separate account balance is positive, and the combined net balance is negative, then the negative amount not covered by the positive amount is not allowable. Report only the allowable portion as a negative liability in the General Account Statement and follow the above instructions for handling the disallowed portion of negative IMR balances in the General Account Statement.

Attachment III

IMR Illustration – Liquidity, Solvency and Claims Paying Ability

Essentially, a negative IMR balance from an individual trade represents the present value of the future positive interest rate differential, from the new investment compared to the old investment, that puts one in the same economic position, when compared to before the trade, including total liquid assets available to pay claims.

This phenomenon can be illustrated in the following table where a 10-year bond is sold, one year after purchase, and immediately reinvested in another 10-year bond with equivalent credit quality in an interest rate environment where market interest rates increased from 2% to 4% in the intervening year.

	Coupon Rate of Bond	Market Interest Rate @ Purchase	Par Value of Bond	Fair Value @ Purchase	Fair Value @ Time of Sale	Loss on Sale	Claims Paying Liquidity
Old Bond	2%	2%	100	100	85.13	14.87	85.13
New Bond	4%	4%	85.13	85.13	85.13	N/A	85.13

The short-term acceleration of negative IMR to surplus (e.g., its disallowance) is strictly a timing issue and not a true loss of financial strength or claims paying liquidity, but it does present a temporary and inappropriate optics issue in surplus/financial strength until the IMR is fully amortized.

This phenomenon can further be illustrated by comparing two separate hypothetical companies. Assume Company A and B both have the exact same balance sheets. Then assume Company A keeps the old bond and Company B affects the trade mentioned above.

With the disallowance of a negative IMR balance, Company B now has a balance sheet that shows a relative decline of financial strength of \$14.87. This weakened balance sheet contrasts with both the principle behind the development of IMR, the relative actual economic financial strength, and claims paying ability of the two entities.

There is no difference in balance sheet economics of the two entities. The negative IMR balance for Company B essentially represents the difference between cost and fair value of the investment sold, that is already embedded on Company A's balance sheet based on the existing interest rate environment. The negative IMR balance should be recognized as there is no change in economics pre and post trade (or in this instance between Company A and Company B) which is consistent with the overall principle behind IMR.

Attachment 2

Some actuaries test the option risk in assets (e.g., calls) by assuming an immediate drop in the discount rate used in the GPV. The drop test is often set as severe as needed to represent a drop in earned rate that would occur if all options were exercised.

Q22. The AOMR states that the interest maintenance reserve (IMR) should be used in asset adequacy analysis. Why?

The IMR is part of the total reported statutory reserves. The IMR typically defers recognition of the portion of realized capital gains and losses resulting from changes in the general level of interest rates. These gains and losses are amortized into investment income over the expected remaining life of the investments sold, rather than being recognized immediately. This amortization is after tax.

The purpose of the IMR usually is to maintain the original matching between assets and liabilities that might be weakened by the sale of an asset. Originally, it was anticipated that the IMR would be allowed to become negative, as long as the asset adequacy analysis showed that the total statutory reserves, including the negative IMR, were sufficient to cover the liabilities. However, a negative IMR is not an admitted asset in the annual statement. So, some actuaries do not reflect a negative value of IMR in the liabilities used for asset adequacy analysis.

In the 2012 survey of appointed actuaries, more than 80 percent of the respondents indicated they include the IMR in their testing. Some actuaries use a starting IMR of zero if IMR is negative. Other actuaries use negative IMR to adjust starting assets and therefore model future lower asset yields than if zero IMR were assumed. Half of the respondents who indicated they used IMR in testing also indicated they lower assets by the absolute value of a negative IMR balance; the other half indicated they use a value of zero for the starting IMR if it is negative at the beginning of the projection period. There is no prohibition regarding the use of negative IMR within asset adequacy analysis. So, a number of actuaries allow the IMR to fall below zero within the testing period. About 60 percent of actuaries responding to the survey indicated they do not have to deal with a negative IMR.

Q23. How does the actuary determine which portion of the IMR can be used to support certain products? How is the portion of the IMR used?

If the actuary allocates the assets and IMR by line, then one possible approach is line of business-level inclusion of starting assets in the amount of the unamortized portion of the IMR relating to those assets that were owned by the line prior to being sold. Another possible approach is the allocation of company-level IMR proportionately to starting assets. An advantage of this second approach is that it is generally simpler, while a disadvantage is that longer liabilities probably have longer assets, which usually produce higher capital gains when sold, after a given drop in interest rates, than shorter assets do,

**Life Actuarial (A) Task Force/ Health Actuarial (B) Task Force
 Amendment Proposal Form***

1. Identify yourself, your affiliation and a very brief description (title) of the issue.

Identification:

Rachel Hemphill, FSA, FCAS, MAAA, Ph.D.

Title of the Issue:

Clarifying guidance for allocation of negative IMR.

2. Identify the document, including the date if the document is “released for comment,” and the location in the document where the amendment is proposed:

VM- 20 Section 7.D.7, VM-30 Section 3.B.5

January 1, 2023 NAIC Valuation Manual

3. Show what changes are needed by providing a red-line version of the original verbiage with deletions and identify the verbiage to be deleted, inserted or changed by providing a red-line (turn on “track changes” in Word®) version of the verbiage. (You may do this through an attachment.)

See attached.

4. State the reason for the proposed amendment? (You may do this through an attachment.)

Clarify allocation of negative IMR for VM-20 and VM-30; in particular, non-admitted IMR is excluded. Note that VM-21 Section 4.A.7 currently requires a treatment consistent with VM-30, and so additional guidance is not needed for VM-21.

* This form is not intended for minor corrections, such as formatting, grammar, cross–references or spelling. Those types of changes do not require action by the entire group and may be submitted via letter or email to the NAIC staff support person for the NAIC group where the document originated.

NAIC Staff Comments:

Dates: Received	Reviewed by Staff	Distributed	Considered
<u>05/22/23</u>	<u>SO</u>		
Notes: <u>APF 2023-08</u>			

VM-20 7.D.7

7. Under Section 7.D.1, any PIMR balance allocated to the group of one or more policies being modeled at the projection start date is included when determining the amount of starting assets and is then subtracted out, under Section 4 and Section 5, as the final step in calculating the modeled reserves. The determination of the PIMR allocation is subject to the following:

- a. The amount of PIMR allocable to each model segment is the approximate statutory interest maintenance reserve liability that would have developed for the model segment, assuming applicable capital gains taxes are excluded. The allocable PIMR may be either positive or negative.
- b. In performing the allocation to each model segment, ~~the company shall use a reasonable approach to allocate any portion of the total company IMR balance that is disallowable-not admitted under statutory accounting procedures (i.e., when the total company balance is an asset rather than a liability)-~~shall first be removed. The company shall use a reasonable approach to allocate the total company balance, after removing any non-admitted portion thereof, between PBR and non-PBR business and then allocate the PBR portion among model segments in an equitable fashion.
- c. The company may use a simplified approach to allocate the PIMR, if the impact of the PIMR on the minimum reserve is minimal.

VM-30 Section 3.B.5

5. An appropriate allocation of assets in the amount of the IMR, whether positive or negative, shall be used in any asset adequacy analysis. In performing the allocation, any portion of the total company IMR balance that is not admitted under statutory accounting procedures shall first be removed. Analysis of risks regarding asset default may include an appropriate allocation of assets supporting the asset valuation reserve; these AVR assets may not be applied for any other risks with respect to reserve adequacy. Analysis of these and other risks may include assets supporting other mandatory or voluntary reserves available to the extent not used for risk analysis and reserve support.

Draft: 7/3/23

Life Actuarial (A) Task Force
and the Life Risk-Based Capital (E) Working Group
May 18, 2023

The Life Actuarial (A) Task Force met May 18, 2023, in joint session with the Life Risk-Based Capital (E) Working Group of the Capital Adequacy (E) Task Force. The following Task Force members participated: Cassie Brown, Chair, represented by Rachel Hemphill (TX); Scott A. White, Vice Chair, represented by Craig Chupp (VA); Lori K. Wing-Heier represented by Sharon Comstock (AK); Mark Fowler represented by Sanjeev Chaudhuri (AL); Ricardo Lara represented by Ahmad Kamil (CA); Andrew N. Mais represented by Wanchin Chou (CT); Doug Ommen represented by Mike Yanacheak (IA); Dana Popish Severinghaus represented by Vincent Tsang (IL); Amy L. Beard represented by Scott Shover (IN); Vicki Schmidt represented by Nicole Boyd (KS); Grace Arnold represented by Fred Andersen and Ben Slutsker (MN); Chlora Lindley-Myers represented by William Leung (MO); Marlene Caride represented by Seong-min Eom (NJ); Adrienne A. Harris represented by Bill Carmello (NY); Judith L. French represented by Peter Weber (OH); Glen Mulready represented by Andrew Schallhorn (OK); Michael Humphreys represented by Steve Boston (PA); and Jon Pike represented by Tomasz Serbinowski (UT). The following Working Group members participated: Philip Barlow, Chair (DC); Sanjeev Chaudhuri (AL); Thomas Reedy (CA); Wanchin Chou (CT); Dalora Schafer (FL); Mike Yanacheak (IA); Vincent Tsang (IL); Fred Andersen (MN); William Leung (MO); Seong-min Eom (NJ); Bill Carmello (NY); Andrew Schallhorn (OK); Rachel Hemphill (TX); and Tomasz Serbinowski (UT).

1. Discussed VM-20, Requirements for Principle-Based Reserves for Life Products, GOES Field Test Results

Hemphill said that Scott O'Neal (NAIC) would present results from the generator of economic scenarios (GOES) field test. O'Neal walked through the presentation of results (Attachment Four-A). Mark Tenney (Mathematical Finance Company) asked whether the universal life with secondary guarantee (ULSG) model office results that Matt Kauffman (Moody's Analytics) presented showing approximately a doubling of reserves were consistent with the GOES field test participant results. O'Neal replied that although the average results of the participants were much less significant than the increases shown in the model office testing, there were some participants with ULSG products that did experience reserve increases in line with those shown in the model office testing.

Having no further business, the Life Actuarial (A) Task Force and Life Risk-Based Capital (E) Working Group adjourned.

SharePoint/NAIC Support Staff Hub/Member Meetings/A CMTE/LATF/2023-2-Summer/LATF Calls/05 18/May 18 Minutes.docx



NAIC Economic Scenario Generator Field Test: VM-20 Quantitative Results

Scott O'Neal FSA, MAAA

May 18, 2023



Agenda

1. Background and Purpose
2. Limitations
3. Field Test Run Descriptions
4. Field Test Participation
5. High-Level Observations
6. Quantitative Results
 - A. DR/SR Baseline Comparisons
 - B. DR/SR Valuation Date Comparisons
 - C. VM-20 Minimum Reserve Impact
7. Next Steps

Appendix 1: SERT Scenario Overview
Appendix 2: Treasury and Equity Scenario Overview



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2

Background and Purpose

- The purpose of this presentation is to summarize quantitative information from the VM-20 field test participants to:
 - Understand the impact on reserves and capital,
 - Review the range of results across field test participants,
 - Compare the stability of results over time, and
 - Inform regulator decision-making on model and calibration choices.

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3

Limitations

- The NAIC took steps to review the quantitative results for reasonableness, including reviewing qualitative survey responses, sending questions to participants, and asking participants to confirm that the NAIC compilations matched their intended result submission. However, the accuracy and reliability of the results are ultimately dependent on the quality of participant submissions.
- The field test analytics (average reserves, range of impacts, etc.) can be strongly dependent on a subset of the participants. Results shown today for the different field test runs will include varying numbers of participants corresponding to the levels of participation for that run. The lack of participation in some of the runs will limit their applicability to the overall industry.
- A number of comparisons between company-provided field test or baseline runs are made in the presentation. These comparisons are limited to the participation of whichever run had the least participation. For example, as Baseline 2 (as of 12/31/19 + 200 BP) had significantly lower participation than run 2A, many of the 2A results will not be included in the baseline comparison.
- Only three of the 15 companies made changes to their models to account for different features of the field test scenario sets (e.g. negative interest rates). Therefore, field test results may not be fully representative of company results post-implementation of the new GOES.
- Some companies mentioned that they would assess the need for changes to their assumptions prior to implementation of the new GOES but had not done so for the field test.
- Some of the field test SERT scenario sets contained errors, including the deterministic reserve (DR) scenario #12. Therefore, deterministic results cannot be shared for field test runs 5A, 5B, and 6.
- The VM-20 portion of the qualitative survey did not ask companies to specifically comment on the drivers of their results as was done for VM-21/C3 Phase II. Most companies did not comment on the drivers of their results.
- Variable and indexed products are included in the GOES field test VM-20 results, but isolating the specific impacts is challenging as some participants included those products with others in the same reserving category in one model (e.g. a model containing VULSG with ULSG). Further, we do not have data on the participants' separate account fund mapping.

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4

Field Test Run Descriptions

Note: **Bold** = Required Run

Run #	Description	Purpose of Run
Baseline #1	Scenario set(s) the company used for 12/31/21 statutory reporting	Baseline used as comparative basis for 12/31/21 runs
Baseline #2	ESG the company used for 12/31/21 statutory reporting of reserves and RBC, but modified to produce scenario sets with a 12/31/19 yield curve modified using a 200 BP increase across all maturities	Baseline used as comparative basis for 12/31/19 + 200 BP runs
Test #1a	GEMS Baseline Equity and Corporate model scenarios as of 12/31/21, and Conning Treasury model calibration with generalized fractional floor as of 12/31/21	Tests Conning Treasury model w/ GFF and Baseline Equity at YE 2021
Test #1b	Same as Test #1a, but with Alternative Treasury model calibration with shadow floor as of 12/31/21	Tests Alternative Treasury model with shadow floor and Baseline Equity at YE 2021
Test #2a	Same as Test #1a, but with Equity, Corporate, and Treasury models with a 12/31/19 starting yield curve modified using a 200 BP increase across all maturities. All other initial market conditions are unchanged. The Equity model parameters would be adjusted from #1a so that the year 30 median Large Cap Equity gross wealth factors remain consistent with #1a.	Stresses the starting Treasury rates using the same calibration as 1a to evaluate whether the model produces appropriate results in different economic environments
Test #2b	Same as Test #2a, but with the Alternative Treasury model calibration with shadow floor instead of the Conning Treasury model calibration with generalized fractional floor	Same as 2a, but designed to stress the 1b calibration

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5

Field Test Run Descriptions

Note: **Bold** = Required Run

Run #	Description	Purpose of Run
Test #3	Conning Treasury model calibration with generalized fractional floor as of 12/31/21, GEMS Corporate model as of 12/31/21, and GEMS Baseline Equity model corresponding to a 12/31/19 yield curve with a 200 BP increase across all maturities	Attribution analysis that will illustrate how much of the difference between runs #1a and #2a is driven by the equity model vs the Treasury and Corporate models
Test #4	Same as Test #3, but using Alternative Treasury model calibration with shadow floor as of 12/31/21	Same as #3, but with respect to runs #1b and #2b.
Test #5a	Same as #1a, but with Conning's original Equity model calibration that had significantly lower Gross Wealth Factor's (GWFs) than the AIRG Equity Model.	Tests Conning Treasury model w/ GFF and original equity model as of year-end 2021.
Test #5b	Same as #5a but using a 12/31/19 starting yield curve modified using a 200 BP increase across all maturities. The parameters of Conning's original Equity model are used without any adjustment.	Stresses the starting Treasury rates to understand the full impact of equity-Treasury linkage in Conning's original equity model
Test #6	Same as #1a, but with the ACLI's GEMS® Equity Calibration	Tests the ACLI's GEMS® Equity Calibration that assumes a constant mean equity return independent of rates and increases alignment with AIRG equity model GWFs

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6

Field Test Participation

- The chart below shows the number of legal entities that submitted VM-20 results for the field test by reserving category and reserve component.
- Many companies submitted multiple products, and some submitted multiple model segments for a given reserving category. Other companies aggregated products with distinct risks (e.g. Variable Universal Life with Secondary Guarantee, vanilla Universal Life with Secondary Guarantee) into a single model segment (e.g. ULSG). Ranges of results shown in the presentation are reflective of a legal entity view, rather than a model segment view.
- There are two basic types of comparisons of the field test results in this presentation; 1) comparisons of field test runs to their respective baseline run, and 2) comparisons of field test runs across the two tested valuation dates. These comparisons are limited by the run with the least participation (e.g. comparisons to the baseline for the 12/31/19 + 200 BP valuation date are limited to Baseline 2 participation).

Participation by Legal Entity

VM-20 Reserving Category	SR/DR	Baseline 1*	Baseline 2	1A*	1B*	2A*	2B*	5A*	5B*	6
Term	DR	11	<5	11	10	9	9	10	10	<5
ULSG	DR	11	<5	11	11	11	11	9	9	<5
Other	DR	<5	<5	<5	<5	<5	<5	<5	<5	<5
Combined	DR	15	6	15	14	14	14	11	11	6
Term	SR	<5	<5	<5	<5	<5	<5	<5	<5	<5
ULSG	SR	9	<5	10	10	10	10	8	8	<5
Other	SR	<5	<5	<5	<5	<5	<5	<5	<5	<5
Combined	SR	11	<5	11	11	11	11	8	8	<5

Participation by Model Segment

Product	Number of Model Segments	Variable?	Indexed?
Term	15	N/A	N/A
ULSG	20	7	4
Whole Life	3	N/A	N/A
Universal Life	1	0	0

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Valuation Dates:

12/31/21

12/31/19 + 200 BP

*Required Run

7

High-Level Observations

- When directly comparing baseline DR to field test DR results or baseline SR to field test SR results, there was a wide range of impacts across participating legal entities. Some legal entities saw large increases to their modeled reserves, and others experienced decreases. The range of results was in some cases greater when looking at a model segment level, with some model segments exhibiting much larger increases than were seen at a legal entity level. The range of modeled results by legal entity, however, was much smaller than it was for the VM-21/C3 Phase II GOES field test.
- While the range of modeled results was wide, the average increase to VM-20 minimum reserves by legal entity was muted given the domination of the NPR for many participants, even with large increases to modeled reserves. As VM-20 only became mandatory in 2020, the dominance of the NPR could be related to how recently the business was issued and may not be reflective of a mature block.
- Valuation date comparisons across baseline and field test runs were challenging given the limited participation in Baseline 2. For the DR considering all reserve categories combined, the field test runs were not, on average, more variable across valuation dates compared to the baseline runs. For SR, there was not enough participation in Baseline 2 to compare the change in valuation date results for field test runs to the baseline runs. However, for both DR and SR, the average change across valuation dates and the range of results were significantly smaller in magnitude than the results shown for VM-21.

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8

Baseline Reserve Comparisons: Term Reserving Category

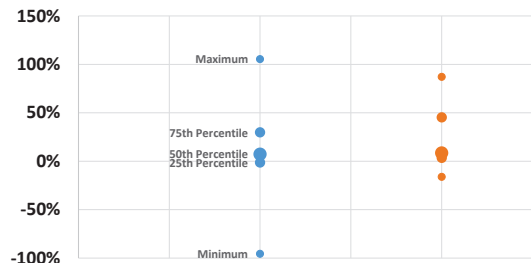
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9

Change in Deterministic Reserve by Legal Entity

Field Test	1A	1B
Average % Increase	29%	19%
# of Participants	11	10

Percentage Increase: Range and Percentile Statistics



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- Limited participation and SERT scenario errors did not allow for public sharing of DR baseline comparisons for 2A, 2B, 5A, 5B, and 6.
- Approximately half of the participant's Baseline 1 Term deterministic reserves were negative. Comparisons between relatively small negative values, or values that change signs between field test runs require adjustments to the standard (B-A)/A formula that typically is used for percentage change. The formula that was used was as follows: **Absolute Value** [(B-A)/A] * IF(B<A, -1, 1)
- The 1A (Conning Treasury and Baseline Equity scenario set as of 12/31/21) average DR increase of 29% was significantly larger than the 19% average DR increase seen in 1B (Alternative Treasury with Baseline Equity parameters).
- Field test participants saw more variation in the field test 1A reserve impacts, with a higher maximum (105%) and lower minimum (-96%) than what was seen in 1B.
- For both 1A and 1B,
 - the maximum end of the range was from a positive baseline reserve increasing, and
 - The minimum end of the range was from a negative baseline reserve becoming more negative.

10

Baseline Reserve Comparisons: ULSG Reserving Category

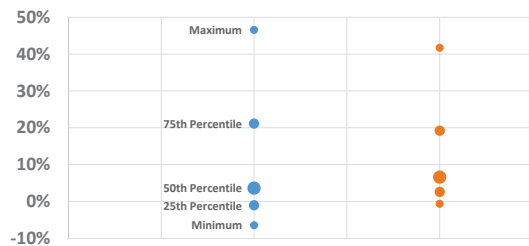
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11

ULSG Reserve Category: Deterministic Reserve (DR) Change from Baseline by Legal Entity

Field Test	1A	1B
Average % Increase	2%	6%
# of Participants	11	11

Percentage Increase: Range and Percentile Statistics



- Limited participation and SERT scenario errors did not allow for public sharing of DR baseline comparisons for 2A, 2B, 5A, 5B, and 6.
- The 1A (Conning Treasury and Baseline Equity scenario set as of 12/31/21) average DR increase of 2% was relatively smaller than the 6% average DR increase seen in 1B (Alternative Treasury with Baseline Equity parameters). A partial explanation for the higher average DR in 1B could be related to lower S&P 500 equity gross wealth factors (GWFs) present in 1B in later years of the projection compared to 1A.
- Field test participants saw more variation in the field test 1A results, with a higher maximum (47%) and lower minimum (-6%) than in 1B.
- Model segment level results fell within the legal entity level ranges for all but one of the participants.

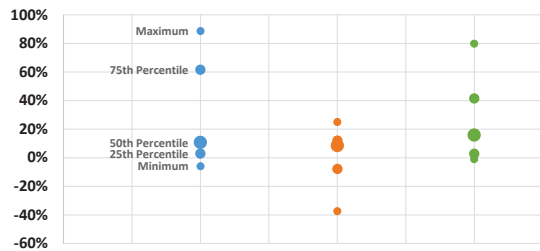
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12

Change in Stochastic Reserve by Legal Entity

Field Test	1A	1B	5A
Average % Increase	19%	11%	21%
# of Participants	9	8	7

Percentage Increase: Range and Percentile Statistics



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- Limited participation did not allow for public sharing of SR baseline comparisons for 2A, 2B, 5B, and 6.
- The 1A (Conning Treasury and Baseline Equity scenario set as of 12/31/21) average SR increase of 19% was significantly larger than the 11% average SR increase seen in 1B (Alternative Treasury with Baseline Equity parameters).
- Field test 5A (Conning Treasury and original Conning Equity calibration with lower equity GWFs) saw the highest average stochastic reserve increase. The treasury scenarios in 5A were the same as 1A, but the lower equity GWFs present in 5A resulted in larger reserve increases for indexed and variable life products in 5A compared to 1A.
- There was a higher maximum reserve increase in the field test 1A results compared to 1B, and 5A.
- When looking at the range of results at the individual model segment level, there were a number of reserve increases that were greater than those shown in the chart on the left. A company with one of these large model segment impacts noted that the increases would put their reserves higher than AXXX reserves.

13

Baseline Reserve Comparisons: Combined Reserving Categories

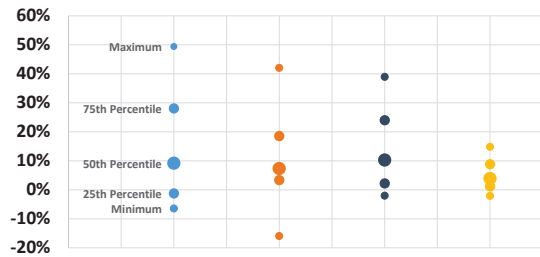
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14

Combined Reserve Categories: Deterministic Reserve Change from Baseline by Legal Entity

Field Test	1A	1B	2A	2B
Average % Increase	3%	7%	8%	2%
# of Participants	15	14	6	6

Percentage Increase: Range and Percentile Statistics



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- The results shown on this page are reflective of the aggregated Term, ULSG, and Other (as applicable) model segment results by legal entity. Combining reserve categories increases the number of participants, allowing 2A and 2B results to be shared.
- Limited participation and SERT scenario errors did not allow for public sharing of DR baseline comparisons for 5A, 5B, and 6.
- ULSG represented over 97% of the Baseline 1 deterministic reserves in the combined category, and just over half of the model segments.
- The 1A (Conning Treasury and Baseline Equity scenario set as of 12/31/21) average DR increase of 3% was smaller than the 7% average DR increase for 1B (Alternative Treasury with Baseline Equity parameters). However, the relationship flipped for the 12/31/19 + 200BP field test runs shown, with a larger average DR increase of 8% for 2A compared to a smaller increase of 2% for 2B (both compared to Baseline 2).

15

Valuation Date Reserve Comparisons: Combined Reserving Categories

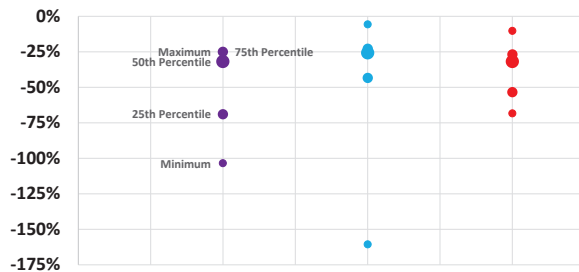
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16

Change in Deterministic Reserve by Legal Entity

Field Test	B2 vs B1	2A vs 1A	2B vs 1B
Average % Increase	-29%	-22%	-28%
# of Participants	6	14	14

Percentage Decrease: Range and Percentile Statistics



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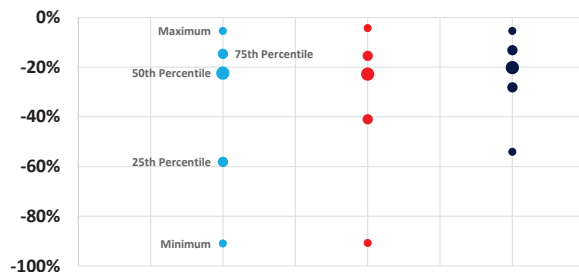
- Limited participation and SERT scenario errors did not allow for public sharing of DR valuation date comparisons for 5B vs 5A
- Across the baseline and field test runs, reserves significantly decreased in the 12/31/19 + 200 BP (higher starting interest rate level) runs compared to the 12/31/21 (lower starting interest rate) runs.
- The average percentage decrease was similar across the field test runs, although the comparison to the Baseline runs was challenging given the limited participation.
- The range of results was highest for the 2A vs 1A comparison. The largest decreases were driven by comparisons where the term DR was negative in both the 1A and 2A runs.

17

Change in Stochastic Reserve by Legal Entity

Field Test	2A vs 1A	2B vs 1B	5B vs 5A
Average % Increase	-24%	-22%	-22%
# of Participants	11	11	8

Percentage Decrease: Range and Percentile Statistics



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- Limited participation did not allow for public sharing of SR valuation date comparisons for Baseline 2 vs. Baseline 1.
- Across the baseline and field test runs, reserves significantly decreased in the 12/31/19 + 200 BP (higher starting interest rate level) runs compared to the 12/31/21 (lower starting interest rate) runs.
- The average percentage decrease in the SR was similar across the different field test run comparisons.
- The large range of results was similar across the 2A vs 1A and 2B vs 1B comparisons, but somewhat narrower in the 5B vs 5A (same UST as 1A/2A, but Conning original equity model with equity Treasury Linkage) comparison. This result is somewhat counterintuitive, given the additional variation in the Equity GWFs between valuation dates present in the 5B vs 5A comparison. This can be partially explained by:
 - Some companies included variable, indexed, and/or “vanilla” ULSG in the same model segment making it challenging to isolate impacts,
 - Limited indexed and variable product participation, and
 - There were less participants in the 5B vs 5A comparison.

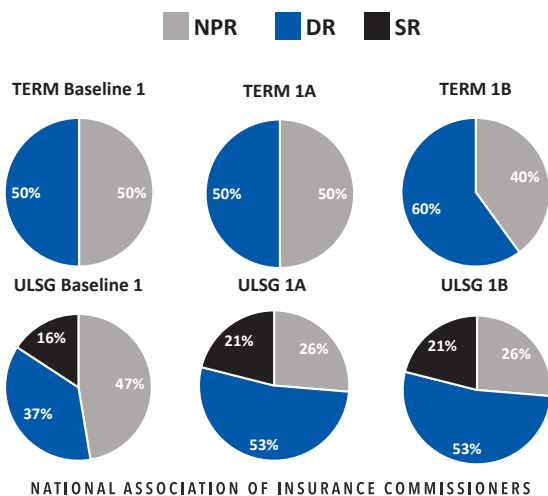
18

VM-20 Minimum Reserve Impact

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19

Proportion of Reserve Category/Model Segments by Dominant Reserve Type



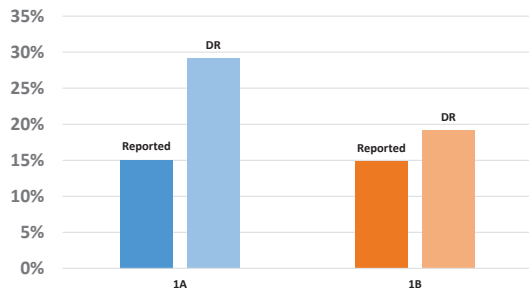
- A partial survey of 2021 PBR Actuarial Reports indicated that:
 - Of 99 companies that included Term results, 63% held NPR, 35% held the DR, and the remaining 2% had the stochastic reserve as the dominant reserve, and
 - Of 68 companies that included ULSG results, 57% held the NPR, 31% held the DR, and the remaining 12% held the SR as the dominant reserve.
- For the term reserving category, approximately half of the participants held negative deterministic reserves for their Baseline 1 submission.
- While the chart for Term 1B seems to indicate a switch from NPR to DR, the change in proportion of NPR/DR is entirely due to less participation in 1B.
- Almost half of the participant ULSG products held a net premium reserve as their minimum reserve for Baseline 1. For field tests 1A and 1B, there was a large shift to the deterministic reserve and a smaller shift to the stochastic reserve as the dominant reserve.
- Although the proportions of winning NPR, DR, and SR are the same across ULSG 1A and 1B, there was movement in the winning reserve type for some model segments between 1A and 1B.

20

Term Reserve Category: VM-20 Minimum Reserve Change from Baseline

Field Test	1A	1B
# of Participants	11	10

Average % Reserve Increase: Minimum and DR



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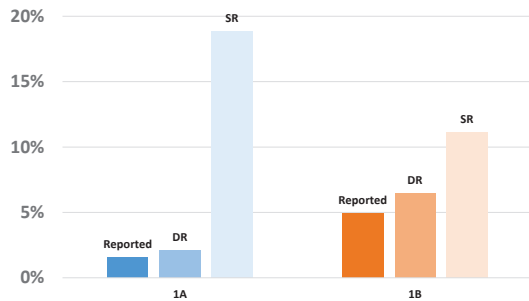
- The graph on the left shows average percentage increases in the VM-20 minimum reserve and DR for the Term Reserving Category.
- Despite reserve increases for many of the participants for their field test modeled reserve runs (DR), the effect on the legal entity level minimum reserve was muted due to the net premium reserve still dominating in many cases.
- Field test 1A saw a larger increase to DR than 1B, but the change to the average reported (minimum) reserve was very similar due to:
 - There were no companies that switched dominant reserves from their Baseline 1 result to either the 1A or 1B for the Term Reserving Category. For the companies where the NPR was the dominant reserve, the change in reported reserve was zero.
 - When the DR was the winning reserve, some companies had larger increases in 1A and others saw larger increases in the 1B run.
- The dominant reserve may change throughout a product’s lifecycle. PBR only became mandatory in 2020, so all of the business was recently issued. Therefore, these results may not be applicable to business that is in a more mature phase.

21

ULSG Reserve Category: VM-20 Minimum Reserve Change from Baseline

Field Test	1A	1B
# of Participants	11	11

Average % Reserve Increase: Minimum, DR, and SR



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- The graph on the left shows average percentage increases in the VM-20 minimum reserve, DR and SR for the ULSG Reserve Category.
- Despite reserve increases for many of the participants for their field test modeled reserve runs (DR and SR), the effect on the legal entity level minimum reserve was muted due to:
 - the net premium reserve still dominating in many cases, and
 - several of the largest increases to modeled reserves did not end up being the winning reserve.
- The dominant reserve may change throughout a product’s lifecycle. PBR only became mandatory in 2020, so all of the business was recently issued. Therefore, these results may not be applicable to business that is in a more mature phase.

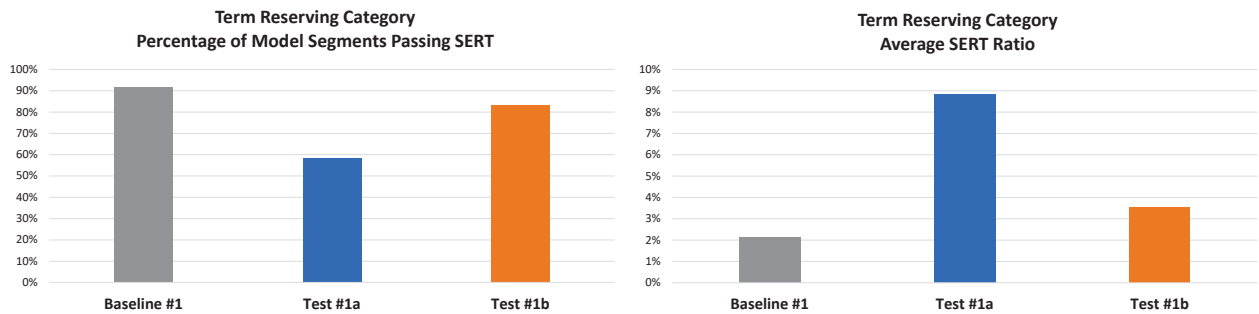
22

Stochastic Exclusion Ratio Test (SERT) Scenario Results

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23

Field Test SERT Results - Term

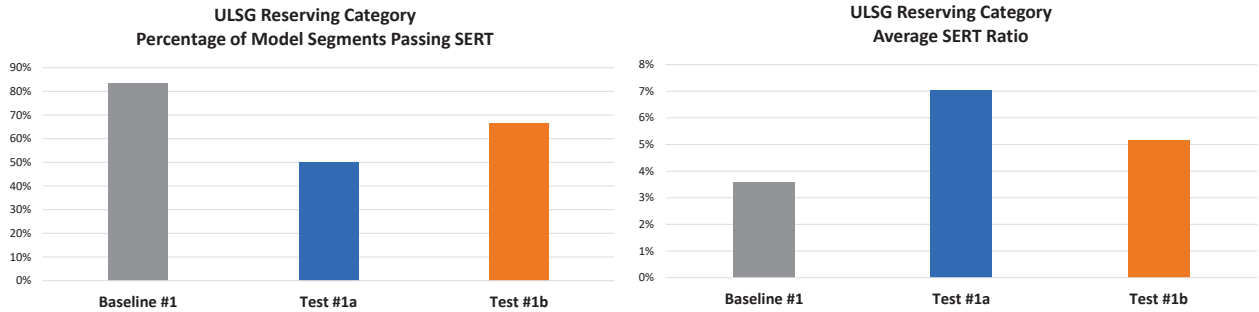


- As compared to company Baseline #1 results, less of the field test run term model segments passed the SERT, with the biggest drop-off seen for the Conning Calibration w/ GFF (1A).
- The average (non-weighted) SERT result for term model segments increased for the field test runs compared to Baseline #1. Average SERT ratios increased the most for the Conning Calibration w/ GFF (1A).
- For the term model segment, the “b” largest adjusted DR scenario was mostly consistent for a given model segment between the different field test runs. However, across model segments/legal entities, different “b” SERT scenarios were constraining.

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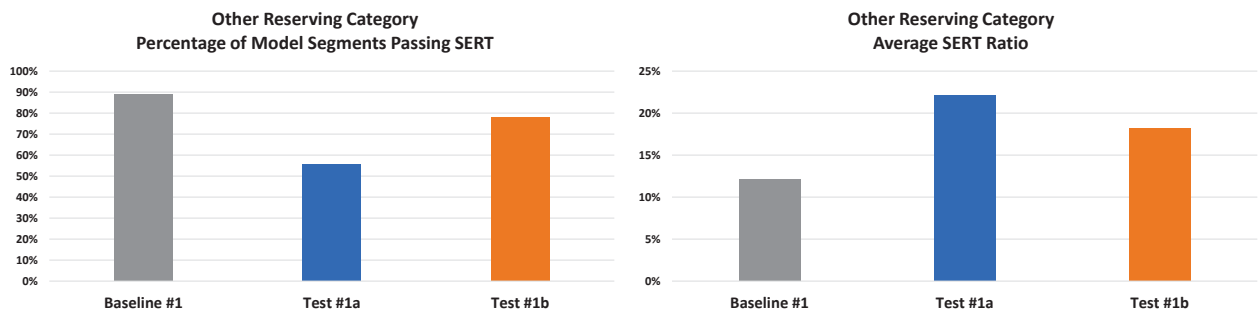
24

Field Test SERT Results - ULSG



- As compared to company Baseline #1 results, less of the field test run ULSG model segments passed the SERT, with the biggest drop-off seen for the Conning Calibration w/ GFF (1A).
- The average (non-weighted) SERT result for term model segments increased for the field test runs compared to Baseline #1. Average SERT ratios increased the most for the Conning Calibration w/ GFF (1A).
- The “b” scenario in the SERT calculation fluctuated between field test runs for some ULSG model segments but was stable in others

Field Test SERT Results - Other



- As compared to company Baseline #1 results, less of the field test run ULSG model segments passed the SERT, with the biggest drop-off seen for the Conning Calibration w/ GFF (1A).
- The average (non-weighted) SERT result for term model segments increased for the field test runs compared to Baseline #1. Average SERT ratios increased the most for the Conning Calibration w/ GFF (1A).
- For the Other model segment, the “b” scenario frequently changed between the baseline and field test runs. Of those that change, most switched to a pop-down UST SERT scenario. Across model segments/legal entities, different “b” SERT scenarios were constraining.

Next Steps

- The NAIC will look to present economic scenario generator field test results for the C3 Phase I in late June. Additional time for follow-up discussions may be necessary.
- Regulators will continue to work with interested parties in economic scenario generator drafting groups to continue progress on reserve/capital framework specific implementation tasks.
- The Life Actuarial (A) Task Force will engage with the American Academy of Actuaries and other interested parties to decide on stylized facts and acceptance criteria ahead of a recalibration of the economic scenario generator and a second field test.



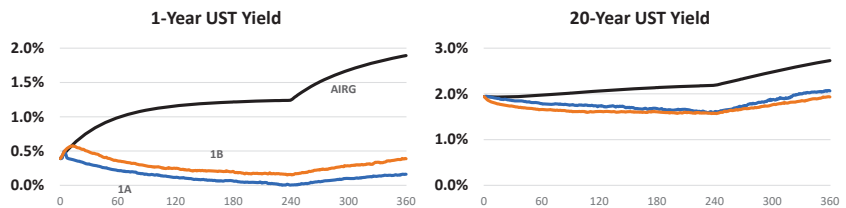
Appendix 1: Stochastic Exclusion Test Ratio (SERT) Scenario Overview

Deterministic Reserve 12/31/21 Scenario Statistics

- SERT Scenario 12 (the DR scenario) has significantly lower UST rates for 1A/5A/6* and 1B compared to the AIRG. Lower and longer interest rates can tend to increase VM-20 reserves due to, for example, challenges with companies being able to reinvest in assets with enough yield to support minimum crediting rates and/or a lower discount rate on future claim payments.
- The deterministic reserves for variable insurance products with direct investment in equity funds and indexed products are also impacted by equity scenarios. The table below shows the Gross Wealth Factors (GWFs) for the 12/31/21 AIRG and field test runs. 1A, 1B, and 6 have similar GWFs to the AIRG, but the 5A field test run that utilized the original Conning equity calibration with the equity-Treasury linkage had significantly lower GWFs given the low starting interest rate environment.

Large Cap (S&P 500) Equity Gross Wealth Factors

	12	60	120	240	360
AIRG	1.04	1.22	1.48	2.19	4.52
1A	1.03	1.16	1.38	2.01	4.29
1B	1.04	1.19	1.40	2.00	4.04
5A	1.03	1.09	1.17	1.36	2.47
6	1.06	1.27	1.56	2.29	4.77

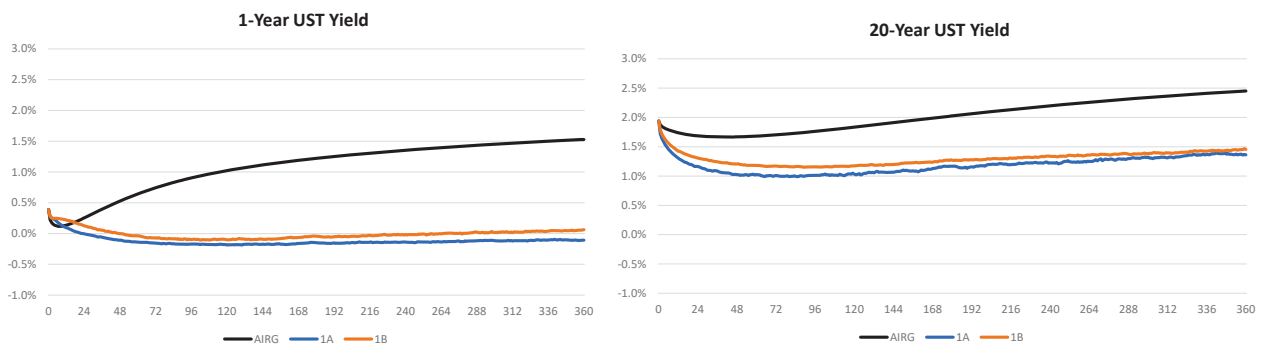


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*Note: 5A and 6 have the same UST scenarios as 1A.

29

UST SERT Scenario 3 (Pop-down) at 12/31/21

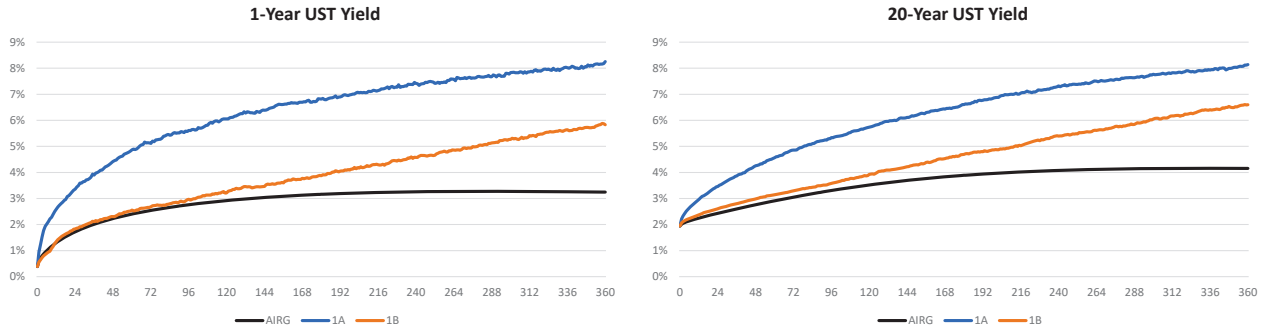


- The pop-down UST scenario for field test runs 1A and 1B are significantly lower than those produced by the AIRG
- **Pop-down description:** Interest rate shocks are selected to maintain the cumulative shock at the 10% level (1.282 standard errors).

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30

UST SERT Scenario 1 (Pop-up) at 12/31/21



- The pop-up UST scenario for field test runs 1A and 1B are significantly higher than those produced by the AIRG. However, in the pop-up scenarios, field test 1A is also materially higher than field test 1B
- **Pop-up description:** Interest rate shocks are selected to maintain the cumulative shock at the 90% level (1.282 standard errors).

Appendix 2: Treasury and Equity Scenario Overview

Field Test 1A: US Treasury Overview

- Field Test 1A (as of 12/31/21) included a recalibration of the Conning GEMS® US Treasury model that was designed to meet the regulator’s acceptance criteria related to low for long, the prevalence of high interest rates, upper and lower bounds, initial yield curve fit, and yield curve shape. The frequency and severity of negative interest rates were controlled using a generalized fractional floor.
- The 1A UST scenario set as of 12/31/21 had a much higher prevalence of low UST rates, including negative interest rates, compared to the scenarios produced by the AIRG as of 12/31/21, which is floored at 1 BP.
- The 1A UST scenario set also included greater and more frequent high UST rates, with maximum UST rates greatly exceeding that of the AIRG. While a floor was employed in all of the field test UST scenario sets, no cap was employed on how high rates could get.

1A: 10,000 1-yr UST Scenario Percentiles by Projection Month as of 12/31/21

Percentile	12	60	120	240	360
Min	-0.49%	-0.97%	-0.94%	-0.91%	-0.93%
1%	-0.17%	-0.51%	-0.58%	-0.56%	-0.56%
10%	0.10%	-0.14%	-0.19%	-0.13%	-0.11%
25%	0.25%	0.14%	0.14%	0.19%	0.25%
50%	0.62%	0.84%	1.18%	1.61%	2.09%
75%	1.63%	2.83%	3.59%	4.39%	4.93%
95%	3.15%	6.14%	7.78%	9.35%	10.38%
99%	4.32%	8.86%	11.38%	13.53%	14.47%
Max	7.93%	14.36%	19.89%	25.18%	26.72%

AIRG: 10,000 1-yr UST Scenario Percentiles by Projection Month as of 12/31/21

Percentile	12	60	120	240	360
Min	0.01%	0.01%	0.01%	0.01%	0.01%
1%	0.01%	0.21%	0.33%	0.32%	0.32%
10%	0.27%	0.66%	0.87%	0.98%	0.99%
25%	0.47%	0.96%	1.22%	1.41%	1.45%
50%	0.69%	1.35%	1.68%	1.99%	2.10%
75%	0.92%	1.78%	2.27%	2.74%	2.90%
95%	1.29%	2.57%	3.40%	4.29%	4.66%
99%	1.59%	3.37%	4.75%	6.17%	6.31%
Max	2.31%	5.82%	10.94%	13.22%	12.76%

1A-AIRG: 10,000 1-yr UST Scenario Percentiles by Projection Month

Difference	12	60	120	240	360
Min	-0.5%	-1.0%	-0.9%	-0.9%	-0.9%
1%	-0.2%	-0.7%	-0.9%	-0.9%	-0.9%
10%	-0.2%	-0.8%	-1.1%	-1.1%	-1.1%
25%	-0.2%	-0.8%	-1.1%	-1.2%	-1.2%
50%	-0.1%	-0.5%	-0.5%	-0.4%	0.0%
75%	0.7%	1.0%	1.3%	1.7%	2.0%
95%	1.9%	3.6%	4.4%	5.1%	5.7%
99%	2.7%	5.5%	6.7%	7.4%	8.2%
Max	5.6%	8.5%	8.9%	12.0%	14.0%

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33

Field Test 1A: Equity Overview

- The 1A equity scenario set used a calibration that targeted the median gross wealth factor (GWF) produced by the AIRG at the end of 30 years. This recentering of the equity return distribution with changes to the starting interest environment partially mitigates the impact of the GEMS® equity-Treasury linkage functionality.
- While the GWF’s between the AIRG and field test 1A are consistent at the 50th percentile at the end of the 30th projection year, the 1A scenario set generally has somewhat lower GWFs in the lower percentiles and earlier projection years compared to the AIRG.
- In the later durations and higher percentiles, the 1A GWFs are greater than those produced by the AIRG.

1A: 10,000 SP500 GWF %-tiles by Projection Month

	12	60	120	240	360
Min	0.50	0.28	0.24	0.39	0.39
1.0%	0.71	0.59	0.59	0.83	1.17
2.5%	0.77	0.68	0.75	1.06	1.60
5.0%	0.82	0.78	0.87	1.34	2.11
10.0%	0.87	0.89	1.05	1.69	2.86
25.0%	0.97	1.09	1.40	2.54	4.88
50.0%	1.07	1.35	1.88	4.01	8.99
75.0%	1.16	1.64	2.57	6.49	16.98
90.0%	1.25	1.96	3.41	10.26	31.70
95.0%	1.31	2.20	4.04	13.67	47.46
97.5%	1.35	2.45	4.70	17.57	66.83
99.0%	1.41	2.77	5.65	23.45	101.58
Max	1.81	4.53	13.89	55.97	457.07

AIRG: 10,000 SP500 GWF %-tiles by Projection Month

	12	60	120	240	360
Min	0.41	0.32	0.26	0.35	0.38
1.0%	0.70	0.62	0.66	0.83	1.22
2.5%	0.76	0.72	0.77	1.10	1.69
5.0%	0.82	0.81	0.92	1.41	2.25
10.0%	0.89	0.93	1.12	1.83	3.09
25.0%	0.98	1.16	1.51	2.74	5.11
50.0%	1.09	1.45	2.09	4.27	8.84
75.0%	1.19	1.81	2.88	6.80	15.35
90.0%	1.30	2.22	3.81	10.15	24.98
95.0%	1.37	2.48	4.44	12.92	34.25
97.5%	1.44	2.72	5.17	15.65	45.88
99.0%	1.52	3.06	6.18	20.49	60.45
Max	1.92	4.77	11.86	66.94	235.95

1A/AIRG: GWF Ratios by Projection Month

SP500	12	60	120	240	360
Min	123%	90%	94%	113%	101%
1.0%	101%	96%	90%	100%	95%
2.5%	102%	95%	97%	96%	95%
5.0%	100%	96%	95%	95%	94%
10.0%	99%	96%	93%	92%	92%
25.0%	98%	94%	92%	93%	96%
50.0%	98%	93%	90%	94%	102%
75.0%	98%	90%	90%	95%	111%
90.0%	97%	88%	90%	101%	127%
95.0%	95%	89%	91%	106%	139%
97.5%	94%	90%	91%	112%	146%
99.0%	93%	90%	92%	114%	168%
Max	94%	95%	117%	84%	194%

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34

Field Test 1B: US Treasury Overview

- Field Test 1B (as of 12/31/21) included a calibration of the Conning GEMS® US Treasury model that was designed to meet regulator acceptance criteria but placed additional emphasis on maintaining realistic term premiums throughout the projection. Towards that end, there was a significantly lower frequency of inversions (e.g. ~5% of 1B scenarios had 10 year/2year UST inversions at the end of year 30 compared to ~12% seen in 1A). The average level of inversion was also significantly lower (e.g. in 1B 10 year/2 year UST inversions average ~30 BP at the end of year 30, compared to ~90 BP average inversion level for 1A).
- 1B also included lower and less frequent high interest rates than 1A, but still contained greater and more frequent high interest rates than the AIRG.
- The frequency and severity of negative interest rates were controlled using a shadow floor that preserves the arbitrage free nature of the scenarios. The 1B UST scenario set has a comparable amount of low/negative UST rates to 1A, but significantly more severe and frequent low (and negative) UST rates compared to the AIRG.

1B: 10,000 1-yr UST Scenario Percentiles by Projection Month

Percentile	12	60	120	240	360
Min	-0.59%	-1.08%	-1.24%	-1.18%	-1.19%
1%	-0.10%	-0.51%	-0.61%	-0.59%	-0.58%
10%	0.22%	-0.04%	-0.10%	-0.02%	0.06%
25%	0.42%	0.26%	0.27%	0.37%	0.49%
50%	0.65%	0.65%	0.71%	0.88%	1.28%
75%	0.88%	1.24%	1.67%	2.60%	3.52%
95%	1.76%	3.38%	4.38%	5.99%	7.49%
99%	2.57%	4.89%	6.44%	8.90%	10.64%
Max	4.25%	10.28%	11.63%	17.99%	22.87%

AIRG: 10,000 1-yr UST Scenario Percentiles by Projection Month

Percentile	12	60	120	240	360
Min	0.01%	0.01%	0.01%	0.01%	0.01%
1%	0.01%	0.21%	0.33%	0.32%	0.32%
10%	0.27%	0.66%	0.87%	0.98%	0.99%
25%	0.47%	0.96%	1.22%	1.41%	1.45%
50%	0.69%	1.35%	1.68%	1.99%	2.10%
75%	0.92%	1.78%	2.27%	2.74%	2.90%
95%	1.29%	2.57%	3.40%	4.29%	4.66%
99%	1.59%	3.37%	4.75%	6.17%	6.31%
Max	2.31%	5.82%	10.94%	13.22%	12.76%

Difference	12	60	120	240	360
Min	-0.6%	-1.1%	-1.2%	-1.2%	-1.2%
1%	-0.1%	-0.7%	-0.9%	-0.9%	-0.9%
10%	0.0%	-0.7%	-1.0%	-1.0%	-0.9%
25%	-0.1%	-0.7%	-1.0%	-1.0%	-1.0%
50%	0.0%	-0.7%	-1.0%	-1.1%	-0.8%
75%	0.0%	-0.5%	-0.6%	-0.1%	0.6%
95%	0.5%	0.8%	1.0%	1.7%	2.8%
99%	1.0%	1.5%	1.7%	2.7%	4.3%
Max	1.9%	4.5%	0.7%	4.8%	10.1%

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35

Field Test 1B: Equity Overview

- The 1B equity scenario set used the same calibration as 1A. However, due to the equity-Treasury linkage, the resulting GWFs are different. The largest differences between the 1A and 1B equity GWFs are seen at the upper percentiles at the end of the 30th projection year, with the 1B being substantially lower and more in line with the AIRG.
- The median GWF at the end of the 30th projection year for 1B (7.99) is materially lower than both 1A (8.99) and the AIRG (8.84).
- Finally, the 1st percentile GWF at the end of the 30th projection year for 1b (1.19) was consistent with those of 1A (1.17) and the AIRG (1.22).

1B: 10,000 SP500 GWF %-tiles by Projection Month

	12	60	120	240	360
Min	0.51	0.30	0.26	0.34	0.27
1.0%	0.71	0.61	0.61	0.82	1.19
2.5%	0.78	0.70	0.76	1.05	1.59
5.0%	0.83	0.80	0.90	1.33	2.07
10.0%	0.88	0.92	1.08	1.68	2.72
25.0%	0.98	1.12	1.42	2.47	4.57
50.0%	1.08	1.38	1.90	3.78	7.99
75.0%	1.17	1.68	2.56	5.85	13.71
90.0%	1.26	2.00	3.32	8.61	23.14
95.0%	1.32	2.24	3.94	10.91	32.00
97.5%	1.36	2.50	4.53	13.70	43.02
99.0%	1.42	2.80	5.44	17.25	61.86
Max	1.83	4.67	14.21	76.72	258.35

AIRG: 10,000 SP500 GWF %-tiles by Projection Month

	12	60	120	240	360
Min	0.41	0.32	0.26	0.35	0.38
1.0%	0.70	0.62	0.66	0.83	1.22
2.5%	0.76	0.72	0.77	1.10	1.69
5.0%	0.82	0.81	0.92	1.41	2.25
10.0%	0.89	0.93	1.12	1.83	3.09
25.0%	0.98	1.16	1.51	2.74	5.11
50.0%	1.09	1.45	2.09	4.27	8.84
75.0%	1.19	1.81	2.88	6.80	15.35
90.0%	1.30	2.22	3.81	10.15	24.98
95.0%	1.37	2.48	4.44	12.92	34.25
97.5%	1.44	2.72	5.17	15.65	45.88
99.0%	1.52	3.06	6.18	20.49	60.45
Max	1.92	4.77	11.86	66.94	235.95

1B/AIRG: GWF Ratios by Projection Month

SP500	12	60	120	240	360
Min	124%	94%	102%	98%	71%
1.0%	102%	98%	93%	99%	98%
2.5%	103%	98%	99%	95%	94%
5.0%	101%	99%	97%	94%	92%
10.0%	100%	99%	96%	92%	88%
25.0%	99%	97%	94%	90%	89%
50.0%	99%	95%	91%	88%	90%
75.0%	99%	93%	89%	86%	89%
90.0%	97%	90%	87%	85%	93%
95.0%	96%	90%	89%	84%	93%
97.5%	95%	92%	88%	88%	94%
99.0%	94%	91%	88%	84%	102%
Max	95%	98%	120%	115%	109%

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36

Field Test 2A: US Treasury Overview

- Field Test 2A (as of 12/31/19 + 200 BP) used the same calibration as 1A (Conning Calibration with a Generalized Fractional Floor) but with a 12/31/19 starting yield curve modified using a 200 BP increase across all maturities.
- The higher starting interest environment leads to greater and more frequent high interest rates and less severe and less frequent low interest rates in 2A compared to 1A.
- Compared to the AIRG with a 12/31/19 + 200 BP starting interest environment, the 2A scenario set has a greater frequency and severity of high UST rates and more prevalent and severe low (and negative) UST rates.

2A (12/31/19 + 200 BP): 10,000 1-yr UST Scenario Percentiles by Projection Month

Percentile	12	60	120	240	360
Min	-0.13%	-0.78%	-0.82%	-0.89%	-0.92%
1%	0.29%	-0.27%	-0.42%	-0.49%	-0.53%
10%	1.34%	0.19%	0.02%	-0.04%	-0.06%
25%	2.26%	0.87%	0.39%	0.31%	0.32%
50%	3.34%	2.89%	2.69%	2.43%	2.54%
75%	4.49%	5.15%	5.38%	5.47%	5.53%
95%	6.19%	8.80%	10.06%	10.86%	11.30%
99%	7.44%	11.88%	13.61%	15.32%	15.70%
Max	11.48%	17.62%	22.91%	27.07%	28.97%

AIRG (12/31/19 + 200 BP): 10,000 1-yr UST Scenario Percentiles by Projection Month

Percentile	12	60	120	240	360
Min	0.31%	0.01%	0.01%	0.01%	0.01%
1%	1.25%	0.47%	0.34%	0.29%	0.31%
10%	1.82%	1.22%	1.06%	1.04%	1.00%
25%	2.16%	1.72%	1.58%	1.53%	1.50%
50%	2.53%	2.35%	2.24%	2.21%	2.18%
75%	2.92%	3.06%	3.08%	3.10%	3.05%
95%	3.55%	4.39%	4.77%	4.96%	4.94%
99%	4.06%	5.66%	6.73%	7.29%	6.73%
Max	5.24%	9.85%	16.66%	15.13%	13.59%

2A-AIRG: 10,000 1-yr UST Scenario Percentiles by Projection Month

Difference	12	60	120	240	360
Min	-0.4%	-0.8%	-0.8%	-0.9%	-0.9%
1%	-1.0%	-0.7%	-0.8%	-0.8%	-0.8%
10%	-0.5%	-1.0%	-1.0%	-1.1%	-1.1%
25%	0.1%	-0.8%	-1.2%	-1.2%	-1.2%
50%	0.8%	0.5%	0.4%	0.2%	0.4%
75%	1.6%	2.1%	2.3%	2.4%	2.5%
95%	2.6%	4.4%	5.3%	5.9%	6.4%
99%	3.4%	6.2%	6.9%	8.0%	9.0%
Max	6.2%	7.8%	6.3%	11.9%	15.4%

NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

37

Field Test 2A: Equity Overview

- The targets of the 2A equity scenarios is designed to align the GWF at the end of the 30th projection year (8.97) with those produced by the AIRG (8.84) no matter the starting interest rate environment. However, there is still an impact to the 2A equity scenarios due to the increased starting interest rate environment and the equity-Treasury linkage compared to the 1A equity scenarios.
- The largest differences between the 2A and 1A equity GWFs are seen at the upper percentiles at the end of the 30th projection year, for example the 99th percentile GWF for 1b is 127.28 at the end of the 30th year compared to 101.58 for the 1A scenario set.
- The same considerations apply when comparing 2A to the AIRG with a 12/31/19 + 200 BP starting interest rate environment, with the largest differences between the GWFs of 2A and the AIRG occurring in the higher percentiles and later projection years.

2A: 10,000 SP500 GWF %-tiles by Projection Month

	12	60	120	240	360
Min	0.51	0.30	0.26	0.40	0.36
1.0%	0.73	0.65	0.64	0.83	1.07
2.5%	0.79	0.75	0.80	1.08	1.46
5.0%	0.84	0.85	0.95	1.34	1.93
10.0%	0.90	0.97	1.15	1.73	2.63
25.0%	1.00	1.20	1.54	2.64	4.71
50.0%	1.10	1.48	2.11	4.38	8.97
75.0%	1.20	1.82	2.96	7.42	18.20
90.0%	1.29	2.19	4.01	12.10	35.66
95.0%	1.35	2.46	4.74	16.60	54.53
97.5%	1.39	2.73	5.63	22.33	83.32
99.0%	1.45	3.10	7.00	30.39	127.28
Max	1.87	5.11	15.80	86.26	817.22

AIRG: 10,000 SP500 GWF %-tiles by Projection Month

	12	60	120	240	360
Min	0.41	0.32	0.26	0.35	0.38
1.0%	0.70	0.62	0.66	0.83	1.22
2.5%	0.76	0.72	0.77	1.10	1.69
5.0%	0.82	0.81	0.92	1.41	2.25
10.0%	0.89	0.93	1.12	1.83	3.09
25.0%	0.98	1.16	1.51	2.74	5.11
50.0%	1.09	1.45	2.09	4.27	8.84
75.0%	1.19	1.81	2.88	6.80	15.35
90.0%	1.30	2.22	3.81	10.15	24.98
95.0%	1.37	2.48	4.44	12.92	34.25
97.5%	1.44	2.72	5.17	15.65	45.88
99.0%	1.52	3.06	6.18	20.49	60.45
Max	1.92	4.77	11.86	66.94	235.95

2A/AIRG: GWF Ratios by Projection Month

SP500	12	60	120	240	360
Min	124%	95%	99%	116%	94%
1.0%	104%	104%	97%	100%	88%
2.5%	105%	103%	103%	98%	87%
5.0%	103%	105%	103%	95%	86%
10.0%	101%	104%	102%	94%	85%
25.0%	101%	103%	102%	96%	92%
50.0%	101%	102%	101%	103%	101%
75.0%	101%	100%	103%	109%	119%
90.0%	100%	99%	105%	119%	143%
95.0%	98%	99%	107%	129%	159%
97.5%	97%	100%	109%	143%	182%
99.0%	96%	101%	113%	148%	211%
Max	98%	107%	133%	129%	346%

NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

38

Field Test 5A: Treasury and Equity Overview

- The 5A scenario set uses the exact same UST scenarios as 1A.
- For the 5A equity scenario set, the Conning’s original equity model calibration is used that includes the full impact of the equity-Treasury linkage. With 5A’s lower overall UST rates, the equity GWFs at the lower percentiles are much more severe than the AIRG and other field test scenario sets. For example, the 1st percentile of equity GWFs for 5A is .39, compared to 1.22 for the AIRG and 1.19 for 1A.
- The median GWF at the end of the 30th projection year for 5A (5.88) is significantly lower than with both 1A (8.99) and the AIRG (8.84).

5A: 10,000 SP500 GWF %-tiles by Projection Month

	12	60	120	240	360
Min	0.47	0.13	0.06	0.04	0.05
1.0%	0.71	0.45	0.36	0.38	0.39
2.5%	0.76	0.57	0.48	0.54	0.65
5.0%	0.82	0.67	0.63	0.73	0.95
10.0%	0.87	0.80	0.82	1.04	1.48
25.0%	0.96	1.02	1.20	1.79	2.93
50.0%	1.05	1.28	1.69	3.09	5.88
75.0%	1.14	1.56	2.31	5.11	11.43
90.0%	1.21	1.85	3.02	8.11	21.44
95.0%	1.26	2.04	3.59	10.76	32.94
97.5%	1.30	2.23	4.11	13.83	47.77
99.0%	1.35	2.50	4.83	18.95	71.23
Max	1.68	3.79	10.89	64.69	494.22

AIRG: 10,000 SP500 GWF %-tiles by Projection Month

	12	60	120	240	360
Min	0.41	0.32	0.26	0.35	0.38
1.0%	0.70	0.62	0.66	0.83	1.22
2.5%	0.76	0.72	0.77	1.10	1.69
5.0%	0.82	0.81	0.92	1.41	2.25
10.0%	0.89	0.93	1.12	1.83	3.09
25.0%	0.98	1.16	1.51	2.74	5.11
50.0%	1.09	1.45	2.09	4.27	8.84
75.0%	1.19	1.81	2.88	6.80	15.35
90.0%	1.30	2.22	3.81	10.15	24.98
95.0%	1.37	2.48	4.44	12.92	34.25
97.5%	1.44	2.72	5.17	15.65	45.88
99.0%	1.52	3.06	6.18	20.49	60.45
Max	1.92	4.77	11.86	66.94	235.95

5A/AIRG: GWF Ratios by Projection Month

SP500	12	60	120	240	360
Min	114%	40%	24%	11%	13%
1.0%	101%	73%	54%	46%	32%
2.5%	100%	79%	62%	49%	39%
5.0%	100%	83%	68%	51%	42%
10.0%	99%	86%	73%	57%	48%
25.0%	98%	88%	79%	65%	57%
50.0%	97%	88%	81%	72%	66%
75.0%	96%	86%	80%	75%	74%
90.0%	94%	83%	79%	80%	86%
95.0%	92%	82%	81%	83%	96%
97.5%	91%	82%	80%	88%	104%
99.0%	89%	82%	78%	92%	118%
Max	87%	80%	92%	97%	209%

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39

Field Test 6: Treasury and Equity Overview

- The field test 6 scenario set uses the exact same UST scenarios as 1A.
- The equity calibration for scenario set 6 assumes a constant mean equity return independent of rates and increases alignment with AIRG equity model GWFs.
- The median GWF at the end of the 30th projection year for 6 is 9.49, which is close but somewhat higher than the the corresponding GWFs for both 1A (8.99) and the AIRG (8.84).
- While there are differences (somewhat lower GWFs in low percentiles, lower GWFs at higher percentiles), the equity scenarios from 6 overall are more consistent with those produced by the AIRG than other field test scenario sets.

6: 10,000 SP500 GWF %-tiles by Projection Month

	12	60	120	240	360
Min	0.43	0.14	0.13	0.31	0.23
1.0%	0.71	0.57	0.59	0.79	1.20
2.5%	0.77	0.68	0.76	1.08	1.73
5.0%	0.83	0.80	0.92	1.41	2.32
10.0%	0.89	0.94	1.14	1.85	3.20
25.0%	0.99	1.19	1.58	2.90	5.41
50.0%	1.09	1.50	2.17	4.55	9.49
75.0%	1.19	1.82	2.90	6.83	15.89
90.0%	1.28	2.15	3.66	9.85	24.35
95.0%	1.33	2.34	4.22	12.01	31.70
97.5%	1.38	2.52	4.76	14.36	39.68
99.0%	1.43	2.75	5.37	17.19	52.06
Max	1.79	3.97	9.38	33.26	135.23

AIRG: 10,000 SP500 GWF %-tiles by Projection Month

	12	60	120	240	360
Min	0.41	0.32	0.26	0.35	0.38
1.0%	0.70	0.62	0.66	0.83	1.22
2.5%	0.76	0.72	0.77	1.10	1.69
5.0%	0.82	0.81	0.92	1.41	2.25
10.0%	0.89	0.93	1.12	1.83	3.09
25.0%	0.98	1.16	1.51	2.74	5.11
50.0%	1.09	1.45	2.09	4.27	8.84
75.0%	1.19	1.81	2.88	6.80	15.35
90.0%	1.30	2.22	3.81	10.15	24.98
95.0%	1.37	2.48	4.44	12.92	34.25
97.5%	1.44	2.72	5.17	15.65	45.88
99.0%	1.52	3.06	6.18	20.49	60.45
Max	1.92	4.77	11.86	66.94	235.95

6/AIRG: GWF Ratios by Projection Month

SP500	12	60	120	240	360
Min	106%	44%	50%	88%	60%
1.0%	101%	92%	89%	95%	98%
2.5%	102%	95%	99%	98%	102%
5.0%	101%	100%	100%	100%	103%
10.0%	100%	101%	102%	101%	103%
25.0%	101%	103%	104%	106%	106%
50.0%	100%	103%	104%	107%	107%
75.0%	100%	100%	101%	101%	104%
90.0%	99%	97%	96%	97%	97%
95.0%	97%	95%	95%	93%	93%
97.5%	96%	92%	92%	92%	86%
99.0%	94%	90%	87%	84%	86%
Max	93%	83%	79%	50%	57%

NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

40

Draft: 7/3/23

Life Actuarial (A) Task Force
Virtual Meeting
May 11, 2023

The Life Actuarial (A) Task Force met May 11, 2023. The following Task Force members participated: Cassie Brown, Chair, represented by Rachel Hemphill (TX); Scott A. White, Vice Chair, represented by Craig Chupp (VA); Lori K. Wing-Heier represented by Sharon Comstock (AK); Mark Fowler represented by Sanjeev Chaudhuri (AL); Ricardo Lara represented by Ahmad Kamil (CA); Andrew N. Mais represented by Wanchin Chou (CT); Doug Ommen represented by Mike Yanacheak (IA); Dana Popish Severinghaus represented by Vincent Tsang (IL); Amy L. Beard represented by Scott Shover (IN); Vicki Schmidt represented by Nicole Boyd (KS); Grace Arnold represented by Fred Andersen and Ben Slutsker (MN); Chlora Lindley-Myers represented by William Leung (MO); Adrienne A. Harris represented by Bill Carmello (NY); Judith L. French represented by Peter Weber (OH); Glen Mulready represented by Andrew Schallhorn (OK); Michael Humphreys represented by Steve Boston (PA); and Jon Pike represented by Tomasz Serbinowski (UT).

1. Adopted APF 2021-08

Hemphill said that the Task Force would be considering adoption of amendment proposal form (APF) 2021-08. Brian Bayerle (American Council of Life Insurers—ACLI) walked through the ACLI’s comment letter (Attachment Five-A), noting a concern with the language that could potentially not allow companies wishing to choose a claim cutoff date later than April 1. Angela McNabb (NAIC) explained that the language in APF 2021-08 would allow for companies to use a claim cutoff date later than April 1. Bayerle agreed and thanked McNabb for looking into the concern.

Weber made a motion, seconded by Leung, to adopt APF 2021-08 (Attachment Five-B). The motion passed unanimously.

2. Re-Exposed APF 2023-05

Hemphill said that APF 2023-05, which revised the modeling of hedging for index-based crediting, had been modified after the prior exposure to address comments that the Task Force received. Bayerle walked through the ACLI’s comment letters (Attachment Five-C and Attachment Five-D). Chupp noted issues with the currently proposed language in Section 4.A.4.b.iii of the APF where it could be implied that only a company with a strategy that combined index credits, guaranteed benefits, and other risks would not be eligible for the hedge treatment in Section 4.A.4.b.i, rather than the intent of a company that combined any of those elements. The Task Force discussed the issue, and Hemphill suggested replacing the language with “and/or” to imply that any combination of the previously mentioned benefits would not be eligible for the hedge treatment in 4.A.4.b.i. Chupp then pointed out an incorrect reference and another error correction in the APF language.

Maambo Mujala (American Academy of Actuaries—Academy) spoke about the Academy’s comment letter (Attachment Five-E), specifically noting that margin accounting for hedge error should only be applied to the portion of the index that is hedged given that many companies do not hedge 100% of their index-based credited interest. Bayerle noted that he supports making a language change in the re-exposure of 2023-05 to capture the comment from the Academy. Slutsker asked for an example of hedging less than 100% of the index credit. Mujala responded that companies do not typically hedge 100% of the index credit due to expected decrements.

Hemphill noted that an additional comment letter was received from Risk & Regulatory Consulting (RRC) (Attachment Five-F). The letter was generally supportive of APF 2023-05, but it had questions on the rationale behind the parameters.

Slutsker made a motion, seconded by Leung, to expose APF 2023-05 (Attachment Five-G) with the edits that Chupp and the Academy suggested for a 16-day public comment period ending May 26. The motion passed unanimously.

Having no further business, the Task Force adjourned.

SharePoint/NAIC Support Staff Hub/Member Meetings/A CMTE/LATF/2023-2-Summer/LATF Calls/05 11/May 11 Minutes.docx



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May 5, 2023

Rachel Hemphill
Chair, Life Actuarial (A) Task Force (LATF)

Re: Re-Exposure of APF 2021-08 (VM-51 Data Call Lag Reduction)

Dear Ms. Hemphill:

The American Council of Life Insurers (ACLI) appreciates the opportunity to submit comments on the re-exposure of APF 2021-08 on reducing the VM-51 Data Call Lag reduction from two years to one year. We support this update, but we have a clarifying question and a request.

The updated language for reported terminations suggests that companies can use any date so long as it is on or after 4/1/20XX+1. We wanted to confirm that the flexibility for the reporting cutoff will not generate any errors in submission or processing. Perhaps to accommodate companies that currently are comfortable with their existing processes, the language defaults to the current with the allowance for the earlier cutoff:

- i. Report terminations that were incurred in calendar year 20XX and reported before July 1, 20XX+1. **Companies may report terminations through April 1, 20XX+1, if they choose.** However, exclude rescinded policies (e.g., 10-day free look exercises) from the data submission.

Consistent with the prior occurrence in which two years of data were submitted concurrently, we request the NAIC continue to provide flexibility around the timing of individual company submissions to account for this one-time impact.

Thank you once again for consideration of our comments and we are looking forward to continued conversations with LATF on this topic.

American Council of Life Insurers | 101 Constitution Ave, NW, Suite 700 | Washington, DC 20001-2133

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acli.com

Sincerely,

A handwritten signature in black ink that reads "B Bonfedi Colin Masterson". The signature is written in a cursive style, with the first name "B Bonfedi" and the last name "Colin Masterson" clearly legible.

cc: Scott O'Neal, NAIC

Dates: Received	Reviewed by Staff	Distributed	Considered
4/21/23	SO		
Notes: APF 2021-08			

Life Actuarial (A) Task Force/ Health Actuarial (B) Task Force

Amendment Proposal Form*

1. Identify yourself, your affiliation and a very brief description (title) of the issue.

Society of Actuaries Valuation Basic Table Team – Chair Larry Bruning

Revisions to VM-51 to allow for the data experience reporting observation calendar year to be one year prior to the reporting calendar year.
2. Identify the document, including the date if the document is “released for comment,” and the location in the document where the amendment is proposed:

January 1, ~~2021~~ 2023, version of the Valuation Manual – VM-51 Section 2.D.
3. Show what changes are needed by providing a red-line version of the original verbiage with deletions and identify the verbiage to be deleted, inserted or changed by providing a red-line (turn on “track changes” in Word®) version of the verbiage. (You may do this through an attachment.)

Section 2: Statistical Plan for Mortality

D. Process for Submitting Experience Data Under This Statistical Plan

Data for this statistical plan for mortality shall be submitted on an annual basis. Each company required to submit this data shall submit the data using the Regulatory Data Collection (RDC) online software submission application developed by the Experience Reporting Agent. For each data file submitted by a company, the Experience Reporting Agent will perform reasonability and completeness checks, as defined in Section 4 of VM-50, on the data. The Experience Reporting Agent will notify the company within 30 days following the data submission of any possible errors that need to be corrected. The Experience Reporting Agent will compile and send a report listing potential errors that need correction to the company.

Data for this statistical plan for mortality will be compiled using a calendar year method. The reporting calendar year is the calendar year that the company submits the experience data. The observation calendar year is the calendar year of the experience data that is reported. The observation calendar year will be ~~two~~ one years prior to the reporting calendar year. For example, if the current calendar year is ~~2018~~ 2024 and that is the reporting calendar year, the company is to report the experience data that was in-force or issued in calendar year ~~2016~~ 2023, which is the observation calendar year. For the 2024 reporting calendar year, companies who are required to submit data for this statistical plan for mortality will be required to submit two observation calendar years of data, namely observation calendar year 2022 and observation calendar year 2023. For reporting calendar years after 2024, companies who are required to submit data for this statistical plan for mortality will be required to submit one observation calendar year of data.

Given an observation calendar year of 20XX, the calendar year method requires reporting of experience data as follows:

- i. Report policies in force during or issued during calendar year 20XX.
- ii. Report terminations that were incurred in calendar year 20XX and reported before ~~July~~ April 1, 20XX+1. Companies may report terminations reported after April 1, 20XX+1 if they choose to do so. However, exclude rescinded policies (e.g., 10-day free look exercises) from the data submission.

For any reporting calendar year, the data call will occur during the second quarter, and the data is to be submitted according to the requirements of the *Valuation Manual* in effect during that calendar year. Data submissions must be made by Sept. 30 of the reporting calendar year. Corrections of data submissions must be completed by ~~Dec. 31~~ Feb. 28 of the year following the reporting calendar year. The NAIC may extend either of these deadlines if it is deemed necessary.

4. State the reason for the proposed amendment? (You may do this through an attachment.)

This APF is needed for the following reasons:

1. There is a need to shorten the time period between data observation and data collection to facilitate more timely analysis and reporting of mortality experience.
2. Under a Principle Based Reserving methodology, valuation basic tables should reflect recent and current mortality experience.



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April 18, 2023

Rachel Hemphill
Chair, NAIC Life Actuarial (A) Task Force (LATF)

Re: APF 2023-05

Dear Ms. Hemphill:

The American Council of Life Insurers (ACLI) appreciates the opportunity to comment on APF 2023-05 (VM-21 Index Hedging) which was exposed by LATF during the Spring National Meeting in Louisville. ACLI supports the exposure with the changes proposed by LATF and the following one non-substantive change:

We observed small grammatical error in Section VM-21 4.A.4.b.ii.b and suggest striking “no” as a correction:

“...a second CTE70 (“adjusted”) which shall use only hedge assets held by the company on the valuation date and only ~~no~~ future hedge purchases associated solely with indexed interest credited.”

Regarding the 1% minimum suggested in the APF, we have a few points reflecting why we believe this is more appropriate than the current 5% minimum for VA hedging:

- Index hedging is tighter than dynamic VA hedging.
- The percentage used must be supported by company experience and would be subject to ongoing regulatory scrutiny. The 1% is not a safe harbor, but rather a floor.
- The higher the percentage, the more companies doing the tightest hedging would be penalized.
- We also do not think a survey of company experience would be fruitful because it would be aggregating apples and oranges. For example, some companies may employ a static hedging strategy, while others may use a dynamic strategy, and still others may hedge only certain Greeks, e.g., delta. The assumption should be based on the company’s specific strategy, not on an aggregation of different company strategies.

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acli.com

Thank you once again for considering our comments and we look forward to future discussions with LATF to develop this APF.

Sincerely,

 Colin Masterson

cc: Scott O'Neal, NAIC



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May 5, 2023

Rachel Hemphill
Chair, NAIC Life Actuarial (A) Task Force (LATF)

Re: Regulator Edits to APF 2023-05 (Index Credit Hedging)

Dear Ms. Hemphill:

The American Council of Life Insurers (ACLI) appreciates the opportunity to submit comments to LATF regarding APF 2023-05.

Based on informal feedback from regulators as well as additional input from ACLI members, we are submitting an updated APF and requesting re-exposure once the changes have been reviewed by LATF.

Among these changes, the APF incorporates for consideration a regulator suggestion to change the minimum Index Credit Hedge Margin from 1% to 2%. Our members have concerns about this and request that a re-exposure include both 1% and 2% as alternatives.

ACLI received other regulator suggestions to eliminate the provision that would allow for separation of strategies that combine index credit hedging and other objectives and provide additions to VM-31 documentation. We are amenable to these suggestions and have modified the APF accordingly. The APF also incorporates other regulator-suggested textual edits of a “clean up” nature.

ACLI is also proposing to add language to Section 9.E.7 to confirm that it is appropriate to use experience on similar products for purposes of the Index Credit Hedge Margin as well as the error factor.

Thank you once again for your consideration of our comments and we look forward to continued dialogue with regulators on this APF.

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acli.com

Sincerely,

A handwritten signature in cursive script that reads "Colin Masterson". The signature is written in a dark ink and is positioned to the right of a large, stylized initial "C" that spans across the beginning of the name.

cc: Scott O'Neal, NAIC



April 18, 2023

Rachel Hemphill
Chair, Life Actuarial Task Force (LATF)
National Association of Insurance Commissioners (NAIC)

Re: APF 2023-05; Hedging language to address index credit hedging in VM-21

Dear Chair Hemphill,

The Variable Annuity Reserves and Capital Working Group (VARCWG) of the American Academy of Actuaries¹ (the “Academy”) appreciates the opportunity to provide comments on the proposed changes to VM-21 as outlined in APF 2023-05.

VARCWG offers the following comments and proposals:

Recommendation for a principle-based approach

First, the VARCWG wishes to reiterate what has been stated in the past, including the most recent [comment letter from the Academy’s Life Valuation Committee](#) on APF 2020-12 in reference to modeling hedges. The VARCWG believes companies should model their investment strategies as part of a principle-based reserve calculation, which includes the modeling of hedging activities with appropriate margins.

The ideal approach for index credit hedging would be to follow the VM-20 approach, where hedge cash flows are modeled consistently with how other cash flows are projected. Any “error” to hedge cash flows can be reflected in margins that are added to best estimate cash flows with the hedges reflecting the level of uncertainty in the modeled cash flows.

It should also be noted that the current VM-21 approach could result in an error/residual risk of \$0 when CTE70 (adjusted) is less than CTE70 (best efforts). This approach may not capture the underlying risk and may underestimate the level of margin that would be appropriate for statutory valuation purposes.

Proposed revisions to exposed APF

Second, the VARCWG would propose the following redline revisions to the exposed APF:

¹ The American Academy of Actuaries is a 19,500-member professional association whose mission is to serve the public and the U.S. actuarial profession. For more than 50 years, the Academy has assisted public policymakers on all levels by providing leadership, objective expertise, and actuarial advice on risk and financial security issues. The Academy also sets qualification, practice, and professionalism standards for actuaries in the United States.

- *VM-01*: The term “Index Credit” means any interest credit, multiplier, factor, bonus, charge reduction, or other enhancement to policy or contract values that is directly linked to one or more indices. Amounts credited to the policy or contract resulting from a floor on an index account are included. An Index Credit may be positive or negative.
- *VM-21 Section 4.A.4*: An Index Credit Hedge Margin for these hedge instruments shall be reflected in both the “best efforts” and the “adjusted” runs by reducing index interest credit hedge payoffs by a margin multiple that shall be justified by sufficient and credible company experience and account for model error. It shall be no less than [1%] multiplicatively of the portion of the interest credited that is hedged. In the absence of sufficient and credible company experience, a margin of at least [20%] shall be assumed. There is no cap on the index credit hedge margin if company experience indicates actual error is greater than [20%].

The VARCWG suggests that the margin be applied only to the portion of interest credit that is hedged.

Determining the minimum index credit hedge margins

Regarding the determination of the minimum index credit hedge margins, the Academy is currently deliberating on this topic. An approach to determine the minimum hedge error is being designed for the VM-22 field test, which will be a joint effort between the Academy, NAIC, and The American Council of Life Insurers. VARCWG would propose the same approach be used for VM-21 when that approach is finalized.

Other comments for consideration

In any field test to determine level of hedge margins, the VARCWG suggests testing alternative methodologies as well, such as the VM-20 principle-based approach.

We thank you for your consideration of these comments and would be pleased to answer corresponding questions or provide additional support as needed. Should you have questions or comments in response to this letter, please contact Amanda Barry-Moilanen, life policy analyst (barrymoilanen@actuary.org).

Sincerely,

Maambo Mujala, MAAA, FSA
Chairperson, Variable Annuity Reserves and Capital Work Group
American Academy of Actuaries

CC: Scott O’ Neal, NAIC



Memo

To: Cassie Brown, Chair, Life Actuarial (A) Task Force (LATF)

From: Ben Leiser, Director, RRC

Date: April 11, 2023

Subject: RRC Comments Regarding the Proposal for Valuation Manual Revised Hedge Modeling Language in VM-21

Background

The Life Actuarial Task Force exposed for comment a proposal to revise the hedge modeling language in the Valuation Manual to address index credit hedging. RRC appreciates the opportunity to offer our comments. Should you have any questions, we would be glad to discuss our comments with you and the LATF members.

RRC Comments

We generally agree with including updated language to address index credit hedging in VM-21 in light of its use in products that have recently experienced market growth, especially given recent regulator and audit agreement as to the interpretation of the current VM-21 guidance.

While we agree with the concept of an index credit hedge margin, it is unclear as to the rationale or support for the level of the proposed minimum guardrail of 1% or the proposed level of 20% if there is no company experience to support the margin.

- a. It doesn't appear appropriate that a company could have no experience to support their index credit hedging assumptions and assume that the hedging is effective with a 20% margin. If their hedging is not well designed, the margin of 20% could be too low. We suggest that there be a requirement for a company to provide justification and support for including hedging at all. In addition, the assumed margin included in the regulation should be justified and supported.
- b. We also suggest that the guidance point to how the margin is set more generally; e.g., the less experience and the more volatility, the higher the required margin, and to include model based testing of the appropriateness of the margin, in a range of interest rate environments.

We also suggest that LATF consider whether to implement this change as a temporary measure and update accordingly when VM-22 is in place, given that the exposure is intended to align the index credit hedging guidance between VM-21 and VM-22; this would ensure that they be kept in alignment from the start and not result in different or inconsistent requirements or margin guardrails.

Thank you for the opportunity to provide comments on this important initiative. I can be reached at ben.leiser@riskreg.com/(201) 870-7713 if you or other LATF members have any questions.

Dates: Received	Reviewed by Staff	Distributed	Considered
3/7/23, 5/5/23, 5/10/23	SO		
Notes: APF 2023-05			

**Life Actuarial (A) Task Force/ Health Actuarial (B) Task Force
 Amendment Proposal Form***

1. Identify yourself, your affiliation and a very brief description (title) of the issue.

Identification:

Brian Bayerle, ACLI

Title of the Issue:

Revise hedge modeling language to address index credit hedging.

2. Identify the document, including the date if the document is “released for comment,” and the location in the document where the amendment is proposed:

VM-01, VM-21 Section 4.A.4, VM-21 Section 6.B.3, VM-21 Section 9, VM-21 Section 9.C.2, VM-21 Section 9.E.7, VM-31 Section 3.F.8.d

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January 1, 2023 NAIC Valuation Manual, APF 2020-12

3. Show what changes are needed by providing a red-line version of the original verbiage with deletions and identify the verbiage to be deleted, inserted or changed by providing a red-line (turn on “track changes” in Word®) version of the verbiage. (You may do this through an attachment.)

See attached.

4. State the reason for the proposed amendment? (You may do this through an attachment.)

Index credit hedging is fundamentally different than the dynamic GMxB hedging which formed the conceptual underpinnings for VM-21. For example, the relatively fixed parameters of traditional GMxBs drive the hedging approach. In contrast, indexed products (including RILAs) have flexible crediting parameters which are continually reset based on hedge availability and costs, as well as current market conditions. In short, GMxB contract features drive hedging, while index product hedging drives contract features.

Since the reforms of VM-21 and C3P2, ILVA products have experienced major market growth. Several carriers, with the agreement of regulators and auditors, have interpreted the current VM-21 guidance as permitting the effects of index credit hedging to be reflected in product cash flows instead of within the “best efforts” and “adjusted” scenarios. Both regulators and industry would benefit from the codification of this approach within VM-21.

ACLI’s proposal borrows heavily from the Academy’s draft VM-22. The “error” for index credit hedging is describes as a percentage reduction to hedge payoffs. The percentage reduction must be supported by relevant, credible, and documented experience. A minimum of [1%/2%] is proposed as a regulatory guardrail.

The ACLI proposal would subject index credit hedging to the “clearly defined” documentation requirements of VM-21. Substantively, the change would (a) include index credit hedge purchases with the VM-21 “adjusted” run, and (b) permit index credit hedging to reflect a different, and potentially lower, level of ineffectiveness.

Dates: Received	Reviewed by Staff	Distributed	Considered
3/7/23, 5/5/23, 5/10/23	SO		
Notes: APF 2023-05			

ACLI supports aligning the index credit hedging guidance between VM-21 and VM-22. We started with draft VM-22 verbiage in creating this APF. In a few areas, our members have suggested technical improvements to the draft VM-22 definitions. It may be appropriate to carry these over to VM-22.

* This form is not intended for minor corrections, such as formatting, grammar, cross-references or spelling. Those types of changes do not require action by the entire group and may be submitted via letter or email to the NAIC staff support person for the NAIC group where the document originated.

NAIC Staff Comments:

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Dates: Received	Reviewed by Staff	Distributed	Considered
3/7/23, 5/5/23, 5/10/23	SO		
Notes: APF 2023-05			

VM-01

The term “Index Credit Hedge Margin” means a margin capturing the risk of inefficiencies in the company’s hedging program supporting index credits. This includes basis risk, persistency risk, and the risk associated with modeling decisions and simplifications. It also includes any uncertainty of costs associated with managing the hedging program and changes due to investment and management decisions.

The term “Index Credit” means any interest credit, multiplier, factor, bonus, charge reduction, or other enhancement to policy or contract values that is directly linked to one or more indices. Amounts credited to the policy or contract resulting from a floor on an index account are included. An Index Credit may be positive or negative.

The term “Index Crediting Strategies” means the strategies defined in a contract to determine index credits for a contract. For example, this may refer to underlying index, index parameters, date, timing, performance triggers, and other elements of the crediting method.

VM-21 Section 4.A.4

4. Modeling of Hedges

- a. For a company that does not have a future hedging strategy supporting the contracts:
 - i. The company shall not consider the cash flows from any future hedge purchases or any rebalancing of existing hedge assets in its modeling, since they are not included in the company’s investment strategy supporting the contracts.
 - ii. Existing hedging instruments that are currently held by the company in support of the contracts falling under the scope of these requirements shall be included in the starting assets.
- b. For a company with one or more future hedging strategies supporting the contracts:
 - i. For a future hedging strategy with hedge payoffs that solely offset ~~interest-index credits~~ associated with indexed interest strategies (~~indexed interest-credits~~):
 - a) In modeling cash flows, the company shall include the cash flows from future hedge purchases or any rebalancing of existing hedge assets that are intended solely to offset ~~interest-index credits~~ to contract holders.
 - b) Existing hedging instruments that are currently held by the company for offsetting the ~~indexed credits~~ in support of the contracts falling under the scope of these requirements shall be included in the starting assets.
 - c) An Index Credit Hedge Margin for these hedge instruments shall be reflected in both the “best efforts” and the “adjusted” runs, as applicable, by reducing index ~~interest-credit~~ hedge payoffs by a margin multiple that shall be justified by sufficient and credible company experience and account for model error. It shall be no less than [1%/2%] multiplicatively of the portion of the ~~interest-index credited~~ that is hedged. In the absence of sufficient and credible company experience, a margin of at least 20% shall be assumed. There is no cap on the index credit hedge margin if company experience indicates actual error is greater than ~~these minimums~~[20%].

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Commented [A1]: Replace with "these minimums" as rereading this applies to either 2% or 20% scenarios. Not strictly needed if we are trying to be minimal with edits.

Dates: Received	Reviewed by Staff	Distributed	Considered
3/7/23, 5/5/23, 5/10/23	SO		
Notes: APF 2023-05			

- ii. For a company with one or more future hedging strategies supporting the contracts that do not solely offset indexed interest credits, the detailed requirements for the modeling of the hedges are defined in Section 9. The following requirements do not supersede the detailed requirements.
- The appropriate costs and benefits of hedging instruments that are currently held by the company in support of the contracts falling under the scope of these requirements shall be included in the projections used in the determination of the SR.
 - The projections shall take into account the appropriate costs and benefits of hedge positions expected to be held in the future through the execution of the future hedging strategies supporting the contracts. Because models do not always accurately portray the results of hedge programs, the company shall, through back-testing and other means, assess the accuracy of the hedge modeling. The company shall determine a SR as the weighted average of two CTE values; first, a CTE70 ("best efforts") representing the company's projection of all of the hedge cash flows, including future hedge purchases, and a second CTE70 ("adjusted") which shall use only hedge assets held by the company on the valuation date and only future hedge purchases associated solely with indexed interest credits. These are discussed in greater detail in Section 9. The SR shall be the weighted average of the two CTE70 values, where the weights reflect the error factor determined following the guidance of Section 9.C.4.
 - The company is responsible for verifying compliance with all requirements in Section 9 for all hedging instruments included in the projections.
 - The use of products not falling under the scope of these requirements (e.g., equity-indexed annuities) as a hedge shall not be recognized in the determination of accumulated deficiencies.
- iii. If a company has a more comprehensive hedge strategy combining index credits with guaranteed benefit and/or other risks (e.g., full fair value or economic hedging), no portion of this hedge strategy is eligible for the treatment described in section 4.A.4.b.ian appropriate and documented bifurcation method should be used in the application of sections 4.A.4.b.i and 4.A.4.b.ii above for the hedge modeling and justification. Such bifurcation methods may quantify the specific risk exposure attributable to index credit liabilities versus other liabilities such as guaranteed living benefits, and apply such for the basis for allocation.

Commented [A2]: Until industry can provide quantitative evidence on historical hedging errors as a percent of interest credited, suggest no allowing bifurcation.

VM-21 Section 6.B.3 Footnote

¹ Throughout this Section 6, references to CTE70 (adjusted) shall also mean the SR for a company that does not have a future hedging strategy supporting the contracts that does not solely offset index credits as discussed in Section 4.A.4.a.

VM-21 Section 9

Section 9: Modeling Hedges under a Future Non-Index Credit Hedging Strategy

A. Initial Considerations

Dates: Received	Reviewed by Staff	Distributed	Considered
3/7/23, 5/5/23, 5/10/23	SO		
Notes: APF 2023-05			

1. ~~This section applies to modeling of hedges other than situations where the company only hedges index credits. If the company clearly separates index credit hedging from other hedging, then this section only applies to the other hedging if the index hedging follows the requirements in Section 4.A.4.b.i. If the company does not clearly separate index credit hedging from other hedging, then this section is applicable for modeling of all hedges.~~

Commented [A3]: Delete

2. Subject to Section 9.C.2, the appropriate costs and benefits of hedging instruments that are currently held by the company in support of the contracts falling under the scope of these requirements shall be included in the calculation of the SR, determined in accordance with Section 3.D and Section 4.D.

(Subsequent sections to be renumbered)

VM-21 Section 9.C.2

2. The company shall calculate a CTE70 (adjusted) by recalculating the CTE70 assuming the company has no future hedging strategies supporting the contracts except hedge purchases solely related to strategies to hedge index credits, therefore following the requirements of Section 4.A.4.a and 4.A.4.b.i.

However, for a company with a future hedging strategy supporting the contracts, existing hedging instruments, except hedging instruments solely related to strategies to hedge index credits, that are currently held by the company in support of the contracts falling under the scope of these requirements may be considered in one of two ways for the CTE70 (adjusted):

- a) Include the asset cash flows from any contractual payments and maturity values in the projection model.
- b) No hedge positions, in which case, the hedge positions held on the valuation date are replaced with cash and/or other general account assets in an amount equal to the aggregate market value of these hedge positions.

VM-21 Section 9.E.7

7. The company may also consider historical experience for similar current or past hedging programs on similar products to support the error factor or Index Credit Hedge Margin determined for the projection.

Commented [A4]: Expanding provision for index credit hedging, noting that the index credit adjustment is described as the Index Credit Hedge Margin, not the error factor.

VM-31 Section 3.F.8.d.x (new subsection)

x. Justification for the margin for any future hedging strategy that offsets interest index credits associated with indexed interest strategies (indexed interest credits), including relevant experience, other relevant analysis, and an assessment of potential model error

Commented [A5]: Modify to "index credits" to be consistent throughout the draft and the additional definition.

Dates: Received	Reviewed by Staff	Distributed	Considered
3/7/23, 5/5/23, 5/10/23	SO		
Notes: APF 2023-05			

- xi. Ten years of historical experience on hedge gains/losses as a percent of index credited for hedge programs supporting index credits. **Commented [A6]:** VM-31 requirement for historical experience to support error factor.

- xii. If there is less than five years of historical experience of this hedging program or a hedging program on similar products, an explanation of how the company considered increases in the error factor to account for limited historical experience. **Commented [A7]:** Explanation for how margin was increased if there was less than 5 years of experience.

- x. The method used to bifurcate comprehensive hedge strategies (i.e., strategies combining index credits, guaranteed benefit, and other risks (e.g., full fair value or economic hedging), per section 4.A.4.b.iii. **Commented [A8]:** Only include if bifurcation is allowed

DRAFT

Draft: 6/26/23

Life Actuarial (A) Task Force
Virtual Meeting
May 4, 2023

The Life Actuarial (A) Task Force met May 4, 2023. The following Task Force members participated: Cassie Brown, Chair, represented by Rachel Hemphill; Scott A. White, Vice Chair, represented by Craig Chupp (VA); Lori K. Wing-Heier represented by Sharon Comstock (AK); Mark Fowler represented by Sanjeev Chaudhuri (AL); Ricardo Lara represented by Ahmad Kamil (CA); Andrew N. Mais represented by Wanchin Chou and); Doug Ommen represented by Mike Yanacheak (IA); Dana Popish Severinghaus represented by Vincent Tsang (IL); Amy L. Beard represented by Scott Shover (IN); Vicki Schmidt represented by Nicole Boyd (KS); Grace Arnold represented by Fred Andersen and Ben Slutsker (MN); Timothy Schott represented by Marti Hooper (ME); Adrienne A. Harris represented by Bill Carmello (NY); Judith L. French represented by Peter Weber (OH); Glen Mulready represented by Andrew Schallhorn (OK); Michael Humphreys represented by Steve Boston (PA); and Jon Pike represented by Tomasz Serbinowski (UT).

1. Considered LATF Response to VOSTF Referral – Bond Risk Measures

Hemphill walked through the proposed response (Attachment Six-A) to the Valuation of Securities (E) Task Force (VOSTF) referral related to bond risk measures. Hemphill asked if there was any objection from a Task Force member to the response to the VOSTF referral. As no Task Force members objected, Hemphill noted that the response would be sent to VOSTF.

2. Exposed APF 2023-07 – Company Specific Market Paths (CSMP) Removal

Slutsker introduced amendment proposal form (APF) 2023-07 that removes the Company-Specific Market Path (CSMP) standard projection amount method from the VM-21, Requirements for Principle-Based Reserves for Variable Annuities requirements. Slutsker noted that there has been very little usage of the CSMP method among companies and that adapting the method for the new generator of economic scenarios would require a significant effort. Slutsker said that the CSMP method would be removed starting in 2025 which would give companies ample time to prepare.

Slutsker made a motion, seconded by Chupp, to expose APF 2023-07 (Attachment Six-B) for a 21-day public comment period ending May 24. During discussion of the motion, Weber asked if there had been communication with the companies who would be affected by the removal of the CSMP method. Hemphill replied that there had been a survey conducted to determine the number of companies that use the CSMP method and that additional communication with the affected companies had taken place to allow those companies to provide feedback. The motion passed unanimously.

Having no further business, the Life Actuarial (A) Task Force adjourned.

SharePoint/NAIC Support Staff Hub/Member Meetings/A CMTE/LATF/2023-2-Summer/LATF Calls/05 04/May 04 Minutes.docx



MEMORANDUM

TO: Carrie Mears, Chair, Valuation of Securities (E) Task Force

FROM: Rachel Hemphill, Chair, Life Actuarial (A) Task Force
Craig Chupp, Vice-Chair, Life Actuarial (A) Task Force

RE: Life Actuarial (A) Task Force Response to Bond Risk Measures Referral

DATE: May 5, 2023

Background

On February 13, 2023 a memorandum from the Valuation of Securities (E) Task Force (VOSTF) was received by the Life Actuarial (A) Task Force (LATF) requesting that the Task Force consider the following items:

1. Whether the LATF was supportive of the NAIC's Securities Valuation Office (SVO) building out a new capability to calculate market and analytical information for bonds utilizing commercially available data sources and investment models,
2. Which investment analytical measures and projections would be most helpful to support the work of the LATF,
3. How the LATF would utilize the investment data and why it would be of value,
4. Whether other investment data or projection capabilities would be useful to the LATF that could be provided by commercially available data sources or investment models, and
5. Any other thoughts the LATF had on the SVO initiative.

Recommendation

At their public meeting on April 20th, 2023 the LATF developed the following responses with respect to the VOSTF referral: 1) the LATF was supportive of the SVO initiative to build out a new capability to calculate market data fields; 2) weighted-average life (WAL), option-adjusted spread (OAS), duration, and convexity are some of the most helpful measures, along with comparisons of credit rating provider ratings to SVO ratings, to support regulator review of principle-based reserves (PBR) and asset adequacy testing (AAT); 3) the investment data would be used to complement Actuarial Guideline 53 (AG 53), PBR, and AAT reporting, which is less granular than the proposed risks measures, to give regulators additional insights into the risk/reward profile of insurer assets while reducing the need for LATF stress testing, and; 4) that a description of the scenarios or situations where an asset (such as a collateralized loan obligation) could lose much of its value would assist regulators in assessing tail risk in PBR, AAT, and other reviews.

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New York One New York Plaza, Suite 4210, New York, NY 20004 p | 212 398 9000 f | 212 382 4207

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**Life Actuarial (A) Task Force/ Health Actuarial (B) Task Force
 Amendment Proposal Form***

1. Identify yourself, your affiliation and a very brief description (title) of the issue.

Identification:

California Office of Principles-Based Reserving and Minnesota Department of Commerce

Title of the Issue:

Company-Specific Market Path (CSMP) Removal

2. Identify the document, including the date if the document is “released for comment,” and the location in the document where the amendment is proposed:

VM-21 Section 6.A.1

January 1, 2024 NAIC *Valuation Manual*

3. Show what changes are needed by providing a red-line version of the original verbiage with deletions and identify the verbiage to be deleted, inserted or changed by providing a red-line (turn on “track changes” in Word®) version of the verbiage. (You may do this through an attachment.)

See attached.

4. State the reason for the proposed amendment? (You may do this through an attachment.)

The standard projection amount drafting group found that there is very little use of the CSMP method for the VM-21 standard projection amount. Therefore, we recommend removing this method from VM-21 starting in 2025, which gives time to transition to the CTEPA method for the few companies that currently employ the CSMP method.

* This form is not intended for minor corrections, such as formatting, grammar, cross-references or spelling. Those types of changes do not require action by the entire group and may be submitted via letter or email to the NAIC staff support person for the NAIC group where the document originated.

NAIC Staff Comments:

Dates: Received	Reviewed by Staff	Distributed	Considered
5/1/2023	SO		
Notes: APF 2023-07			

VM-21 Section 6: Requirements for the Additional Standard Projection Amount

A. Overview

1. Determining the Additional Standard Projection Amount

a. ~~For valuation dates before January 1, 2025, the additional standard projection amount shall be the larger of zero and an amount determined in aggregate for all contracts falling under the scope of these requirements, excluding those contracts to which the Alternative Methodology is applied, by calculating the Prescribed Projections Amount by one of two methods, the Company-Specific Market Path (CSMP) method or the CTE with Prescribed Assumptions (CTEPA) method. The company shall assess the impact of aggregation on the additional standard projection amount.~~

Deleted: T

b. ~~For valuation dates after January 1, 2025, the additional standard projection amount shall be the larger of zero and an amount determined in aggregate for all contracts falling under the scope of these requirements, excluding those contracts to which the Alternative Methodology is applied, by calculating the Prescribed Projections Amount by the CTEPA method. The company shall assess the impact of aggregation on the additional standard projection amount.~~

c. The additional standard projection amount shall be calculated based on the scenario reserves, as discussed in Section 4.B, with certain prescribed assumptions replacing the company prudent estimate assumptions. As is the case in the projection of a scenario in the calculation of the SR, the scenario reserves used to calculate the additional standard projection amount are based on an analysis of asset and liability cash flows produced along certain equity and interest rate scenario paths.

Draft: 6/28/23

Life Actuarial (A) Task Force
Virtual Meeting
April 27, 2023

The Life Actuarial (A) Task Force met April 27, 2023. The following Task Force members participated: Cassie Brown, Chair, represented by Rachel Hemphill (TX); Scott A. White, Vice Chair, represented by Craig Chupp (VA); Lori K. Wing-Heier represented by Sharon Comstock (AK); Mark Fowler represented by Sanjeev Chaudhuri (AL); Ricardo Lara represented by Ahmad Kamil (CA); Andrew N. Mais represented by Wanchin Chou (CT); Doug Ommen represented by Mike Yanacheak (IA); Dana Popish Severinghaus represented by Vincent Tsang (IL); Amy L. Beard represented by Scott Shover (IN); Vicki Schmidt represented by Nicole Boyd (KS); Grace Arnold represented by Fred Andersen and Ben Slutsker (MN); Eric Dunning represented by Michael Muldoon (NE); Adrienne A. Harris represented by Bill Carmello (NY); Judith L. French represented by Peter Weber (OH); Michael Humphreys represented by Steve Boston (PA); and Jon Pike represented by Tomasz Serbinowski (UT).

1. Re-Exposed APF 2021-08

Larry Bruning (Society of Actuaries—SOA) noted that the purpose of amendment proposal form (APF) 2021-08 is to shorten the data lag period for the mortality experience data collection from two years to one year. Hemphill said that there was one comment received from the American Council of Life Insurers (ACLI) (Attachment Seven-A). Angela McNabb (NAIC) stated that in response to the comment letter, the previously exposed version of APF 2021-08 had been modified to: 1) require that companies include terminations that were reported before April 1 following the year of the data collection instead of the following July 1; and 2) allow for corrected submissions to be submitted by Feb. 28 of the year following the reporting calendar year instead of by Dec. 31 of the reporting calendar year. Brian Bayerle (ACLI) said that he thinks the changes were responsive to their comment letter.

Chupp made a motion, seconded by Andersen, to expose APF 2021-08 (Attachment Seven-B) for a 10-day public comment period ending May 8. The motion passed unanimously.

2. Consider the IMR Referral from the Statutory Accounting Practices (E) Working Group

Hemphill walked through a Statutory Accounting Practices (E) Working Group referral (Attachment Seven-C) regarding negative interest maintenance reserve (IMR) balances. Hemphill proposed that the Task Force responds to the referral by: 1) drafting a template with additional disclosures on the reflection of IMR in principle-based reserving (PBR) and asset adequacy testing (AAT), including confirming that any IMR amounts do not generate subsequent cash flows and that the IMR does not reflect excess withdrawals; 2) drafting guidance for companies for year-end 2023, consistent with year-end 2022 guidance but updated for the Working Group's potential admission of some portion of aggregate negative IMR; 3) drafting an APF for the 2025 *Valuation Manual* consistent with the guidance; and 4) recommending to the Working Group that any decision to admit or not admit aggregate negative IMR not rely on AAT at this time.

Carmello discussed the potential for a disclosure that could illustrate that the proceeds of bond sales were reinvested at higher interest rates and, therefore, more worthy of reporting an associated negative IMR asset. Robust discussion ensued, with some indicating the value of such a disclosure and others noting challenges with the approach. Hemphill noted that a Statutory Accounting Principles (E) Working Group exposure stated that any negative IMR balances that would be admitted would be limited to those where the proceeds of the sale of bonds held at amortized cost were immediately reinvested into other qualifying fixed-income assets that would also be held at amortized cost.

Hemphill asked if any Task Force members objected to moving forward with the proposed response to the Working Group referral. As none objected, Hemphill noted that work would proceed on the response to the Working Group.

Having no further business, the Life Actuarial (A) Task Force adjourned.

SharePoint/NAIC Support Staff Hub/Member Meetings/A CMTE/LATF/ 2023-2-Summer/LATF Calls/04 27/April 27 Minutes.docx

**Brian Bayerle**

Chief Life Actuary

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Policy Analyst

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April 13, 2023

Rachel Hemphill

Chair, Life Actuarial (A) Task Force (LATF)

Re: Re-Exposure of APF 2021-08 (VM-51 Data Call Lag Reduction)

Dear Ms. Hemphill:

The American Council of Life Insurers (ACLI) appreciates the opportunity to submit comments on the re-exposure of APF 2021-08 on reducing the VM-51 Data Call Lag reduction from two years to one year. ACLI is generally supportive of this change though we have some concerns about the timing of the switch and the impact it could have on industry.

For many companies, the data needed for the data call is not finalized until sometime around mid-August. With the current timeline, this would only give companies around six weeks to generate submissions. This is a problem that could be exacerbated even further if the companies have to submit on behalf of additional legal entities and subsidiaries within their organization. The short timeline between IBNR and the submission date could also reduce the quality of data submitted by companies which is antithetical to the primary goal of the APF.

To ensure that companies are given ample time to collect and package data in a manner in line with the desires of regulators, ACLI proposes that the IBNR date be moved to March 31st instead of June 30th.

Additionally, there is an additional sentence that allows the NAIC to extend the deadline if deemed necessary. It is not clear if this applies to only the last or all the deadlines. ACLI would suggest revising this language to apply to all the deadlines.

These suggested edits are redlined in VM-51 Section 2.D (in part) from the proposed APF language:

American Council of Life Insurers | 101 Constitution Ave, NW, Suite 700 | Washington, DC 20001-2133

The American Council of Life Insurers (ACLI) is the leading trade association driving public policy and advocacy on behalf of the life insurance industry. 90 million American families rely on the life insurance industry for financial protection and retirement security. ACLI's member companies are dedicated to protecting consumers' financial wellbeing through life insurance, annuities, retirement plans, long-term care insurance, disability income insurance, reinsurance, and dental, vision and other supplemental benefits. ACLI's 280 member companies represent 94 percent of industry assets in the United States.

acli.com

Given an observation calendar year of 20XX, the calendar year method requires reporting of experience data as follows:

- i. Report policies in force during or issued during calendar year 20XX.
- ii. Report terminations that were incurred in calendar year 20XX and reported before ~~July~~ April 1, 20XX+1. However, exclude rescinded policies (e.g., 10-day free look exercises) from the data submission.

For any reporting calendar year, the data call will occur during the second quarter, and the data is to be submitted according to the requirements of the Valuation Manual in effect during that calendar year. Data submissions must be made by Sept. 30 of the reporting calendar year. Corrections of data submissions must be completed by Feb. 28 of the year following the reporting calendar year. The NAIC may extend ~~either of these~~ ~~this~~ deadlines if it is deemed necessary.

Thank you once again for consideration of our comments and we are looking forward to continued conversations with LATF on this topic.

Sincerely,

Handwritten signature of Colin Masterson in cursive script.

cc: Scott O'Neal, NAIC

Dates: Received	Reviewed by Staff	Distributed	Considered
4/21/23	SO		
Notes: APF 2021-08			

**Life Actuarial (A) Task Force/ Health Actuarial (B) Task Force
 Amendment Proposal Form***

1. Identify yourself, your affiliation and a very brief description (title) of the issue.

 Society of Actuaries Valuation Basic Table Team – Chair Larry Bruning

 Revisions to VM-51 to allow for the data experience reporting observation calendar year to be one year prior to the reporting calendar year.
2. Identify the document, including the date if the document is “released for comment,” and the location in the document where the amendment is proposed:

 January 1, ~~2021~~ 2023, version of the Valuation Manual – VM-51 Section 2.D.
3. Show what changes are needed by providing a red-line version of the original verbiage with deletions and identify the verbiage to be deleted, inserted or changed by providing a red-line (turn on “track changes” in Word®) version of the verbiage. (You may do this through an attachment.)

Section 2: Statistical Plan for Mortality

- D. Process for Submitting Experience Data Under This Statistical Plan

 Data for this statistical plan for mortality shall be submitted on an annual basis. Each company required to submit this data shall submit the data using the Regulatory Data Collection (RDC) online software submission application developed by the Experience Reporting Agent. For each data file submitted by a company, the Experience Reporting Agent will perform reasonability and completeness checks, as defined in Section 4 of VM-50, on the data. The Experience Reporting Agent will notify the company within 30 days following the data submission of any possible errors that need to be corrected. The Experience Reporting Agent will compile and send a report listing potential errors that need correction to the company.

Data for this statistical plan for mortality will be compiled using a calendar year method. The reporting calendar year is the calendar year that the company submits the experience data. The observation calendar year is the calendar year of the experience data that is reported. The observation calendar year will be ~~two~~ one years prior to the reporting calendar year. For example, if the current calendar year is ~~2018~~ 2024 and that is the reporting calendar year, the company is to report the experience data that was in-force or issued in calendar year ~~2016~~ 2023, which is the observation calendar year. **For the 2024 reporting calendar year, companies who are required to submit data for this statistical plan for mortality will be required to submit two observation calendar years of data, namely observation calendar year 2022 and observation calendar year 2023. For reporting calendar years after 2024, companies who are required to submit data for this statistical plan for mortality will be required to submit one observation calendar year of data.**

Given an observation calendar year of 20XX, the calendar year method requires reporting of experience data as follows:

- i. Report policies in force during or issued during calendar year 20XX.
- ii. Report terminations that were incurred in calendar year 20XX and reported before ~~July~~ April 1, 20XX+1. Companies may report terminations reported after April 1, 20XX+1 if they choose to do so. However, exclude rescinded policies (e.g., 10-day free look exercises) from the data submission.

For any reporting calendar year, the data call will occur during the second quarter, and the data is to be submitted according to the requirements of the *Valuation Manual* in effect during that calendar year. Data submissions must be made by Sept. 30 of the reporting calendar year. Corrections of data submissions must be completed by ~~Dec. 31~~ Feb. 28 of the year following the reporting calendar year. The NAIC may extend either of these deadlines if it is deemed necessary.

4. State the reason for the proposed amendment? (You may do this through an attachment.)

This APF is needed for the following reasons:

1. There is a need to shorten the time period between data observation and data collection to facilitate more timely analysis and reporting of mortality experience.
2. Under a Principle Based Reserving methodology, valuation basic tables should reflect recent and current mortality experience.



MEMORANDUM

TO: Rachel Hemphill, Chair of the Life Actuarial (A) Task Force
Craig Chupp, Vice-Chair of the Life Actuarial (A) Task Force

FROM: Dale Bruggeman, Chair of the Statutory Accounting Principles (E) Working Group
Kevin Clark, Vice-Chair of the Statutory Accounting Principles (E) Working Group

DATE: March 27, 2023

RE: SAPWG Referral for Negative Interest Maintenance Reserve (IMR)

During the 2023 Spring National Meeting, the Statutory Accounting Principles (E) Working Group held a detailed discussion on the potential to permit admittance of negative interest maintenance reserve (IMR). The Working Group discussed the potential for both a 2023 solution and a long-term solution. With this discussion, the Working Group recommended continued engagement with the Life Actuarial (E) Task Force with a referral for consideration of the Asset Adequacy Testing (AAT) implications of negative IMR.

Specifically, the Working Group recommended a referral to the Task Force to consider the following:

1. Development of a template summarizing how IMR (positive and negative) is reflected within AAT.
2. Consideration of the actual amount of negative IMR that is to be used in AAT, noting that as negative IMR is included, there is a greater potential for an AAT liability.
3. Better consideration and documentation of cash flows within AAT, as well as any liquidity stress test considerations.
4. Ensuring that excessive withdrawal considerations are consistent with actual data. (Insurers selling bonds because of excess withdrawals should not use the IMR process.)
5. Ensuring that any guardrails for assumptions in AAT are reasonable and consistent with other financial statement / reserving assumptions.

The Working Group appreciates your time and partnership in assessing the impact of negative IMR and working towards an appropriate solution for statutory accounting and overall insurer financial solvency. If you have any questions, please contact Dale Bruggeman, or Kevin Clark, SAPWG Chair and Vice Chair, with any questions.

Cc: Julie Gann, Robin Marcotte, Jake Stultz, Jason Farr, Wil Oden, Scott O'Neal,

https://naiconline.sharepoint.com/teams/FRSStatutoryAccounting/Stat Acctg_Statutory_Referrals/2023/SAPWG to LATF - 3-27-23.docx

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Draft: 6/28/23

Life Actuarial (A) Task Force
Virtual Meeting
April 20, 2023

The Life Actuarial (A) Task Force met April 20, 2023. The following Task Force members participated: Cassie Brown, Chair, represented by Rachel Hemphill (TX); Scott A. White, Vice Chair, represented by Craig Chupp (VA); Lori K. Wing-Heier represented by Sharon Comstock (AK); Mark Fowler represented by Sanjeev Chaudhuri (AL); Ricardo Lara represented by Ahmad Kamil and Thomas Reedy (CA); Andrew N. Mais represented by Wanchin Chou (CT); Doug Ommen represented by Mike Yanacheak (IA); Dana Popish Severinghaus represented by Vincent Tsang (IL); Amy L. Beard represented by Heir Cooper (IN); Vicki Schmidt represented by Nicole Boyd (KS); Grace Arnold represented by Fred Andersen and Ben Slutsker (MN); Eric Dunning represented by Michael Muldoon (NE); Marlene Caride represented by Seong-min Eom (NJ); Adrienne A. Harris represented by Bill Carmello (NY); Judith L. French represented by Peter Weber (OH); Glen Mulready represented by Andrew Schallhorn (OK); Michael Humphreys represented by Steve Boston (PA); and Jon Pike represented by Tomasz Serbinowski (UT).

1. Disbanded the Index-Linked Variable Annuity (A) Subgroup

Hemphill thanked Weber, the members of the Index-Linked Variable Annuity (A) Subgroup, and the interested parties for working to complete the charges of the Subgroup. Weber noted that he supports disbanding the Subgroup.

Hemphill asked Task Force members if there are any objections to disbanding the Subgroup. With no objections, the Subgroup disbanded.

2. Adopted APF 2023-04

Hemphill said amendment proposal form (APF) 2023-04 clarifies the requirements for the mortality rates the company expects to emerge. She noted that no comments were received during the exposure period.

Chupp made a motion, seconded by Reedy, to adopt APF 2023-04 (Attachment Eight-A). The motion passed unanimously.

3. Exposed APF 2023-06

Hemphill noted that APF 2023-06 was taken from Sections 1 and 2 of the originally exposed version of APF 2023-03. She said APF 2023-06 addresses: 1) an inconsistency in the net premium reserve (NPR) calculation in VM-20, Requirements for Principle-Based Reserves for Life Products; and 2) adding a cash surrender value floor to the calculation of scenario reserves to be consistent with VM-21, Requirements for Principle-Based Reserves for Variable Annuities.

On item #1, Dylan Strother (American Academy of Actuaries—Academy) walked through the Academy's comment letter (Attachment Eight-B) and noted that initial testing showed a material increase to the NPR for new business. Chupp asked how the formulae for the NPR differs from the methodology used in *Actuarial Guideline XXXVIII—The Application of the Valuation of Life Insurance Policies Model Regulation* (AG 38) Section 8D. Strother noted that the calculations are not directly comparable. Colin Masterson (American Council of Life Insurers—ACLI) walked through the ACLI's comment letter (Attachment Eight-C) and noted that the ACLI supports delaying consideration on APF 2023-06 and holistically reviewing the NPR formula before making changes. Hemphill

responded that she supports taking the appropriate amount of time to consider the changes in APF 2023-06, and she requested additional analysis from the Academy.

Regarding the changes in Section 2 of APF 2023-06, Dave Neve (Academy) noted that the Academy does not support flooring the VM-20 scenario reserve at the cash surrender value due to a floor already being present in the NPR calculation, as well as the Academy's view that a floor in the scenario reserve component would distort the VM-20 stochastic reserve measure. Masterson agreed with Neve, and he noted a lack of support from the ACLI for this change. Hemphill noted concerns that without this change, the measure of tail risk could be understated in the VM-20 stochastic reserve, to which Carmello agreed.

Carmello made a motion, seconded by Weber, to expose APF 2023-06 (Attachment Eight-D) for a 21-day public comment period ending May 10. During discussion of the motion, Neve asked if it would make sense to determine the impact of these changes prior to adoption. Hemphill responded that some quantification was already provided, and interested parties were free to comment during the exposure period regarding any additional quantification that is necessary. The motion passed unanimously.

4. Discussed the VOSTF Bond Risk Measures Referral

Hemphill introduced the Bond Risk Measures referral (Attachment Eight-E) from the Valuation of Securities (E) Task Force (VOSTF) that had been exposed for comment. She proposed responding to items #1 through #4 of the referral by: 1) indicating that the Life Actuarial (A) Task Force was supportive of the Securities Valuation Office (SVO) initiative to build out a new capability to calculate market data fields; 2) noting that weighted-average life (WAL), option-adjusted spread (OAS), duration, and convexity are some of the most helpful measures, along with comparisons of credit rating provider (CPR) ratings to SVO ratings, to support state insurance regulator review of principle-based reserves (PBR) and asset adequacy testing (AAT); 3) noting that the investment data would be used to complement *Actuarial Guideline LIII—The Application of the Valuation Manual for Testing the Adequacy of Life Insurer Reserves* (AG 53), PBR, and AAT reporting, which is less granular than the proposed risk measures, to give state insurance regulators additional insights into the risk/reward profile of insurer assets, while reducing the need for Life Actuarial (A) Task Force stress testing; and 4) stating that a description of the scenarios or situations where an asset, such as a collateralized loan obligation (CLO), could lose much of its value would assist state insurance regulators in assessing tail risk in PBR, AAT, and other reviews.

Hemphill then summarized comment letters that had been received from the Academy (Attachment Eight-F) and the ACLI (Attachment Eight-G). Craig Morrow (Academy) spoke to the Academy's comment letter, and he stated that it recommends developing a proof-of-concept initiative to identify how the additional investment information could be utilized.

Hemphill asked if any Life Actuarial (A) Task Force members object to directing NAIC staff to draft a memo to the Valuation of Securities (E) Task Force with the discussed response. No members objected, and NAIC staff were given the direction to draft the memo.

5. Discussed the Valuation of Securities (E) Task Force Structured Equity and Funds Referral

Hemphill summarized the VOSTF Structured Equity and Funds referral (Attachment Eight-H), and she noted that a comment letter (Attachment Eight-I) was received from the ACLI. Masterson said the ACLI noted some concerns to the VOSTF regarding this initiative in a separate comment letter.

Hemphill asked if any Life Actuarial (A) Task Force members object to directing NAIC staff to draft a memo to the Valuation of Securities (E) Task Force noting support of the related efforts continuing through an open process. No members objected, and NAIC staff were given the direction to draft the memo.

Having no further business, the Life Actuarial (A) Task Force adjourned.

SharePoint/NAIC Support Staff Hub/Member Meetings/A CMTE/LATF/2023-2-Summer/LATF Calls/04 20/April 20 Minutes.docx

**Life Actuarial (A) Task Force/ Health Actuarial (B) Task Force
 Amendment Proposal Form***

1. Identify yourself, your affiliation and a very brief description (title) of the issue.

Identification:

PBR Staff of Texas Department of Insurance

Title of the Issue:

Companies appear unclear how to support the requirement that “company experience mortality rates shall not be lower than the mortality rates the company expects to emerge” in PBR Actuarial Report under VM-31 Section 3.D.3.1.iv.

2. Identify the document, including the date if the document is “released for comment,” and the location in the document where the amendment is proposed:

VM-31 Section 3.D.3.1.iv

January 1, 2023 NAIC *Valuation Manual*

3. Show what changes are needed by providing a red-line version of the original verbiage with deletions and identify the verbiage to be deleted, inserted or changed by providing a red-line (turn on “track changes” in Word®) version of the verbiage. (You may do this through an attachment.)

See attached.

4. State the reason for the proposed amendment? (You may do this through an attachment.)

We have observed a consistent issue, where there is not adequate support showing compliance with the requirement that “the company experience mortality rates shall not be lower than the mortality rates the company expects to emerge”. The most commonly provided support is a retrospective quantitative analysis (e.g., the actual to expected analysis), without any further discussion of the mortality rates that the company expects to emerge. The intention of this requirement is to discuss any forward-looking qualitative analysis, rather than just a historical quantitative analysis. The disclosure shall include, but is not limited to, the discussion of underwriting standard changes (or the lack thereof), distribution channel changes (or the lack thereof), any pandemic adjustments (or the lack thereof), and the results of ongoing experience monitoring.

* This form is not intended for minor corrections, such as formatting, grammar, cross-references or spelling. Those types of changes do not require action by the entire group and may be submitted via letter or email to the NAIC staff support person for the NAIC group where the document originated.

NAIC Staff Comments:

Dates: Received	Reviewed by Staff	Distributed	Considered
2/24/23	SO		
Notes: APF 2023-04			

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VM-31 Section 3.D.3.I.iv

Description and justification of the mortality rates the company actually expects to emerge, and a demonstration that the anticipated experience assumptions are no lower than the mortality rates that are actually expected to emerge. The description and demonstration should include the level of granularity at which the comparison is made (e.g., ordinary life, term only, preferred term, etc.). For the mortality rates that are actually expected to emerge, the description should include a forward-looking qualitative analysis which includes, but is not limited to, the discussion of any underwriting standard changes (or lack thereof), distribution channel changes (or lack thereof), any pandemic adjustments (or lack thereof), and the results of ongoing experience monitoring.



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April 13, 2023

Rachel Hemphill
Chair, Life Actuarial Task Force (LATF)
National Association of Insurance Commissioners (NAIC)

Re: Proposed changes to VM-20 outlined in APF 2023-03 (Part 1)

Dear Chair Hemphill,

The American Academy of Actuaries¹ Life Reserves Work Group (“LRWG”) appreciates the opportunity to comment on the proposed changes to VM-20 as outlined in APF 2023-03 (Part 1).

The proposed change to Section 3.B.5.c.ii.4 of VM-20 would apply the secondary guarantee funding ratio² (“SG funding ratio”) to the expense allowance when determining the NPR amount assuming the secondary guarantee is in effect (“SG NPR”) and may result in an increase to this reserve amount. (i.e., when the contract secondary guarantee is not fully funded)

The expense allowance is a provision to reserve³ that accounts for acquisition expenses incurred by the insurer to issue the business. The expense allowance represents the present value of an approximation of average industry acquisition expenses and provides initial surplus strain relief in the reserves. Rationale provided for applying the SG funding ratio to the expense allowance states that reserve movement should be consistent with funding levels. However, acquisition expenses paid by the issuer are not expected to change based on the level of secondary funding by the policyholder. In addition, the net single premium in the SG NPR is already adjusted by the SG funding ratio, which increases or decreases the reserve relative to funding of the secondary guarantee.

Regarding consistency between the Base NPR and the SG NPR, the proposed change would result in applying a ratio to the expense allowance in both reserve components but not a consistent result for the same set of acquisition expenses:

- Base NPR expense allowance is subject to the “Base funding ratio” which measures current account value to expected account value assuming payment of a level premium and guaranteed charges; and

¹ The American Academy of Actuaries is a 19,500-member professional association whose mission is to serve the public and the U.S. actuarial profession. For more than 50 years, the Academy has assisted public policymakers on all levels by providing leadership, objective expertise, and actuarial advice on risk and financial security issues. The Academy also sets qualification, practice, and professionalism standards for actuaries in the United States.

² Ratio of actual secondary value to fully funded secondary guarantee values at time t , capped at 1

³ Expense allowance provisions are applicable for all NPR calculations, including ULSG, Term, Other Life business subject to VM-C and pre-PBR (“legacy”) reserve calculations including an unscaled expense allowance in Actuarial Guideline XXXVIII

- APF proposes the SG NPR expense allowance be adjusted by the SG funding ratio

Using a shadow account design product as an example, the SG funding ratio would be the policy's current shadow account value to a fully funded shadow account value. In early years of a shadow account SG contract, the fully funded shadow account value is significantly larger than the expected account value used in the Base funding ratio, which means the SG funding ratio will be significantly smaller than the Base funding ratio and the expense allowances between the two reserve components will be different for the same set of acquisition expenses.

The proposed change may result in expense allowances that vary based on contract funding behavior and even SG type (i.e. shadow versus cumulative premium), both have little relation to the acquisition expenses incurred by the issuer and may be unintended consequences of this proposal.

The following quantitative impacts have been estimated for universal life with secondary guarantee ("ULSG") business subject to VM-20:

- **New business:** For a newly issued block of business offering lifetime secondary guarantees the increase to reserves was estimated to be 28% at the end of the first year⁴
- **Existing business⁵:** Estimated increase to reserve for the same block of business above are 22% in year 2 reducing to 9% by year 5 as the expense allowance amortizes and the SG funding ratio grows⁴

In light of the quantitative and qualitative analysis, the LRWG recommends further review of this proposal and its industry impact.

The Life Reserves Work Group appreciates your attention to the issues raised in this letter and looks forward to discussing them further with you. Should you have any questions or comments in response to this letter, please contact Amanda Barry-Moilanen, life policy analyst (barrymoilanen@actuary.org).

Sincerely,



Dylan Strother, MAAA, FSA
Chairperson, Life Reserves Work Group

Angela McShane, MAAA, FSA
Vice Chairperson, Life Reserves Work Group

American Academy of Actuaries

⁴ Impacts stated were developed using a sample model consisting of a mix of business shadow account of varying guarantee lengths (e.g., to a defined age, lifetime) issued over the last three years. Some of the business also has shorter term specified premium policies in addition to their long-term guarantee.

⁵ This includes business issued since 1/1/2020 and for some insurers, business issued as far back as 1/1/2017



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April 17, 2023

Rachel Hemphill
Chair, NAIC Life Actuarial (A) Task Force (LATF)

Re: APF 2023-03 Parts 1 and 2

Dear Ms. Hemphill:

The American Council of Life Insurers (ACLI) appreciates the opportunity to submit comments on Parts 1 and 2 of APF 2023-03 which was exposed during the LATF session on February 2, 2023.

Regarding Part 1, the APF suggests that the expense allowance also be multiplied by the policy's SG funding ratio. In VM-20 this ratio is $[ASG_{x+t}/FFSG_{x+t}]$. For reference, Section 3.B defines what is meant by the terms ASG_{x+t} and $FFSG_{x+t}$. For shadow account policies which are minimally funded, this ratio is naturally low, and depending on policyholder behavior, could remain low for all policy years. For specified premium policies, the ratio grows from a low ratio at the first policy year to 1.00 at the end of the secondary guarantee period. Thus, the structure of the secondary guarantee and the underlying policyholder payment behavior influences how much of the amortized expense allowance is permitted to be recognized.

The $[ASG_{x+t}/FFSG_{x+t}]$ ratio makes sense for the "NSP_{x_t}" component of the VM-20 Section 3.B.5.c formula because the ratio reflects the degree to which the policy is closing in on a "paid up" secondary guarantee provision. However, we do not see this ratio as appropriate for calibrating how much of the expense allowance is recognized. After all, the expense allowance construct is intended as a proxy for industry-level acquisition costs, and those costs do not change based on policyholder behavior, nor do they change according to the structure of the secondary guarantee provision. The concept that the expense allowance is independent of policyholder behavior would further draw into question whether the application of the ratio to the expense allowance in Section 3.B.5.d (when the secondary guarantee is not in effect) calculation is appropriate. Removing this

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The American Council of Life Insurers (ACLI) is the leading trade association driving public policy and advocacy on behalf of the life insurance industry. 90 million American families rely on the life insurance industry for financial protection and retirement security. ACLI's member companies are dedicated to protecting consumers' financial wellbeing through life insurance, annuities, retirement plans, long-term care insurance, disability income insurance, reinsurance, and dental, vision and other supplemental benefits. ACLI's 280 member companies represent 94 percent of industry assets in the United States.

acli.com

application of the ratio to the expense allowance, which we acknowledge is a deviation from CRVM, would bring both components of the NPR calculation into alignment on this concept.

As compared to company calculations to date (i.e., using VM-20's current expression of ULSG NPR) the changes proposed in APF 2023-03 Part 1 would have a significant impact on the NPR reserve calculation in early durations, with a decreasing effect over time. This is because the expense allowance deduction, when multiplied by the $[ASG_{x+t}/FFSG_{x+t}]$ ratio, would be significantly smaller in earlier durations, and as the expense allowance amortizes, the difference would get smaller over time regardless of the ratio.

It is unclear what the aggregate impact of this change would be to reserves, and a thorough analysis would require updates to valuation systems. Therefore, ACLI would recommend no change to VM-20 as proposed in Part 1 until these impacts can be determined.

Regarding Part 2, ACLI believes the requirement to floor each stochastic scenario at the cash surrender value (CSV) prior to calculating CTE70 could be problematic. For example, applying the CSV floor to each scenario would result in making the effect of the floor more difficult to predict, forecast, and manage (e.g., via hedging).

The VM-20 and VM-21 frameworks are different in several ways; for example, VM-20 has an NPR with a cash surrender value floor while VM-21 does not, and the VM-20 Deterministic Reserve also serves a different purpose than the Standard Projection Amount in VM-21. From a technical standpoint, it is not clear why additional flooring at the SR scenario level is appropriate and necessary for VM-20. Therefore, ACLI would recommend no change to VM-20 as proposed in Part 2.

Thank you once again for the consideration of our comments and we are looking forward to future discussions with regulators on this APF.

Sincerely,



cc: Scott O'Neal, NAIC

**Life Actuarial (A) Task Force/ Health Actuarial (B) Task Force
 Amendment Proposal Form***

1. Identify yourself, your affiliation and a very brief description (title) of the issue.

Identification:

PBR Staff of Texas Department of Insurance

Title of the Issue:

Address several clean-up items for VM-20

2. Identify the document, including the date if the document is “released for comment,” and the location in the document where the amendment is proposed:

VM- 20 Section 3.B.5.c.ii.4 and VM-20 Section 5.B.3

January 1, 2023 NAIC Valuation Manual

3. Show what changes are needed by providing a red-line version of the original verbiage with deletions and identify the verbiage to be deleted, inserted or changed by providing a red-line (turn on “track changes” in Word®) version of the verbiage. (You may do this through an attachment.)

See attached.

4. State the reason for the proposed amendment? (You may do this through an attachment.)

1. The formula for calculating the NPR for ULSG based on the value of the SG in VM-20 Section 3.B.5.c.ii.4 excludes the EA from the scaling of the NPR. This is inconsistent with the formula for calculating the NPR for ULSG disregarding the SG in VM-20 Section 3.B.5.d.iv. The scale is the prefunding ratio of actual SG (denoted ASG) to fully funded SG (denoted FFSG), and it makes intuitive sense that the NPR would be scaled to decrease or increase relative to the level of funding of the SG.
2. The VM-20 Section 5.B.3 stochastic reserve methodology is missing an aggregate cash surrender value (CSV) floor for scenario reserves before calculating CTE70. This allows scenario reserves that exceed the CSV to be dampened or eliminated by being averaged with scenario reserves. A CSV floor in the NPR does not address this concern, because it does not reflect the scenario reserves in the SR that exceed the CSV. In contrast, in VM-21 Section 4.B.1 scenario reserves are floored at the aggregate CSV as appropriate. Scenario reserves, as the asset requirement for specific scenarios, should be held at or above the CSV.

* This form is not intended for minor corrections, such as formatting, grammar, cross-references or spelling. Those types of changes do not require action by the entire group and may be submitted via letter or email to the NAIC staff support person for the NAIC group where the document originated.

NAIC Staff Comments:

Dates: Received	Reviewed by Staff	Distributed	Considered
1/30/23	SO		
Notes: APF 2023-06 – taken from Sections 1 and 2 of APF 2023-03.			

VM-20 Section 3.B.5.c.ii.4

- 4) The NPR for an insured age x at issue at time t shall be according to the formula below:

$$\frac{\text{Min} [ASG_{x+t} / FFSG_{x+t}, 1] \cdot NSP_{x+t} - E_{x+t}}{\text{Min} [ASG_{x+t} / FFSG_{x+t}, 1] \cdot (NSP_{x+t} - E_{x+t})}$$

VM-20 Section 5.B.3

3. Set the scenario reserve equal to the sum of the statement value of the starting assets across all model segments and the maximum of the amounts calculated in Subparagraph 2 above.

The scenario reserve for any given scenario shall not be less than the cash surrender value in aggregate on the valuation date for the group of contracts modeled in the projection.

COVER LETTER

The Valuation of Securities (E) Task Force has made a referral to the Life Actuarial (A) Task Force to consider five questions regarding the potential for obtaining additional measures of company investment risk by adding additional modeling capabilities to the NAIC's Securities Valuation Office. The five questions are copied below for convenience, and also embedded in Attachment 1 along with additional background.

Please send comments to [Scott O'Neal](#).

Referral – VOSTF refers this matter to the above referenced Committees, Task Forces and Working Groups for consideration and requests a response from you by May 15th outlining:

1. Indicate if your group is supportive of creating this capability within the SVO.
2. List the investment analytical measures and projections that would be most helpful to support the work performed by your respective group.
3. Describe how your group would utilize the data and why it would be of value.
4. Are there other investment data or projection capabilities that would be useful to your group that could be provided by commercially available data sources or investment models? And if so, please list them.
5. Any other thoughts you may have on this initiative.

Attachment Listing:

Attachment 1 - Referral on Additional Market and Analytical Information for Bond Investments

Attachment 2 – Blanks Market Data Disclosure

Attachment 3 – Blanks Market Data Options



TO: Elizabeth Kelleher Dwyer, Chair, Financial Conditions (E) Committee
 Marlene Caride, Chair, Financial Stability (E) Task Force
 Bob Kasinow, Chair, Macroprudential (E) Working Group
 Thomas Botsko, Chair, Capital Adequacy (E) Task Force
 Phillip Barlow, Chair, Risk-Based Capital Investment Risk and Evaluation (E) Working Group
 Cassie Brown, Chair, Life Actuarial (A) Task Force
 Judy Weaver, Chair, Financial Analysis (E) Working Group
 Dale Bruggeman, Chair, Statutory Accounting Principles (E) Working Group
 Fred Andersen, Chair, Valuation Analysis (E) Working Group

FROM: Carrie Mears, Chair, Valuation of Securities (E) Task Force

CC: Charles A. Therriault, Director, NAIC Securities Valuation Office (SVO)
 Eric Kolchinsky, Director, NAIC Structured Securities Group (SSG) and Capital Markets Bureau
 Dan Daveline, Director, NAIC Financial Regulatory Services
 Todd Sells, Director, NAIC Financial Regulatory Policy & Data
 Marc Perlman, Managing Investment Counsel, NAIC Securities Valuation Office (SVO)
 Julie Gann, Assistant Director, NAIC Solvency Policy
 Bruce Jenson, Assistant Director, NAIC Solvency Monitoring
 Pat Allison, Managing Life Actuary, NAIC Financial Regulatory Affairs
 Jane Koenigsman, Sr. Manager II, NAIC L/H Financial Analysis
 Andy Daleo, Sr. Manager I, NAIC P/C Domestic and International Analysis
 Dave Fleming, Sr. Life RBC Analyst, NAIC Financial Regulatory Affairs
 Jennifer Frasier, Life Examination Actuary, NAIC Financial Regulatory Affairs
 Scott O'Neal, Life Actuary, NAIC Financial Regulatory Affairs
 Eva Yeung, Sr. P/C RBC Analyst/Technical Lead, NAIC Financial Regulatory Affairs

RE: Referral on Additional Market and Analytical Information for Bond Investments

DATE: February 13, 2023

Summary – The Investment Analysis Office (IAO) staff recommended in its Feb. 25, 2022, memorandum to the Valuation of Securities (E) Task Force (VOSTF) (attached hereto, Blanks Market Data Disclosure v2.pdf) that it would like additional market-data fields added to the annual statement instructions for bond investments. This was, in part, based upon the NAIC's adoption in 2010 of the recommendations of

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the Rating Agency (E) Working Group (RAWG), which was formed following the Great Financial Crisis of 2007-2008 to study the NAIC's reliance on rating agencies, and the IAO staff's recent findings in its Nov. 2021 memo regarding disparities between rating agencies. RAWG recommended that: 1) regulators explore how reliance on rating agencies can be reduced when evaluating new, structured, or alternative asset classes, particularly by introducing additional or alternative ways to measure risk; and 2) consider alternatives for regulators' assessment of insurers' investment risk, including expanding the role of the NAIC Securities Valuation Office ("SVO"); and 3) VOSTF should continue to develop independent analytical processes to assess investment risks. These mechanisms can be tailored to address unique regulatory concerns and should be developed for use either as supplements or alternatives to ratings, depending on the specific regulatory process under consideration.

The NAIC's need for alternative measures of investment risk has only increased since RAWG made its recommendations, as privately issued and rated complex structured finance transactions have become commonplace without adequate ways of identifying them. The SVO recommended the following market data fields to be added to the annual statement instructions: Market Yield, Market Price, Purchase Yield, Weighted Average Life, Spread to Average Life UST, Option Adjusted Spread, Effective Duration, Convexity and VISION Issue ID. Please refer to the attached memo for more detail on each data field.

In comments received from industry there were question as to how the SVO, VOSTF and/or other regulators who would receive the analytic data included in the proposal would utilize that information and why it is of value to them. The SVO was also asked to consider industry's recommendation that the NAIC be responsible for calculating this analytical information by utilizing commercially available data sources and investment models instead of having each individual insurance company incur the costs to implement system changes. The SVO shared their thoughts on the alternatives in the Jul. 14, 2022, memorandum to the VOSTF (attached, Blanks_Market_Data_Options_v3.pdf).

Capabilities like this within the SVO would permit it to calculate for regulators all the analytic values previously mentioned for any Schedule D investment along with additional measures such as key rate duration (a measure of interest rate sensitivity to maturity points along the yield curve), sensitivity to interest rate volatility, principal and interest cash flow projections for any security or portfolio for any given interest rate projection, loss estimates for any security for any given scenario and many others measures.

Referral – VOSTF refers this matter to the above referenced Committees, Task Forces and Working Groups for consideration and requests a response from you by May 15th outlining:

1. Indicate if your group is supportive of creating this capability within the SVO.
2. List the investment analytical measures and projections that would be most helpful to support the work performed by your respective group.
3. Describe how your group would utilize the data and why it would be of value.
4. Are there other investment data or projection capabilities that would be useful to your group that could be provided by commercially available data sources or investment models? And if so, please list them.
5. Any other thoughts you may have on this initiative.

Please contact Charles Therriault or Marc Perlman with any questions.

VOSTF_Referral_Bond_Risk_Measures_2023-02-13.docx



TO: Carrie Mears, Chair, Valuation of Securities (E) Task Force
Members of the Valuation of Securities (E) Task Force

FROM: Charles A. Therriault, Director, NAIC Securities Valuation Office (SVO)
Marc Perlman, Managing Investment Counsel, NAIC Securities Valuation Office (SVO)

CC: Eric Kolchinsky, Director, NAIC Structured Securities Group (SSG) and Capital Markets Bureau

RE: Additional Market Data Fields for Bond Investments

DATE: February 25, 2022

The SVO proposes adding additional market-data fields for bond investments to the annual statement instructions based on 2010 adopted recommendations of the Rating Agency (E) Working Group (RAWG) and the IAO staff's findings regarding the discrepancies between ratings, presented in its Nov. 2021 memo.

The RAWG was formed after the Financial Crisis of 2008 and was charged with gathering and assessing information on:

1. *The problems inherent in reliance on ratings, including impact on the filing exempt ("FE") process and Risk-Based Capital ("RBC");*
2. *The reasons for recent rating shortcomings, including but not limited to structured security and municipal ratings;*
3. *The current and potential future impact of ratings on state insurance financial solvency regulation; and*
4. *The effect of the use of NRSRO ratings on public confidence and public perception of regulatory oversight of the quality of insurance.*

The RAWG made the following summary recommendations in their Apr. 28, 2010, report that was adopted by the Financial Condition (E) Committee (emphasis added):

1. **Regulators *explore how reliance* on ARO (Approved Ratings Organization) ratings *can be reduced* when evaluating new, structured, or alternative asset classes, particularly by **introducing additional or alternative ways to measure risk**;**
2. **Consider alternatives for regulators' assessment of insurers' investment risk, including expanding the role of the NAIC Securities Valuation Office ("SVO"); and**

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3. *When considering continuing the use of ratings in insurance regulation, the **steps taken by the NRSROs in correcting the causes that led to recent rating shortfalls**, including the NRSROs' efforts in implementing the recommended structural reforms, should be taken into account.*

As the IAO staff demonstrated with the analysis in its Nov. 29, 2021, memo regarding ratings discrepancies, not all credit rating provider (CRP) ratings reflect a reasonable assessment of a security's risk, indicating that rating shortfalls persist today. The NAIC has not made additional progress in reducing reliance on CRPs and the IAO proposed several steps in its memo to accomplish that objective. As noted by the RAWG and reflected in the IAO's memo, there persists a situation where "... ratings are neither consistent nor uniform for individual securities, nor across different types and classes of securities..." However, the role of the SVO has not been expanded to include "... evaluating credit and other risks of securities."¹

One step towards introducing alternative ways to measure a security's risk would be to require insurers to report various analytical measures about each security including metrics such as its current market yield, interest rate sensitivity, spread relative to risk-free securities such as United States Treasuries and average remaining life. The more a security's market yield and spread differ from similarly rated securities, the more likely it is that the implied market-perceived risk of that security differs from the risk indicated by the credit rating assigned to it. The yield difference or spread in basis points can potentially help identify securities whose risk assessment warrants further review by the SVO, examiners or other regulatory groups, for example, a AAA rated security with a yield of 5%. Other fields that measure a security's price sensitivity to interest rate movements may also help to identify market-perceived risk inconsistent with the assigned credit rating. These additional market data fields would align with the RAWG's referral to the Task Force and SVO Initiatives (EX) Working Group, as noted in their following detailed recommendations (emphasis added):

1. *Referral to the NAIC Valuation of Securities (E) Task Force: VOS should continue to **develop independent analytical processes to assess investment risks**. These mechanisms can be tailored to address unique regulatory concerns and should be developed for **use either as supplements or alternatives to ratings**, depending on the specific regulatory process under consideration.*
2. *Referral to the NAIC Valuation of Securities (E) Task Force: ARO ratings have a role in regulation; however, since **ratings cannot be used to measure all the risks that a single investment or a mix of investments may represent in an insurer's portfolio**, NAIC policy on the use of ARO ratings should be **highly selective and incorporate both supplemental and alternative risk assessment benchmarks**.*
3. *Referral to the NAIC's SVO Initiatives (EX) Working Group: NAIC should evaluate whether to **expand the use of SVO and increase regulator reliance on the SVO for evaluating credit and other risks of securities**.*

Recommendation: The SVO recommends the following market data fields and related descriptions be added to all the annual statement instructions, through a referral to the Blanks (E) Working Group, for all bonds reported on Schedule D, Part 1 (those within scope of SSAP No. 26R – Bonds and SSAP No. 43R – Loan-Backed and Structured Securities). To allow sufficient time for insurers to update their systems, the SVO further recommends that the changes be implemented as electronic only fields effective beginning with the reporting year ending December 31, 2023.

- Market Yield – The Market Yield is the internal rate of return discount rate that makes the net present value (NPV) of all expected cash flows equal to zero in a discounted cash flow analysis. Therefore, Fair

¹ Evaluating the Risks Associated with NAIC Reliance on NRSRO Credit Ratings – Final Report of the RAWG to the Financial Conditions (E) Committee, April 28, 2010

Value, which is already reported, is the present value (PV) of all expected cash flows discounted at the Market Yield.

- Market Price – The Market Price per unit of Par Value, which is already reported, is reflected in the Fair Value as of the financial statement date. The Market Price, which excludes accrued interest, when multiplied by Par Value and divided by 100 will be equal to the Fair Value.
- Purchase Yield – The Purchase Yield is the internal rate of return discount rate that makes the net present value (NPV) of all expected cash flows equal to zero in a discounted cash flow analysis as of the Acquired Date. Therefore, Actual Cost is the present value (PV) of all expected cash flows discounted at the Purchase Yield as of the Acquired Date.
- Weighted Average Life – The Weighted Average Life is the average length of time that each dollar of unpaid principal remains outstanding. The time weightings used in weighted average life calculations are based on payments to the principal. The calculation is "weighted" because it considers when the payments to the principal are made—if, for example, nearly all of the principal payments are made in five years, WAL will be close to five years. Weighted average life does not consider payments to interest on the loan. This value is recalculated at each statement date for the remaining principal payments.
- Spread to Average Life UST - The spread is the difference between the interpolated U.S. Treasury bond yield that matches the reported debt security's Weighted Average Life. Spreads between interpolated U.S. Treasuries and other bond issuances are measured in basis points, with a 1% difference in yield equal to a spread of 100 basis points.
- Option Adjusted Spread - The option-adjusted spread (OAS) is the measurement of the spread of a fixed-income security rate and the risk-free rate of return (typically U.S. Treasury yield), which is then adjusted to take into account an embedded option and expressed in basis points. The spread is added to the fixed-income security price to make the risk-free bond price the same as the bond. The option-adjusted spread considers historical data such as the variability of interest rates and prepayment rates. These calculations are complex since they attempt to model future changes in interest rates, prepayment behavior of mortgage borrowers, and the probability of early redemption.
- Effective Duration - This is a duration calculation for bonds that have embedded options. This measure of duration takes into account the fact that expected cash flows will fluctuate as interest rates change and is, therefore, a measure of risk given the security's Fair Value. As a formula, Effective Duration = $(P(1) - P(2)) / (2 \times P(0) \times Y)$, where $P(0)$ = the bond's Market Price per \$100 worth of par value, $P(1)$ = the price of the bond if the yield were to decrease by Y percent, $P(2)$ = the price of the bond if the yield were to increase by Y percent, and Y = the estimated change in yield used to calculate $P(1)$ and $P(2)$.
- Convexity - This is a measure of the curvature, or the degree of the curve, in the relationship between bond prices and bond yields. Convexity demonstrates how the duration of a bond changes as the interest rate changes.
- VISION ISSUE ID: The NAIC VISION system security ID reported in AVS+.

<https://naiconline.sharepoint.com/teams/SVOVOSTaskForce/Shared Documents/Meetings/2022/2022-04 - Spring National Meeting/04 - Blanks Referral Analytical Risk Measures/2021-053.01 Blanks Market Data Disclosure v2.docx>



TO: Carrie Mears, Chair, Valuation of Securities (E) Task Force
Members of the Valuation of Securities (E) Task Force

FROM: Charles A. Therriault, Director, NAIC Securities Valuation Office (SVO)
Marc Perlman, Managing Investment Counsel, NAIC Securities Valuation Office (SVO)

CC: Eric Kolchinsky, Director, NAIC Structured Securities Group (SSG) and Capital Markets Bureau

RE: Possible Options for Additional Market Data Fields for Bond Investments

DATE: July 14, 2022

Summary - The SVO proposed adding additional market-data fields for bond investments to the annual statement instructions in its memo dated Feb. 25, 2022, titled "Additional Market Data Fields for Bond Investments" that was discussed at the 2022 Spring National Meeting. The recommendation was based, in part, on 2010 adopted recommendations of the Rating Agency (E) Working Group (RAWG) and the NAIC Investment Analysis Office's (IAO) staff's findings regarding the discrepancies between ratings, presented in its Nov. 29, 2021 memo, "Rating Issues and Proposed Changes to the Filing Exemption Process." In this memo the SVO further outlines the regulatory benefits and proposes two possible approaches.

The benefits of collecting additional market-data for each insurer bond investment are several:

- Assist in SVO identification of securities with credit rating provider (CRP) ratings which may be inconsistent with a security's actual overall risk.
- Greater transparency for regulators into the risks and characteristics of insurer investments.
- Incorporation of insurer investment portfolio analysis into the examination process.
- Availability of more Level 1 and 2 Inputs which will be included in the AVS+ pricing data for all securities compared to the mostly Level 3 Inputs for only some securities today.
- Allow state insurance regulators to assess the capabilities of an insurer's investment management or risk management processes by reviewing the quality and accuracy the market data fields.
- Provide NAIC staff with the capability to run cash flow simulations on insurer investments.

Regarding the first bullet, the SVO would use this market-data information to help identify securities with credit rating provider (CRP) ratings that may be inconsistent with the security's actual overall risk. The SVO and SSG have raised concerns over the years about a number of asset classes (e.g. residential

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mortgage backed securities (RMBS), commercial mortgage backed securities (CMBS), public and private fund investments, principal protected securities (PPS) including CLO Combo Notes, regulatory transactions, residual interests, and now collateralized loan obligations (CLO), and structure equity and funds) and specific securities in other asset classes where a rating agency rating often does not adequately reflect the investment risk for NAIC purposes. The SVO needs this analytical information so that it can identify and take potential action on investment risk assessment inaccuracies. Without this data and potentially other information in the future, coupled with some level of discretion over NAIC Designations derived from ratings, the SVO and regulators will remain in the dark about these risks. Additionally, the incentive for significant risk-based capital arbitrage utilizing CRP ratings will likely continue to increase and rating agencies will effectively remain a de-facto “super regulator” in that any investment they assign a rating to is automatically accepted by the NAIC without any regulatory discussion, analysis, oversight or consideration as to how the rating agency’s decisions align to the NAIC’s statutory framework.

Inconsistent and potentially inaccurate assessments of investment risk is a critical issue not only for the Valuation of Securities (E) Task Force but for other state insurance regulatory groups that are interested in identifying and analyzing investment risks, whether it be at the individual security, asset class, legal entity or industry level. The following are just a few groups that have active work streams involving investment risk: Life Actuarial (A) Task Force, Capital Adequacy (E) Task Force and its Working Groups, Statutory Accounting Principles (E) Working Group, Financial Stability (E) Task Force, Macroprudential (E) Working Group and Financial Analysis (E) Working Group. The proposed market data fields will benefit each of these groups in their work assessing insurer investments and portfolio risks.

The requested market data fields other than purchase yield, which should be available from any investment accounting system, are all at the security issue level (i.e. CUSIP). Any insurer system that can receive security issue level data such as a market prices, credit ratings, bond factors, cashflows, or NAIC Designations should be able to accommodate these proposed security issue-level data fields. The SVO acknowledges this change will require time for insurer system providers to accommodate these new data fields into their data structures and Schedule D reporting applications. However, these data fields are very common in the management of a bond portfolio, and it would be a significant enterprise risk deficiency if an insurer’s investment managers did not have them.

Some alternate measures of risk (e.g. Sharpe Ratio and Sortino Ratio) were mentioned during the Task Force discussion. These metrics, however, would require insurers to calculate the total return and the standard deviation of those returns for each security they own in order to produce and report these metrics which would be significantly more costly and more appropriate for assessing relative value and less applicable for assessing investment risk.

Alternatives – The SVO was asked to consider industry’s recommendation that the NAIC produce these fields. Below are our thoughts on each alternative.

- **NAIC Produced Analytics** – The SVO can take on the responsibility for producing the analytical data elements requested in this proposal. To do so it would require enhancements to the SVO’s existing systems (VISION, AVS+ and STS), and vendor pricing data, investments in new systems to provide the modeling, more staff for the incremental and on-going support of these systems and processes, new data feeds to support the modeling software, and new data bases and reporting capabilities to provide the information to regulators. Enhancements would also

need to include the ability for insurers to provide electronically to the SVO the full security structure of any security that the modeling software does not know about. We strongly believe that the benefits to be gained by state regulators, the SVO and other NAIC groups with interests in investment risk of bringing this modelling capability in-house greatly outweigh, in the long run, the initial costs and effort to make these capabilities operational.

- **Pros:**

- Market analytical information would be independently and consistently produced.
- The SVO's pricing data would need to include more Level 1 and 2 Inputs for all securities versus primarily Level 3 Inputs for only some securities today.
- Regulators would eventually be able to ask NAIC staff to model the risks or cash flows of any bond security or insurer bond portfolio, including, stress testing those securities and portfolios.
- Regulators would have significantly greater transparency into the risks and characteristics of insurer investments.
- Analytical analysis of insurer investment portfolios could be incorporated into the examination process.
- The overall cost to insurers through any increased fee would likely be much less than each insurer building out its own capability to provide the data.

- **Cons:**

- The NAIC would need to make significant enhancements to VISION, AVS+, and STS, and develop new reporting data bases.
- The NAIC will need to license a security analytic modelling system and provide it with the data it requires, some of which may require new data licenses. This includes full access to vendor applications like Bloomberg or Aladdin.
- The NAIC will incur additional fees for higher level of security pricing data. The NAIC will also need additional staff to develop and support the technology enhancements and to support the on-going modeling of securities and portfolios.
- It may take longer for the NAIC to build this capability.
- Insurers would still need to report some of this information on their Schedule D filings from data published through AVS+.
- Insurers would need to provide the SVO with full security structure modeling and supporting data (e.g. collateral, payments, actions) for any security the analytic modelling system does not have within its data base.

- **Insurer Produced Analytics** – Insurer investment managers should already have the market data fields requested in this proposal. Insurers would need to get this information into their systems that produce their Schedule D filings. This option would require more up-front work on the part of the insurers and less by the NAIC. The uses of the data, however, whether by regulators, the SVO or other interested

NAIC groups, could be significantly more limited than in the first option, because of the inconsistency in data between insurers.

- **Pros:**
 - Insurers already have this information as part of their investment management or risk management processes.
 - State insurance regulators could assess the capabilities of an insurer's investment management or risk management processes by reviewing the quality and accuracy the market data fields.
 - The timeframe to implement would likely be shorter than the SVO having to build out this capability.
- **Cons:**
 - Insurer security pricing is very inconsistent today which will lead to a high degree of variability in these analytical values.
 - The modeling software and assumptions used by insurers to produce these analytical value can vary significantly which will also lead to a high degree of variability in the values.
 - Insurers and their system providers will need to develop new interfaces to ingest this data and produce it in their Schedule D filing. That time frame could vary significantly by vendor and insurer.
 - State insurance regulators would not be able to request the modeling of any investment security or portfolio.
 - Insurers would directly bear the expense of these changes which will likely be greater than it would be if the NAIC produced this information.

Next Steps – The SVO continues to strongly believe that these market data fields are an important first step in finding alternative ways to measure insurers investment risk and reducing the NAIC reliance rating agency ratings. As noted by the RAWG and reflected in the IAO's memo, there persists a situation where *"... ratings are neither consistent nor uniform for individual securities, nor across different types and classes of securities..."* yet the role of the SVO has not been expanded to include using these alternatives in *"... evaluating credit and other risks of securities."* The objective of this request is to begin addressing these investment risk issues but this may not be the only information needed.

Both alternatives will involve a commitment of resources either by the NAIC or industry. The major question before the Task Force is whether it has a preferred source for these market data fields: the NAIC's SVO or insurer reporting? The SVO believes that the first option would provide the most standardization in data and utility to regulators, the SVO and other interested NAIC groups and would be worth the slightly longer time and cost needed to develop the capabilities.

If, as the SVO recommends, the Task Force prefers the NAIC's SVO as the source of this analysis, then the next step would be a referral to the Financial Condition (E) Committee to request their sponsorship for this initiative and, if provided, begin a fiscal request. If Financial Condition (E) Committee declines to sponsor the initiative or if insurer reporting is the preferred source, we would recommend reverting to insurer reporting and directing the SVO staff to prepare the Blanks referral.

<https://naiconline.sharepoint.com/teams/SVOVOSTaskForce/Shared Documents/Meetings/2022/2022-08-11 - Summer National Meeting/07 - Blanks Referral Analytical Risk Measures/2021-053.XX Blanks Market Data Options.docx>



AMERICAN ACADEMY of ACTUARIES

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April 11, 2023

Rachel Hemphill
Chair
National Association of Insurance Commissioners (“NAIC”)
Life Actuarial Task Force (“LATF”)

Re: VOS Referral to LATF – Bond Risk Measures

Dear Chair Hemphill,

The American Academy of Actuaries¹ Life Valuation Committee (the “committee”) appreciates the opportunity to provide comments on the VOS Referral to LATF—Bond Risk Measures.

The Securities Valuation Office (“SVO”) has been charged with exploring approaches that rely less on ratings from Nationally Recognized Statistical Rating Organizations (“NRSRO”) and to consider additional processes that will help regulators better understand and regulate insurers’ investment risk. The SVO is considering the disclosure of additional data related to asset holdings with the purpose of developing analytical capabilities within the SVO. The expectation is that these capabilities would allow the SVO to identify securities whose NRSRO ratings fall into a range identified as questionable (i.e., rating outliers). This data would also provide additional risk-related information with respect to an insurer’s investment portfolio.

It would be helpful to understand how the disclosure of the additional data the SVO is considering will be used. For example, with respect to ratings outliers, how will this information be used to identify outliers, how will outliers be reconciled to NRSRO ratings, and what is the impact to Risk Based Capital and potentially reserves? Regarding investment risk, there is a currently information included in insurers’ investment portfolios and related risks from documents such as the Memorandum supporting the Actuarial Opinion (including the recently adopted Actuarial Guideline LIII disclosure), principle-based reserve reports, the Own Risk And Solvency Assessment report, and risk-based capital filings, to name a few. The committee suggests regulators consider identifying the specific information not obtained in documents already produced before creating new risk measures and disclosures.

¹ The American Academy of Actuaries is a 19,500-member professional association whose mission is to serve the public and the U.S. actuarial profession. For more than 50 years, the Academy has assisted public policymakers on all levels by providing leadership, objective expertise, and actuarial advice on risk and financial security issues. The Academy also sets qualification, practice, and professionalism standards for actuaries in the United States.

The committee also suggests that Valuation of Securities Task Force and other interested NAIC groups work with interested parties to perform a proof-of-concept exercise. The outcome could be informative for all parties of the ability of additional data and processing thereof to meet the objectives, the amount of work involved, and the effectiveness of the outcomes in reducing NRSRO reliance and providing better information on investment risks to regulators.

If the proof-of-concept process demonstrates feasibility, the committee believes it is equally important to understand which groups within the NAIC and state insurance departments may use this information and for what purposes.

Thank you for your consideration of these comments and we look forward to discussing these further with you. Should you have any questions or comments in response to this letter, please contact Amanda Barry-Moilanen, life policy analyst (barrymoilanen@actuary.org).

Sincerely,

Craig Morrow
Chairperson, Life Valuation Committee
American Academy of Actuaries

CC: Scott O'Neil, NAIC
Dave Fleming, NAIC
Philip Barlow
Amanda Barry-Moilanen

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April 17, 2023

Rachel Hemphill

Chair, NAIC Life Actuarial (A) Task Force (LATF)

Re: NAIC Valuation of Securities (E) Task Force (VOSTF) Referral to LATF – Bond Risk Measures

Dear Ms. Hemphill:

The American Council of Life Insurers (ACLI) appreciates the opportunity to comment on the VOSTF referral to LATF regarding Bond Risk Measures. ACLI believes that it is premature for LATF to weigh in on the creation of this capacity within the NAIC Securities Valuation Office (SVO).

As stated in the attached joint comment letters, the memorandum from the SVO does not fully discuss or specify how the SVO, VOSTF, and other regulators who would receive the analytic data included in the proposal would utilize that information and why it is of value to them. This is especially important given the costs associated with compliance by the industry.

We also understand some of the data proposed to be gathered would be used to help identify rating agency disparity concerns by the SVO (e.g., “excess yields”), but much of the other data would be used for other means and/or by other parts of the NAIC or individual regulators.

Therefore, given the costs associated with this request, we believe clear articulation on how the data would be utilized by regulators is very important before deciding on the creation of this capacity.

American Council of Life Insurers | 101 Constitution Ave, NW, Suite 700 | Washington, DC 20001-2133

The American Council of Life Insurers (ACLI) is the leading trade association driving public policy and advocacy on behalf of the life insurance industry. 90 million American families rely on the life insurance industry for financial protection and retirement security. ACLI's member companies are dedicated to protecting consumers' financial wellbeing through life insurance, annuities, retirement plans, long-term care insurance, disability income insurance, reinsurance, and dental, vision and other supplemental benefits. ACLI's 280 member companies represent 94 percent of industry assets in the United States.

acli.com

Thank you once again and we look forward to future discussion.

Sincerely,

  Colin Masterson

cc: Scott O'Neal, NAIC

**Mike Monahan**

Senior Director, Accounting Policy
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mikemonahan@acli.com

September 12, 2022

Ms. Carrie Mears, Chair
Valuation of Securities Task Force
National Association of Insurance Commissioners
110 Walnut Street, Suite 1500
Kansas City, MO 64106-2197

Re: SVO Memorandum on Alternative to Add Fixed Income Analytical Risk Measures to Investments Reported on Schedule D, Part One, Insurer Credit Obligations (Bonds)

Dear Ms. Mears,

The undersigned (ACLI, PPiA, NASVA, NAMIC, APCIA) appreciate the opportunity to comment on the exposure draft, referred to above, that was released for comment by the Valuation of Securities Task Force (VOSTF) at the NAIC Summer National Meeting.

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PPiA is a business association of insurance companies, other institutional investors, and affiliates thereof, that are active investors in the primary market for privately placed debt instruments. The association exists to provide a discussion forum for private debt investors; to facilitate the development of industry best practices; to promote interest in the primary market for privately placed debt instruments; and to increase accessibility to capital for issuers of privately placed debt instruments. The PPiA serves 63 member companies and works with regulators, NASVA, the American College of Investors Counsel, and the investment banking community to efficiently implement changes within the private placement marketplace.

NASVA is an association of insurance company representatives who interact with the NAIC Securities Valuation Office ("SVO") to provide important input, and to exchange information, in order to improve the interaction between the SVO and its users. In the past, NASVA committees have worked on issues such as improving filing procedures, suggesting enhancements to the NAIC's ISIS electronic security filing system, and commenting on year-end processes.

NAMIC membership includes more than 1,500 member companies. The association supports regional and local mutual insurance companies on main streets across America and many of the country's largest national writers. NAMIC member companies write \$323 billion in annual premiums. Our members account for 67 percent of homeowners, 55 percent of automobile, and 32 percent of the business insurance markets. Through our advocacy programs NAMIC promotes public policy solutions that benefit NAMIC member companies and the policyholders they serve and foster greater understanding and recognition of the unique alignment of interests between management and policyholders of mutual companies.

The American Property Casualty Insurance Association (APCIA) is the primary national trade association for home, auto, and business insurers. APCIA promotes and protects the viability of private competition for the benefit of consumers and insurers, with a legacy dating back 150 years. APCIA members represent all sizes, structures, and regions—protecting families, communities, and businesses in the U.S. and across the globe.

The undersigned are also appreciative that the Securities Valuation Office (SVO) and VOSTF took into consideration our concerns and recommendation from our previous letter on this topic dated May 20, 2022, and we will not reiterate any previous points unless they are specifically relevant to additional concerns and considerations within the proposed alternative.

Centralized Aggregation of Data at the SVO

If it is determined by the VOSTF that the members of the VOSTF would like the SVO to collate additional data on investment risk, for a variety of potentially different reasons, we appreciate that the proposed alternative recommends that such data is best aggregated and centralized by the SVO. This is consistent with the recommendation from our previous letter as well as consistent with many of the reasons stated in the proposed alternative.

However, given the significant cost and effort involved, prior to embarking on any effort to aggregate such data, we would encourage the VOSTF to ensure there is broad agreement by regulators on the specific objectives for such data. This would help prevent a situation where, after expending significant cost and effort on aggregating such data and developing the appropriate systems, it is found that both the data and systems subsequently do not adequately fulfill those objectives.

As noted in our previous letter, our understanding was that the data was primarily centered around comparing market yields for securities with rating agency (CRP) ratings in order to identify outlier ratings (of 2x plus variances) where the market (through demanding higher yields) ascribes more risk to a particular security than the CRP rating would imply (e.g., the excess spread above the "risk free", or US Treasury rate, exceeds the expectation for the security's inherent credit risk) and if applicable, for illiquidity and/or complexity premium. The current proposal more specifically states that the benefits of such data would be several, including:

- Assist in SVO identification of securities with credit rating provider (CRP) ratings which may be inconsistent with a security's actual overall risk.
- Greater transparency for regulators into risks and characteristics of insurer investments.
- Incorporation of insurer investment portfolio analysis into the examination process.
- Availability of more Level 1 and 2 inputs which will be included in the AVS+ pricing data for all securities compared to the mostly Level 3 inputs for only some securities today.
- Allow state insurance regulators to assess the capabilities of an insurer's investment management or risk management process by reviewing the quality and accuracy of market data fields.
- Provide NAIC staff with the capability to run cash flow simulations on insurer investments.

This would appear to be a material change to the SVO's current mandate and capabilities. Should this be desired by the VOSTF, and more broadly regulators in general, it would benefit from clear regulatory objectives to ensure the appropriate data is being aggregated and the appropriate systems are being developed, prior to embarking on an admittedly costly undertaking.

Insurance Company Risk Management Practices

We also note the concern stated in the proposal that "these data fields are very common in the management of a bond portfolio, and it would be a significant enterprise risk deficiency if an insurer's investment managers did not have them."

We would caution that insurance companies have very sophisticated risk management practices that monitor investment risk, liquidity risk, as well as company risk related to asset and liability management, among many other risks, that incorporate many factors above and beyond the data fields suggested as well as in a fashion that is not as linearly implied in the current proposal.

These practices, which vary by individual company, and are highly dependent upon each company's overall specific risk management framework which is informed by their industry, product mix, and size, among many other factors, including different emphases based overall philosophy. To suggest that such data should be readily available in the format requested, is a significant simplification that is not necessarily reflective of insurance companies' risk management practices.

In conclusion, we continue to believe it is more cost effective for this data to be aggregated and centralized at the SVO if the VOSTF determines this information will benefit regulators. However, given the significant cost and effort involved, prior to embarking on any effort to aggregate such data, we would encourage the VOSTF to ensure there is broad agreement by regulators on the specific objectives for such data, to ensure the appropriate data is being aggregated.

We stand ready to assist regulators and staff with regards to this proposal. If you have any questions in the interim, please do not hesitate to contact us.

Sincerely,



Mike Monahan
Senior Director, Accounting Policy

Tracey Lindsey

Tracey Lindsey
NASVA

John Petchler

John Petchler
on behalf of PPIA
Board of Director



Jonathan Rodgers

Director of Financial and Tax Policy

A handwritten signature in black ink, appearing to read "Stephen W. Broadie". The signature is written in a cursive style with a distinct loop at the end.

Stephen W. Broadie
Vice President, Financial & Counsel

**Mike Monahan**

Senior Director, Accounting Policy
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May 20, 2022

Ms. Carrie Mears, Chair
Valuation of Securities Task Force
National Association of Insurance Commissioners
1100 Walnut Street, Suite 1500
Kansas City, MO 64106-2197

Re: A Proposed Referral to the Blanks (E) Working Group to Add Fixed Income Analytical Measures to Investments Reported on Schedule D, Part One – Additional Market Data Fields for Bond Investments – Comments Due May 20, 2022

Dear Ms. Mears,

The undersigned (ACLI, APCIA, PPIA, NASVA) appreciate the opportunity to comment on the exposure entitled “Additional Market Data Fields for Bond Investments” that was released for comment by the NAIC Valuation of Securities Task Force (VOSTF).

The undersigned note that the memorandum from the Securities Valuation Office (SVO) does not fully discuss or specify how the SVO, VOSTF and/or other regulators who would receive the analytic

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NASVA is an association of insurance company representatives who interact with the NAIC Securities Valuation Office (“SVO”) to provide important input, and to exchange information, in order to improve the interaction between the SVO and its users. In the past, NASVA committees have worked on issues such as improving filing procedures, suggesting enhancements to the NAIC’s ISIS electronic security filing system, and commenting on year-end processes.

data included in the proposal would utilize that information and why it is of value to them. This is especially important given the costs associated with compliance by the industry.

The undersigned understand that one of the reasons for requesting this analytic data is to compare market yields for securities with rating agency (CRP) ratings, in order to identify outlier ratings (of 2x plus variances) where the market (through demanding higher yields) ascribes more risk to a particular security than the CRP rating would imply (e.g., the excess spread above the “risk free”, or US Treasury rate, exceeds the expectation for the security’s inherent credit risk, and if applicable, for illiquidity and/or complexity premium).

The undersigned also understand this is especially desired for privately offered structured securities – e.g., as noted under item 10 of the Summary of Referrals from Macroprudential Working Group “Regulatory Considerations Related to but not exclusive to PE” exposure, with comments due June 13, 2022, as well as from comments from various NAIC staff and regulators.

Given the costs associated with this request, the undersigned would appreciate further dialogue on how the data will be utilized and the tangible benefits to regulators. This discussion would allow the benefits to be weighed against the substantial costs associated with providing the data, i.e., compliance with the proposal.

For public securities much, if not all, of this data is already available from other commercially available sources (e.g., Bloomberg, Clearwater, Aladdin, etc.) and it may be more feasible for the SVO to aggregate this data, rather than have each individual insurance company incur the costs to implement systems changes and provide the data. This is especially true when considering that much of the requested data is based on somewhat complex modeling and outputs are heavily dependent upon inputs, which by their nature require significant judgment and therefore will vary by company.

For private securities, the SVO has (or will have) meaningful data from Private Rating Rationale Reports which are likely meant to help address rating agency disparity concerns.

Our comments below are organized into two different sections – 1) Utility of the Data for Regulators and 2) Compliance Costs for Industry. The undersigned’s desire is to help address valid regulator concerns in the most cost beneficial way.

Utility of the Data for Regulators

This section of our letter will address each requested piece of data individually.

Market Yield – The Market Yield is the internal rate of return discount rate that makes the net present value (NPV) of all expected cash flows equal to zero in a discounted cash flow analysis. Therefore, Fair Value, which is already reported, is the present value (PV) of all expected cash flows at the Market Yield.

We would not expect this data to be very useful or insightful for the vast majority of securities that will be reported as Issuer Credit Obligations under the new Statutory Accounting Principles Working Group (SAPWG) Proposed Bond Definition (e.g., US Treasuries, US Government Agency, Municipal Bonds, Public Corporate Bonds or Private Corporate Bonds that are designated by the SVO and issued from operating entities). Further, for publicly rated securities, the NAIC has access to analytic data through public information sources, such as Bloomberg.

In addition, the vast majority (~75%) of what will be reported as asset-backed securities (ABS) under the new SAPWG Proposed Bond Definition (e.g., CMBS, RMBS, and potentially CLOs) are, or potentially will be, modeled by the SVO and provided an SVO designation with no weight given to CRP ratings.

For much of the remaining securities, both private credit issuer obligations and private ABS, with a private letter rating, pricing is frequently done via “matrix pricing”. While there is a variety of different methodologies utilized, this pricing methodology often uses some type of yield attributed to internal designations (e.g., use of a CRP rating, and related public index-derived yield, or an internal rating, with a similar index-derived yield). Some companies, in whole or in part, also utilize broker provided spreads or quotes for determining market values. At a minimum, there will be meaningful inconsistencies in the data supplied, as each insurer may bring different methodologies to bear in the market valuation process.

Worse, the data could be of dubious usefulness. For example, if a company internally rates a security as a BBB (based on an external CRP’s BBB rating) and uses a BBB index bond yield to determine fair value, the market yield reflected will closely approximate average BBB yields for public bonds and will not signal whether a security is more or less risky than a typical BBB bond. Said differently, because CRP ratings are a critical variable in determining matrix-based market pricing, it would be a circular process to then use a matrix pricing-derived market yield to identify CRP rating outliers.

The undersigned therefore question the utility of this data to the SVO and regulators.

Market Price – The Market Price per unit of Par Value, which is already reported, is reflected in the Fair Value as of the financial statement date. The Market Price, which excludes accrued interest, multiplied by Par Value and divided by 100 will be equal to the Fair Value.

This information is already currently reported in column 8 of Schedule D. The electronic only columns further identify the source of the market price and the fair value level attributed to it. It is unclear if the SVO is looking for something more on this item.

Purchase Yield – The Purchase Yield is the internal rate of return discount rate that makes the net present value (NPV) of all expected cash flows equal to zero in a discounted cash flow analysis as of the Acquired Date. Therefore, Actual Cost is the present value of all expected cash flows discounted at the Purchase Yield as of the Acquired Date.

The undersigned note that the Effective Rate of Interest is already included on Schedule D (Column 17) and defined in the reporting instructions as follows:

For issuer obligations, include the effective rate at which the purchase was made. For mortgage-backed/loan-backed and structured securities, report the effective yield used to value the security at the reporting date. The Effective Yield calculation should be modified for other-than-temporary impairments recognized.

The undersigned note that both of these definitions essentially equate book value to the future expected cash flows, which is the same as NPV = 0. Therefore, it makes sense to align these definitions to ensure the information being utilized by regulators is being efficiently obtained. Further, book yield is an objective yield that may be more beneficial for the stated intent (i.e., yield disparity for an initial CRP rating).

The utility of purchase yield for purposes of identifying excess spread, is the most relevant as it compares the excess spread, to a CRP rating when the deal is committed to. Purchase yield is a fact. For private securities, all valuations assigned subsequent to time of commitment are educated estimates. These estimates may vary for any number of reasons, beyond just the CRP rating including: short-term market movements, impairments, changing circumstances with respect to specific companies or industries, delay in rating agency downgrades, etc. For outliers, the SVO can certainly dig deeper to identify the root causes – e.g., for private securities, note purchase agreements, rating rationale reports, copies of the notes, etc. which the SVO should already have; for public securities, Bloomberg or SEC websites are readily available. In short, in attempting to identify 2x plus variances, the spread over the US Treasury rate (utilizing purchase yield at the time of commitment is going to be the most significant indicator of an outlier CRP rating. The remaining data has very limited additional value in identifying such outliers – e.g., duration matters but is less impactful as it pertains to identifying 2x variances.

Weighted Average Life (WAL) – The Weighted Average Life is the average length of time that each dollar of unpaid principal remains outstanding. The time weightings used in weighted average life calculations are based on payments to the principal. The calculation is "weighted" because it considers when the payments to the principal are made—if, for example, nearly all the principal payments are made in five years, WAL will be close to five years. Weighted average life does not consider payments to interest on the loan. This value is recalculated at each statement date for the remaining principal payments.

WAL can be thought about as a way of estimating the tenor of an investment and is often considered in establishing the interest rate. On a stand-alone basis, the undersigned do not understand why the WAL is particularly useful as other factors related to each investment are considered. The value of WAL as a measure may be diminished when there is potential variability in cash flows due to embedded options or in asset-backed securities. This potential for cash flow variability also increases the likelihood that the WAL measure will vary by company. Therefore, focusing on spread over the US Treasury rate (utilizing purchase yield) should be sufficient to identify outliers. See our discussion on duration below.

Spread to Average Life UST (UST Spread) - The spread is the difference between the interpolated U.S. Treasury bond yield that matches the reported debt security's Weighted Average Life. Spreads between interpolated U.S. Treasuries and other bond issuances are measured in basis points, with a 1% difference in yield equal to a spread of 100 basis points.

Option Adjusted Spread (OAS) - The option-adjusted spread is the measurement of the spread of a fixed income security rate and the risk-free rate of return (typically U.S. Treasury yield), which is then adjusted to take into account an embedded option and expressed in basis points. The spread is added to the fixed income security price to make the risk-free bond price the same as the bond. The option-adjusted spread considers historical data such as the variability of interest rates and prepayment rates. These calculations are complex since they attempt to model future changes in interest rates, prepayment behavior of mortgage borrowers, and the probability of early redemption.

Both the UST Spread and OAS are certainly different ways to calculate the spread over the US Treasury rate, just as with using purchase yield and market yield.

For securities without embedded prepayment or extension risk, we believe spread at time of commitment (e.g., utilizing the purchase yield) will be the most relevant metric and will be most meaningful to the SVO and regulators.

For securities with embedded prepayment or extension risk, while OAS could provide some incremental additional insight, it also has some additional drawbacks. Calculating the OAS involves projecting many future interest-rate scenarios and their probabilities, as well as assumed borrower behavior. To the extent that each insurer has its own proprietary optionality model, OAS for the same security will differ insurer to insurer.

In any case, these are just other forms of spread over treasury which the undersigned believe are unnecessary when trying to identify 2x plus variances, especially considering the costs for each company to comply, and their reliability due to subjective inputs in a complex calculation. Therefore, focusing on spread over the US Treasury rate at time of commitment (utilizing purchase yield) should be sufficient to identify outliers.

Lastly, there is concern among industry that this data would be inconsistent with other data utilized by insurance companies (e.g., the NAIC Valuation Manual for Life and Annuity Reserves requires the use of spreads in very prescriptive form).

Effective Duration - This is a duration calculation for bonds that have embedded options. This measure of duration takes into account the fact that expected cash flows will fluctuate as interest rates change and is, therefore, a measure of risk given the security's Fair Value. As a formula, Effective Duration = $(P(1) - P(2)) / (2 \times P(0) \times Y)$, where $P(0)$ = the bond's Market Price per \$100 worth of par value, $P(1)$ = the price of the bond if the yield were to decrease by Y percent, $P(2)$ = the price of the bond if the yield were to increase by Y percent, and Y = the estimated change in yield used to calculate $P(1)$ and $P(2)$.

Convexity - This is a measure of the curvature, or the degree of the curve, in the relationship between bond prices and bond yields. Convexity demonstrates how the duration of a bond changes as the interest rate changes.

Both Effective Duration and Convexity are interest rate risk measures and are not indicators of credit risk. While such measures are certainly useful for a life insurance company, it is primarily in the context of comparing the duration and convexity of their asset portfolios to the duration and convexity of their liabilities. These data are most useful in estimating prices given changes in interest rates, while the price drivers are based on an investor's view of cash flows, including any embedded options. Because of this, we question their ability to explain a 2x variance in the purchase yield. Additionally, these calculations require very challenging assumptions on volatility which would certainly lead to different outcomes for different companies. Thus, in the context of the varying assumptions on the inputs, and the limited value in identifying 2x variances, the undersigned do not believe there is sufficient value in pursuing the creation of these fields.

VISION ISSUE ID - The NAIC VISION system security ID reported in AVS+.

The undersigned are not aware of any instance in which the VISION ISSUE ID is currently captured by industry, nor included on any reporting schedule. If a company is a filer of a particular security, they typically do not save the VISION ISSUE ID, and if they are not the filer, they would have no reason to seek and retain it.

Due to these factors and our limited understanding of the technical architecture of the NAIC VISION system, the undersigned wonder whether the SVO could utilize the identifiers (e.g., CUSIP) for each investment on Schedule D to cross-reference the VISION ISSUE ID.

Compliance Costs for Industry

The effort and cost of supplying this data is significant. We see the effort broken into two challenges: data capture and creation of the electronic Schedule D:

The data capture challenge fits into one of the following scenarios:

- The data in whole or in part is not utilized by some companies for a variety of reasons, including because some companies do not manage their investment portfolio internally,
- The data is utilized by companies on an ad hoc basis and is not saved or stored, or
- If the data is saved or stored, it is done so on a de-centralized basis and not maintained in the companies' reporting systems.

Capturing the data is only one of the challenges. In order to deliver the requested data fields, the data would need to be included in the electronic Schedule D that is included in a Company's Annual Statement software package. There are several vendors that provide annual statement packages, and they work similarly. Each schedule is loaded to the package as a flat file in the specified format. Flat files are a collection of records in which the data follows a uniform format and follows rules on value types where applicable. The database is flat because every line only holds one data input, depending on the categorization of the columns within the file. The software packages can't take feeds from multiple sources to prepare the schedule. The annual statement software providers likely won't change their requirements to facilitate creation of the schedule that includes these fields so it would be up to companies to create the reporting in the required flat file.

Today, the Schedule D flat files are generated by the investment accounting system used by the company. There are several of these systems in the market. Most, if not all, of these systems do not contain information or programming to calculate the requested fields. Nor do they have a place to store the data with programming to reference such stored fields to facilitate the requested reporting. To do this would be a significant, and likely expensive, development project.

Because of these circumstances, the creation of the requested electronic Schedule D would require a manual process that combines information from multiple data sources. Beyond the cost of creating this manual process and previously stated concerns about data availability, implementing this process in a controlled manner that is required for all financial reporting would require development and testing, which would take considerable time, in addition to the implementation and ongoing cost, given the complexity. Coupled with the other significant NAIC activities, the resources to implement this broad and extensive proposal are very challenging even with a proposed year-end 2023 effective date.

These data capture and schedule creation scenarios present varying degrees of significant challenges in providing the requested information on potentially thousands or tens of thousands of securities for a single company. Each would require companies to develop and maintain processes and internal controls over centralized data capture and financial reporting protocols for data elements which currently don't exist.

Conclusion

Given the concerns expressed above; the data may be available from other sources, the potential lack of utility of the requested data, and the costs and efforts to comply, the undersigned would like to work with regulators to get a better understanding of the actual need for this data, as well as how

the SVO expects to use the data. This would allow us to provide more constructive feedback on this proposal so it can be implemented in the most cost-efficient manner. Due to the significant effort and cost associated with complying with this proposal, for each and every insurance company, it should be evaluated against the actual benefits that will accrue to regulators, especially in the context of other SVO/VOSTF initiatives. The undersigned believe it would be unwise to hastily implement this proposal "as is" only to acknowledge later that the utility of this data is of limited value. Furthermore, we would like to explore whether it is more cost efficient for such data, or a subset of such data, to be centrally aggregated by the SVO for their use in analysis, rather than by insurers individually.

Thank you for considering the undersigned comments. If you have any questions in the interim, please do not hesitate to contact us.

Sincerely,



Mike Monahan
Senior Director, Accounting Policy

Tracey Lindsey

Tracey Lindsey
NASVA

John Petchler

John Petchler
on behalf of PPIA
Board of Directors



Stephen W. Broadie
Vice President, Financial & Counsel

Cc: NAIC Staff
Interested Parties



TO: Thomas Botsko, Chair, Capital Adequacy (E) Task Force
Rachel Hemphill, Chair, Life Actuarial (A) Task Force
Philip Barlow, Chair, Risk-Based Capital Investment Risk and Evaluation (E) Working Group

FROM: Carrie Mears, Chair, Valuation of Securities (E) Task Force

CC: Charles A. Therriault, Director, NAIC Securities Valuation Office (SVO)
Marc Perlman, Managing Investment Counsel, NAIC Securities Valuation Office (SVO)
Eric Kolchinsky, Director, NAIC Structured Securities Group (SSG) and Capital Markets Bureau
Dave Fleming, Sr. Life RBC Analyst, NAIC Financial Regulatory Affairs
Jennifer Frasier, Life Examination Actuary, NAIC Financial Regulatory Affairs
Scott O'Neal, Life Actuary, NAIC Financial Regulatory Affairs
Eva Yeung, Sr. P/C RBC Analyst/Technical Lead, NAIC Financial Regulatory Affairs

RE: Referral regarding a Proposed Purposes and Procedures Manual (P&P Manual) Amendment to Define and Add Guidance for Structured Equity and Funds

DATE: February 3, 2023

Summary – The SVO has processed several private letter rating (PLR) filings for investments in notes issued by special purpose vehicles or other legal entities that operate as feeder funds which themselves then invest, directly or indirectly, in one or more funds or other equity investments. The SVO proposes defining these investments as Structured Equity and Fund investments.¹ The SVO proposed at the 2022 Fall National Meeting the removal of Structured Equity and Fund investments from Filing Exemption, the reliance upon a credit rating provider (CRP) ratings for the assignment of NAIC Designations. The SVO is concerned about this general structure for the following reasons:

¹ Proposed Definition: A Structured Equity and Fund investment is a note issued by, or equity or limited partnership interest in, a special purpose vehicle, trust, limited liability company, limited partnership, or other legal entity type, as issuer, the contractually promised payments of which are wholly dependent, directly or indirectly, upon payments or distributions from one or more underlying equity or fund investments. The inclusion of an intervening legal entity or entities between the Structured Equity and Fund investment issuer and the underlying equity or fund(s), does not change the risk that the insurer investment is ultimately dependent, in whole or in part, upon an investment in equity or one or more funds and its underlying investments. Any design that circumvents this definition, and related examples, through technical means but which in substance achieves the same ends or poses the same risk, shall be deemed a Structured Equity and Fund.

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- 1) Circumvent Regulatory Guidance - The introduction of an intervening entity as debt issuer, when the underlying investment is in substance an equity investment, circumvents regulatory guidance established by the Valuation of Securities (E) Task Force, the Statutory Accounting Principles (E) Working Group and the Capital Adequacy (E) Task Force for the reporting of equity investments because, according to the P&P Manual (i) equity and fund investments are ineligible to use credit rating provider (CRP) ratings in the assignment of an NAIC Designation and (ii), in the case of funds, only the SVO is tasked with determining whether a fund produces fixed-income like cash flows and is therefore eligible for specific classification.

All non-SEC registered funds are required to be reported on Schedule BA. Life insurance entities are permitted to file investments in non-SEC registered private equity funds, partnerships, limited liability companies and joint ventures with the SVO for specific classification on Schedule BA;

- 2) Reliance on Ratings - These investments are being reported as bonds and receiving bond risk-based capital (RBC) factors based upon the mechanical assignment of NAIC Designations that rely upon CRP ratings through the filing exempt process. The use of CRP ratings would not be permitted for the fund or equity investments which underly these notes if the equity or fund investments were held directly;
- 3) RBC / Investment Limit Arbitrage - The structure may permit in-substance equity and fund investments to obtain better RBC treatment than would otherwise be received if the investments had been directly reported. In addition to improved RBC treatment, the structures could permit entities to hold more underlying equity / fund investments than would be permitted under state investment law; and
- 4) Transparency - The structures typically use two or more interconnected private entities through which the privately rated “bond” securities are issued that are backed by investments in non-public assets. The many non-public layers deny regulators, and possibly insurer investors, transparency into the true underlying risks, credit exposure and nature of the investment. The notes issued are described generically as a “senior note” or “term loan” further obscuring their actual structure and complexity. These structures can invest in any asset including affiliate investments, non-fixed income investments, derivatives, borrowings for the purpose of leverage and non-admitted assets.

It is possible that many of the transactions the SVO has processed would not qualify as bonds eligible for Schedule D-1 reporting according to the principles-based bond definition currently being drafted by the Statutory Accounting Principles (E) Working Group, while others likely will qualify. The bond definition requires a review of the substance of the investment to determine whether it has the substance of a bond; significantly, that the ultimate underlying collateral has fixed income cash flows. In either case, however, the use of a fund intermediary has the potential to be abused and requires significant judgment to understand the substance and nature of the ultimate underlying risk. This has already been recognized by the establishment of processes for the SVO to provide NAIC Designations for fixed-income-like funds. It would then follow that debt instruments backed by the types of funds that would ordinarily be required to be filed with the SVO, should follow the same process.

Informational Referral – Given the magnitude of the multiple regulatory arbitrage opportunities, the judgment involved in assessing the nature of the ultimate risk, the lack of transparency, circumvention of regulatory guidance and the reliance on CRP ratings to accomplish these ends, the SVO proposed amending the P&P Manual to include a definition for Structured Equity and Fund and to exclude such investments from Filing Exemption eligibility. The proposed amendment would not change how the investment is classified for reporting by the insurer but it would ensure that the NAIC Designation and Category assigned are appropriate for the risk. This is an informational referral and no direct action is required by the Capital Adequacy (E) Task Force, Life Actuarial (A) Task Force or Risk-based Capital Investment Risk and Evaluation (E) Working Group unless those groups wish to comment on the proposal.

Please contact Charles Therriault or Marc Perlman with any questions.

<https://naiconline.sharepoint.com/teams/SVOVOSTaskForce/Shared Documents/Meetings/2023/Referrals/To CATF LATF RBCIRE/VOSTF Referral to CATF LATF RBCIRE - Structured Equity and Funds 2022-02-03.docx>

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March 23, 2023

Rachel Hemphill

Chair, NAIC Life Actuarial (A) Task Force (LATF)

Re: NAIC Valuation of Securities (E) Task Force (VOSTF) Referral to LATF – Structured Equity and Funds

Dear Ms. Hemphill:

The American Council of Life Insurers (ACLI) appreciates the opportunity to submit comments on the VOSTF referral to LATF regarding Structured Equity and Funds that was exposed for feedback on March 2, 2023.

ACLI believes that this informational referral does not warrant formal comment from LATF. ACLI is comfortable continuing the dialogue with VOSTF to address our main technical concerns with the proposal. For your reference, attached to this comment letter is a February 13, 2023, joint comment letter from ACLI, PPIA, and NASVA outlining those concerns.

Were LATF to formally comment, we would ask for an opportunity to present the main concerns described in the joint letter at a future LATF meeting before any such comments were sent to VOSTF.

Thank you once again for the consideration of our feedback and we are looking forward to any future discussions on this subject.

American Council of Life Insurers | 101 Constitution Ave, NW, Suite 700 | Washington, DC 20001-2133

The American Council of Life Insurers (ACLI) is the leading trade association driving public policy and advocacy on behalf of the life insurance industry. 90 million American families rely on the life insurance industry for financial protection and retirement security. ACLI's member companies are dedicated to protecting consumers' financial wellbeing through life insurance, annuities, retirement plans, long-term care insurance, disability income insurance, reinsurance, and dental, vision and other supplemental benefits. ACLI's 280 member companies represent 94 percent of industry assets in the United States.

acli.com



Colin Masterson

cc: Scott O'Neal, NAIC



Mike Monahan
Senior Director, Accounting Policy
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February 13, 2023

Ms. Carrie Mears, Chair
Valuation of Securities Task Force
National Association of Insurance Commissioners
110 Walnut Street, Suite 1500
Kansas City, MO 64106-2197

Re: Proposed Amendment to Define and Add Guidance for Structured Equity and Funds to the P&P Manual

Dear Ms. Mears,

The undersigned (ACLI, PPIA, and NASVA) appreciate the opportunity to comment on the exposure referred to above that was released for comment by the Valuation of Securities Task Force (VOSTF) on December 14th, 2022.

The Undersigned’s Response to the Exposure – In Summary

The exposure has a variety of SVO concerns that are somewhat commingled. Our concerns, some of which are addressed in more detail following, are summarized below.

1. It appears some of the SVO’s concerns include:
 - a. Pure regulatory arbitrage, when comparing pre-and post-securitization, while holding the same economic risk,
 - b. What constitutes a “bond” in concept, specifically for eligibility under SSAP No. 26R and SSAP No. 43R, and
 - c. Lack of transparency on the structures and investments held by the underlying fund.

2. Industry is confused by the overlap with other initiatives and exposures, specifically the “Principles-based Bond Definition” initiative, the Risk-Based Capital Investment Risk and Evaluation (E) Working Group (Investment RBC WG) activities, and this Exposure. Projects and other initiatives address those concerns as follows:
 - a. The Investment RBC WG agenda currently includes a project to determine the appropriate risk-based capital charge for residual tranches of structured investments, which will address the arbitrage concerns raised in this proposal,

- b. SAPWG is currently near finalization of a project to define a bond, including determining eligibility for reporting on Schedule D. The SVO already has an avenue to raise concerns on investments that they do not believe meet the definition of a bond,
 - c. Private rating letters are now being filed. These letters are quite substantive and should include significant information about fund structures and their largest underlying investments.
3. The exposure name implies that the SVO is focused on feeder funds and structured equity investments. However, concerns associated with potential PIK interest, maturity extensions or other features that are common among securities appear to be commingled within the feeder fund example. To the extent a security has the potential to PIK or defer interest, where such interest is otherwise not capitalized or required to be accrued, or the potential to extend the maturity without paying interest for that extension, the Undersigned agree such a security has non-payment risk. Otherwise, the potential to PIK or defer interest, or the potential to extend the maturity, has real economic or business benefits, often mitigating risk, and should not be in the purview of the SVO for determining NAIC designations that are ultimately used for risk-based capital purposes.

Presumably, the SVO has concerns related to liquidity risk, but this is not a factor in determining an NAIC designation, nor should it be, and the SVO is not in a position to assess liquidity risk for insurers. The SVO has been focused on securities with the potential to PIK or defer interest, as well as the potential to extend maturity, but we have yet to discern what that concern is other than liquidity risk.

4. The proposed definitional change to the P&P Manual would potentially capture a whole host of more traditional fixed income securities that industry does not believe were intended to be in scope and may be difficult for the SVO to evaluate. The following fixed income securities are explicitly not feeder funds, nor share the same risk profile. Industry notes the following examples potentially captured by the exposure (including but not limited to):
- Senior secured debt issued by a comingled fund, private or public (SEC 40 Act regulated funds, mutual funds etc.)
 - Senior secured debt issued by SPVs that own or invest in debt instrument(s), whether directly or through tax or jurisdictionally required blockers
 - Senior debt issued by REITs
 - Senior debt issued by BDCs
 - Senior debt issued by entities owning stakes in one active corporate subsidiary, or multiple related active corporate subsidiaries (“holding companies”),
 - Senior debt issued by Collateralized Fund Obligations (“CFOs”) through a trust securitization offering
 - Senior debt issued as NAV Loans generally with very low LTVs

In addition to the cost associated with reviewing these additional transactions, the question arises as to whether the SVO can better assess risk than rating agencies. Some of these structures (such as CFOs) are non-homogenous and require substantial modelling resources to evaluate. Certain rating agencies have developed a niche in assessing these risks. We also note these securities often have significant credit enhancement retained by the issuer that are not

part of the securitization (e.g., CFOs) as well as significant overcollateralization (e.g., NAV Loans, often with LTVs at 10%).

5. The exposure mentions that the SVO could use any methodology that it deems appropriate to designate such funds. There is concern about the lack of transparency of SVO methodologies, and related consistency in designations for similar risk. We believe transparency in methodology, as is happening with CLOs, is important and SVO methodologies should be fully transparent. This would accomplish two objectives – 1) Ensure the SVO is applying methodologies consistently and 2) Provide transparency to the market and industry.
6. A 2021 NAIC Capital Markets Bureau Special Report stated, “On average, designations were 2.375 notches higher, with designations 2.4 notches higher at small CRPs and 1.9 notches higher at large CRPs” than SVO’s designations”. This statement implies that SVO designations are conservative, even when compared with larger rating agencies. We believe that conservative designations for their own sake should not be the objective of the SVO. Rather, the pursuit of consistent, accurate, and transparent investment risk assessments should be the joint objective of the NAIC, VOSTF, SVO, and Industry. Excess conservatism and lack of transparency for critical processes within the SVO’s designation methodology have the potential to create a disconnect between the appropriate risk-based capital charges set by the NAIC’s Capital Adequacy’s Task Force and SVO designations. Risk-based capital charges are based upon public rating agency experience and is the foundation upon which the capital charges are ultimately based.

While acknowledging the SVO’s designation process generally works well for most traditional corporate bonds that are filed with the SVO, although not without examples of unsubstantiated deviations, the potential for inconsistency in appropriate risk assessment becomes even greater as structural complexity increases. Additionally, having concentrated critical processes under the SVO’s sole discretionary purview, including choice of rating methodology to apply, application of that methodology, and the lack of a robust and independent appeals process for industry, does not offer appropriate checks and balances. Currently, industry struggles to understand how the SVO might view securities with new, unusual, or outlier risks and what type of designation the SVO might assign to such securities. The potential for inconsistency in appropriate risk assessment becomes even greater as structural complexity increases. If an SVO designation methodology exists for all asset classes, industry does not understand why they cannot be made both public and transparent. If an SVO designation methodology does not exist for all asset classes, that would be concerning as the SVO looks to expand its role for designating even more complex securities.

There is also concern that a lack of transparency and applied consistency with the SVO’s undisclosed designation methodologies will lead to material capital uncertainties and inconsistent designations. Capital certainty may not officially be a component of an NAIC designation, but we believe all should agree that consistent application of, and transparency of, designation methodology is important to all stakeholders, including the SVO and state regulators. Further, capital certainty and timeliness of designations are very important to insurance companies to manage risk-appetites for risk-based capital in a meaningful way, and to ensure that return on investments covers not only expected losses but also an acceptable return on capital.

- The undersigned believe the proposed amendment should focus on what we consider should be mutual areas of agreement in principle.

The SVO should make their methodologies public to help ensure they are applied consistently, the SVO’s powers have appropriate checks and balances, and/or they are not overly conservative when compared to rating agencies’ ratings and upon which risk-based capital charges are based.

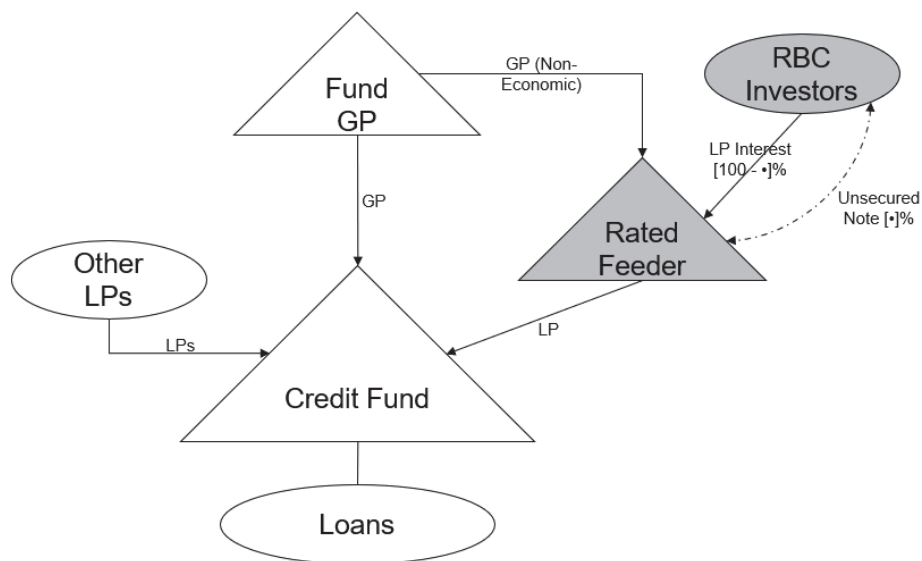
Even the large rating agencies, who have extensive resources (including sizable staff with dedicated teams for specific asset classes with unique characteristics, trained economists, the latest technology, access to tailored seminars/training for specific asset classes, and access to management), are not experts in all areas.

As a result, both large and smaller rating agencies have developed particular niche expertise, and no one rating agency rates every type of debt asset class.

The undersigned would like to work together with the SVO and NAIC to better understand their concerns so approaches more tailored toward those specific concerns can be more efficiently addressed. We look forward to having dialogue with you on these issues and stand ready to help.

Feeder Fund Structures

The remaining part of our letter focuses on the feeder fund structure and the examples included within the exposure. A visual depiction of a feeder fund can be shown as follows:



This type of structure, as well as other structures such as CFOs, were subject to significant discussion during the principles-based bond definition project. Early in the project, complex and unworkable rules were being developed in an attempt to address risk-based capital concerns of structures (i.e., allowing for potential risk-based capital arbitrage without a substantial change in economic risk). It was ultimately decided by SAPWG that such concerns were best addressed by revising the definition of a bond in combination with the Investment RBC WG addressing the

appropriate risk-based capital charges for residual tranches. All residual tranches have subsequently moved to Schedule BA and are in scope for potentially higher risk-based capital charges.

During the bond project, industry also shared with regulators that these feeder fund structures provide valuable benefits to the insurance industry, as well for those outside the insurance industry. Feeder funds allow companies to obtain diverse exposure to mezzanine debt (or junior debt, 1st lien debt, etc.) which investors would otherwise not be able to do individually due to materiality, individual underwriting expertise, lack of diversification, etc.

The feeder fund structure was initially developed, at least in part, for anti-arbitrage reasons and to allow insurance companies to access funds with a capital charge that puts insurance company investors on a level playing field with pension funds, banks, and other non-insurance investors. The key is that some investors cannot commit sufficiently large capital to do a separately managed account directly, and thus must choose between either foregoing attractive credit risk exposure or taking an overstated risk-based capital charge to access a diversified portfolio of ultimately debt instruments via a fund investment. A pension fund, for example, can invest in the limited partnership directly without similar risk-based capital consequences. But for an insurance company, the risk-based capital charge is 30%. Meanwhile, as noted in the SVO example, the real risk-based capital risk on a look-through basis is lower – in the example only 9.5% – resulting in anti-arbitrage.

The Investment RBC WG agenda currently has a project to determine the appropriate risk-based capital charge for residual tranches commensurate with the levered risk of the residual tranche. An interim solution is anticipated in time for concurrent adoption with the principles-based bond project. In the SVO's example, if the residual tranche risk-based capital charge was set at 65% (i.e., half-way between 30% and 100%) the aggregate risk-based capital charge of owning both the debt and equity tranche would be 7.635% versus 9.535%, essentially eliminating the "arbitrage" as laid out in the feeder fund exposure example. However, the SVO's example only has a 10% equity tranche which is substantially lower than a typical equity tranche. A more representative equity tranche of 25% with a 30% risk-based capital charge would yield an aggregate risk-based capital charge of 8.446% essentially eliminating any arbitrage. A risk-based capital charge of 65% on the residual tranche would yield an aggregate RBC charge of 17.196% which would still be significantly anti-arbitrage.

Further, securities issued by feeder funds are often issued as tranches with associated waterfall structures. These more complicated structures allow apportionment of risk potentially between different entities and/or segments to further allocate risk. Often the investment teams at insurance companies that manage fixed income versus equity portfolios are separate entities. To the extent a debt-oriented fund must be evaluated by an equity portfolio team, the fund will generally not gain traction being a "lower returning opportunity" compared to equity asset classes. This can make the access to this attractive asset class effectively fall through the cracks at many insurance companies. Feeder vehicles can assist these companies to shift the evaluation from their equity portfolio teams to their debt-oriented teams.

Not all feeder fund investors are primarily motivated by risk-based capital treatment; some of them are very focused on having the "reliable and predictable income" that debt tranches from a feeder fund would provide. The complex structuring and apportionment of senior/subordinate risk between tranches is both experience and technology intensive. CRPs have invested materially for years in their capabilities to assess credit risk in these tranching waterfall-based securitizations, and their published methodologies are transparent and consistently applied. We question whether the SVO

could evaluate such structures, for all different types of asset classes, in a more efficient, transparent and/or consistent manner than already performed by the CRPs.

The SVO's WARF methodology can work well where it is currently applied such as when there is direct ownership in an LP interest with no debt, but it becomes problematic when there is debt or when multiple tranches exist with a waterfall structure. Absent this already being addressed by the Investment RBC WG, it might be reasonable to have the SVO apply the WARF methodology and utilize that charge, if the SVO would apply the aggregate 9.535% charge they note is appropriate in the exposure. However, this comes with several practical problems:

- 1) The SVO exposure suggests any methodology for a designation could be used by the SVO, in their sole discretion without transparency as to considerations given or to ensure consistency of application. A lack of transparency as to methodology has long been a significant challenge industry has raised regarding the SVO, as designations received from the SVO can sometimes seem variable and inconsistent. This can lead to industry uncertainty regarding assessment of risk. While acknowledging the SVO's designation process generally works well with traditional corporate bonds that are filed with the SVO, although not without examples of unsubstantiated deviations, the potential for inconsistency in appropriate risk assessment becomes even greater as structural complexity increases. Trying to gain an understanding of potential outlier risk assessment is generally not achievable with today's SVO structure.
- 2) The cost of filing such securities with the SVO, which is significant given the proposed scope, could be prohibitively expensive and time consuming given the potential for limited incremental benefits, if any, compared to the status quo. For example, if the underlying debt itself is not rated by a CRP, our understanding is the designation for that underlying bond is automatically deemed a 5B, which is inappropriate, or each individual underlying instruments needs to be filed with an RTAS. The hard cost of filing each security, and each RTAS, combined with the requisite filing requirement for each underlying security (if all such information is even available in the form required), is prohibitive. Rating agencies have devoted significant cost and staff to analyze such securities. For example, industry understands that rating agencies stress each individual CUSIP within the securitization under different scenarios. Many rating agencies also have niche expertise in certain variations of asset backed securities, with different underlying collateral.
- 3) The SVO's exposure questions both the PIKing or deferral and accruing of interest and circumstances where the weighted average life of the underlying junior debt differs from the term of the note. However, there are valid economic reasons for why these structural features exist, and we think it is an oversimplification to assume that such features are inherently risky.

For example, while acknowledging significant variations exist (one example cannot cover all contingencies), it is common that the underlying investments in the portfolios of these funds are not typically traded. While the fund manager has the authority to actively manage the fund, in large part the average fund ends up pursuing a "buy and hold" strategy. During the investment period of the underlying fund, investments are originated and purchased by the fund. After the end of the investment period, the fund goes into a "run-off" mode and no further investments are purchased by the fund. As cash is generated from the underlying investments in the fund is distributed to investors in the fund on a pro-rata basis per their respective commitment to the fund. To the extent the investor has come into the fund via a feeder vehicle, then the waterfall provisions of that vehicle will dictate how the cash is distributed to the tranches of securities

that were issued by the feeder vehicle. The portfolio manager has no discretion to redirect these cash flows, and again they are contractually directed per the waterfall.

Generally speaking, feeder vehicles are structured such that once an underlying fund portfolio has “ramped-up”, given the inherent overcollateralization of these structures from the viewpoint of the rated notes, ample cash flow is generated from the fund’s assets to pay the contractual cash coupons on the rated notes issued by the feeder vehicle. After paying administrative expenses, all cash received during each period is first available to pay the interest due on the Senior Notes of the feeder vehicle, followed by interest due on any Subordinated Note tranches. During the investment period, it is typical that any remaining cash be distributed to the residual or equity tranche of the feeder vehicle, while after the investment period this cash would otherwise be used to pay down principal of the Senior Notes (until fully repaid) and then any Subordinated Notes, prior to being applied to the residual tranche.

Given the structure of a typical feeder vehicle and the waterfall priorities, it is highly unlikely that interest due to the Senior Notes issued by a vehicle would not be paid in cash. For any Subordinated Notes, to the extent there is not sufficient cash flow received on a current basis in a particular period of time to pay the interest due on those notes, then that interest is PIKed or otherwise accrued for the current period. Per the priority structure of the waterfall, that interest will then have to be paid in cash from cash received from the underlying fund investments in subsequent periods. This amount due will remain outstanding and retain its priority in the waterfall until fully repaid.

For an underlying fund that primarily holds private debt investments in its portfolio, these investments may typically have legal maturities of 7-10 years. Given that these investments can generally be prepaid by their issuing companies several years before the legal final maturities, and with the normal life cycle of private equity ownerships of companies generally, it is very common that these investments will only be held by the underlying fund for ~3-4 years.

With a typical structure for a feeder vehicle, the note tranches issued by the vehicle will generally have debt maturities longer than the maturities of the investments in the underlying fund (and practically speaking much longer than the actual hold period for most investments in those funds). Since all cash received from the underlying investments is directed by the feeder vehicle waterfall structure to pay down interest and then principal of the notes issued by the feeder vehicle, this potential mismatch is not problematic. In fact, this is a credit enhancement for the notes issued by the feeder vehicle that ensures there is no need for distributions in kind.

As noted in our previous letter on Subscript S and non-payment risk, there are valid reasons for potential PIK interest (or deferral of interest) as well as for potential maturity extension features, and if structured appropriately, they do not represent non-payment risk. A US Treasury security can be a PIK security, for example. The SVO’s exposure says the interest “could” be deferred without capitalization. It is unclear in the example cited, whether this is the case or “could” is used more generally. However, if the debt interest can be deferred without capitalization or otherwise being accrued, as stated in the deal documents, we agree that is non-payment risk and have no disagreement that it should be filed with the SVO as a non-filing exempt security. Although we are generally not aware of such securities being utilized, we agree that, to extent such securities exist, we are comfortable filing them. However, we do not think the presence of a PIK interest feature that capitalizes interest when used, is problematic.

- 4) The exposure's second example doesn't appear to have an equity tranche, and therefore the analysis presented in the exposure would not be practically appropriate. In any instance, we do not believe the math is correct in the SVO's analysis. To arrive at the SVOs risk-based capital charges, both debt tranches would have to be 50 and 50, not 55 and 55. The "BB Debt" would not be debt and would have an equity charge of 30% resulting in an aggregate RBC charge of 17.6925% in this instance. Should it be 65% the aggregate risk-based capital charge would be 37%. That is greater than the risk-based capital charge of the underlying equity.

Industry believes that feeder fund structures should be left, as originally planned by SAPWG, to be addressed by the Investment RBC WG. Additionally, industry does not deem the presence of PIK interest and principal extension features in securities to automatically translate to higher risks that would necessitate a filing with the SVO. The SVO was recently granted the authority to review private rating letter rationales (which are in-depth reports) and report suspected non-bonds to regulators, and regulators can react accordingly. It is unnecessary to make a large swath of any given asset class non-filing exempt in order to identify instances of potential abuse.

We stand ready to work collaboratively with the Task Force and SVO on this and other matters in the future

Sincerely,



Mike Monahan
Senior Director, Accounting Policy

Tracey Lindsey
Tracey Lindsey
NASVA

John Petchler
John Petchler
on behalf of PPIA
Board of Director

Draft: 6/15/23

Life Actuarial (A) Task Force
and the Life Risk-Based Capital (E) Working Group
Virtual Meeting
April 13, 2023

The Life Actuarial (A) Task Force met April 13, 2023, in joint session with the Life Risk-Based Capital (E) Working Group of the Capital Adequacy (E) Task Force. The following Task Force members participated: Cassie Brown, Chair, represented by Rachel Hemphill (TX); Scott A. White, Vice Chair, represented by Craig Chupp (VA); Lori K. Wing-Heier represented by Sharon Comstock (AK); Mark Fowler represented by Sanjeev Chaudhuri (AL); Ricardo Lara represented by Ahmad Kamil (CA); Andrew N. Mais represented by Wanchin Chou (CT); Doug Ommen represented by Mike Yanacheak (IA); Dana Popish Severinghaus represented by Vincent Tsang (IL); Amy L. Beard represented by Scott Shover and Heir Cooper (IN); Vicki Schmidt represented by Nicole Boyd (KS); Grace Arnold represented by Fred Andersen and Ben Slutsker (MN); Chlora Lindley-Myers represented by William Leung (MO); Eric Dunning represented by Michael Muldoon (NE); Adrienne A. Harris represented by Bill Carmello (NY); Judith L. French represented by Peter Weber (OH); Glen Mulready represented by Andrew Schallhorn (OK); Michael Humphreys represented by Steve Boston (PA); and Jon Pike represented by Tomasz Serbinowski (UT). The following Working Group members participated: Philip Barlow, Chair (DC); Sanjeev Chaudhuri (AL); Thomas Reedy (CA); Wanchin Chou (CT); Mike Yanacheak (IA); Vincent Tsang (IL); Fred Andersen (MN); William Leung (MO); Derek Wallman (NE); Seong-min Eom (NJ); Bill Carmello (NY); Andrew Schallhorn (OK); Rachel Hemphill (TX); and Tomasz Serbinowski (UT).

1. Approved the Formation of the Economic Scenarios (E/A) Subgroup and its Associated Charges

Hemphill said a joint Economic Scenarios (E/A) Subgroup was being considered for formation, noting that it was a joint subgroup of the Life Actuarial (A) Task Force and Life Risk-Based Capital (E) Working Group due to the impact of economic scenarios on life insurance and annuity reserves and capital. She said charges (Attachment Nine-A) were exposed, and one comment letter from Mark Tenney (Mathematical Finance Company) (Attachment Nine-B) was received. She stated that in response to a portion of Tenney's comments, an additional charge was added to develop and maintain acceptance criteria reflective of history and plausibly more extreme scenarios. Tenney said he agrees with the edits to the charges, but he noted that there were challenges with interpreting the results of the Cox-Ingersoll-Ross (CIR) model. Jason Kehrborg (American Academy of Actuaries—Academy) said the Academy Economic Scenario Working Group approved of the addition to the charges, and it is actively working on developing acceptance criteria.

Hemphill asked Task Force and Working Group members if they approve of the formation of the Economic Scenarios (E/A) Working Group. All responded in the affirmative.

2. Discussed the VM-20/VM-21 GOES Technical Drafting Group Topics Exposure

Hemphill said the VM-20, Requirements for Principle-Based Reserves for Life Products/VM-21, Requirements for Principle-Based Reserves for Variable Annuities Generator of Economic Scenarios (GOES) Technical Drafting Group exposed a series of topics (Attachment Nine-C) that would be discussed at meetings of the Drafting Group.

3. Reported on a Regulator-to-Regulator Meeting of the SPA Drafting Group

Hemphill said the Standard Project Amount (SPA) Drafting Group met April 6 in regulator-to-regulator session, pursuant to paragraph 3 (specific companies, entities or individuals) of the NAIC's Policy Statement on Open Meetings, to share the results of a confidential survey sent to companies requesting data related to the SPA.

Having no further business, the Life Actuarial (A) Task Force and Life Risk-Based Capital (E) Working Group adjourned.

SharePoint/NAIC Support Staff Hub/Member Meetings/A CMTE/LATF/2023-2-Summer/LATF Calls/04 13/April 13 Minutes.docx

The **Economic Scenarios (E/A) Subgroup** of the Life Risk-Based Capital (E) Working Group and the Life Actuarial (A) Task Force will:

- A. Monitor that the economic scenario governance framework is being appropriately followed by all relevant stakeholders involved in scenario delivery.
- B. Review material economic scenario generator updates, either driven by periodic model maintenance or changes to the economic environment and provide recommendations.
- C. Regularly review key economic conditions and metrics to evaluate the need for off-cycle or significant economic scenario generator updates and maintain a public timeline for economic scenario generator updates.
- D. Support the implementation of an economic scenario generator for use in statutory reserve and capital calculations.
- E. **Develop and maintain acceptance criteria that reflect history as well as plausibly more extreme scenarios.**

Mathematical Finance Company
QTSM CIR Green's Function Multifactor CIR and Affine Options SIRP ESG RS-ESG DMRP RS-DMRP

Mar 15, 2023

Honorable Rachel Hemphill
Chair, Life Actuarial (A) Task Force (LATF)
Honorable Philip Barlow
Chair, NAIC Life Risk-Based Capital (E) Working Group (Life RBC)
National Association of Insurance Commissioners

Re: Economic Scenarios (E/A) Subgroup

Dear Ms. Rachel Hemphill and Mr. Philip Barlow,

Please accept this comment on the NAIC LATF Economic Scenarios Subgroup Draft Charges.

Sincerely yours,

Mark S. Tenney

The 3 factor CIR model tuned to the lower bound and moderate negative rates is overly focused on that region. This results in extreme values of reserves and capital. This is an artefact of the model's limitations.

Regime Switching DMRP does not have this limitation. It can model rates trapped at the zero lower bound or negative rate regimes without overweighting to zero or negative rates.

Currently, the Fed is running inflation higher than the two percent target in the past. Prior to the recent increase, the actual value of inflation trended below the target. Greg Mankiw talked to me after a recent Brookings event in February 2023. During the session he indicated that inflation at 3 percent would be treated as being as good as two percent by the Fed.

I brought up the view that the Fed wanted to be relevant. It did not want to be stuck at the zero lower bound and have its policy irrelevant and therefore it was running inflation intentionally higher now in order to have room to lower rates.

The Federal Reserve's model of the economy, FRBUS, is structured very differently from multifactor CIR or the Regime Switching DMRP. In its standard setting, zero is a lower bound on the Fed Funds Rate, but treasury yields can be negative even in this case.

The two models, RS-DMRP and FRBUS both have negative rates but they can have more moderate impacts on pricing in some cases or for some calibrations while still having enough of a tail of negative rates for regulatory purposes. If FRBUS is more moderate on negative rates than is the 3 factor CIR GFF in its current calibration, then the Fed model should guide a recalibration of the 3 factor CIR GFF model to be more moderate on pricing. This is because the GFF does not really contain fundamental economic information on negative interest rate episodes.

It is proposed that the Economic Scenarios Subgroup study using RS-DMRP and the Fed's model as replacements for the 3 factor CIR GFF or to modify its calibration. It is proposed this be added to its list of charges. This could save the industry from having to substantially retrench and remove many product designs. This would result in a huge loss of jobs. This would only be justified if it was based on fundamental economic data and models. The FRBUS model is the best empirically of such models. It is eclectic compared to a more academic DSGE model.

In addition to the above, there should be an effort to explore the Fed agreeing to lend to insurance companies during episodes of negative rates for their cash needs. This could then be modeled. This would result in substantial relief of reserve and capital strain from negative rates. For this purpose, the RS-DMRP or the Fed's own FRBUS will be more useful than the 3 factor CIR GFF model.

Equity models can be linked or be part of the RS-DMRP. These models do not have to have the extreme march down to almost zero wealth ratios. Stock market decline regimes tend to be short is what the published literature has found.

The subgroup should proceed on an evidence based approach. This should be added to its charges or made explicitly part of them. This currently favors the view of less negative rates than in the GEMS calibration in the US and of equity stock market returns that do not have the extreme down movements. The extent of low and negative rates in the 3 factor CIR model arose from limitations in the model's structure. From an evidence based approach, RS-DMRP especially is better at having some negative rate scenarios but not being required to be overweighted to it. In addition, RS-DMRP is easier to understand and control for this purpose. The Fed's model has at times changed, and so use of it as the main economic scenario generator is risky. Along with its other flaws, this favors RS-DMRP. It can provide some low for long and negative rates but it doesn't become trapped into an excessive amount of those. This then reduces the strain on reserves and capital.

Economic Scenario Generator Technical Drafting Group Planned Topics, Tentative Timing, and initial Decision Points

1) Stochastic Exclusion Ratio Test

Timeline: Initially, meetings on 4/12 and 4/26, to finish covering field test results and discuss decision points below. Subsequently, two additional meetings after the second round of field testing, to discuss SERT field test results, pick a version of the SERT (if multiple were tested), and to determine SERT cutoff (assuming this form of SERT is selected).

SERT Goals:

- Practically sort products that may have a constraining SR from those that would not have a constraining SR.
- Give reasonably consistent results over time and in different economic environments.

Comment (Mark Tenney, Mathematical Finance Company): *"The NAIC ESG GEMS generator is calibrated to negative rates and low for long. It has some ability with other rate environments or in transitions, but these are at least partly limited in their scope and accuracy because of the orientation to low for long and negative rates. Pop-up type scenarios are not as strong as in the recent movement starting in 2021.*

These type of scenarios are handled at least partly outside of the ESG in current practice. The exclusion test is to determine whether to exclude testing with the ESG when the ESG by itself is already inadequate for many key tests. This is a sort of paradox. The ESG can not really tell what to exclude, because key risks are not in the ESG. The lack of a more robust ESG thus makes the exclusion test difficult to assess.

At a minimum, a second ESG, a scorekeeper ESG or risk ESG should be used to check the ESG and the exclusion test. This might be an ESG like Regime Switching DMRP. Companies might be encouraged to self-test with their own ESGs or ones they use."

SERT Decision Points:

1. **Decision Point:** Should the SERT be removed entirely, given that it is duplicative of what could be provided for the certification method? This could include moving the primary SERT outline to the examples for a broadened certification method. With a QA certifying as to the risks, a more judgment-based evaluation of the variability could be performed

rather than having a rough cutoff that does not consider the size of the business or the materiality standard.

Advantage for removal: The SERT discourages a holistic assessment and discussion of risk that is more appropriate for PBR. It could potentially be replaced with versions of the certification or demonstration method. One suggested alternative was to run a small, representative scenario set (e.g., 50 scenarios) and show it is not constraining compared to the NPR and DR. This is currently allowable under the stochastic exclusion demonstration test option outlined in 6.A.3.b.iii, except that it is left up to the company to determine “a sufficient number of adverse scenarios”.

Advantage for retaining: The SERT is often used because it is simple to implement. Following the same approach but as part of a certification method would require additional reporting and may trigger follow-up questions.

2. **Decision Point:** What products are generally expected to pass the SERT, what products are generally expected to fail, and what percentage of the time should this single test be able to accurately sort these accordingly?

Proposal: Pass: most Term with 20 year or shorter level period (non-ROP); Fail: most ULSG (unless minimal guarantees); the current SERT appears to fail roughly 10% of the time.

3. **Decision Point:** Do the SERT scenarios need to be at a moderately adverse level?

Proposal: No. The SERT is not a set of scenarios that need to be “passed”. They should reasonably assess whether performing an SR and taking a CTE(70) is likely to produce a higher reserve than the DR. Thus, they should assess whether tail scenarios lead to significant increases. They should generally be representative of the tail, but tail results may not be driven by the 85th percentile. Ultimately, the cutoff, which will be calibrated based on the SERT methodology, is what will determine whether products pass or fail the SERT.

4. **Decision Point:** Should the SERT scenarios be derived directly from the stochastic scenario distribution, as Conning has done or modified, or should they be “stylized” scenarios be created that reflect starting conditions and a level of reversion to a mean? Is there an alternative approach?

Advantages for scenarios based on full scenario set: Direct relationship for goal #1; avoids disconnect between the test and its effectiveness for the intended purpose of determining whether there would likely be a SR excess over the DR. The intent is for economic scenario generator updates to be more gradual over time now that we have a vendor to maintain the economic scenario generator. Each update would require an evaluation and potential update of the stylized scenarios as well.

Advantages for scenarios based on stylized set: Ease of implementation. Being less responsive means being more predictable.

Alternative (suggested by Matt Kauffman, Moody's): *"The alternative approach that I am proposing is similar in nature to the existing SERT methodology, with **prescribed vectors of pre-determined random shocks** to replace the stochastic random shocks. Because the structure of the AIRG model is different than the structure of the GEMS model, however, the existing prescribed vectors of shocks need to be translated somewhat to work with the random drivers used in the new GEMS model. I have done some limited testing that confirms it appears possible to do so in a way that will produce acceptably similar results to the existing SERT methodology (and much more similar results than the targeted percentile methodology that was used in the field test). I will be happy to provide more technical details on my proposal, if requested.*

Advantages for scenarios based on prescribed random shocks:

- *Direct relationship for goal #1.*
- *Ease of implementation; no need to generate 10,000 scenarios and analyze their percentiles to produce the 16 scenarios.*
- *Removes some of the conservatism that was unintentionally added by Conning's proposed methodology of targeting percentiles.*
- *It should adapt/respond fairly well to changes in calibration, as long as the calibration rationale remains consistent (i.e. the 3 CIR factors still roughly correspond to level, slope, and curve shape).*
- *Deterministic Reserve (DR) scenarios can dynamically be re-generated quickly for pricing/sensitivity testing/risk management (i.e. non-valuation) purposes."*

5. **Decision Point:** How do we evaluate whether the SERT is appropriately calibrated, independent of the additional risk reflected in the new scenarios? That is, what must be included in a subsequent Field Test to calibrate an appropriate cutoff?

Proposal: Adequate coverage of different starting conditions, adequate representation of products (Term, ULSG, VULSG, VULnoSG par & non-par WL).

2) Deterministic Reserve

Timeline: Initially, meetings on 5/10 and 5/24. Subsequent to the second round of field testing, two meetings to review DR field test results and to select a version of the DR (if multiple were tested) and confirm DR methodology.

DR Goal:

- Provide a moderately adverse deterministic scenario that will be adequate to capture risk for products that do not have significant interest rate and or equity risk.

DR Decision Points:

1. **Decision Point:** Should this scenario be linked to the stochastic exclusion ratio test or can it be separate?

Proposal: Separate. The DR must primarily be suitable for the DR goal above.

Comment (Matt Kauffman, Moody's): *"A related question is whether the DR scenario should be linked directly to the underlying scenario generating model. If, as proposed, a completely separate DR scenario is devised, then this linkage would no longer exist and there could be undesired side effects.*

If my proposed alternative SERT methodology of using prescribed vectors of pre-determined random shocks were implemented, however, then the linkage could be maintained while also removing some of the unwanted conservatism that existed in the field test DR scenarios. (The new targeted percentile methodology is a more conservative approach to develop the DR scenario because the upward "pull" of mean reversion after year 20 is significantly dampened).

If, after applying my proposal, the resulting DR scenario would still be considered too conservative (i.e. beyond moderately adverse), then I would suggest this is an indication that the calibration of the underlying model producing the SR scenarios is itself too conservative. In other words, if a one standard deviation level of random shocks spread out over a 20 year period is enough shocks for the model to produce a scenario that is considered well beyond moderately adverse, then the model is probably also producing a full distribution of 10,000 scenarios that is unreasonable from a real world probability perspective. Approximately 16% of scenarios would be using stochastic random shocks that produce an even more adverse scenario than the DR scenario over the first 20 years.

In this event, I would recommend revisiting the calibration (and the underlying acceptance criteria that is being calibrated to) to produce a more realistic distribution of stochastic scenarios, rather than designing a separate deterministic scenario to avoid the issue."

2. **Decision Point:** Do we agree with the format of the current deterministic scenario (adverse for 20 years, followed by reversion to mean)?

Proposal: Generally yes, but should consider whether the reversion to mean after 20 years particularly impacts specific products, giving less than a moderately adverse result. The focus for DR reserve adequacy should be policies passing the SET, but we should be mindful that it can be constraining for those with an SR as well.

3. **Decision Point:** Is the deterministic reserve scenario methodology used for the first field test appropriate?

Proposal: The DR scenario used may be beyond moderately adverse. While re-calibration will impact the DR level, ask Conning to develop a form of DR that is more consistent with the current DR.

3) Scenario Picker Tool

Timeline: 3 meetings, 6/7, 6/21, and 7/5

Scenario Picker Tool Goal:

- Provide scenario subsets that are reasonably representative of the full 10,000 scenario set for policies and/or contracts that are sensitive primarily to interest rates, equities, or both.

Scenario Picker Tool Decision Points:

1. **Decision Point:** Should there be a scenario picker that is included as part of the economic scenario generator?
Proposal: Yes.
2. **Decision Point:** Should custom stratifications be allowed, for both VM-20 and VM-21, if the company provides an off-cycle or model office comparison between the subset and full 10,000 to show there is not material understatement or bias?
Proposal: Yes. This may reduce the importance of having a perfect response for items #3-#5 below.
3. **Decision Point:** What size of subsets are needed?
Proposal: 50, 200, 1000, 2000.
4. **Decision Point:** Should there be stratification based on interest rates and/or equity?
Proposal: There should be two or three versions of the scenario picker tool, which stratify scenarios based on interest rate, equity, and/or both.
5. **Decision Point:** For interest rates, what tenor(s) should be used for stratification?
Proposal: This may be a limitation in the current scenario picker tool. Consider multiple metrics based on different tenors.

6. **Decision Point:** What metric should be used for stratification?

Proposal: Evaluate whether the current scenario picker's metric is reasonable, aside from its narrow focus on a specific interest rate tenor.

4) Company-Specific Market Paths (CSMP)

Timeline: Covered as part of meeting on 7/19

CSMP Goal:

- Provide a reasonable alternative to the CTEPA that gives consistent results but is more tractable, if necessary.

CSMP Decision Points:

1. **Decision Point:** Should the CSMP be removed entirely?

Proposal: Yes, with an appropriate phase out if needed, although the need for a phase out is not anticipated based on initial responses from the two companies utilizing the CSMP. The CTEPA is very widely used, provides greater insight into the differences between company and prescribed assumptions, and is more straightforward to implement (although more time-intensive).

~~2. **Decision Point:** Should there be any update to the CSMP Market paths?~~

~~**Proposal:** Primarily, updates would be designed to ensure that the 40 scenarios are likely to bracket CTE70(Adj). May need to replace the 1 bps floor on interest rates with a negative [25 bps] floor on interest rates, given the update to the economic scenarios to allow for negative interest rates. No other changes to magnitude of initial equity/interest rate shocks or subsequent equity returns. Interest rate paths (VM requires "all random variables in the generator are set to zero across all time periods" with the intention that "interest rates revert to the same long-term mean") may be determined as Conning has done for SERT scenario #9 from the initial field test (median path), or we can consider whether Conning can more directly calculate the CSMP subsequent interest rate paths.~~

~~**Comment (Matt Kauffman, Moody's):** "I agree there is a need to replace the floor to allow for negative rates in the starting interest rate conditions. Ideally the flooring would be consistent with whatever flooring approach (generalized fractional floor or shadow rate floor) is applied to the starting conditions in the generation of the 10,000 SR scenarios.~~

~~For the same reasons as was described earlier in the Stochastic Exclusion Ratio Test (SERT) section, I also recommend using **prescribed vectors of pre-determined random shocks**~~

to produce the CSMP interest rate paths, rather than targeting the median of a 10,000 scenario distribution. In this case, the baseline SERT scenario #9 used as the basis for CSMP would be very easy to implement, because the pre-determined random shocks are all 0. I expect the resulting scenario would be acceptably close to the median."

5) Alternative Methodology

Timeline: Primary focus of meeting on 7/19. Note that a request for additional information on the use of the Alternative Methodology has been sent to the nine companies utilizing this approach.

Alternative Methodology Goal:

- Provide a reasonable alternative to stochastic modeling that captures the risk of the guarantee for contracts with GMDBs only. Note that for contracts with no guarantees, the Alternative Methodology simply refers to AG33, so the focus of our consideration is on contracts with GMDBs.

Alternative Methodology Decision Points:

1. **Decision Point:** Should the Alternative Methodology be removed entirely?
Proposal: Potentially, with appropriate reliance on existing Actuarial Guidelines (AG33, AG34) with strengthening for rich GMDBs. In addition, there was a question of whether LATF would look for companies with a material block of "rich" GMDBs to follow full SR modeling. Finally, consider not allowing **new** use of the Alternative Methodology.
2. **Decision Point:** Should there be a significant update to the Alternative Methodology (updating the table of factors)?
Proposal: No. Based on early input from the AAA, an update of the current factor-based approach would be onerous if not impossible. If the equity scenarios materially differ from the AIRG, and the Alternative Methodology is maintained, can consider a crude adjustment as was previously done for mortality during VA reform if the impact for the Alternative Methodology is also likely material.
3. **Decision Point:** The Alternative Methodology uses the current AIRG in VM-21 Section 7.C.8 when describing "typical" adjustments to F and G for product design variations. Can Section 7.C.8 be removed, as it only outlines a possible approach, and it will be left to the actuary's judgment how to adjust results for product design variations?
Alternately, can the "prescribed scenarios" be replaced with the option to use either CFT

scenarios or the updated prescribed (Conning) scenarios rather than the current AIRG (again, since this is an example)?

Proposal: Need input on whether this approach is being relied on. If this is not being used, remove for simplicity since it is not a requirement. If it is being used, and the Alternative Methodology is maintained, update with the option to use CFT scenarios or the updated prescribed (Conning) scenarios.

DRAFT

August 11, 2023

From: Fred Andersen, Chair
The Experience Reporting (A) Subgroup

To: Rachel Hemphill, Chair
The Life Actuarial (A) Task Force

Subject: The Report of the Experience Reporting (A) Subgroup to the Life Actuarial (A) Task Force

The Experience Reporting (A) Subgroup has not met since the Spring National Meeting. Upcoming projects include monitoring the plans for collecting life insurance mortality and policyholder behavior data using the NAIC as the statistical agent, starting to develop mandatory reporting of variable annuity data, and continuing to work on evaluating actuarial aspects of accelerated underwriting.

Note that the Valuation Analysis Working Group (VAWG), through its company-specific reviews of asset adequacy analysis will monitor emerging trends, particularly with respect to dynamic policyholder behavior resulting from the rise in interest rates. Findings from VAWG may inform the need for upcoming data collection.

August 11, 2023

From: Fred Andersen, Chair
Indexed Universal Life (IUL) Illustration (A) Subgroup

To: Rachel Hemphill, Chair
The Life Actuarial (A) Task Force

Subject: The Report of the Indexed Universal Life (IUL) Illustration (A) Subgroup (IUL Illustration SG) to the Life Actuarial (A) Task Force

The IUL Illustration SG has not met since the adoption of group's main work product, revisions to Actuarial Guideline 49A, by the Life Actuarial (A) Task Force on December 11, 2022. The revisions to Actuarial Guideline 49A were subsequently adopted by the NAIC's Executive (EX) Committee and Plenary at the Spring National Meeting on March 25. Regulators are reviewing the impact of the Guideline revisions on the market.

August 11th, 2023

From: Seong-min Eom, Chair
The Longevity Risk (E/A) Subgroup

To: Rachel Hemphill, Chair
The Life Actuarial (A) Task Force

Subject: The Report of the Longevity Risk (E/A) Subgroup to the Life Actuarial (A) Task Force

The Longevity Risk (E/A) Subgroup has not met since the Spring National Meeting. The subgroup will resume the meetings once the currently exposed VM-22 PBR methodology is finalized and adopted to develop and recommend longevity risk factor(s) for the product(s) that were excluded from the application of the current longevity risk factors.

August 11, 2023

From: Pete Weber, Chair
The Variable Annuities Capital and Reserve (E/A) Subgroup

To: Rachel Hemphill, Chair
The Life Actuarial (A) Task Force

Subject: The Report of the Variable Annuities Capital and Reserve (E/A) Subgroup (VACR SG) to the Life Actuarial (A) Task Force

The VACR SG has not met since the Spring National Meeting. At the request of LATF, the Chair has made a request to the Society of Actuaries to expand the work they are currently carrying out for the VM-22 Standard Projection Amount Mortality DG to include variable annuities. More specifically, to develop mortality rates to be used as prescribed assumptions within the VM-21 Standard Projection Amount. Work continues on this project and a report and recommendations are expected later this year.

August 11, 2023

From: Ben Slutsker, Chair
The VM-22 (A) Subgroup

To: Rachel Hemphill, Chair
The Life Actuarial (A) Task Force

Subject: The Report of the VM-22 (A) Subgroup to the Life Actuarial (A) Task Force

The VM-22 (A) Subgroup has been meeting roughly every other week since the beginning of April this year. After several Subgroup calls, nearly 200 comments on the 2022 exposed draft of VM-22 were addressed and reflected in an updated document, which is available on the [NAIC website](#). The updates to the newest draft include guidance related to the VM-22 Exemption, exclusion testing, longevity reinsurance, hedging, rider valuation treatment, and various other items.

Subsequent to developing an updated to draft of VM-22, the Subgroup exposed a draft of the standard projection amount requirements during the July 29 call. The exposure focuses on the structure and methodology of the SPA rather than the assumptions themselves, which only contain placeholders in the exposed draft. For upcoming calls, the Subgroup plans to hear updated presentations from the SPA mortality drafting group, led by Seong-min Eom (NJ), including recommendations from the Society of Actuaries on SPA mortality assumptions for payout annuities, deferred annuities, and structured settlements.

Draft: 8/2/23

Valuation Manual (VM)-22 (A) Subgroup
Virtual Meeting
July 26, 2023

The VM-22 (A) Subgroup of the Life Actuarial (A) Task Force met July 26, 2023. The following Subgroup members participated: Ben Slutsker, Chair (MN); Elaine Lam and Thomas Reedy (CA); Lei Rao-Knight (CT); Vincent Tsang (IL); William Leung (MO); Seong-min Eom (NJ); Bill Carmello (NY); Rachel Hemphill and Iris Huang (TX); Tomasz Serbinowski (UT); and Craig Chupp (VA).

1. Exposed the VM-22 SPA Draft

Slutsker walked through the VM-22, Requirements for Principle-Based Reserves for Non-Variable Annuities, standard projection amount (SPA) draft.

Leung made a motion, seconded by Lam, to expose the SPA draft (Attachment Fifteen-A) for a 90-day public comment period ending Oct 24.

Having no further business, the VM-22 (A) Subgroup adjourned.

SharePoint/NAIC Support Staff Hub/Member Meetings/A CMTE/LATF/2023-2-Summer/VM-22 Calls/07 26/July 26 Minutes.docx

****All Redline edits are on top of VM-21, Section 6 (Requirements for the ASPA)****

Section 6: Requirements for the Additional Standard Projection Amount

A. Overview

1. Determining the Additional Standard Projection Amount

- a. The additional standard projection amount shall be the larger of zero and an amount determined in aggregate for all contracts within each reserving category falling under the scope of these requirements, excluding those contracts that pass the exclusion tests in Section 7 and to which VM-A, VM-C, and VM-V are applied, by calculating the Prescribed Projections Amount under the CTE with Prescribed Assumptions (CTEPA) method. The company shall assess the impact of aggregation on the additional standard projection amount.

Deleted: the Alternative Methodology is
Deleted: by
Deleted: one of two methods, the Company-Specific Market Path (CSMP) method or

Guidance Note: The following outlines one method that may be used to assess the impact of aggregation. If a company plans to use a different method, they should discuss that method with their domiciliary commissioner.

The benefit of aggregation is determined using the following steps, using the same scenario used for the cumulative decrement analysis, and using prescribed assumptions and discount rates:

Deleted: If a company uses the CSMP method, t
Deleted: based on Path A
Deleted: used to calculate prescribed amount A

1. Calculate the present value of each contract’s accumulated deficiency up through the duration of the aggregate GPVAD. When determining the contract accumulated deficiency: (a) contract starting assets equal CSV; (b) contract level starting assets include both separate account and general account assets, and exclude any hedge assets; (c) discount rate for the PVAD is the NAER; and (d) for a contract that terminates prior to the duration of the GPVAD, there will no longer be liability cash flows, but assets (positive or negative) continue to accumulate.
2. The impact of aggregation is the sum of the absolute value of the negative amounts from step 1 above.

Apply steps 1 and 2 above to each model point.

Deleted: If a company uses the CTEPA method, it should a
Deleted: .
Deleted: using the same scenario used for the cumulative decrement analysis, and using that scenario’s NAER as the discount rates for discounting the accumulated deficiency from the time of the GPVAD
Deleted: For GMWBs and hybrid GMIBs that use the Withdrawal Delay Cohort Method as specified in VM-21 Section 6.C.5, cash flows for each contract or for each model point shall be determined as the aggregate across all of the constituent cohorts of the contract or model point.

- b. The additional standard projection amount shall be calculated based on the scenario reserves, as discussed in Section 4.B, with certain prescribed assumptions replacing the company prudent estimate assumptions. As is the case in the projection of a scenario in the calculation of the DR and SR, the scenario reserves used to calculate the additional standard projection amount are based on an analysis of asset and liability cash flows produced along certain equity and interest rate scenario paths.

B. Additional Standard Projection Amount

1. General

Where not inconsistent with the guidance given here, the process and methods used to determine the additional standard projection amount under the CTEPA method shall be the same as required in the calculation of the DR and SR as described in Section 3.D and Section 3.E of these requirements. Any additional assumptions needed to determine the additional standard projection amount shall be explicitly documented.

Deleted: either the CSMP method or

2. The company shall determine the Prescribed Projections Amount by following ~~the CTEPA~~ Method below.

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3. ~~For determining the CTE70 (adjusted), the assumptions for hedging programs with hedge payoffs that offset interest credits associated with indexed interest strategies (indexed interest credits) shall be the same as those used for the CTE70 (best efforts), following the requirements in Section 4.A.4.b.~~

Deleted: A company may not change the method used from one valuation to the next without the approval of the domiciliary commissioner.

4. Calculation Methodology

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a. CTEPA Method:

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- i. If the company used a model office to calculate the CTE Amount, then the company may continue to use the same model office, or one that is no less granular than the model office that was used to determine the CTE Amount, provided that the company shall maintain consistency in the grouping method used from one valuation to the next.
- ii. Calculate the Prescribed Projections Amount as the CTE70 (adjusted) using the same method as that outlined in Section 9.C (which is the same as the DR and SR following Section 4.A.4.b for a company that does not have a future hedging strategy supporting the contracts other than those supporting index interest credits) but substituting the assumptions prescribed by Section 6.C. The calculation of this Prescribed Projections Amount also requires that the scenario reserve for any given scenario be equal to or in excess of the cash surrender value in aggregate on the valuation date for the group of contracts modeled in the projection.

Deleted: CSMP Method:¶

- i. Calculate the scenario reserve, as defined in VM-01 and discussed further in Section 4.B, for each of the prescribed market paths outlined in Section 6.B.6 using the same method and assumptions as those that the company uses to calculate scenario reserves for the purposes of determining the CTE70 (adjusted),[¶] as outlined in Section 9.C. These scenario reserves shall collectively be referred to as a Company Standard Projection Set.[¶]
 - ii. Identify the market path from the Company Standard Projection Set such that the scenario reserve is closest to the CTE70 (adjusted), designated as Path A. This scenario reserve shall be referred to as Company Amount A.[¶]
 - iii. Identify the following four market paths:[¶]
 - Two paths with the same starting interest rate as Path A, but equity shocks +/- 5% from that of Path A.[¶]
 - Two paths with the same equity fund returns as Path A, but the next higher and next lower interest rate shocks.[¶]
- From the four paths, identify Path B whose reserve value is:[¶]
 If Company Amount A is lower than CTE70 (adjusted), the smallest reserve value that is greater than CTE70 (adjusted).[¶]
 If Company Amount A is greater than CTE70 (adjusted), the greatest reserve value that is less than CTE70 (adjusted).[¶]
 If none of the four paths satisfy the stated condition, discard the identified Path A, and redo steps (ii) and (iii) using the next closest scenario to CTE70 (adjusted) to be the new Path A in step (ii).

b. Once the Prescribed Projections Amount is determined by ~~the method~~ above, then the company shall reduce the Prescribed Projections Amount by the CTE70 (adjusted). The difference shall be referred to as the Unbuffered Additional Standard Projection Amount.

Deleted: For the path designated as Path B, the scenario reserve shall be referred to as Company Amount B.[¶]

c. Reduce the Unbuffered Additional Standard Projection Amount by an amount equal to the difference between (i) and (ii), where (i) and (ii) are calculated in the following manner:

iv. Recalculate the scenario reserves for Path A and Path B using the same method as outlined in step (i) above, but substitute the assumptions prescribed in Section 6.C and use a seriatim in force. These scenario reserves shall be referred to as Prescribed Amount A and Prescribed Amount B, respectively.[¶]

- i. Calculate the Unfloored CTE70 (adjusted), using the same procedure as CTE70 (adjusted) but without requiring that the scenario reserve for any scenario be no less than the cash surrender value in aggregate on the valuation date.
- ii. Calculate the Unfloored CTE65 (adjusted), which is calculated in the same way as Unfloored CTE70 (adjusted) but averaging the 35% (instead of 30%) largest values.

v. Calculate the Prescribed Projections Amount as:[¶]

$$\text{Prescribed Projections Amount}^{\text{¶}} = \text{Prescribed Amount A} + (\text{CTE70 (adjusted)} - \text{Company Amount A})^{\text{¶}}$$

$$\times \left(\frac{\text{Prescribed Amount B} - \text{Prescribed Amount A}}{\text{Company Amount B} - \text{Company Amount A}} \right)^{\text{¶}}$$
 b

d. The additional standard projection amount shall subsequently be the larger of the quantity calculated in Section 6.B.4c and zero.

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5. Modeled Reinsurance

Cash flows associated with reinsurance shall be projected in the same manner as that used in the calculation of the DR and SR as described in Section 3.

~~6. Modeled Hedges~~

Cash flows associated with hedging shall be projected in the same manner as that used in the calculation of the CTE70 (adjusted) as discussed in Section 9.C or Section 4.A.4.a for a company without a future hedging strategy supporting the contracts other than a future hedging strategy with hedge payoffs that offset interest credits associated with indexed interest strategies.

C. Prescribed Assumptions

1. Assignment of Guaranteed Benefit Type

- a. Assumptions shall be set for each contract in accordance with the contract's guaranteed benefit type, where a number of common benefit types are specifically defined in VM-01 (e.g., GMDB, GMWB, etc.).
- b. Certain **guaranteed living benefit** products have features that can be described by multiple types of guaranteed benefits. If the **guaranteed living benefit** can be described by more than one of the definitions in VM-01 for the purpose of determining the additional standard projection amount, the company shall select the guaranteed benefit type that it deems best applicable and shall be consistent in its selection from one valuation to the next. For instance, if a **guaranteed living benefit** has both lifetime GMWB and non-lifetime GMWB features and the company determines that the lifetime GMWB is the most prominent component; assumptions for all contracts with such a **guaranteed living benefit** shall be set as if the **guaranteed living benefit** were only a lifetime GMWB and did not contain any of the non-lifetime GMWB features. If the company determines that the non-lifetime GMWB is the most prominent component; assumptions for all contracts with such a **guaranteed living benefit** shall be set as if the **guaranteed living benefit** were only a non-lifetime GMWB and did not contain any of the lifetime GMWB features.
- c. If a contract cannot be classified into any categories within a given assumption, the company shall determine the defined benefit type with the most similar benefits and risk profile as the company's benefit and utilize the assumption prescribed for this benefit.

2. Maintenance Expenses

Maintenance expense assumptions shall be determined as the sum of (a) plus (b) if the company is responsible for the administration or (c) if the company is not responsible for the administration of the contract:

- a. Each contract for which the company is responsible for administration incurs an annual expense equal to the Base Maintenance Expense Assumption shown in the table below for each product type, multiplied by $[1.025]^{(valuation\ year - 2015)}$ in the first projection year, and increased by an assumed annual inflation rate of $[2\%]$ for subsequent projection years.

Table 6.1: Base Maintenance Expense Assumptions

Contract Type	Base Maintenance Expense Assumption
---------------	-------------------------------------

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Deleted: 6. Market Paths for CSMP Method¶
If the company elects the CSMP method described in Section 6.B.3.a, the additional standard projection amount shall be determined from the scenario reserves calculated for the prescribed market paths defined below. Each prescribed market path shall be defined by an initial equity fund stress and an initial interest rate stress, after which equity fund returns steadily recover and interest rates revert to the same long-term mean.¶

All combinations of prescribed equity fund return scenarios and interest rate scenarios shall be considered prescribed Standard Projection market paths. Accordingly, each company shall calculate scenario reserves for a minimum of 40 market paths.¶

a. Equity Fund Returns ¶

Eight equity fund return market paths shall be used. These market paths differ only in the prescribed gross return in the first projection year.¶

The eight prescribed gross returns for equity funds in the first projection year shall be negative 25% to positive 10%, at 5% intervals. These gross returns shall be projected to occur linearly over the full projection year. After the first projection year, all prescribed equity fund return market paths shall assume total gross returns of 3% per annum.¶

If the eight prescribed equity fund market paths are insufficient for a company to calculate the additional standard projection amount via steps (i) through (v) outlined in Section 6.B.3.a, then the company shall include additional equity fund market paths that increase or decrease the prescribed gross returns in the first projection year by 5% increments at a time.¶

b. Interest Rates¶

Five interest rate market paths shall be used. ¶

The five prescribed interest rate market paths shall differ in the starting Treasury Department rates used to generate the mean interest rate path. Specifically, the following five sets of starting Treasury Department rates shall be used:¶

¶ The actual Treasury Department rates as of the valuation date.¶

¶ The actual Treasury Department rates as of the valuation date, reduced at each point on the term structure by 25% of the difference between the Treasury Department rate as of the valuation date and 0.01%.¶

¶ The actual Treasury Department rates as of the valuation date, reduced at each point on the term structure by 50% of the difference between the Treasury Department rate as of the valuation date and 0.01%.¶

... [1]

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Deleted: In addition, a simple 403(b) VA contract shall be defined as a variable annuity contract that:¶

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Is issued within a 403(b) retirement savings plan.¶
Does not have a VAGLB.

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Commented [VM221]: Discuss whether to leave as a fixed rate or follow treasury path

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Contracts in the Payout Annuity Reserving Category	[\$50]
Fixed Indexed Annuities and other contracts in the Accumulation Reserving Category with guaranteed living benefits	[\$100]
All other contracts	[\$75]

Drafting Note: The expense assumptions may be updated closer to adoption, such that the base maintenance expense assumptions are higher and the starting calendar year for accumulating inflation is updated to be more in line with the effective year of VM-22 PBR.

Commented [VM222]: Also coordinate with any updates to VM-21 SPA expense assumption

- b. Seven basis points of the projected account value for each year in the projection.
- c. Each contract for which the company is not responsible for administration (e.g., if the contract were assumed by the company in a reinsurance transaction in which only the risks associated with a guaranteed benefit rider were transferred) incurs an annual expense equal to \$35 multiplied by $[1.025]^{(\text{valuation year} - 2015)}$ in the first projection year, increased by an assumed annual inflation rate of [2%] for subsequent projection years.
- 3. Guarantee Actuarial Present Value

The Guarantee Actuarial Present Value (GAPV) is used in the determination of the full surrender rates (Section 6.C.3) and other voluntary contract terminations (Section 6.C.10). The GAPV represents the actuarial present value of the lump sum or income payments associated with a guaranteed benefit. For the purpose of calculating the GAPV, such payments shall include the portion that is paid out of the contract holder's Account Value.

The GAPV shall be calculated in the following manner:

- a. If a guaranteed benefit is exercisable immediately, then the GAPV shall be determined assuming immediate or continued exercise of that benefit unless otherwise specified in a subsequent subsection of Section 6.C.3.
- b. If a guaranteed benefit is not exercisable immediately (e.g., because of minimum age or contract year requirements), then the GAPV shall be determined assuming exercise of the guaranteed benefit at the earliest possible time unless otherwise specified in a subsequent subsection of Section 6.C.3.
- c. Determination of the GAPV of a guaranteed benefit that is exercisable or payable at a future projection interval shall take account of any guaranteed growth in the basis for the guarantee (e.g., where the basis grows according to an index or an interest rate), as well as survival to the date of exercise using the mortality table specified in Section 6.C.3.h.
- d. Once a GMWB is exercised, the contract holder shall be assumed to withdraw in each subsequent contract year an amount equal to 100% of the GMWB's guaranteed maximum annual withdrawal amount in that contract year.
- e. If account value growth is required to determine projected benefits or product features, then the account value growth shall be assumed to be 0% net of all fees chargeable to the account value.

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Guidance Note: The framework adopted by the Variable Annuities Issues (E) Working Group includes the review and possible update of these assumptions every three to five years.¶

Deleted: Withdrawal Delay Cohort Method (Section 6.C.5),...

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- f. If a market index is required to determine projected benefits or product features, then the required index shall be assumed to remain constant at its value during the projection interval.
- g. The GAPV for a GMDB that terminates at a certain age or in a certain contract year shall be calculated as if the GMDB does not terminate. Benefit features such as guaranteed growth in the GMDB benefit basis may be calculated so that no additional benefit basis growth occurs after the GMDB termination age or date defined in the contract.
- h. The mortality assumption used shall be the following:

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- i. Individual annuity contracts within the Accumulation Reserving Category shall use the following adjustment factors applied to the 2012 IAM Table with no mortality improvement applied:

Table 6.2: Mortality for Individual Annuities in Accumulation Reserving Category

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Attained Age	Without Guaranteed Living Benefits		With Guaranteed Living Benefits	
	Female	Male	Female	Male
<u>50 and below</u>				
<u>51</u>				
<u>52 to 56</u>				
<u>57 to 61</u>				
<u>62 to 66</u>				
<u>67 to 71</u>				
<u>72 to 76</u>				
<u>77 to 81</u>				
<u>82 to 86</u>				
<u>87 to 91</u>				
<u>92 to 96</u>				
<u>97 to 101</u>				
<u>102 and above</u>				

- ii. Individual annuity contracts within the Payout Annuity Reserving Category other than Structured Settlement Contracts shall use the 2012 IAM Table with the following factors applied:

Deleted: the 2012 IAM Basic Mortality Table, improved to Dec. 31, 2017, using Projection Scale G2 but not applying any additional mortality improvement in the projection.¶

Table 6.3: Mortality for Individual Annuities in Payout Annuity Reserving Category

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Attained Age	Without Guaranteed Living Benefits	
	Female	Male
50 and below		
51		
52 to 56		
57 to 61		
62 to 66		
67 to 71		
72 to 76		
77 to 81		
82 to 86		
87 to 91		
92 to 96		
97 to 101		
102 and above		

iii. Individual Structured Settlement Contracts on standard lives shall use the 1983 Individual Annuity Mortality (IAM) Table 'A' with the following factors applied:

Table 6.4: Mortality for Structured Settlement Contracts

<u>Attained Age</u>	<u>Structured Settlements – Standard Lives</u>		
	<u>Durations 1 to 5</u>	<u>Durations 6 to 10</u>	<u>Durations 11 and greater</u>
<u>40 and below</u>			
<u>41 to 45</u>			
<u>46 to 50</u>			
<u>51 to 55</u>			
<u>56 to 60</u>			
<u>61 to 65</u>			
<u>65 to 70</u>			
<u>71 to 75</u>			
<u>76 to 80</u>			
<u>81 to 85</u>			
<u>86 to 90</u>			
<u>91 to 95</u>			
<u>96 to 100</u>			
<u>101 and above</u>			

Substandard lives shall use the mortality described above for standard lives, with the “Constant Extra Death” (CED) methodology, as described in Actuarial Guideline IX. The factors for rate-up are provided as follows:

Attained Age	Factors for Rate-Up 1 to 20			
	Durations 1 to 10	Durations 11 to 20	Durations 21 to 31	Durations 31 and greater
40 and below				
41 to 80				
81 and above				

Attained Age	Factors for Rate-Up 21 and greater			
	Durations 1 to 10	Durations 11 to 20	Durations 21 to 31	Durations 31 and greater
40 and below				
41 to 80				
81 and above				

iv. Group annuities, international business, and contracts within the Longevity Reinsurance Reserving Category shall use the lower of the 1994 GAM Table with Projection Scale AA applied to the valuation date and the company’s prudent estimate assumptions. The company prudent estimate assumptions for group annuities, international business, and contracts within the Longevity Reinsurance Reserving Category shall be developed separately from each other as appropriate.

Guidance Note: The above tables include implicit historical mortality improvement until Dec 31, 2021. Projecting mortality to a specific date rather than the valuation date in the above step is a practical expedient to streamline calculations. This date should be considered an experience assumption to be periodically reviewed and updated as the Life Actuarial (A) Task Force reviews and updates the assumptions used in the Standard Projection.

i. The discount rate used shall be the 10-year Treasury Department bond rate on the valuation date unless otherwise specified in a subsequent subsection of Section 6.C.3.

4. Partial Withdrawals

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j. For hybrid GMIBs, two types of GAPVs shall be calculated: the Annuitization GAPV and the Withdrawal GAPV. The Annuitization GAPV is determined as if the hybrid GMIB were a traditional GMIB such that the only benefit payments used in the GAPV calculation are from annuitization. The Withdrawal GAPV is determined as if the hybrid GMIB were a lifetime GMWB with the same guaranteed benefit growth features and, at each contract holder age, a guaranteed maximum withdrawal amount equal to the partial withdrawal amount below which partial withdrawals reduce the benefit by the same dollar amount as the partial withdrawal amount and above which partial withdrawals reduce the benefit by the same proportion that the withdrawal reduces the account value.

Partial withdrawals required contractually or previously elected (e.g., a contract operating under an automatic withdrawal provision, or that has voluntarily enrolled in an automatic withdrawal program, on the valuation date) are to be deducted from the Account Value in each projection interval consistent with the projection frequency used, as described in Section 4.F, and according to the terms of the contract. However, if a GMWB contract's automatic withdrawals results in partial withdrawal amounts in excess of the GMWB's guaranteed maximum annual withdrawal amount, such automatic withdrawals shall be revised such that they equal the GMWB's guaranteed maximum annual withdrawal amount. However, for tax qualified contracts with ages greater than or equal to the federal required minimum distribution (RMD) age, if the prescribed withdrawal amount is below the RMD amount, the withdrawal amount may be reset to the RMD amount.

- Deleted:** or hybrid GMIB
- Deleted:** or the maximum amount above which withdrawals reduce the GMIB basis by the same dollar amount as the withdrawal amount (the "dollar-for-dollar maximum withdrawal amount")
- Deleted:** or the GMIB's dollar-for-dollar maximum withdrawal amount

Guidance Note: Companies are expected to model withdrawal amounts consistent with the RMD amount where applicable and where practically feasible; however, it is understood that this level of modeling sophistication may not be available for all companies.

For any contract not on an automatic withdrawal provision as described in the preceding paragraph, depending on the guaranteed benefit type, other partial withdrawals shall be projected as follows but shall not exceed the free partial withdrawal amount above which surrender charges are incurred and may be floored at the RMD amount for tax qualified contracts with ages greater than or equal to the federal RMD age:

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a. For contracts in the Accumulation Reserving Category either without a guaranteed living benefit or prior to exercising a guaranteed living benefit, the partial withdrawal amount each year shall equal the following percentages of account value, based on the contract holder's attained age:

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Deleted: a. For simple 403(b) VA contracts, the partial withdrawal amount each year shall equal the following percentages, based on the contract holder's attained age:¶

¶

Table 6.2: Partial Withdrawals, 403(b)¶

Attained Age	...
	[2]

Table 6.5: Partial Withdrawals for Accumulation Reserving Category contracts without Guaranteed Living Benefits

Attained Age	Contracts with GLBs prior to exercising	Contracts without GLBs
59 and under	[1.50%]	[2.25%]
60 – 69	[1.75%]	[2.75%]
70 – 74	[3.75%]	[4.50%]
75 and over	[4.25%]	[4.50%]

Deleted: For contracts that do not have VAGLBs but that have GMDBs that offer guaranteed growth—i.e., benefit growth that does not depend on the performance of the Account Value—in the benefit basis, the partial withdrawal amount each year shall equal 2% of the Account Value.

Deleted: c. For contracts that do not have VAGLBs GMDBs that do not offer guaranteed growth in the benefit basis, the partial withdrawal amount each year shall equal 3.5% of the Account Value.¶

d. For contracts with (1) traditional GMIBs that do not offer guaranteed growth in the benefit basis; or (2) GMABs, the partial withdrawal amount each year shall equal to 2.0% of the Account Value.¶

e. For contracts with traditional GMIBs that offer guaranteed growth in the benefit basis, the partial withdrawal amount each year shall equal 1.5% of the Account Value.f. For contracts with GMWBs and Account Values of zero, the partial withdrawal amount shall be the guaranteed maximum annual withdrawal amount.¶

g

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Deleted: or the GMIB's dollar-for-dollar maximum withdrawal amount

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Deleted: or the GMIB's dollar-for-dollar maximum withdrawal amount

b. For contracts in the Accumulation Reserving Category with a guaranteed living benefit and an account value of zero, the partial withdrawal amount shall be the guaranteed maximum withdrawal amount.

c. For contracts in the Accumulation Reserving Category with guaranteed living benefits that, in the contract year immediately preceding that during the valuation date, withdrew a non-zero amount not in excess of the guaranteed living benefit's guaranteed annual withdrawal amount, the partial withdrawal amount shall be the guaranteed maximum annual withdrawal amount each year until the contract Account Value reaches zero.

d. For other contracts in the Accumulation Reserving Category with lifetime guaranteed living benefits, partial withdrawals shall be projected to commence pursuant to the company's own prudent best estimate assumptions, but ensuring that, at a minimum, guaranteed living benefit utilization rates in aggregate, measured by benefit base under the scenario that produces the scenario reserve that is closest to the CTE70 amount, are at least as high as the utilization rates shown in the table below. Once guaranteed living benefit withdrawals are projected to commence, the partial withdrawal amount shall be 100% of the guaranteed annual withdrawal amount each year until the contract's account value reaches zero.

- Deleted: h
- Deleted: e
- Deleted: contracts
- Deleted: Lifetime GMWBs or hybrid GMIBs
- Deleted: Path A replicating

Table 6.6: Partial Withdrawals for Accumulation Reserving Category Contracts with Lifetime Benefits

Qualification Status	Before 65	65 to 70	71 to 75	76 and above
Qualified	[12%]	[20%]	[30%]	[35%]
Non-Qualified	[15%]	[40%]	[80%]	[95%]

Deleted: no partial withdrawals shall be projected until the projection interval (the "initial withdrawal period") determined using the "withdrawal delay cohort method" as described in Section 6.C.5. During the initial withdrawal period and thereafter, the partial withdrawal amount shall be 90% of the GMWB's guaranteed annual withdrawal amount or the GMIB's dollar-for-dollar maximum withdrawal amount each year until the contract Account Value reaches zero.

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e. For contracts in the Accumulation Reserving Category with Non-lifetime guaranteed living benefits that, in the contract year immediately preceding that during the valuation date, withdrew a non-zero amount not in excess of the guaranteed living benefits annual withdrawal amount, the partial withdrawal amount shall be 70% of the guaranteed living benefits guaranteed annual withdrawal amount each year until the contract Account Value reaches zero.

- Deleted: i
- Deleted: f
- Deleted: contracts
- Deleted: GMWBs
- Deleted: GMWB's guaranteed
- Deleted: GMWB's

f. For contracts in the Accumulation Reserving Category with Non-lifetime guaranteed living benefits, partial withdrawals shall be projected to commence pursuant to the Company's own prudent best estimate assumptions, but ensuring that, at a minimum, guaranteed living benefit utilization rates in aggregate, measured by benefit base under the scenario that produces a scenario reserve closest to the CTE70 amount, are at least as high as the utilization rates shown in the table below. Once guaranteed living benefit withdrawals are projected to commence, the partial withdrawal amount shall be 70% of the guaranteed annual withdrawal amount each year until the contract's account value reaches zero.

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- Deleted: other contracts
- Deleted: GMWBs
- Deleted: Path A, replicating

Table 6.7: Partial Withdrawals for Accumulation Reserving Category Contracts with Non-Lifetime Benefits

Qualification Status	Before 65	65 to 70	71 to 75	76 and above
Qualified	[12%]	[20%]	[30%]	[35%]
Non-Qualified	[15%]	[40%]	[80%]	[95%]

Deleted: no partial withdrawals shall be projected until the projection interval (the "initial withdrawal period") determined using the "withdrawal delay cohort method" as described in Section 6.C.5. During the initial withdrawal period and thereafter, the partial withdrawal amount shall be 70% of the guaranteed annual withdrawal amount each year until the contract Account Value reaches zero.

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~~g.~~ For contracts with no minimum guaranteed benefits, the partial withdrawal amount each year shall equal 3.5% of the Account Value.

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~~h.~~ There may be instances where the company has certain data limitations, (e.g., with respect to policies that are not enrolled in an automatic withdrawal program but have exercised a non-excess withdrawal in the contract year immediately preceding the valuation date. The company may employ an appropriate proxy method if it does not result in a material understatement of the reserve.

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Deleted: [Section 6.C.4.g and Section 6.C.4.i]

Commented [VM223]: The PHB drafting subgroup is preparing a set of surrender tables based on the industry experience in 2019-2020. The suggested formula in here serves as a placeholder.

~~5.~~ Full Surrenders

For contracts within the Accumulation Reserving Category, base lapse and full surrender rates shall be dynamically adjusted upward (or downward) when the actual credited rate is below (or above) the competitor rate. For contracts with a guaranteed living benefit, base lapse and full surrender rates shall be further adjusted based on the ITM of the rider value. The following formula shall be used:

$$\text{Total Lapse} = (\text{Base Lapse} + \text{Rate Factor}) \times \text{ITM Factor where}$$

$$\text{ITM Factor} = 1 \quad \text{if } \text{ITM} \leq 1.25$$

$$\text{ITM Factor} = (1.25 \div \text{ITM})^2 \quad \text{if } \text{ITM} > 1.25$$

$$\text{ITM} = \text{GAPV} \div \text{Account Value}$$

$$\text{Rate Factor} = \text{Market Factor} \times \text{Max}(0, 1 - 5 \times \text{SCPercentage}) / 100$$

$$\text{Market Factor} = -1.25 \times (\text{CR} - \text{MR})^{2.5} \quad \text{if } \text{CR} \geq \text{MR}$$

$$\text{Market Factor} = 0 \quad \text{if } \text{MR} > \text{CR} \geq (\text{MR} - \text{BF})$$

$$\text{Market Factor} = 1.25 \times (\text{MR} - \text{BF} - \text{CR})^{2.5} \quad \text{if } \text{CR} < (\text{MR} - \text{BF})$$

$$\text{Minimum Lapse} = 1\%$$

$$\text{Maximum Lapse} = 60\% \quad \text{if other than interest rate guarantee period}$$

$$\text{Maximum Lapse} = 90\% \quad \text{if at the end of the interest guaranteed period}$$

$$\text{CR} = \text{the crediting rate at the time of the projection}$$

$$\text{MR} = \text{the market competitor rate at the time of the projection}$$

$$\text{BF} = \text{a buffer factor where dynamic lapses do not occur}$$

Deleted: 5. Withdrawal Delay Cohort Method¶
To model the initial withdrawal for certain GMWBs and hybrid GMIBs as discussed in Section 6.C.4.h and Section 6.C.4.j, the actuary shall adopt a modeling approach whereby a contract is split into several copies (referred to as "cohorts"), each of which is subsequently modeled as a separate contract with a different initial withdrawal period. The contract Account Value, bases for guaranteed benefits, and other applicable characteristics shall be allocated across the cohorts based on different weights that are determined using the method discussed below in this section.¶
For example, assume that the method discussed below results in the creation of two cohorts: the first, weighted 70%, has an initial withdrawal period of two years after the valuation date; and the second, weighted 30%, has an initial withdrawal period of ten years after the valuation date. The contract shall therefore be split into two copies; the first copy shall have Account Value and guaranteed benefit bases equal to 70% of those of the original contract, and the second copy shall have Account Value and guaranteed benefit bases equal to 30% of those of the original contract. The first copy shall be projected to begin withdrawing in two years, while the second shall be projected to begin withdrawing in 10 years. The cash flows from both copies shall thereafter be aggregated to yield the final cash flows of the overall contract.¶
The following steps shall be used to construct the cohorts and determine the weights attributed to each cohort. These steps shall be conducted for each issue age for each GMWB and hybrid GMIB product that the company possesses in the modeled in force.¶
a. Calculate the GMWB GAPV or the Withdrawal GAPV (for hybrid GMIBs) for each potential age of initiating withdrawals ("initial withdrawal age") until the end of the projection period or the contract holder reaches age 120 if sooner. In each of these GAPV calculations:¶ ... [3]

Commented [VM224]: Buffer Factor needs to be specified

Deleted: The full surrender rate for all contracts shall be calculated based on the Standard Table for Full Surrenders as detailed below in Table 6.3, except for simple 40% ... [4]

Deleted: 7

Deleted: that do not have a GMIB

Deleted: For GMIB contracts, the annuitization rate shall be synonymous with the benefit exercise rate. As such, the annuitization rate is 0% in projection intervals during which the GMIB is not exercisable.¶ ... [5]

~~6.~~ Annuitizations

The annuitization rate for contracts shall be 0% at all projection intervals.

Commented [VM225]: Review whether appropriate to keep this section and apply to index strategy/ fixed account transfers for FIAs

~~7.~~ Index Transfers and Future Deposits

a. No transfers between ~~fixed and index strategies or accounts~~ shall be assumed in the projection unless required by the contract (e.g., contractual rights given to the insurer to implement a contractually specified portfolio insurance management strategy). When transfers must be modeled, to the

Deleted: Table 6.5: Standard Table for Traditional GMIB Annuitization ... [6]

Deleted: Account

Deleted: funds

Deleted: transfers from a dollar cost averaging fund or

Deleted: or a contract operating under an automatic re-balancing option

extent not inconsistent with contract language, the allocation of transfers to indices, accounts, or funds must be in proportion to the contract's current allocation to funds.

- b. ~~No~~ future deposits to account value shall be assumed unless required by the terms of the contract, in which case they must be modeled. When future deposits must be modeled, to the extent not inconsistent with contract language, the allocation of the deposit to funds must be in proportion to the contract's current allocation to such funds.

Deleted: Except for simple 403(b) VA contracts, n
Deleted: to prevent contract or guaranteed benefit lapse

8. Mortality

The following mortality rates shall be used:

a. Individual annuity contracts within the Accumulation Reserving Category shall use the mortality rates in Section 6.C.3.h.i with Projection Scale G2 mortality improvement factors applied from December 31, 2021 up until each future projection year.

Deleted: <#>For simple 403(b) VA contracts, total deposits to account value in any projected future policy year shall be modeled as a percentage of the total deposits from the immediately preceding policy year. The percentage shall be determined based on the following table:
Table 6.48: Deposit Rates, 403(b)
 Attained Age ... [7]

b. Individual annuity contracts within the Payout Annuity Reserving Category other than Structured Settlement Contracts shall use the mortality rates in Section 6.C.3.h.ii with Projection Scale G2 mortality improvement factors applied from December 31, 2021 up until each future projection year.

Commented [VM226]: SOA will provide the table central date and scale of improvement in their recommendation; reflect the central date in the GAPV section, and then include improvement from the central date to the projection date in this section

c. Individual Structured Settlement Contracts shall use the mortality rates in Section 6.C.3.h.iii with the following mortality improvement factors applied from December 31, 2021 up until each future projection year.

Commented [VM227]: Same comment as above for payout annuities

[Future improvement]

d. Group annuities, international business, and contracts within the Longevity Reinsurance Category shall use the mortality rates in Section 6.C.3.h.iv with Projection Scale AA mortality improvement factors applied from the valuation date up until each future projection year. However, if the company's prudent estimate assumption is used in Section 6.C.3.h.iv and already reflects mortality improvement from December 31, 2021 up until the projection year, then Projection Scale AA mortality improvement factors shall not be used.

Deleted: <#>mortality rate for a contract holder with age x in year (2012 + n) shall be calculated using the following formula, where q_x denotes mortality from the 2012 IAM Basic Mortality Table multiplied by the appropriate factor (F_x) from Table 6.9 and $G2_x$ denotes mortality improvement from Projection Scale G2:
 $q_x^{2012+n} = q_x^{2012} (1 - G2_x)^n * F_x$
Table 6.9
 Attained Age (x) ... [8]

9. Account Value Depletions

The following assumptions shall be used when a contract's Account Value reaches zero:

- a. If the contract has a guaranteed living benefit, the contract shall take benefits that are equal in amount each year to the guaranteed maximum annual withdrawal amount.
- b. If the contract has any other guaranteed benefits, including a GMDB, the contract shall remain in-force. If the guaranteed benefits contractually

Deleted: 10
Deleted: GMWB
Deleted: partial withdrawals
Deleted: ¶
 b. If the contract has a GMIB, the contract shall annuitize immediately. If the GMIB contractually terminates upon account value depletion, such termination provision is assumed to be voided in order to approximate the contract holder's election to annuitize immediately before the depletion of the account value.
Deleted: c

terminate upon account value depletion, such termination provisions are assumed to be voided in order to approximate the contract holder's retaining adequate Account Value to maintain the guaranteed benefits in-force. At the option of the company, fees associated with the contract and guaranteed benefits may continue to be charged and modeled as collected even if the account value has reached zero. While the contract must remain in-force, benefit features may still be terminated according to contractual terms other than account value depletion provisions.

~~9.~~ If the contract has no minimum guaranteed benefits, the contract should be terminated according to contractual terms.

Deleted: d

~~10.~~ Other Voluntary Contract Terminations

Deleted: 11

For contracts that have other elective provisions that allow a contract holder to terminate the contract voluntarily, the termination rate shall be calculated as detailed above in Section 6.C.5 with the following adjustments:

Deleted: based on the Standard Table for Full Surrenders

Deleted: 4 Table 6.3

a. If the contract holder is not yet eligible to terminate the contract under the elective provisions, the termination rate shall be zero.

b. After the contract holder becomes eligible to terminate the contract under the elective provisions, the termination rate shall be determined using assumptions in Section 6.C.5.

Deleted: 4 the "Subsequent years" column of Table 6.3

c. In Section 6.C.5, the ITM of a contract's guaranteed benefit shall be calculated based on the ratio of the guaranteed benefit's GAPV to the termination value of the contract. The termination value of the contract shall be calculated as the GAPV of the payment stream that the contract holder is entitled to receive upon termination of the contract; if the contract holder has multiple options for the payment stream, the termination value shall be the highest GAPV of these options.

Deleted: using Table 6.3

Deleted: 4

d. For contracts with guaranteed living benefits, for all contract years in which a withdrawal is projected, the termination rate obtained from Section 6.C.5 shall be additionally multiplied by 60%.

Deleted: GMWB or hybrid GMIB

Deleted: 4 Table 6.3

~~11.~~ Crediting Rates and Investment Spread

a. For Fixed Index Annuities, the option budget is the assumed crediting rate for quantifying the investment spread between the net portfolio earned rate and the crediting rate.

Deleted: For calculating the ITM of a hybrid GMIB, the guaranteed benefit's GAPV shall be the larger of the Annuityization GAPV or the Withdrawal GAPV.
 e. For contracts with no minimum guaranteed benefits, the ITM is 0%; for all contract years in which a withdrawal is projected, the termination rate obtained from Table 6.3 shall be the row in the table for ITM < 50% using the "Subsequent years" column of Table 6.3.

b. With respect to setting a limit on the annual spread between the net portfolio earned rate and the crediting rate:

i. The maximum annual spread is [2.25%] for policies without an initial bonus.

ii. For policies with an initial bonus of [B%], the maximum annual spread is [2.25%] + [B%]/SCP during the surrender charge period (SCP). The maximum annual spread is reduced back to [2.25%] after the SCP.

iii. The extra maximum annual spread [B%]/SCP allows the insurer to recapture the initial bonus via higher spread during the SCP.

iv. An insurer may ask the regulators in its state of domicile for special permission if the insurer can justify an exception.

Guidance Note: As it can create non-uniform practices among states, such permission should only be granted with strong supports and may be scrutinized by VAWG. In other words, granting such permission should be a rare event.

Commented [VM228]: Consider whether to remove if companies are allowed to make simplifications/approximations in general?

Page 3: [1] Deleted Benjamin M. Slutsker 5/1/2023 4:28:00 PM

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Page 11: [6] Deleted Benjamin M. Slutsker 1/25/2023 3:19:00 PM

Page 12: [7] Deleted Benjamin M. Slutsker 1/25/2023 3:21:00 PM

Page 12: [8] Deleted Benjamin M. Slutsker 1/31/2023 12:45:00 PM

Draft: 7/19/23

Valuation Manual (VM)-22 (A) Subgroup
Virtual Meeting
June 13, 2023

The VM-22 (A) Subgroup of the Life Actuarial (A) Task Force met June 13, 2023. The following Subgroup members participated: Ben Slutsker, Chair (MN); Elaine Lam and Thomas Reedy (CA); William Leung (MO); Seong-min Eom (NJ); Bill Carmello (NY); Rachel Hemphill and Iris Huang (TX); Tomasz Serbinowski (UT); and Craig Chupp (VA).

1. Discussed Tier 3 and 4 Comments on the VM-22 Draft

Slutsker introduced a comment from Chupp relating to a desire for consistency between the error factor language in VM-21, Requirements for Principle-Based Reserves for Variable Annuities, and that in the VM-22, Requirements for Principle-Based Reserves for Non-Variable Annuities draft. He noted that it appeared that language specifying that a series of examples was not exhaustive was dropped from the VM-22 draft. After a short discussion, with Lam noting support for Chupp's comment, the Subgroup agreed to make the change suggested by Chupp. Slutsker then walked through a comment from Brian Bayerle (American Council of Life Insurers—ACLI) that suggested that a list of assumptions where sensitivity testing is needed should be revised to be more reflective of those used in modeling fixed annuities. After some discussion, the Subgroup decided to leave the language in the VM-22 draft as is.

Slutsker then introduced a comment from the ACLI on a section of the VM-22 draft stating that policyholder behavior assumptions should be at least as conservative as company experience unless clear evidence indicates otherwise. He said the ACLI suggested replacing "clear evidence" with "sufficient credibility" and including a reference to materiality. After some discussion, the Subgroup settled on replacing "clear evidence" with "credible evidence." After concluding the Tier 3 comments discussion, the Subgroup resolved some editorial Tier 4 items on which Chupp had commented.

Having no further business, the VM-22 (A) Subgroup adjourned.

SharePoint/NAIC Support Staff Hub/Member Meetings/A CMTE/LATF/2023-2-Summer/VM-22 Calls/06 13/June 13 Minutes.docx

Draft: 8/1/23

Valuation Manual (VM)-22 (A) Subgroup
Virtual Meeting
May 24, 2023

The Valuation Manual (VM)-22 (A) Subgroup of the Life Actuarial (A) Task Force met May 24, 2023. The following Subgroup members participated: Ben Slutsker, Chair (MN); Elaine Lam and Thomas Reedy (CA); Lei Rao-Knight (CT); Vincent Tsang (IL); Nicole Boyd (KS); William Leung (MO); Seong-min Eom (NJ), Bill Carmello (NY); Rachel Hemphill and Iris Huang (TX); Tomasz Serbinowski (UT); and Craig Chupp (VA).

1. Discussed Tier 3 Comments on the VM-22 Draft

Slutsker noted that the Subgroup would discuss several comments on the VM-22, Requirements for Principle-Based Reserves for Non-Variable Annuities, draft (VM-22 draft) related to the exemption from the exclusion test for payout annuities. Slutsker described the first comment from Brian Bayerle (American Council of Life Insurers—ACLI) that suggested including a reference to exhibit 7 of the NAIC Annual Statement to reinforce that term certain payout annuities would be eligible for the exemption from the exclusion test and included in the exemption threshold. Chris Conrad (American Academy of Actuaries—Academy), Lam, and Huang all noted support for the ACLI's comment, and the Subgroup agreed to make the suggested changes.

Slutsker then introduced another comment from the ACLI to consider allowing for “plain-vanilla” forms of longevity reinsurance to be eligible for the exemption from the exclusion test. Conrad suggested that the Academy could be supportive of this idea if there was a proposal for a methodology to distinguish “plain vanilla” longevity reinsurance agreements from more complex ones. Bayerle noted that he could take this issue back to his group to provide a proposal. Several regulators approved of the approach to have the ACLI come back with a proposal, but Reedy noted that he would like to see a rigorous methodology applied to distinguishing between “plain vanilla” and more complex longevity reinsurance arrangements. After further discussion, the Subgroup agreed to move forward with having the ACLI draft a proposal.

Bayerle then described the ACLI's next comment, which suggested that if a “plain-vanilla” form of longevity reinsurance could be exempted from the exclusion test, then that business should not be included in the determination of the overall VM-22 exclusion threshold. Slutsker noted that this brings up two issues: 1) contracts with guaranteed living benefits (GLBs) are not allowed to be excluded from VM-22 calculations but are included in the exemption threshold in the current VM-22 draft; and 2) there may be a desire for consistency with exemption language in VM-20, Requirements for Principle-Based Reserves for Life Products. Bayerle noted that broad consistency with other sections of the *Valuation Manual* made sense but that it could also be appropriate for some framework-specific differences. Conrad noted that it was the Academy's position that any business not eligible for exemption not be included in the determination of the exemption threshold. Chupp noted that it may be helpful to look at the definitions for longevity reinsurance and pension risk transfer (PRT) and isolate where the risk is and what should be automatically excluded. Slutsker requested that when the ACLI looks into a proposal that it leverages the definitions available in the VM-22 draft, to which Bayerle agreed.

Slutsker said that the final comment on the exclusion test was from the ACLI and concerned provisions that did not allow for contracts with: 1) changes to benefits in excess of 5% over time; and 2) material policyholder options to automatically pass the exclusion test. Slutsker further said that the commenter was concerned that contracts with cost-of-living adjustments (COLAs) and joint and survivor annuities would not be allowed to automatically pass the exclusion test. Conrad noted that the Academy felt that contracts with a predetermined schedule of increases that are not based on an index or are capped at a predefined level could be allowed to automatically

pass exclusion testing. Chupp said he could support modifying the current VM-22 language to allow for scheduled increases, but he is concerned with the potential for vague enough language to allow contracts with balloon payments to be automatically excluded from VM-22 calculations. After additional discussion from regulators and interested parties, the Subgroup decided to modify the VM-22 draft language to include the examples mentioned in the ACLI comment while maintaining the existing guardrails.

Chupp noted that VM-21, Requirements for Principle-Based Reserves for Variable Annuities, has two additional sentences (compared to the VM-22 draft) that define what the investment policy adopted by the board of directors must include when companies are following one or more future hedging strategies and requested that the additional sentences from VM-21 be added to the VM-22 draft. The Subgroup decided to add these additional sentences into the next version of the VM-22 draft.

Having no further business, the VM-22 (A) Subgroup adjourned.

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Draft: 8/2/23

Valuation Manual (VM)-22 (A) Subgroup
Virtual Meeting
May 10, 2023

The Valuation Manual (VM)-22 (A) Subgroup of the Life Actuarial (A) Task Force met May 10, 2023. The following Subgroup members participated: Ben Slutsker, Chair (MN); Elaine Lam and Thomas Reedy (CA); Lei Rao-Knight (CT); Vincent Tsang (IL); Nicole Boyd (KS); William Leung (MO); Seong-min Eom (NJ), Bill Carmello (NY); Rachel Hemphill and Iris Huang (TX); Tomasz Serbinowski (UT); and Craig Chupp (VA).

1. Discussed Tier 3 Comments

Brian Bayerle (American Council of Life Insurers—ACLI) discussed the ACLI's comment that longevity risk transfer (LRT) premiums are usually predetermined, and therefore language in the VM-22, Requirements for Principle-Based Reserves for Non-Variable Annuities, draft implying otherwise should be removed. Eom asked to confirm that the premium amount for the LRT would not change despite deviations from expectations, such as the number of annuitants remaining. Laura Hanson (Pacific Life) stated that typically a company would pay a set premium to the assuming company that would not vary based on, for example, the number of annuitants remaining on the plan versus expectations. Additional discussion ensued, and it was decided that LRT comments would be lumped together and discussed during a future meeting.

Slutsker noted comments from the American Academy of Actuaries (Academy) and the ACLI on an apparent inconsistency in the language where the projection period was required to be as long as needed until: 1) no obligations remain as in the VM-22 draft compared to 2) when no material business is remaining in VM-31, PBR Actuarial Report Requirements for Business Subject to a Principle-Based Valuation, and 3) no materially greater total asset requirement would result in VM-21, Requirements for Principle-Based Reserves for Variable Annuities. Hemphill said that each of these specific callouts to the projection period length are unnecessary, as they are already covered by the overarching concept of materiality and that the existing language in the VM-22 draft is appropriate. There was additional discussion from Subgroup members, and then a roll call vote was held, which determined the language should be left as is.

Chris Conrad (Academy) then described the Academy's comment that if a certain portion of assets, beyond a materiality threshold, are held at market value in support of the product, then that portion of cash surrender value should be subject to a market value adjustment (MVA). Carmello said that given that statutory accounting was focused primarily on book value, the MVA should be ignored. After additional discussions from Subgroup members and interested parties, the Subgroup decided to move forward with Carmello's approach and add a guidance note for additional clarity.

Bayerle spoke to the ACLI's comment that a guidance note that discussed longevity reinsurance contracts where a single deterministic assumption would not adequately capture the risk should either be further clarified or removed. Carmello suggested removing the guidance note given that stochastic mortality had not yet been implemented in principle-based reserves, to which Eom agreed. The Subgroup decided to remove the guidance note.

Having no further business, the VM-22 (A) Subgroup adjourned.

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Draft: 8/2/23

Valuation Manual (VM)-22 (A) Subgroup
Virtual Meeting
April 26, 2023

The Valuation Manual (VM)-22 (A) Subgroup met April 26, 2023. The following Subgroup members participated: Ben Slutsker, Chair (MN); Elaine Lam and Thomas Reedy (CA); Lei Rao-Knight (CT); Mike Yanacheak (IA); Vincent Tsang (IL); Nicole Boyd (KS); Seong-min Eom (NJ), Bill Carmello (NY); Rachel Hemphill and Iris Huang (TX); Tomasz Serbinowski (UT); and Craig Chupp (VA).

1. Discussed Tier 3 Comments

Slutsker discussed the first comment from the American Council of Life Insurers (ACLI) that questioned why “after-issuance” language was included in the section of the VM-22, Requirements for Principle-Based Reserves for Non-Variable Annuities, draft that determined whether to value a rider in combination with the base policy or on a standalone basis. To explain the rationale behind the language, Chris Conrad (American Academy of Actuaries—Academy) gave an example of a waiver of premium rider that may reference the overall premium amount at issue but does not depend on policy values after issue, compared to a long-term care (LTC) combination product where base contract benefits that could vary after issue may be drawn upon in the event of an LTC claim. Subgroup members supported the inclusion of the after-issuance language.

Slutsker noted that the next comment from the ACLI suggested there was an inconsistency in the VM-22 draft with language that stated policyholder behavior efficiency will increase over time unless there was credible experience to the contrary and language elsewhere that said that it may generally be assumed that policyholders elect the most valuable benefit if more than one option exists. Colin Masterson (ACLI) said that the “may generally” should be replaced with “should” for the election of the most valuable benefit to be consistent. Discussion ensued, and the Subgroup decided that replacing “may generally” with “should generally” would make the two sections consistent.

Slutsker said that the next comment from the ACLI concerned the definition of longevity reinsurance and that the ACLI suggested striking the “over the expected lifetime of benefits, paid to specified annuitants” language to allow for more flexibility in the definition. Carmello suggested adding the word “generally” to the language to add flexibility, which Subgroup members approved. Slutsker then said that the next comment from the ACLI suggested removing references to separate accounts in the VM-22 draft. Masterson further stated that a survey question could be asked of the future VM-22 field test participants asking if they had any separate accounts supporting their VM-22 business, and Subgroup members agreed with striking the language and adding a field test question.

Slutsker introduced the next comment from the ACLI that stated that the language in a guidance note, specifying contacts valued under VM-A, Appendix A – Requirements, and VM-C, Appendix C – Actuarial Guidelines, are ones that pass exclusion tests and elect not to use modeling, should be included in the main body of the text rather than a guidance note. Subgroup members agreed to moving the language into the main body from a guidance note. Slutsker then moved on to an ACLI comment stating that reserving categories should be determined in a principle-based fashion rather than prescribed. Masterson added that principle-based reserving (PBR) categories could be included in the field test. Conrad noted that aggregation was going to be looked at as part of the field test.

Masterson spoke to the ACLI’s next comment that suggested including a definition in the *Valuation Manual* for supplementary contracts. Chupp noted that there are several items that are not defined in the *Valuation Manual*

and wondered whether it was necessary to have a definition for supplementary contracts. Additional discussion ensued and a roll call vote was taken, which resulted in the Subgroup deciding not to add a definition for supplementary contracts.

Having no further business, the VM-22 (A) Subgroup adjourned.

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Draft: 7/31/23

Valuation Manual (VM)-22 (A) Subgroup
Virtual Meeting
April 19, 2023

The Valuation Manual (VM)-22 (A) Subgroup met April 19, 2023. The following Subgroup members participated: Ben Slutsker, Chair (MN); Elaine Lam and Thomas Reedy (CA); Lei Rao-Knight (CT); Vincent Tsang (IL); Nicole Boyd (KS); Seong-min Eom (NJ), Bill Carmello (NY); Rachel Hemphill and Iris Huang (TX); Tomasz Serbinowski (UT); and Craig Chupp (VA).

1. Discussed the Tier 2 Item – Combo Product Valuation

Slutsker introduced a question from Chupp regarding whether the nursing home riders and other combo products should be valued under principle-based reserving (PBR) or the prior formulaic reserve method. Chupp pointed out that the reference to nursing home benefits was removed in the October 2022 exposure of the VM-22, Requirements for Principle-Based Reserves for Non-Variable Annuities, draft, but it was kept in the current exposure. Slutsker asked if there were any comments from the American Academy of Actuaries (Academy) on why nursing home benefits were included or any thoughts on combo products. Chris Conrad (Academy) mentioned that the Academy wanted to include nursing home benefits in the VM-22 draft to ensure that there is an explicit reserve for them. Regarding other combo products, Conrad said that the Academy recommendation is that combo products be included in the model reserves for the base policy. Further discussion ensued, and the Subgroup agreed no changes would be made to the VM-22 draft.

2. Discussed the Tier 2 Item – Reserving Category for GLB with Depleted AV

Slutsker said that the current VM-22 draft places deferred annuities (DAs) with guaranteed living benefits (GLBs) in the payout reserving category once the account value (AV) has been depleted. Slutsker further noted that this can lead to implementation and conceptual challenges given that these contracts start out in the accumulation reserving category. Conrad commented that because this is a principle-based framework, the Academy supports leaving it to the actuary to decide whether to categorize GLB contracts with depleted fund values as either belonging to payout or accumulation reserving categories if they are able to justify that treatment in their VM-31, PBR Actuarial Report Requirements for Business Subject to a Principle-Based Valuation, report. Colin Masterson (American Council of Life Insurers—ACLI) commented that allowing optionality to align categorization with how business is managed is conceptually and operationally appropriate.

Additional discussion ensued, with state insurance regulators split on whether to allow optionality for GLB contracts with depleted AVs or to categorize the contracts in either the payout or accumulation reserving category. Slutsker then asked Subgroup members to voice-vote on whether to allow optionality for categorizing GLB contracts with depleted fund values. The result of the vote was that the majority of Subgroup members supported not allowing optionality. Slutsker then conducted a second voice vote to decide to categorize GLBs with depleted AVs. Because the result of the voice vote was unclear, Slutsker directed Scott O’Neal (NAIC) to conduct a roll call vote, with the accumulation categorization ending up supported by the majority of Subgroup members. Slutsker noted that based on this vote, there will be an edit to the VM-22 draft where the DA contracts with GLBs whose AV is depleted will be removed from the payout reserving category and included in the accumulation reserving category.

3. Discussed the Tier 2 Item – Frequency of Reviewing PBR Assumptions

Slutsker noted that the VM-22 draft currently specified reviewing experience annually and updating assumptions periodically as appropriate, and that there was a question about whether VM-22 should be more prescriptive with the frequency of assumption updates. Subgroup members discussed options, including: 1) either changing the word “periodically” to “annually” to make assumption updates consistent with annual reviews; or 2) changing periodically to every three years like VM-20, Requirements for Principle-Based Reserves for Life Products, and VM-21, Requirements for Principle-Based Reserves for Variable Annuities. The Subgroup voted to update the language from “periodically” to “annually.”

Having no further business, the Subgroup adjourned.

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Draft: 7/25/23

Valuation Manual (VM)-22 (A) Subgroup
Virtual Meeting
April 12, 2023

The VM-22 (A) Subgroup met April 12, 2023. The following Subgroup members participated: Ben Slutsker, Chair (MN); Elaine Lam and Thomas Reedy (CA); Lei Rao-Knight (CT); Mike Yanacheak (IA); Vincent Tsang (IL); Nicole Boyd (KS); William Leung (MO); Seong-min Eom (NJ); Bill Carmello (NY); Rachel Hemphill and Iris Huang (TX); Tomasz Serbinowski (UT); and Craig Chupp (VA).

1. Discussed the VM-22 Exemption

Slutsker said the purpose of the call would be to go over comments received on the latest exposed version of the VM-22, Requirements for Principle-Based Reserves for Non-Variable Annuities draft (Attachment Twenty-One-A). He noted that the Subgroup voted on the VM-22 exemption threshold for the individual company level, but the group threshold still needs to be determined. Chupp said he supports a \$2 billion threshold level, to which Reedy agreed. Hearing no objections from the Subgroup, Slutsker noted that the \$2 billion level for the group exemption threshold would be included in the revised VM-22 draft.

Slutsker then asked whether business included in the Other Annuities column of the Analysis of the Increase in Reserves exhibit should be included in the determination of the threshold, noting that the column could include business that is out of the scope of VM-22. Carmello said business in the Other Annuities column should be included unless it is valued under VM-21, Requirements for Principle-Based Reserves for Variable Annuities. Leung also noted that there is additional business included in the Other Annuities column that is not in the scope of VM-21 but is also exempt from VM-22. Hearing no objection from the Subgroup, Slutsker noted that the revised VM-22 draft would include business in the Other Annuities column in the determination of VM-22 exemption, with language to exclude business subject to VM-21 or otherwise excluded from VM-22.

Slutsker said the current VM-22 draft does not allow for annuities with guaranteed living benefits (GLBs) to be exempted from VM-22. Arguments for and against allowing GLBs to be eligible for exemption were discussed. The Subgroup decided to leave the current language as is for the next draft, leaving room for future proposals to add language to allow companies that are no longer issuing business exemptions for previously issued GLBs on claim status.

2. Discussed Longevity Reinsurance

Brian Bayerle (American Council of Life Insurers—ACLI) noted that the k-factor approach to determining reserves for longevity reinsurance would be complex, and there is likely a simpler method that would also address regulators' concerns with potential negative reserves. Eom noted that the k-factor could be determined at issue and held constant throughout the life of the contract, therefore reducing complexity. Additional discussion ensued, but the Subgroup agreed to continue with the k-factor approach for longevity reinsurance.

3. Discussed Tier 2 Items

Slutsker said discussions of Tier 1 comments had concluded, and the Subgroup would now move on to Tier 2 comments. For the first Tier 2 item, he said a set of principles exists in the draft (VM Section II) that determines whether business would be scoped into VM-21 or VM-22, and both the ACLI and American Academy of Actuaries (Academy) commented on how prescriptive the language should be. Chris Conrad (Academy) noted a preference

for using the prescriptive “shall” language to strictly delineate VM-21 and VM-22 business, while Bayerle expressed support for more flexible language. Subgroup members voted to include the more prescriptive language in the next version of the VM-22 draft.

Having no further business, the VM-22 (A) Subgroup adjourned.

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Comment Categories:

Tier 1: Key Decision Points – Discuss first

Tier 2: High Substance Edits – Discuss second

Tier 3: Moderate Substance Edits – Discuss third

Tier 4: Noncontroversial or Low Substance Edits – Will expose and only discuss upon comment

VM-22 PBR: Requirements for Principle-Based Reserves for Non-Variable Annuities

Table of Contents

Valuation Manual Section II. Reserve Requirements	4	
Subsection 2: Annuity Products	4	
Subsection 6: Riders and Supplemental Benefits	7	Deleted: 6
VM-01: Definitions for Terms in Requirements	9	Deleted: 8
Section 1: Background	12	Deleted: 11
A. Purpose	12	Deleted: 11
B. Principles	12	Deleted: 11
C. Risks Reflected and Risks Not Reflected	13	Deleted: 12
D. Materiality	15	
Section 2: Scope and Effective Date	16	Deleted: 15
A. Scope	16	Deleted: 15
B. Effective Date & Transition	16	Deleted: 15
Section 3: Reserve Methodology.....	17	Deleted: 16
A. Aggregate Reserve.....	17	Deleted: 16
B. Impact of Reinsurance Ceded	17	Deleted: 16
C. The Additional Standard Projection Amount	17	Deleted: 16
D. The SR.....	17	Deleted: 16
E. The DR.....	17	Deleted: 16
F. Aggregation of Contracts for the DR and SR.....	17	Deleted: 16
G. Stochastic Exclusion Test	19	Deleted: 18
H. Allocation of the Aggregate Reserve to Contracts	19	Deleted: 18
I. Prudent Estimate Assumptions.....	19	Deleted: 18
J. Approximations, Simplifications, and Modeling Efficiency Techniques	19	Deleted: 18
Section 4: Determination of SR.....	21	Deleted: 20
A. Projection of Accumulated Deficiencies	21	Deleted: 20
B. Determination of Scenario Reserve	25	Deleted: 24
C. Projection Scenarios	27	Deleted: 26
D. Projection of Assets.....	27	Deleted: 26

E. Projection of Annuitization Benefits	30	Deleted: 29
F. Frequency of Projection	30	Deleted: 29
G. Compliance with ASOPs.....	31	Deleted: 30
Section 5: Reinsurance	32	Deleted: 31
A. Treatment of Reinsurance in the Aggregate Reserve	32	Deleted: 31
Section 6: Standard Projection Amount	35	Deleted: 34
Section 7: Exclusion Testing.....	36	Deleted: 35
A. Stochastic Exclusion Test Requirement Overview	36	Deleted: 35
B. Requirement to Pass the Stochastic Exclusion Tests.....	37	Deleted: 35
C. Stochastic Exclusion Ratio Test	38	Deleted: 36
D. Stochastic Exclusion Demonstration Test	40	Deleted: 39
E. Deterministic Certification Option	41	Deleted: 40
Section 8: To Be Determined (Scenario Generation for VM-21).....	42	
Section 9: Modeling Hedges under a Non-Index Credit Future Hedging Strategy	43	
A. Initial Considerations.....	43	
B. Modeling Approaches	43	
C. Calculation of SR (Reported).....	44	
E. Additional Considerations for CTE70 (best efforts)	47	
D. Specific Considerations and Requirements	47	
Section 10: Guidance and Requirements for Setting Contract Holder Behavior Prudent Estimate Assumptions	50	
A. General	50	
B. Aggregate vs. Individual Margins	50	
C. Sensitivity Testing.....	51	
D. Specific Considerations and Requirements	52	
E. Dynamic Assumptions.....	53	
F. Consistency with the CTE Level.....	54	
G. Additional Considerations and Requirements for Assumptions Applicable to Guaranteed Living Benefits.....	54	Deleted: 55
H. Policy Loans	54	Deleted: 55
I. Non-Guaranteed Elements.....	55	
Section 11: Guidance and Requirements for Setting Prudent Estimate Mortality Assumptions.....	57	
A. Overview	57	
B. Determination of Expected Mortality Curves	58	
C. Adjustment for Credibility to Determine Prudent Estimate Mortality	61	
D. Future Mortality Improvement.....	62	
Section 12: Other Guidance and Requirements for Assumptions	63	

Section 13: Allocation of Aggregate Reserves to the Contract Level	68	
VM-V: Statutory Maximum Valuation Interest Rates for Formulaic Reserves	72	Deleted: 71
1. Income Annuities	72	Deleted: 71
A. Purpose and Scope	72	Deleted: 71
B. Definitions	73	Deleted: 72
C. Determination of the Statutory Maximum Valuation Interest Rate	74	

Valuation Manual Section II. Reserve Requirements

Subsection 2: Annuity Products

- A. This subsection establishes reserve requirements for all contracts classified as annuity contracts as defined in SSAP No. 50 in the AP&P Manual.
- B. Minimum reserve requirements for variable annuity (VA) contracts and similar business, specified in VM-21, Requirements for Principle-Based Reserves for Variable Annuities, shall be those provided by VM-21. The minimum reserve requirements of VM-21 are considered PBR requirements for purposes of the *Valuation Manual*, and therefore are applicable to VM-G.
- C. Minimum reserve requirements for non-variable annuity contracts issued prior to 1/1/2025 are those requirements as found in VM-A, VM-C, and VM-V as applicable, with the exception of the minimum requirements for the valuation interest rate for single premium immediate annuity contracts, and other similar contracts, issued after Dec. 31, 2017, including those fixed payout annuities emanating from host contracts issued on or after Jan. 1, 2017, and on or before Dec. 31, 2017. The maximum valuation interest rate requirements for those contracts and fixed payout annuities are defined in VM-V, Statutory Maximum Valuation Interest Rates for Formulaic Reserves.
- D. Minimum reserve requirements for non-variable annuity contracts issued on 1/1/2025 and later are those requirements as found in VM-22, with the exception of Guaranteed Investment Contracts, Synthetic Guaranteed Investment Contracts, and other Stable Value Contracts which shall follow the requirements found in VM-A, VM-C, and VM-V. The minimum reserve requirements of VM-22 are considered PBR requirements for purposes of the *Valuation Manual*, and therefore are applicable to VM-G.
- E. Annuity PBR Exemption
 - 1. A company meeting at least one of the conditions in Subsection 2.E.2 below may file a statement of exemption for annuity contracts or certificates, except for contracts or certificates in Subsection 2.E.4 below, issued directly or assumed during the current calendar year, that would otherwise be subject to VM-22. If a company has no business issued directly or assumed during the current calendar year that would otherwise be subject to VM-22, a statement of exemption is not required. For a filed statement of exemption, the statement must be filed with the domiciliary commissioner prior to July 1 of that year certifying that at least one of the two conditions in Subsection 2.E.2 was met, and the statement of exemption must also be included with the NAIC filing for the second quarter of that year.

The domiciliary commissioner may reject such statement prior to Sept. 1 and require the company to follow the requirements of VM-22 for the annuity contracts or certificates covered by the statement.

If a filed statement of exemption is not rejected by the domiciliary commissioner, the filing of subsequent statements of exemption is not required as long as the company continues to qualify for the exemption; rather, ongoing statements of exemption for each new calendar year will be deemed to not be rejected, unless: 1) the company does not meet either condition in Subsection 2.E.2 below; 2) the contracts contain those in Subsection 2.E.4 below; or 3) the domiciliary commissioner contacts the company prior

Commented [A1]: ACU: Subsection 3 Deposit-Type Contracts also needs to be updated

Commented [VM222R1]: Added reference for VM-V in Subsection 3

Commented [VM223]: In line with ACU edit in paragraph D. See below.

Commented [CC4]: Should VM-V be added?

Commented [VM225R4]: Edits added to address

Deleted: C

Commented [CC6]: Should also add exception for minimum valuation interest rate in VM-V?

Commented [VM227R6]: Edits added to address

Deleted: v

Deleted: stable value c

Deleted: C

Commented [A10]: ACU: Guidance Note appears to apply to 2.D, so better to put the text there. Also propose similar change for VM-21 PBR requirements.

Commented [VM2211R10]: Took out of Guidance Note

Deleted: The requirements in VM-22this section are still considered a part of PBR requirements and therefore are applicable to VM-G.

Deleted: ¶

Commented [A12]: Incorrect reference (several instances)

Commented [VM2213R12]: Edits added to address

Deleted: D

Commented [CC14]: s/b Subsection 2.E.4

Commented [VM2215R14]: Edits added to address

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Deleted: 3

Commented [CC16]: s/b Subsection 2.E.2

Commented [VM2217R16]: Edits added to address

Deleted: D

Commented [CC18]: s/b Subsection 2.E.2

Commented [VM2219R18]: Edits added to address

Deleted: D

Commented [CC20]: s/b Subsection 2.E.4

Commented [VM2221R20]: Edits added to address

Deleted: D

Deleted: 3

to Sept. 1 and notifies them that the statement of exemption is rejected. If any of these three events occur, then the statement of exemption for the current calendar year is rejected, and a new statement of exemption must be filed and not rejected in order for the company to exempt additional contracts or certificates. In the case of an ongoing statement of exemption, rather than include a statement of exemption with the NAIC filing for the second quarter of that year, the company should enter "SEE EXPLANATION" in response to the Annuity PBR Exemption supplemental interrogatory and provide as an explanation that the company is utilizing an ongoing statement of exemption.

2. Condition for Exemption:

- a. The company has less than ~~\$1.0 billion~~ of Exemption Reserves, and if the company is a member of an NAIC group that includes other life insurance companies, the group has combined exempted prior year reserves of less than ~~\$2 billion~~; or
- b. The only new contract or certificates that would otherwise be subject to VM-22 being issued or assumed by the company are due to election of contract benefits or features from existing contracts or certificates valued under VM-A and VM-C and the company was exempted from, or otherwise not subject to, the requirements of VM-22 in the prior year.

Drafting Note: Request feedback on whether the reserve threshold for the Annuity PBR Exemption should be determined on a gross of reinsurance or net of reinsurance basis.

Drafting Note: Request feedback on the appropriate level for a reserve threshold. Original proposal was based on gross reserves set to \$3 billion for each company and \$6 billion for a group of companies. Discussion on the NAIC VM-22 Subgroup suggested that a lower threshold may be necessary to limit the majority of companies for being eligible for the exemption, resulting in an initial placeholder of \$0.5 billion for each company.

3. Exemption reserves are determined as follows:

- a. The amount reported in the prior calendar year life/health annual statement, Analysis of Increase in Reserves During the Year-Individual Annuities, Column 2 ("Fixed Annuities"), line 15; plus
- b. The amount reported in the prior calendar year life/health annual statement, Analysis of Increase in Reserves During the Year-Individual Annuities, Column 3 ("Indexed Annuities"), line 15; plus
- c. The amount reported in the prior calendar year life/health annual statement, Analysis of Increase in Reserves During the Year-Individual Annuities, Column 6 ("Life Contingent Payout (Immediate and Annuitizations)"), line 15; plus
- d. The amount reported in the prior calendar year life/health annual statement, Analysis of Increase in Reserves During the Year-Group Annuities, Column 2 ("Fixed Annuities"), line 15; plus
- e. The amount reported in the prior calendar year life/health annual statement, Analysis of Increase in Reserves During the Year-Group Annuities, Column 3 ("Indexed Annuities"), line 15; plus

Commented [A22]: Academy: The ARCWG proposed the \$1.0B limit as a reasonable balance between small company PBR compliance burden and companies with a meaningful block of annuities required to hold PBR reserves. Because of the size of annuity deposits, a \$0.5B limit could be easily exceeded with only a few years of sales, even by small companies. Please see the accompanying Academy letter dated January 17, 2023 (Letter) for additional detail.

This limit should be coordinated with and be larger than the limit chosen in (new) section 7.A.1.d.v (as shown in a separate exposure).

Commented [VM2223R22]: VM-22 Subgroup voted on an initial level of \$1 billion.

Deleted: [

Deleted: 0.5

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Deleted: 6

Commented [CC24]: company exemption amount was changed from \$3 billion to \$0.5 billion, so the Group exemption amount should be changed accordingly.

Commented [VM2225R24]: To confirm that, given the \$1b threshold for an individual company, the Subgroup's intention is for a \$2b threshold for a group.

Commented [A26]: ACLI: Some of our members have expressed concerns over the VM-22 draft's proposed exemption amount being set too low at \$0.5 billion in reserves. The Draft Note in the exposure indicated the original proposal of \$3 billion for a company and \$6 billion for a group was revised downward, but these higher levels may cover the vast majority of annuity reserves held (not only those subject to VM-22) and would be more appropriate. The Life PBR Exemption uses a \$300/600 million life premium limit, creating a parallel for annu... [1]

Commented [VM2227R26]: VM-22 Subgroup voted on an initial level of \$1 billion. ... [2]

Commented [A28]: Academy: The ARCWG proposes that the exemption limits here and in Section 7.A.1.d.v be l... [3]

Commented [VM2229R28]: Subgroup voted in favor of a gross of reinsurance basis.

Commented [CC30]: Was this changed from Line 15 to Line 16? It is Line 15 in 2021 AS. Also, in b.-f. below.

Commented [VM2231R30]: Edits added to address

Commented [A32]: Corrected line reference (several instances)

Commented [VM2233R32]: Edits added to address

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f. The amount reported in the prior calendar year life/health annual statement, Analysis of Increase in Reserves During the Year-Group Annuities, Column 6 ("Life Contingent Payout (Immediate and Annuitizations)"), line 15].

g. Adding back in any reserves that were ceded in (a) through (f) above, in order to set the Exemption reserves on a gross of reinsurance basis

Drafting Note: Request feedback on whether to include "Other Annuities" from the Analysis of Increase in Reserve exhibit in the Annual Statement?

Commented [CC34]: Why is this still Line 15?

Commented [VM2235R34]: Edits added in other sections to make consistent

Commented [VM2236]: To put the Exemption threshold on a gross of reinsurance basis.

4. Contracts and Certificates Excluded from the Annuity PBR Exemption:

a. Contracts or certificates with guaranteed living benefits (GMIBs, GMABs, GMMBs, GLWBs).

Drafting Note: Request feedback on whether to render guaranteed living benefits eligible or ineligible for the Annuity PBR Exemption. In addition, feedback is requested for how to treat contracts with guaranteed living benefits where only the guaranteed living benefits are reinsured.

Commented [A37]: ACL: We believe this should only apply to deferred status but not claim status

Commented [A38]: Academy: The ARCWG does not have a consensus opinion. Please see the Letter for arguments for and against GLB's.

5. Each exemption, or lack of an exemption, outlined in Subsection 2.E.1 to Subsection 2.E.4 above applies only to contracts or certificates issued or assumed in the current year, and it applies to all future valuation dates for those contracts or certificates. However, if contracts or certificates did not qualify for the Annuity PBR Exemption during the year of issue but would have qualified for the Annuity PBR Exemption if the current Valuation Manual requirements had been in effect during the year of issue, then the domiciliary commissioner may allow an exemption for such contracts or certificates. The minimum reserve requirements for the annuity contracts and certificates subject to the exemption are those pursuant to applicable methods required in VM-A and VM-C using the mortality tables as defined in VM-M, and valuation rates in VM-V as applicable.

Should it be decided that GLB's are not eligible for the Exemption, the ARCWG proposes that language is included in the VM to permit case by case exemptions to be granted by the domiciliary commissioner. Such language should encompass all blocks of business as many small requests for exemptions may constitute, in aggregate, material risk.

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Commented [CC39]: s/b Subsection 2.E.1-Subsection 2.E.4

Commented [VM2240R39]: Edits added to address

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F. Upon determining whether annuities fall under the requirements in Paragraphs B, C, and D in this subsection, the below principles shall be followed::

Drafting Note: Request feedback on whether the below principles should be phrased as "are generally expected to follow" or "shall follow".

Commented [A41]: ACL: Favor "are generally expected to follow"

Commented [A42]: Academy: The ARCWG proposes the use of "shall" for consistency with the opening sentence and will remove ambiguity.

1. Contracts that do not guarantee the principal amount of purchase payments, net of any partial withdrawals, and interest credited thereto, less any deduction (without regard to its timing) for sales, administrative or other expenses or charges are generally expected to follow the requirements in Paragraph B of this subsection .
2. Contracts that do not credit a rate of interest under the contract prior to the application of any market value adjustments that is at least equal to the minimum rate required to be credited by the standard nonforfeiture law in the jurisdiction in which the contract is issued are generally expected to follow the requirements in Paragraph B of this subsection.
3. Contracts falling under the definition of Index-Linked Variable Annuities provided in VM-01 are generally expected to follow the requirements in Paragraph B of this subsection.

All annuity contracts that do not fall under F.1, F.2, or F.3 in this subsection are generally expected to shall follow the requirements in Paragraph C or D of this subsection, in accordance with the date on which the contract has been issued.

- Commented [CC43]: s/b F.1, F.2, or F.3
- Commented [VM2244R43]: Edits added to address
- Deleted: E
- Deleted: E
- Deleted: E
- Deleted: E

Subsection 3: Deposit-Type Contracts

This subsection establishes reserve requirements for all contracts classified as deposit-type contracts defined in SSAP No. 50 in the AP&P Manual.

Minimum reserve requirements for deposit-type contracts are those requirements as found in VM-A, VM-C, VM-V, and VM-22, as applicable.

Commented [VM2245]: Added reference for VM-V in Subsection 3, per ACLI's comment in Subsection 2

Subsection 6: Riders and Supplemental Benefits

Guidance Note: Designs of policies or contracts with riders and supplemental benefits which are created to simply disguise benefits subject to the Valuation Manual section describing the reserve methodology for the base product to which they are attached, or exploit a perceived loophole, must be reserved in a manner similar to more typical designs with similar riders.

- A. If a rider or supplemental benefit is attached to a health insurance product, deposit-type contract, or credit life or disability product, it may be valued with the base contract unless it is required to be separated by regulation or other requirements.
- B. For supplemental benefits on life insurance policies or annuity contracts, including Guaranteed Insurability, Accidental Death or Disability Benefits, Convertibility, or Disability Waiver of Premium Benefits, the supplemental benefit may be valued with the base policy or contract and follow the reserve requirements for the base policy or contract under VM-20, VM-21, VM-22, VM-A, VM-C, and/or VM-V, as applicable.

- Commented [CC46]: should add VM-V?
- Commented [VM2247R46]: Edits added to address
- Deleted: C

- C. ULSG and other secondary guarantee riders on a life insurance policy and any guaranteed minimum benefits on life insurance policies or annuity contracts including, but not limited to, Guaranteed Minimum Accumulation Benefits, Guaranteed Minimum Death Benefits, Guaranteed Minimum Income Benefits, Guaranteed Minimum Withdrawal Benefits, Guaranteed Lifetime Income Benefits, Guaranteed Lifetime Withdrawal Benefits, Guaranteed Payout Annuity Floors, Waiver of Surrender Charges, Return of Premium, Systematic Withdrawal Benefits under Required Minimum Distributions, and all similar guaranteed benefits shall be valued with the base policy or contract and follow the reserve requirements for the base policy or contract under VM-20, VM-21, VM-22, and VM-A, VM-C, and/or VM-V, as applicable.

- Commented [CC48]: should add "VM-V"?
- Commented [VM2249R48]: Edits added to address
- Deleted: C,
- Commented [CC50]: s/b Paragraphs B and C only
- Commented [VM2251R50]: Edits added to address

- D. If a rider or supplemental benefit to a life insurance policy or annuity contract that is not addressed in Paragraphs B or C above possesses any of the following attributes, the rider or supplemental benefit shall be valued with the base policy or contract and follow the reserve requirements for the base policy or contract under VM-20, VM-21, VM-22, and VM-A, VM-C, and/or VM-V, as applicable.

- Commented [A52]: ACLI: Unclear why this change was made, recommend striking ", or D"
- Commented [VM2253R52]: Edits added to address
- Deleted: ,
- Deleted: , or D

1. The rider or supplemental benefit does not have a separately identified premium or charge.
2. After issuance, the rider or supplemental benefit premium, charge, value or benefits are determined by referencing the base policy or contract features or performance.

- Commented [CC54]: should add VM-V?
- Commented [VM2255R54]: Edits added to address
- Deleted: C
- Commented [A56]: ACLI: Unclear why "after issuance" was added; provide clarification or recommend deleting (two instances)

3. After issuance, the base policy or contract value or benefits are determined by referencing the rider or supplemental benefit features or performance. The deduction of rider or benefit premium or charge from the contract value is not sufficient for a determination by reference.

E. If a term life insurance rider on the named insured[s] on the base life insurance policy does not meet the conditions of Paragraph D above, and either (1) guarantees level or near level premiums until a specified duration followed by a material premium increase; or (2) for a rider for which level or near level premiums are expected for a period followed by a material premium increase, the rider is separated from the base policy and follows the reserve requirements for term policies under VM20, VM-A and/or VM-C, as applicable.

- Commented [CC57]: s/b Paragraph D
- Commented [VM2258R57]: Edits added to address
- Deleted: E
- Deleted: E

F. For all other riders or supplemental benefits on life insurance policies or annuity contracts not addressed in Paragraphs B through E above, the riders or supplemental benefits may be valued with the base policy or contract and follow the reserve requirements for the base policy or contract under VM-20, VM-21, VM-22, VM-A, VM-C, and/or VM-V, as applicable. For a given rider, the election to include riders or supplemental benefits with the base policy or contract shall be determined at the policy form level, not on a policy-by-policy basis, and shall be treated consistently from year-to-year, unless otherwise approved by the domiciliary commissioner.

- Commented [CC59]: s/b Paragraphs B through E
- Commented [VM2260R59]: Edits added to address
- Deleted: F
- Deleted: F
- Commented [CC61]: should add VM-V?
- Commented [VM2262R61]: Edits added to address
- Deleted: C
- Deleted: C

Any supplemental benefits and riders offered on life insurance policies or annuity contracts that would have a material impact on the reserve (for VM-20 and VM-22) or TAR (for VM-21) if elected later in the contract life, such as joint income benefits, nursing home benefits, or withdrawal provisions on annuity contracts, shall be considered when determining reserves (for VM-20 and VM-22) or reserves and TAR (for VM-21). The company must assume that policyholders' and contract holders' efficiency will increase over time unless the company has relevant and credible experience or clear evidence to the contrary. For example, policyholders with living benefits and annuitization in the same contract may generally use the more valuable of the two benefits.

- Commented [CC63]: nursing home benefits were taken out in Subsection 6.B above. Should they be removed here? Are Combo Life/Annuity/LTC products valued under VM-20, VM-21 or VM-22?
- Commented [A64]: ACLI: Suggest changing "may" with "should" and make this a separate item G.

VM-01: Definitions for Terms in Requirements

- The term “Deferred Income Annuity” (DIA) means an annuity contract that guarantees a periodic payment for the life of the annuitant or a term certain and payments begin 13 months or later from the issue date if the contract holder and/or annuitant survives to a predetermined future age.
- The term Guaranteed Investment Contract (GIC) means an accumulation-based group annuity contract issued to a retirement plan (defined contribution) under which the insurer accepts a deposit (or series of deposits) from the purchaser and guarantees to pay a specified interest rate on the funds deposited during a specified period of time.
- The term “Guaranteed Minimum Accumulation Benefit” (GMAB) means a guaranteed benefit providing, or resulting in the provision, that an amount payable on the contractually determined maturity date of the benefit will be increased and/or will be at least a minimum amount. Only such guarantees having the potential to produce a contractual total amount payable on benefit maturity that exceeds the account value, or in the case of an annuity providing income payments, an amount payable on benefit maturity other than continuation of any guaranteed income payments, are included in this definition.
- The term “Guaranteed Minimum Death Benefit” (GMDB) means a provision (or provisions) for a guaranteed benefit payable on the death of a contract holder, annuitant, participant or insured where the amount payable is either (i) a minimum amount; or (ii) exceeds the minimum amount and is:
 - Increased by an amount that may be either specified by or computed from other policy or contract values; and
 - Contains either:
 - The potential to produce a contractual total amount payable on such death that exceeds the account value, or
 - In the case of an annuity providing income payments, guarantees payment upon such death of an amount payable on death in addition to the continuation of any guaranteed income payments.
- The term “Guaranteed Minimum Income Benefit” (GMIB) means an option under which the contractholder has the right to apply a specified minimum amount that could be greater than the amount that would otherwise be available in the absence of such benefit to provide periodic income using a specified purchase basis.
- The term “Index Credit” means any interest credit, multiplier, factor, bonus, charge reduction, or other enhancement to contract values that is linked to an index or indices. Amounts credited to the contract resulting from a floor on an index account are included.
- The term “Index Credit Hedge Margin” means a margin capturing the risk of inefficiencies in the company’s hedging program supporting index credits. This includes basis risk, persistency risk, and the risk associated with modeling decisions and simplifications. It also includes any uncertainty of costs associated with managing the hedging program and changes due to investment and management decisions

Commented [A65]: ACLI: Consider adding “and/or annuitant” in addition to “contract holder” reference

Commented [VM2266R65]: Edits added to address

Commented [VM2267]: Typo

Commented [VM2268R67]: Edits added to address

Deleted: guaranteed minimum death benefit

Commented [VM2269]: Typo

Commented [VM2270R69]: Edits added to address

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Deleted: guaranteed minimum income benefit

- The term “Index Crediting Strategies” means strategies defined in a contract to determine index credits for a contract. For example, this may refer to underlying index, index parameters, date, timing, performance triggers, and other elements of the crediting method.
- The term “Index-Linked Variable Annuity” (ILVA) means an annuity contract with an account value where the contract holder has the option for a portion or all of the account value to grow at a rate linked to an external index, in addition to downside risk exposure that may not guarantee full principal repayment. These contracts may include a cap on upside returns, and may also include a floor on downside returns which may be below zero percent.
- The term “Longevity Reinsurance” means an agreement or reinsurance arrangement covering one or more group or individual annuity contracts, under which an insurance company assumes the longevity risk associated with periodic payments made to specified annuitants under one or more immediate or deferred payout annuity contracts. A common example is participants in one or more underlying retirement plans.
 - The reinsurer pays a portion of the actual benefits due to the underlying annuitants (or, in some cases, a pre-agreed amount per annuitant), while the ceding insurance company retains the assets supporting the reinsured annuity payments and pays periodic, ongoing premiums to the reinsurer over the expected lifetime of benefits paid to the specified annuitants. Such agreements may contain net settlement provisions such that only one party makes ongoing cash payments in a particular period. Under these agreements, longevity risk may be transferred on either a permanent basis or for a prespecified period of time, and these agreements may or may not permit early termination.
 - Agreements which are not treated as reinsurance under Statement of Statutory Accounting Principles (SSAP) No. 61R are not included in this definition. In particular, contracts under which payments are made based on the aggregate mortality experience of a population of lives which are not covered by an underlying group or individual annuity contract (e.g., mortality index-based longevity swaps) are not included in this definition.
- The term “Pension Risk Transfer” (PRT) means an annuity, either a group contract or reinsurance agreement, issued by an insurance company providing periodic payments to annuitants receiving immediate or deferred benefits from one or more retirement plans. Typically, the insurance company holds the assets supporting the benefits, which may be held in the general or separate account, and retains not only longevity risk but also asset risks (e.g., credit risk and reinvestment risk).
- The term “Single Premium Immediate Annuity” (SPIA) means an annuity purchased with a single premium amount which guarantees a periodic payment for the life of the annuitant or a term certain and payments begin within 13 months from the issue date.
- The term “Stable Value Contracts” means accumulation-based group contracts that provide limited investment guarantees, preserving principal while crediting steady, positive returns and protecting against losses or declines in yield. Underlying asset portfolios may consist of fixed income securities, which may sit in the insurer’s general account, a separate account, or in a third-party trust. These contracts often support defined contribution or defined benefit retirement plan liabilities.
- The term “Structured Settlement Contracts” are defined as annuity contracts that provide periodic benefits and purchased with a single premium amount stemming from various types of claims pertaining to court settlements or out-of-court settlements from tort actions arising from

Commented [A71]: ACLI: Suggest removing the struck phrase (“over the expected lifetime of benefits paid to the specified annuitants”) to allow for flexibility in how these transactions could be arranged.

accidents, medical malpractice, and other causes. Structured Settlement Contracts may be treated as either annuity contracts or deposit type contracts.

Commented [A72]: ACLI: See comment below about Term Certain Deposit Type contracts. Clarify that Structured Settlements can be annuity contracts or deposit type contracts

Commented [VM2273R72]: Edits added to address

- The term “Synthetic Guaranteed Investment Contract” (SGIC) means contract that simulates the performance of a traditional GIC through a wrapper, swap, or other financial instruments, with the main difference being that the assets are owned by the contract holder or plan trust.

- The term “Term Certain Payout Annuity” means an annuity contract that offers guaranteed periodic payments for a specified period of time, not contingent upon mortality or morbidity of the annuitant. Term Certain Payouts are treated as Deposit-Type Contracts.

Commented [A74]: ACLI: Under SSAP, Term Certain Payouts are Deposit-Type Contracts and this should be clarified in the definition

Commented [VM2275R74]: Edits added to address

Section 1: Background

A. Purpose

These requirements establish the minimum reserve valuation standard for non-variable annuity contracts as defined in Section II of the Valuation Manual, Subsection 2025. For all contracts encompassed by the Scope, these requirements constitute the Commissioners Annuity Reserve Valuation Method (CARVM) and, for certain contracts and certificates, the Commissioners Reserve Valuation Method (CRVM).

Commented [VM2277R76]: Edits added to address

Deleted: .A and issued on or after 1/1/2024

Guidance Note: CRVM requirements apply to some group pension contracts.

Drafting Note: There is a guidance note in VM-21 that explains that the reserve projection requirements are generally consistent with RBC C-3 Phase II requirements. However, it was decided to exclude this guidance note from VM-22 for the time being, though this may be revisited depending on whether further updates are made to the C-3 Phase I capital framework.

Commented [CC78]: Add the word "that" between "VM-21" and "explains"

Commented [VM2279R78]: Edits added to address

B. Principles

The projection methodology used to calculate the SR is based on the following set of principles. These principles should be followed when interpreting and applying the methodology in these requirements and analyzing the resulting reserves.

Guidance Note: The principles should be considered in their entirety, and it is required that companies meet these principles with respect to those contracts that fall within the scope of these requirements and are in force as of the valuation date to which these requirements are applied.

Principle 1: The objective of the approach used to determine the SR is to quantify the amount of statutory reserves needed by the company to be able to meet contractual obligations in light of the risks to which the company is exposed with an element of conservatism consistent with statutory reporting objectives.

Principle 2: The calculation of the SR is based on the results derived from an analysis of asset and liability cash flows produced by the application of a stochastic cash-flow model to equity return and interest rate scenarios. For each scenario, the greatest present value of accumulated deficiency is calculated. The analysis reflects prudent estimate assumptions for deterministic variables and is performed in aggregate (subject to limitations related to contractual provisions and prescribed guardrails) to allow the natural offset of risks within a given scenario. The methodology uses a projected total cash flow analysis by including all projected income, benefit, and expense items related to the business in the model and sets the SR at a degree of confidence using the CTE measure applied to the set of scenario specific greatest present values of accumulated deficiencies that is deemed to be reasonably conservative over the span of economic cycles.

Guidance Note: Examples where full aggregation between contracts may not be possible include experience rated group contracts and the operation of reinsurance treaties.

Principle 3: The implementation of a model involves decisions about the experience assumptions and the modeling techniques to be used in measuring the risks to which the company is exposed. Generally, assumptions are to be based on the conservative end of the confidence interval. The choice of a conservative estimate for each assumption may result in a distorted measure of the total risk. Conceptually, the choice of assumptions and the modeling decisions should be made so that the final result approximates what would be obtained for the SR at the required CTE level if it were possible to calculate results over the joint distribution of all future outcomes. In applying this concept to the actual calculation of the SR, the company should be guided by evolving practice and expanding knowledge base in the measurement and management of risk.

Guidance Note: The intent of Principle 3 is to describe the conceptual framework for setting assumptions. Section 10 provides the requirements and guidance for setting contract holder behavior assumptions and includes alternatives to this framework if the company is unable to fully apply this principle. More guidance and requirements for setting assumptions in general are provided in Section 12.

Principle 4: While a stochastic cash-flow model attempts to include all real-world risks relevant to the objective of the stochastic cash-flow model and relationships among the risks, it will still contain limitations because it is only a model. The calculation of the SR is based on the results derived from the application of the stochastic cash-flow model to scenarios, while the actual statutory reserve needs of the company arise from the risks to which the company is (or will be) exposed in reality. Any disconnect between the model and reality should be reflected in setting prudent estimate assumptions to the extent not addressed by other means.

Principle 5: A cash-flow scenario model cannot completely quantify a company's exposure to risk. A model attempts to represent reality but will always remain an approximation thereto and, hence, uncertainty in future experience is an important consideration when determining the SR. Therefore, the use of assumptions, methods, models, risk management strategies (e.g., hedging), derivative instruments, structured investments or any other risk transfer arrangements (such as reinsurance) that serve solely to reduce the calculated SR without also reducing risk on scenarios similar to those used in the actual cash-flow modeling are inconsistent with these principles. The use of assumptions and risk management strategies should be appropriate to the business and not merely constructed to exploit "foreknowledge" of the components of the required methodology.

- Commented [CC82]: s/b "cannot"
- Commented [VM2283R82]: Edits added to address
- Deleted: Neither
- Deleted: a
- Deleted: can
- Commented [A84]: ACL: Edit for clarity
- Commented [VM2285R84]: Edits added to address

C. Risks Reflected and Risks Not Reflected

1. The risks reflected in the calculation of reserves under these requirements arise from actual or potential events or activities that are both:
 - a. Directly related to the contracts falling under the scope of these requirements or their supporting assets; and
 - b. Capable of materially affecting the reserve.

2. Categories and examples of risks reflected in the reserve calculations include, but are not necessarily limited to:

a. Asset risks

- i. Credit risks (e.g., default or rating downgrades).
- ii. Commercial mortgage loan roll-over rates (roll-over of bullet loans).
- iii. Uncertainty in the timing or duration of asset cash flows (e.g., shortening (prepayment risk) and lengthening (extension risk)).
- iv. Performance of equities, real estate, and Schedule BA assets.
- v. Call risk on callable assets.
- vi. Separate account fund performance.

Drafting Note: Feedback welcome on whether to remove reference to separate accounts in VM-22. Whether references to separate accounts are retained or removed, consider making the treatment of such references consistent throughout VM-22.

Commented [A86]: ACL: Support eliminating references to separate accounts in VM-22

- vii. Risk associated with hedge instrument (includes basis, gap, price, parameter estimation risks, and variation in assumptions).
- viii. Currency risk.

b. Liability risks

- i. Reinsurer default, impairment, or rating downgrade known to have occurred before or on the valuation date.
- ii. Mortality/longevity, persistency/lapse, partial withdrawal, and premium/fee payment risks.
- iii. Utilization risk associated with guaranteed living benefits.
- iv. Anticipated mortality trends based on observed patterns of mortality improvement or deterioration, where permitted.
- v. Annuitization risks.
- vi. Additional premium dump-ins (high interest rate guarantees in low interest rate environments).
- vii. Applicable expense risks, including fluctuation in maintenance expenses directly attributable to the business, future commission expenses, and expense inflation/growth.

c. Combination risks

- i. Risks modeled in the company's risk assessment processes that are related to the contracts, as described above.
 - ii. Disintermediation risk (including such risk related to payment of surrender or partial withdrawal benefits).
 - iii. Risks associated with revenue-sharing income.
- 3. Categories and examples of risks not reflected in the reserve calculations include, but are not necessarily limited to:
 - a. Asset risks
 - i. Liquidity risks associated with a "run on the bank."
 - b. Liability risks
 - i. Reinsurer default, impairment or rating downgrade occurring after the valuation date.
 - ii. Catastrophic events (e.g., epidemics or terrorist events).
 - iii. Major breakthroughs in life extension technology that have not yet altered recently observed mortality experience.
 - iv. Significant future reserve increases as an unfavorable scenario is realized.
 - c. General business risks
 - i. Deterioration of reputation.
 - ii. Future changes in anticipated experience (reparameterization in the case of stochastic processes), which would be triggered if and when adverse modeled outcomes were to actually occur.
 - iii. Poor management performance.
 - iv. The expense risks associated with fluctuating amounts of new business.
 - v. Risks associated with future economic viability of the company.
 - vi. Moral hazards.
 - vii. Fraud and theft.
 - viii. Operational.
 - ix. Litigation.

D. Materiality

The company shall establish a standard containing the criteria for determining whether an assumption, risk factor, or other element of the principle-based valuation has a material impact on the size of the reserve. This standard shall be applied when identifying material risks.

Section 2: Scope and Effective Date

A. Scope

Non-variable annuity contracts specified in VM Section II, Subsection 2 “Annuity Products”, Paragraph D and applicable contracts in VM Section III, Subsection B are subject to VM-22 requirements.

Deleted: Contracts

Commented [A87]: ACL: Need to include VM Section III Subsection Deposit Type Contracts

Commented [VM2288R87]: Edits added to address

B. Effective Date & Transition

Effective Date

These requirements apply for valuation dates on or after January 1, 2025.

Transition

A company may elect to establish minimum reserves pursuant to applicable requirements in VM-A, VM-C, and VM-V for business otherwise subject to VM-22 PBR requirements and issued during the first three years following the effective date of VM-22. If a company during the three-year transition period elects to apply VM-22 PBR to a block of such business, then a company must continue to apply the requirements of VM-22 for future issues of this business. Irrespective of the transition date, a company shall apply VM-22 PBR requirements to applicable blocks of business on a prospective basis starting at least three years after the effective date.

Commented [CC89]: should add VM-V?

Commented [VM2290R89]: Edits added to address

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Commented [VM2292R91]: Edits added to address

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Section 3: Reserve Methodology

A. Aggregate Reserve

The aggregate reserve for contracts falling within the scope of these requirements shall equal the SR (following the requirements of Section 4) plus the additional standard projection amount (following the requirements of Section 6) plus the DR for those contracts satisfying the Deterministic Certification Option, less any applicable PIMR for all contracts not valued under applicable requirements in VM-A and VM-C, plus the reserve for any contracts valued under applicable requirements in VM-A, VM-C, and VM-V.

Guidance Note: Contracts valued under applicable requirements in VM-A and VM-C are ones that pass the exclusion test and elect to not model PBR SRs, per the requirements in Section 3.E.

B. Impact of Reinsurance Ceded

All components in the aggregate reserve shall be determined post-reinsurance ceded, that is net of any reinsurance cash flows arising from treaties that meet the statutory requirements that allow the treaty to be accounted for as reinsurance. A pre-reinsurance ceded reserve also needs to be determined by ignoring all reinsurance cash flows (costs and benefits) in the reserve calculation.

C. The Additional Standard Projection Amount

The additional standard projection amount is determined by applying one of the two standard projection methods defined in Section 6. The same method must be used for all contracts within a group of contracts that are aggregated together to determine the reserve. The company shall elect which method they will use to determine the additional standard projection amount. The company may not change that election for a future valuation without the approval of the domiciliary commissioner.

D. The SR

1. The SR shall be determined based on asset and liability projections for the contracts falling within the scope of VM-22 requirements, excluding those contracts valued using the methodology pursuant to applicable requirements in VM-A, VM-C, and VM-V over a broad range of stochastically generated projection scenarios described in Section 8 and using prudent estimate assumptions as required in Section 3.I herein.
2. The SR amount for any group of contracts shall be determined as CTE70 of the scenario reserves following the requirements of Section 4.

E. The DR

The DR for groups of contracts for which a company elects the Deterministic Certification Option in Section 7.E shall be determined as the DR following the requirements of Section 4. The reserve may be determined in aggregate across various groups of contracts within each Reserving Category as a single model segment when determining the SR.

F. Aggregation of Contracts for the DR and SR

- Commented [CC95]:** Section 7.E uses "SR" for Deterministic Certification Option
- Commented [VM2296R95]:** DR added for clarification in 7.E
- Commented [CC97]:** Should add VM-V?
- Commented [VM2298R97]:** Edits added to address
- Deleted:** C
- Commented [A99]:** ACLI: Suggest incorporating into 3.A
- Commented [A100]:** ACLI: Be specific on what "these requirements" refers to
- Commented [VM22101R100]:** Edits added to address
- Deleted:** these
- Commented [CC102]:** Should add valuation interest requirements in VM-V?
- Commented [VM22103R102]:** Edits added to address
- Deleted:** C
- Deleted:** C
- Commented [CC104]:** s/b Section 3.I
- Commented [VM22105R104]:** Edits added to address
- Commented [A106]:** Is this the right reference? Maybe 3.I
- Commented [VM22107R106]:** Edits added to address
- Deleted:** G
- Commented [A108]:** ACLI: Is this the right reference?
- Commented [VM22109R108]:** Edits added to address
- Deleted:** ¶
- Commented [A110]:** ACLI: Clarify this statement
- Commented [CC111]:** 3. refers to SR and is misplaced. Section 7.E uses "SR" rather than "DR" for contracts using Deterministic Certification Option.
- Commented [VM22112R111]:** DR added for clarification in 7.E
- Commented [A113]:** ACLI: Numbering is not correct
- Commented [VM22114R113]:** Edits added to address by removing reference to number 1, and combining sentence with preceding paragraph
- Commented [A115]:** ACLI: Consistent with our comments in our November 19, 2021, letter, we are concerned with the need for prescribed reserving categories because we believe the aggregation of contracts for the SR and DR should be principle-based and align with the pricing, operations, and investment management of the assets and liabilities.
- Commented [CC116]:** This entire subsection needs ... [4]
- Commented [VM22117R116]:** DR added for clarifi ... [5]

1. Groups of contracts within different Reserving Categories may not be aggregated together in determining the SR or DR. For the purposes of VM-22, Reserving Categories are classified as the following:

Commented [CC118]: There really is no "DR"
Commented [VM22119R118]: DR added for clarification in 7.E

a. The "Payout Annuity Reserving Category" includes the following categories of contracts, certificates and contract features, whether group or individual, including both life contingent and term certain only contracts, directly written or assumed through reinsurance, with the exception of benefits provided by variable annuities:

- i. Single Premium Immediate Annuity contracts;
- ii. Deferred Income Annuity contracts;
- iii. Structured Settlement Contracts in payout or deferred status;
- iv. Fixed income payment streams resulting from the exercise of settlement options or annuitizations of host contracts issued;
- v. Supplementary contracts, excluding contracts with no scheduled payments (such as retained asset accounts and settlements at interest);
- vi. Fixed income payment streams attributable to guaranteed living benefits associated with deferred annuity contracts, once the contract funds are exhausted;

Commented [A120]: ACLI: For Section 3.F.a.iv and 3.F.a.vi: References to "Host Contracts" and "deferred Annuity Contracts" may cause confusion. VM-21 technically covers all benefit streams emanating from Variable Annuity Contracts. ACLI would like to work with regulators to update the wording in both VM-21 and VM- 22 to codify current accepted practices (such as making it clear that projection of annuitizations and benefits (after AV = 0) should continue to be principle-based and reflect how the business is managed).

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Deleted: income annuity
Deleted: settlements

Drafting Note: Additional feedback is welcome for whether to permit optionality for categorizing guaranteed living benefit contracts with depleted fund value as either in the payout or accumulation reserving category.

Commented [A121]: ACLI: Need definition of "Supplementary Contract."

Commented [A122]: Academy: The ARCWG believes that this decision should be left up to the actuary, with appropriate justification in the VM-31 report.

Commented [A123]: ACLI: Permitting optionality to align categorization with how business is managed is conceptually appropriate. From a conceptual (principle-based) and operational perspective, living benefit contracts with depleted fund values should be included in payout or accumulation categories based on how the business is managed.

- vii. Certificates, emanating from non- variable group annuity contracts specified in Model #820, Section 5.C.2, purchased for the purpose of providing certificate holders fixed income payment streams upon their retirement; and
- viii. Pension Risk Transfer Annuities.

b. The term "Longevity Reinsurance Reserving Category" refers to includes Longevity Reinsurance as defined under the definition provided in VM-01 of the Valuation Manual.

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c. The "Accumulation Reserving Category" are includes all annuities within scope of VM-22 that are not in the "Payout Reserving Category" or "Longevity Reinsurance Reserving Category".

Commented [A124]: ACLI: Is this referring to section II of VM-22, or is it referring to VM Section II, Subsection 2 "Annuity Products," Paragraph D? The wording should be made clearer.

Commented [VM22125R124]: Edits added to address

2. For the purposes of calculating stochastic reserves, the stochastic exclusion test, and determining the final VM-22 reserves, do not aggregate groups of contracts for which the company elects to use the Deterministic Certification Option in Section 7.E with any groups of contracts that do not use such option.

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Commented [A126]: ACLI: Rephrase

Commented [VM22127R126]: Edits added to address

3. To the extent that aggregation results in more than one model segment, the aggregate reserve shall equal the sum of the SR amounts computed for each model segment and DR amounts computed for each model segment for which the company elects to use the Deterministic Certification Option in Section 7.E.

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Commented [CC128]: Defined as "SR" in Section 7.E

Commented [VM22129R128]: DR added for clarification in 7.E

G. Stochastic Exclusion Test

- To the extent that certain groups of contracts pass the stochastic exclusion test in Section 7.B, these groups of contracts may be valued using the methodology and statutory maximum valuation rate pursuant to applicable requirements in VM-A, VM-C, and VM-V.
- For dividend-paying contracts that pass the Stochastic Exclusion Test, a dividend liability shall be established following requirements in VM-A and VM-C, as described above, for the base contract.
- The company may not group together contract types with significantly different risk profiles when performing the exclusion test.

Commented [A130]: ACLI: Is this statement only applicable if it passes the SET? Propose to add clarity

Commented [VM22131R130]: Edits added to address

Commented [CC132]: s/b "contracts"

Commented [VM22133R132]: Edits added to address

Commented [A134]: ACLI: Consider if additional references than DR are needed (e.g. exclusion test).

Commented [VM22135R134]: This was due to an incorrect reference – the intention is for the only exception is for contracts that pass the exclusion test and use pre-PBR reserves

H. Allocation of the Aggregate Reserve to Contracts

The aggregate reserve shall be allocated to the contracts falling within the scope of these requirements using the method outlined in Section 13, with the exception of contracts valued under VM-A, VM-C, or VM-V following Section 3.G, which are to be calculated on a seriatim basis.

Commented [CC136]: Refers to "SR" contracts using Deterministic Certification Method in Section 7.E?

Commented [VM22137R136]: DR added for clarification in 7.E

Deleted: E

Commented [A138]: Academy: The ARCWG agrees with "at least once every 3 years" as it removes ambiguity around "periodically." The ARCWG also supports that this change be made in conjunction with adoption of a similar APF for VM-20/VM-21.

Commented [A139]: ACLI: Need to clarify "this group"

Commented [VM22140R139]: Edits added to address

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Commented [CC141]: This review is required annually, but the prudent estimate assumptions only need be reviewed periodically, so if the review of the anticipated assumptions shows a need for a change, does the actuary need to change the prudent estimate assumption as well?

Commented [CC142]: s/b "company"

Commented [VM22143R142]: Edits added to address

Deleted: Company

Deleted: CompanyC

Commented [A144]: ACLI: Section 9 is hedging

Commented [VM22145R144]: Edits added to address

Deleted: asset

I. Prudent Estimate Assumptions

- With respect to the SR in Section 3.D, the company shall establish the prudent estimate assumption for each risk factor in compliance with the requirements in Section 12 of Model #820 and must periodically review and update the assumptions as appropriate in accordance with these requirements.

Drafting Note: Consider replacing "periodically" with "at least every 3 years" in the paragraph above upon adoption of a similar APF for VM-20/VM-21.

- The qualified actuary, to whom responsibility for a given group of contracts is assigned, shall annually review relevant emerging experience for the purpose of assessing the appropriateness of the anticipated experience assumption. If the results of the review indicate that previously anticipated experience for a given factor is inadequate, then the company shall set a new, adequate, anticipated experience assumption for the factor.
- To determine the prudent estimate assumptions, the SR shall also follow the requirements in Sections 4 and general assumptions including Section 9 for hedging assumptions, Section 10 for contract holder behavior assumptions, Section 11 for mortality assumptions, and Section 12 for general guidance and expense assumptions.

J. Approximations, Simplifications, and Modeling Efficiency Techniques

A company may use simplifications, approximations, and modeling efficiency techniques to calculate the SR and/or the additional standard projection amount required by this section if the company can demonstrate that the use of such techniques does not understate the reserve by a material amount, and the expected value of the reserve calculated using simplifications, approximations, and modeling efficiency techniques is not less than the expected value of the reserve calculated that does not use them.

Guidance Note:

Examples of modeling efficiency techniques include, but are not limited to:

1. Choosing a reduced set of scenarios from a larger set consistent with prescribed models and parameters.
2. Generating a smaller liability or asset model to represent the full seriatim model using grouping compression techniques or other similar simplifications.

There are multiple ways of providing the demonstration required by Section 3.11. The complexity of the demonstration depends upon the simplifications, approximations or modeling efficiency techniques used. Examples include, but are not limited to:

1. Rounding at a transactional level in a direction that is clearly and consistently conservative or is clearly and consistently unbiased with an obviously immaterial impact on the result (e.g., rounding to the nearest dollar) would satisfy 3.11 without needing a demonstration. However, rounding to too few significant digits relative to the quantity being rounded, even in an unbiased way, may be material and in that event, the company may need to provide a demonstration that the rounding would not produce a material understatement of the reserve.
2. A brute force demonstration involves calculating the minimum reserve both with and without the simplification, approximation or modeling efficiency technique, and making a direct comparison between the resulting reserve. Regardless of the specific simplification, approximation or modeling efficiency technique used, brute force demonstrations always satisfy the requirements of Section 3.11.
3. Choosing a reduced set of scenarios from a larger set consistent with prescribed models and parameters and providing a detailed demonstration of why it did not understate the reserve by a material amount and the expected value of the reserve would not be less than the expected value of the reserve that would otherwise be calculated. This demonstration may be a theoretical, statistical or mathematical argument establishing, to the satisfaction of the insurance commissioner, general bounds on the potential deviation in the reserve estimate rather than a brute force demonstration.

Drafting Note: Add back in the WDCM method example in the above guidance note if VM-22 uses this method for the SPA calculation.

Commented [A146]: ACLI: incorrect reference?
 Commented [VM22147R146]: Edits added to address
 Commented [CC148]: s/b Section 3.J
 Commented [VM22149R148]: Edits added to address
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 Commented [CC150]: s/b Section 3.J
 Commented [VM22151R150]: Edits added to address
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Commented [CC152]: s/b Section 3.J
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Section 4: Determination of SR

A. Projection of Accumulated Deficiencies

1. General Description of Projection

The projection of accumulated deficiencies shall be made ignoring federal income tax in both cash flows and discount rates, and it shall reflect the dynamics of the expected cash flows for the entire group of contracts, reflecting all product features, including any guarantees provided under the contracts using prudent estimate liability assumptions defined in Sections 10, 11, and 12 and asset assumptions defined in Sections 4 and 9. The company shall project cash flows including the following:

- a. Gross premium received by the company from the contract holder or the ceding company in the case of reinsurance (including any due premiums as of the projected start date). For purposes of Longevity Reinsurance, net premium shall be used in the projection and defined as the gross premium multiplied by a “K-factor,” where the K-factor is determined as:
 - i. The present value of the expected future benefits and expenses at contract inception or reinsurance effective date in the case of reinsurance using the prudent estimate assumptions determined at contract inception and an interest rate equal to the prescribed interest rate under VM-A and VM-C, divided by item ii immediately below.
 - ii. The present value of the expected future gross premiums at contract inception or reinsurance effective date in the case of reinsurance using the prudent estimate assumptions determined at contract inception or reinsurance effective date and an interest rate equal to the prescribed interest rate under VM-A and VM-C.
 - iii. The resulting amount is capped at 1, in other words the application of the K-factor shall not result in the net premium exceeding the gross premium.
- b. Other revenues, including contractual fees and charges, and revenue-sharing income received by the company (net of applicable expenses). For purposes of Longevity Reinsurance, it is not expected that any such other revenues will apply. To the extent there are other revenues, they should be included with item ii under a. immediately above so that the calculation of the K-factor includes all expected future revenues from the contract holder.
- c. All material benefits projected to be paid to contract holders—including, but not limited to, death claims, surrender benefits and withdrawal benefits—reflecting the impact of all guarantees and adjusted to take into account amounts projected to be charged to account values on general account business. Any guarantees, in addition

Guidance Note: If due premiums are modeled, the final reported reserve needs to be adjusted by adding the due premium asset.

Commented [A154]: ACLI: Consistent with our comments in our August 19, 2022, letter, we do not support the use of a k-factor to modify the premiums used in the longevity reinsurance reserve calculation because the premiums for these policies are not assumptions that vary. We believe an alternative, principle-based solution with prudent margins could better address regulators’ concerns and wish to work with regulators to craft a better solution. If the k-factor approach is retained, the calculation methodology should be as principle-based as possible (e.g., reflect emerging experience and how blocks of business are managed and aggregated consistent with company practices).

Commented [CC155]: should include Section 12

Commented [VM22156R155]: Edits added to address

Deleted: 11

Commented [A157]: ACLI: Premiums are usually pre-determined. It is not clear how this paragraph is applicable.

Commented [A158]: ACLI: References to “contract holder” and “contract inception” seem to imply directly written business. Suggest replacing “contract holder” with “contract holder or the ceding company in the case of reinsurance” and replacing “contract inception” with “contract inception or reinsurance effective date in the case of reinsurance.”

Commented [VM22159R158]: Edits added to address

to market value adjustments assessed on projected withdrawals or surrenders, shall be taken into account.

- d. Non-Guaranteed Elements (NGE) cash flows as described in Section 10.I.
- e. Insurance company expenses (including overhead and maintenance expense), commissions and other acquisition expenses associated with business inforce as of the valuation date,.
- f. Cash flows associated with any reinsurance, to the extent not already covered above (for example, for longevity reinsurance).
- g. Cash flows from hedging instruments as described in Section 4 and Section 9.
- h. Cash receipts or disbursements associated with invested assets (other than policy loans) as described in Section 4.D.4, including investment income, realized capital gains and losses, principal repayments, asset default costs, investment expenses, asset prepayments, and asset sales.
- i. If modeled explicitly, cash flows related to policy loans as described in Section 10.H.2, including interest income, new loan payments and principal repayments.

Commented [A160]: ACLI: it feels like this should be its own subsection (c.)

Commented [VM22161R160]: Edits added to address

Commented [A162]: ACLI: Hedges are addressed in Section 4 and Section 9. Is this reference sufficient?

Commented [VM22163R162]: Edits added to address

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Guidance Note: Future net policy loan cash flows include: policy loan interest paid in cash plus repayments of policy loan principal, including repayments occurring at death or surrender (note that the future benefits in Section 4.A.1.c are before consideration of policy loans), less additional policy loan principal (but excluding policy loan interest that is added to the policy loan principal balance).

Commented [CC164]: s/b 10.H.2

Commented [VM22165R164]: Edits added to address

Commented [A166]: ACLI: Wrong reference – 10.H.2

Commented [VM22167R166]: Edits added to address

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Commented [A168]: ACLI: If we make the 2nd paragraph of 4.A.1.b a separate reference this needs to be updated.

Commented [VM22169R168]: Added edits to address

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2. Grouping of Index Crediting Strategies

Index crediting strategies for non-variable annuities may be grouped for modeling using an approach that recognizes the objectives of each index crediting strategy. In assigning each index crediting strategy to a grouping for projection purposes, the fundamental characteristics of the index crediting strategy shall be reflected, and the parameters shall have the appropriate relationship to the stochastically generated projection scenarios described in Section 8. The grouping shall reflect characteristics of the efficient frontier (i.e., returns generally cannot be increased without assuming additional risk).

Index accounts sharing similar index crediting strategies may also be grouped for modeling to an appropriately crafted proxy strategy normally expressed as a linear combination of recognized market indices, sub-indices or funds, in order to develop the investment return paths and associated interest crediting. Each index crediting strategy's specific risk characteristics, associated index parameters, and relationship to the stochastically generated scenarios in Section 8 should be considered before grouping or assigning to a proxy strategy. Grouping and/or development of a proxy strategy may not be done in a manner that intentionally understates the resulting reserve.

3. Model Cells

Projections may be performed for each contract in force on the date of valuation or by assigning contracts into representative cells of model plans using all characteristics and

criteria having a material impact on the size of the reserve. Assigning contracts to model cells may not be done in a manner that intentionally understates the resulting reserve.

4. **Modeling of Hedges**

a. For a company that does not have a future hedging strategy supporting the contracts:

- i. The company shall not consider the cash flows from any future hedge purchases or any rebalancing of existing hedge assets in its modeling, since they are not included in the company's investment strategy supporting the contracts.
- ii. Existing hedging instruments that are currently held by the company in support of the contracts falling under the scope of these requirements shall be included in the starting assets.

b. For a company that has one or more future hedging strategies supporting the contracts:

i. For a hedging program with hedge payoffs that offset interest credits associated with indexed interest strategies (indexed interest credits):

- a) In modeling cash flows, the company shall include the cash flows from future hedge purchases or any rebalancing of existing hedge assets that are intended solely to offset interest credits to contract holders.
- b) Existing hedging instruments that are currently held by the company for offsetting the indexed credits in support of the contracts falling under the scope of these requirements shall be included in the starting assets.
- c) An Index Credit Hedge Margin for these hedge instruments shall be reflected by reducing index interest credit hedge payoffs by a margin multiple that shall be justified by sufficient and credible company experience and be no less than [X%] multiplicatively of the interest credited. This margin is intended to cover sources of potential error due the hedging itself and the ability for the company to accurately model it. In the absence of sufficient and credible company experience, a margin of [Y%] shall be assumed. There is no cap on the index credit hedge margin if company experience indicates actual error is greater than [Y%].

ii. For a company with any future hedging strategies that hedge any contractual obligation or risks other than indexed interest credits, the detailed requirements for the modeling of hedges are defined in Section 9. The following requirements do not supersede the detailed requirements.

Commented [A170]: ACLI: Hedge Modelling, whether index crediting or non-index crediting, should all be consolidated into one section in VM-22. This will help regulators and practitioners.

Commented [VM22171R170]: As discussed in prior VM-22 Subgroup call in response to this comment, the Subgroup is open to any proposals to accomplish this.

Deleted: Existing hedging instruments that are currently held by the company not for offsetting the indexed credits should be modeled consistently with the requirements of Section 4.A.4.a.ii....

Commented [A174]: Academy: The ARCWG proposes that X and Y be determined subsequent to the VM-22 field test. Modeling will help identify the appropriate level for the Index Credit Hedge Margin.

Commented [A175]: ACLI: For Factor determination, will there be documentation on how the X and Y are determined and reevaluated over time?

Commented [CC176]: the X's and Y's need to be filled in.

Commented [VM22177R176]: To fill in based on results of future field test

Commented [A178]: ACLI: All hedging should be in one section.

Commented [VM22179R178]: Comment discussed during prior VM-22 Subgroup call, during which the Subgroup expressed openness to this concept if a proposal is presented to them by the ACLI.

- a) The appropriate costs and benefits of hedging instruments that are currently held by the company in support of the contracts falling under the scope of these requirements shall be included in the projections used in the determination of the SR.
- b) The projections shall take into account the appropriate costs and benefits of hedge positions expected to be held in the future. Because models do not always accurately portray the results of hedge programs, the company shall, through back-testing and other means, assess the accuracy of the hedge modeling. The company shall determine a SR as the weighted average of two CTE values; first, a CTE70 (“best efforts”) representing the company’s projection of all of the hedge cash flows, including future hedge purchases, and a second CTE70 (“adjusted”) which shall use only hedge assets held by the company on the valuation date and only future hedge purchases associated with indexed interest credited. These are discussed in greater detail in Section 9. The SR shall be the weighted average of the two CTE70 values, where the weights reflect the error factor (I) determined following the guidance of Section 9.C.4.
- c) Consistent with Section 4.A.4.b.i, if the company has an indexed credit hedging program, the index credit hedge margin for instruments associated with indexed interest credited shall be reflected by reducing hedge payoffs by a margin multiple as defined in Section 4.A.4.b.i.c in both the “best efforts” run and the “adjusted” run.
- d) The use of products not falling under the scope of VM-22 (e.g., variable annuities) as a hedge shall not be recognized in the determination of accumulated deficiencies.

Commented [CC182]: there is a stray “l” here. Also, in the 2023 version of VM-21, it shows an “l” instead of an “E”

Commented [VM22183R182]: Edits added to address

Deleted: E

Deleted: I

Commented [A184]: ACLI: Consider refining this to reference VM-22 Section 2 Scope

Commented [VM22185R184]: Edits added to address

Deleted: Section 1 through 13 requirements

Guidance Note: Section 4.A.4.b.i is intended to address common situations for products with index crediting strategies where the company only hedges index credits or clearly separates index credit hedging from other hedging. In this case, the hedge positions are considered similarly to other fixed income assets supporting the contracts, and a margin is reflected rather than modeling using a CTE70 adjusted run with no future hedge purchases. If a company has a more comprehensive hedge strategy combining index credits, guaranteed benefit, and other risks (e.g., full fair value or economic hedging), an appropriate and documented bifurcation method should be used in the application of Sections 4.A.4.b.i and 4.A.4.b.ii above for the hedge modeling and justification. Such bifurcation methods may quantify the specific risk exposure attributable to index credit liabilities versus other liabilities such as guaranteed living benefits, and apply such for the basis for allocation.

Commented [CC186]: s/b capitalized

Commented [VM22187R186]: Edits added to address

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Deleted: sectionss

Guidance Note: The requirements of Section 4.A.4 govern the determination of reserves for annuity contracts and do not supersede any statutes, laws or regulations of any state or jurisdiction related to the

use of derivative instruments for hedging purposes and should not be used in determining whether a company is permitted to use such instruments in any state or jurisdiction.

5. Revenue Sharing

If applicable, projections of accumulated deficiencies may include income from projected future revenue sharing, net of applicable projected expenses (net revenue-sharing income) by following the requirements set forth in VM-21 Sections 4.A.5.a through 4.a.5.f.

6. Length of Projections

Projections of accumulated deficiencies shall be run for as many future years as needed so that no material obligations amount of business remain at the end of the projection periods.

7. Interest Maintenance Reserve (IMR)

The IMR shall be handled consistently with the treatment in the company’s cash flow testing, and the amounts should be adjusted to a pre-tax basis.

Commented [A188]: ACLI: Prefer to spell out the requirements to avoid companies needing to review multiple VM chapters.

Commented [VM22189R188]: Consistent with references to VM-20 for spread assumptions. Not copying same text makes it easier to maintain consistency in VM language.

Commented [A190]: Academy: This change is consistent with VM-31 Section 3.D.2.f.

Commented [A191]: ACLI: VM-21 has “no materially greater reserve value would result from longer projection periods” This language should be consistent with VM-21

B. Determination of Scenario Reserve

1. For a given scenario, the scenario reserve shall be determined using one of two methods described below:

a) The starting asset amount plus the greatest present value, as of the projection start date, of the projected accumulated deficiencies; or

Guidance Note: The greatest present value of accumulated deficiencies can be negative.

b) The direct iteration method, where the scenario reserve is determined by solving for the amount of starting assets which, when projected along with all contract cash flows, result in the defeasement of all projected future benefits and expenses at the end of the projection horizon with no positive accumulated deficiencies at the end of any projection year during the projection period.

The scenario reserve for any given scenario shall not be less than the cash surrender value in aggregate on the valuation date for the group of contracts modeled in the projection. In the case where more than [x%] of assets supporting the liability, excluding derivatives used solely to support index credits, are held at market value, the market value adjustment shall also be applied to the cash surrender value.

Commented [A192]: Academy: Assets backing the reserves may be a combination of assets held at market and at book. X represents an immaterial amount of assets held at market such that a higher percentage requires the market value adjustment to the cash surrender value on the valuation date and amounts below X do not require such adjustment.

2. Discount Rates

In determining the scenario reserve, unless using the direct iteration method pursuant to Section 4.B.1.b, the accumulated deficiencies shall be discounted at the NAER on additional assets, as defined in Section 4.B.3.

3. Determination of NAER on Additional Invested Asset Portfolio

- a. The additional invested asset portfolio for a scenario is a portfolio of general account assets as of the valuation date, outside of the starting asset portfolio, that is required in that projection scenario so that the projection would not have a positive accumulated deficiency at the end of any projection year. This portfolio may include only (i) General Account assets available to the company on the valuation date that do not constitute part of the starting asset portfolio; and (ii) cash assets.

Guidance Note:

Additional invested assets should be selected in a manner such that if the starting asset portfolio were revised to include the additional invested assets, the projection would not be expected to experience any positive accumulated deficiencies at the end of any projection year.

It is assumed that the accumulated deficiencies for this scenario projection are known.

- b. To determine the NAER on additional invested assets for a given scenario:
- i. Project the additional invested asset portfolio as of the valuation date to the end of the projection period,
 - a) Investing any cash in the portfolio and reinvesting all investment proceeds using the company's investment policy.
 - b) Excluding any liability cash flows.
 - c) Incorporating the appropriate returns, defaults and investment expenses for the given scenario.
 - ii. If the value of the projected additional invested asset portfolio does not equal or exceed the accumulated deficiencies at the end of each projection year for the scenario, increase the size of the initial additional invested asset portfolio as of the valuation date, and repeat the preceding step.
 - iii. Determine a vector of annual earned rates that replicates the growth in the additional invested asset portfolio from the valuation date to the end of the projection period for the scenario. This vector will be the NAER for the given scenario.
 - iv. If the projection results contain any extremely negative or positive NAER due to the depletion of assets in the denominator, the NAER shall be reset to a more appropriate discount rate, which may be carried out by imposing upper/lower limits or by using another approach, subject to actuarial judgement, that is appropriately prudent for statutory valuation.

Guidance Note: There are multiple ways to select the additional invested asset portfolio at the valuation date. Similarly, there are multiple ways to determine the earned rate vector. The company shall be consistent in its choice of methods, from one valuation to the next.

C. Projection Scenarios

1. Number of Scenarios

The number of scenarios for which the scenario reserve shall be computed shall be the responsibility of the company, and it shall be considered to be sufficient if any resulting understatement in the SR, as compared with that resulting from running additional scenarios, is not material.

2. Economic Scenario Generation

Treasury Department interest rate curves, as well as investment return paths for index funds, equities, and fixed income assets shall be determined on a stochastic basis using the methodology described in Section 8. If the company uses a proprietary generator to develop scenarios, the company shall demonstrate that the resulting scenarios meet the requirements described in Section 8.

D. Projection of Assets

1. Starting Asset Amount

a. For the projections of accumulated deficiencies, the value of assets at the start of the projection shall be set equal to the approximate value of statutory reserves at the start of the projection plus the allocated amount of PIMR attributable to the assets selected. Assets shall be valued consistently with their annual statement values. The amount of such asset values shall equal the sum of the following items, all as of the start of the projection:

- i. Any hedge instruments held in support of the contracts being valued; and
- ii. An amount of assets held in the general account equal to the approximate value of statutory reserves as of the start of the projections less the amount in (i).

b. If the amount of initial general account assets is negative, the model should reflect a projected interest expense. General account assets chosen for use as described above shall be selected on a consistent basis from one reserve valuation hereunder to the next.

2. Valuation of Projected Assets

For purposes of determining the projected accumulated deficiencies, the value of projected assets shall be determined in a manner consistent with their value at the start of the projection. For assets assumed to be purchased during a projection, the value shall be determined in a manner consistent with the value of assets at the start of the projection that have similar investment characteristics. However, for derivative instruments that are used in hedging and are not assumed to be sold during a particular projection interval, the

company may account for them at an amortized cost in an appropriate manner elected by the company.

Guidance Note: Accounting for hedge assets should recognize any methodology prescribed by a company's state of domicile.

3. General Account Assets

- a. General account assets shall be projected, net of projected defaults, using assumed investment returns consistent with their book value and expected to be realized in future periods as of the date of valuation. Initial assets that mature during the projection and positive cash flows projected for future periods shall be invested in a manner that is representative of and consistent with the company's investment policy, subject to the following requirements:
 - i. The final maturities and cash flow structures of assets purchased in the model, such as the patterns of gross investment income and principal repayments or a fixed or floating rate interest basis, shall be determined by the company as part of the model representation;
 - ii. The combination of price and structure for fixed income investments and derivative instruments associated with fixed income investments shall appropriately reflect the projected Treasury Department curve along the relevant scenario and the requirements for gross asset spread assumptions stated below;
 - iii. For purchases of public non-callable corporate bonds, follow the requirements defined in VM-20 Sections 7.E, 7.F and 9.F. The prescribed spreads reflect current market conditions as of the model start date and grade to long-term conditions based on historical data at the start of projection year four;
 - iv. For transactions of derivative instruments associated with fixed income investments, reflect the prescribed assumptions in VM-20 Section 9.F for interest rate swap spreads;
 - v. For purchases of other fixed income investments, if included in modeled company investment strategy, set assumed gross asset spreads over U.S. Treasuries in a manner that is consistent with, and results in reasonable relationships to, the prescribed spreads for public non-callable corporate bonds and interest rate swaps.
- b. Notwithstanding the above requirements, the aggregate reserve shall be the higher of that produced by the modeled company investment strategy and that produced by substituting an alternative investment strategy in which the fixed income reinvestment assets have the same weighted average life (WAL) as the reinvestment assets in the modeled company investment strategy and are all public non-callable corporate bonds with gross asset spreads, asset default costs, and investment expenses by projection year that are consistent with a credit quality blend of:

- i. ~~5% Treasury~~
15
- ii. 20% PBR credit rating 3 (Aa2/AA)
- iii. 80% PBR credit rating 6 (A2/A)

c. Any disinvestment shall be modeled in a manner that is consistent with the company’s investment policy and that reflects the company’s cost of borrowing where applicable, provided that the assumed cost of borrowing is not lower than the rate at which positive cash flows are reinvested in the same time period, taking into account duration, ratings, and other attributes of the borrowing mechanism. Gross asset spreads used in computing market values of assets sold in the model shall be consistent with, but not necessarily the same as, the gross asset spreads in Section 4.D.3.a.iii and Section 4.D.3.a.v, recognizing that initial assets that mature during the projection may have different characteristics than modeled reinvestment assets.

Guidance Note: This limitation is being referred to Life Actuarial (A) Task Force for review. The simple language above “provided that the assumed cost of borrowing is not lower than the rate at which positive cash flows are reinvested in the same time period” is not intended to impose a literal requirement. It is intended to reflect a general concept to prevent excessively optimistic borrowing assumptions. It is recognized that borrowing parameters and rules can be complicated, such that modeling limitations may not allow for literal compliance, in every time step, as long as the reserve is not materially affected. However, if the company is unable to fully apply this restriction, prudence dictates that a company shall not allow borrowing assumptions to materially reduce the reserve.

- Commented [A193]: ACLI: Incorrect reference
- Commented [VM22194R193]: Edits added to address
- Commented [A195]: ACLI: Incorrect reference
- Commented [VM22196R195]: Edits added to address
- Commented [CC197]: s/b Section 4.D.3.a.iii and 4.D.3.a.v
- Commented [VM22198R197]: Edits added to address
- Deleted: 4
- Deleted: 4

4. Cash Flows from Invested Assets

- a. Cash flows from general account fixed income assets, including starting and reinvestment assets, shall be reflected in the projection as follows:
 - i. Model gross investment income and principal repayments in accordance with the contractual provisions of each asset and in a manner consistent with each scenario.
 - ii. Reflect asset default costs as prescribed in VM-20 Section 9.F and anticipated investment expenses through deductions to the gross investment income.
 - iii. Model the proceeds arising from modeled asset sales and determine the portion representing any realized capital gains and losses.
 - iv. Reflect any uncertainty in the timing and amounts of asset cash flows related to the paths of interest rates, equity returns or other economic values directly in the projection of asset cash flows. Asset defaults are not

subject to this requirement, since asset default assumptions must be determined by the prescribed method as noted in Section 4.a.ii above.

Commented [CC199]: Add "Section" in front of "4.a.ii above"

Commented [VM22200R199]: Edits added to address

- b. Cash flows from index funds and general account equity assets—i.e., non-fixed income assets having substantial volatility of returns, such as common stocks and real estate— including starting and reinvestment assets, shall be reflected in the projection as follows:
 - i. Determine the grouping for asset categories and the allocation of specific assets to each category in a manner that is consistent with that used for index crediting strategies, as discussed in Section 4.A.2.
 - ii. Project the gross investment return including realized and unrealized capital gains in a manner that is consistent with the stochastically generated scenarios.
 - iii. Model the timing of an asset sale in a manner that is consistent with the investment policy of the company for that type of asset. Reflect expenses through a deduction to the gross investment return using prudent estimate assumptions.
- c. Cash flows for each projection interval for policy loan assets shall follow the requirements in Section 10.H.

E. Projection of Annuitization Benefits

1. Assumed Annuitization Purchase Rates
 - a. For payouts specified at issue (such as single premium immediate annuities, deferred income annuities, and certain structured settlements), such purchase rates shall reflect the payout rate specified in the contract.
 - b. For purposes of projecting future elective annuitization benefits (including annuitizations stemming from the election of a GMIB) and withdrawal amounts from GMWBs, the projected annuitization purchase rates shall be determined assuming that market interest rates available at the time of election are the interest rates used to project general account assets, as determined in Section 4.D. ~~h~~
2. Projected Election of GMIBs, GMWBs and Other Annuitization Options
 - a. For contracts projected to elect future annuitization options (including annuitizations stemming from the election of a GMIB) or for projections of GMWB benefits once the account value has been depleted, the projections shall assume the contract will stay in force, the projected periodic payments are paid, and the associated maintenance expenses are incurred.

Commented [CC201]: s/b Section 4.D.3

Commented [VM22202R201]: Edits added to address

Commented [A203]: ACLI: Incorrect reference?

Commented [VM22204R203]: Edits added to address

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F. Frequency of Projection

1. Use of an annual cash-flow frequency ("timestep") is generally acceptable for benefits/features that are not sensitive to projection frequency. The lack of sensitivity to projection frequency should be validated by testing wherein the company should determine

that the use of a more frequent—i.e., shorter—time step does not materially increase reserves. A more frequent time increment should always be used when the product features are sensitive to projection period frequency.

G. Compliance with ASOPs

When determining a SR, the analysis shall conform to the ASOPs as promulgated from time to time by the ASB.

Under these requirements, an actuary will make various determinations, verifications and certifications. The company shall provide the actuary with the necessary information sufficient to permit the actuary to fulfill the responsibilities set forth in these requirements and responsibilities arising from each applicable ASOP.

Deleted: Care must be taken in simulating fee income and expenses when using an annual time step. For example, recognizing fee income

Deleted: at the end of each period after market movements, but prior to persistency decrements, would normally be an inappropriate assumption. It is also important that the frequency of the investment return model be linked appropriately to the projection horizon in the liability model. ¶

Section 5: Reinsurance

A. Treatment of Reinsurance in the Aggregate Reserve

1. Aggregate Reserve Pre- and Post-Reinsurance Ceded

As noted in Section 3.B, the aggregate reserve is determined both pre-reinsurance ceded and post-reinsurance ceded. Therefore, it is necessary to determine the components needed to determine the aggregate reserve—i.e., the additional standard projection amount, the SR, DR, and/or the reserve amount valued using requirements in VM-A, VM-C, and VM-V, as applicable—on both bases. Sections 5.A.2 and 5.A.3 discuss adjustments to inputs necessary to determine these components on both a post-reinsurance ceded and a pre-reinsurance ceded basis.

- Commented [CC207]: There really is no "DR"
- Commented [VM22208R207]: DR added for clarification in 7.E
- Commented [CC209]: Should add VM-V?
- Commented [VM22210R209]: Edits added to address
- Deleted: C
- Deleted: C
- Commented [CC211]: There really is no "DR"
- Commented [VM22212R211]: DR added for clarification in 7.E
- Commented [CC213]: There really is no "DR"
- Commented [VM22214R213]: DR added for clarification in 7.E

2. Reflection of Reinsurance Cash Flows in the DR or SR

- a. In order to determine the aggregate reserve post-reinsurance ceded, accumulated deficiencies, scenario reserves, and the resulting SR and DR shall be determined reflecting the effects of reinsurance treaties that meet the statutory requirements that would allow the treaty to be accounted for as reinsurance within statutory accounting. This involves including, where appropriate, all projected reinsurance premiums or other costs and all reinsurance recoveries, where the reinsurance cash flows reflect all the provisions in the reinsurance agreement, using prudent estimate assumptions.
 - i. In this section, reinsurance includes retrocession, and assuming company includes retrocessionaire.
 - ii. All significant terms and provisions within reinsurance treaties shall be reflected. In addition, it shall be assumed that each party is knowledgeable about the treaty provisions and will exercise them to their advantage.

Guidance Note: Renegotiation of the treaty upon the expiration of an experience refund provision or at any other time shall not be assumed if such would be beneficial to the company and not beneficial to the counterparty. This is applicable to both the ceding party and assuming party within a reinsurance arrangement.

- iii. If the company has knowledge that a counterparty is financially impaired, the company shall establish a margin for the risk of default by the counterparty. In the absence of knowledge that the counterparty is financially impaired, the company is not required to establish a margin for the risk of default by the counterparty.
- iv. A company shall include the cash flows from a reinsurance agreement or amendment in calculating the SR if such qualifies for credit in compliance with Appendix A-791 of the Accounting Practices and Procedures Manual. If a reinsurance agreement or amendment does not qualify for credit for reinsurance but treating the reinsurance agreement or amendment as if it did so qualify would result in a reduction to the company's surplus, then the company shall increase the aggregate reserve by the absolute value of such reductions in surplus.

- Commented [CC215]: Change to "SR" to be consistent with other references
- Commented [VM22216R215]: Edits added to address
- Deleted: stochastic reserve

- b. In order to determine the SR and DR on a pre-reinsurance ceded basis, accumulated deficiencies, scenario reserves, and the resulting SR and DR shall be determined ignoring the effects of reinsurance ceded within the projections. Different approaches may be used to determine the starting assets on the ceded portion of the contracts, dependent upon the characteristics of a given treaty:

- Commented [CC217]: There really is no "DR"
- Commented [VM22218R217]: DR added for clarification in 7.E

- i. For a standard coinsurance treaty, where the assets supporting the ceded liabilities were transferred to the assuming reinsurer, one acceptable approach involves a projection based on using starting assets on the ceded portion of the policies that are similar to those supporting the retained portion of the ceded policies or supporting similar types of policies. Scaling up each asset supporting the retained portion of the contract is also an acceptable method.

Guidance Note: For standard pro rata insurance treaties that do not include experience refunds, where allocated expenses are similar to the renewal expense allowance, a possible approach may be multiplying the quota share by the present value of future reinsurance cash flows pertaining to the reinsured block of business.

- ii. Alternatively, a treaty may contain an identifiable portfolio of assets associated with the ceded liabilities. This could be the case for several forms of reinsurance: funds withheld coinsurance; modified coinsurance; coinsurance with a trust. To the extent these assets would be available to the cedant, an acceptable approach could involve modeling this portfolio of assets. To the extent that these assets were insufficient to defease the ceded liabilities, the modeling would partially default to the approach discussed for a standard coinsurance treaty. To the extent these assets exceeded what might be needed to defease the ceded liabilities (perhaps an over collateralization requirement in a trust), the inclusion of such assets shall be limited.

Guidance Note: Section 3.5.2 in ASOP No. 52, *Principle-Based Reserves for Life Products under the NAIC Valuation Manual*, provides possible methods for constructing a hypothetical pre-reinsurance asset portfolio, if necessary, for purposes of the pre-reinsurance reserve calculation.

- c. An assuming company shall use assumptions to project cash flows to and from ceding companies that reflect the assuming company’s experience for the business segment to which the reinsured policies belong and reflect the terms of the reinsurance agreement.
- d. The company shall assume that the counterparties to a reinsurance agreement are knowledgeable about the contingencies involved in the agreement and likely to exercise the terms of the agreement to their respective advantage, taking into account the context of the agreement in the entire economic relationship between the parties. In setting assumptions for the NGE in reinsurance cash flows, the company shall include, but not be limited to, the following:
 - i. The usual and customary practices associated with such agreements.
 - ii. Past practices by the parties concerning the changing of terms, in an economic environment similar to that projected.
 - iii. Any limits placed upon either party’s ability to exercise contractual options in the reinsurance agreement.
 - iv. The ability of the direct-writing company to modify the terms of its policies in response to changes in reinsurance terms.
 - v. Actions that might be taken by a party if the counterparty is in financial difficulty.
- e. To the extent that a single deterministic valuation assumption for risk factors associated with certain provisions of reinsurance agreements will not adequately capture the risk, the company shall do one of the following:

- Deleted:** reflecting
- Deleted:** applied to
- Commented [A219]:** ACLI: Consider clarifying this guidance note.
- Commented [VM2220R219]:** Edits added to address
- Deleted:** may be considered as a possible approach to determine the ceded reserves

- i. Stochastically model the risk factors directly in the cash-flow model when calculating the SR.
- ii. Perform a separate stochastic analysis outside the cash-flow model to quantify the impact on reinsurance cash flows to and from the company. The company shall use the results of this analysis to adjust prudent estimate assumptions or to determine an amount to adjust the SR to adequately make provision for the risks of the reinsurance features.

Guidance Note: An example of reinsurance provisions where a single deterministic valuation assumption will not adequately capture the risk is longevity reinsurance.

Commented [A221]: ACLI: Guidance note should be removed or clarified.

3. Reserve Determined Upon Passing the Exclusion Test

If a company passes the stochastic exclusion test and elects to use a methodology pursuant to applicable Sections VM-A, VM-C, and VM-V, as allowed in Section 3.G, it is important to note that the methodology produces reserves on a pre-reinsurance ceded basis. Therefore, the reserve must be adjusted for any reinsurance ceded accordingly.

Commented [CC222]: Should VM-V be included here for maximum statutory valuation rate?

Commented [VM2223R222]: Edits added to address

Commented [CC224]: s/b Section 3.G

Commented [VM2225R224]: Edits added to address

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It should be noted that the pre-reinsurance-ceded and post-reinsurance-ceded reserves may result in different outcomes for the exclusion test. In particular, it is possible that the pre-reinsurance-ceded reserves would pass the relevant exclusion test (and allow the use of VM-A and VM-C) while the post-reinsurance-ceded reserves might not, or vice versa.

Commented [A226]: ACLI: Are there some words missing? Seems to be carried from VM-21 reference to "Alternative Methodology"

4. Additional Standard Projection Amount

Where reinsurance is ceded, the additional standard projection amount shall be calculated as described in Section 6 to reflect the reinsurance costs and reinsurance recoveries under the reinsurance treaties. The additional standard projection amount shall also be calculated pre-reinsurance ceded using the methods described in Section 6 but ignoring the effects of the reinsurance ceded.

Commented [VM2227R226]: Edits added to address – eliminated sentence

Deleted: In addition, reserves valued under applicable Sections in VM-A and VM-C, unadjusted for reinsurance, shall be applied to the contracts falling under the scope of these requirements to determine the aggregate reserve prior to reinsurance.

Section 6: Standard Projection Amount

Section 7: Exclusion Testing

A. Stochastic Exclusion Test Requirement Overview

1. The company may elect to exclude one or more groups of contracts from the SR calculation if the stochastic exclusion test (SET) is satisfied for each of the group of contracts. The company has the option to calculate or not calculate the SET.
 - a. If the company does not elect to calculate the SET for one or more groups of contracts, or the company calculates the SET and fails the test for such groups of contracts, the reserve methodology described in Section 4 shall be used for calculating the aggregate reserve for those groups of contracts.
 - b. If the company elects to calculate the SET for one or more groups of contracts, and passes the test for such groups of contracts, then for each group of contracts that passes the SET, the company shall choose whether or not to use the reserve methodology described in Section 4 for that group of contracts. If the reserve methodology described in Section 4 is not used for one or more groups of contracts, then the company shall use the reserve methodology pursuant to applicable requirements in VM-A, VM-C, and VM-V for those groups of contracts.
 - c. A company may not exclude a group of contracts from the SR requirements if there are one or more future hedging strategies supporting the contracts, with the exception of hedging programs solely supporting index credits as described in Section 9.A.1.
 - d. A company not eligible for the Annuity PBR Exemption described in VM Section II 2.E may nevertheless elect to automatically exclude one or more groups of contracts from the stochastic reserve calculation without passing or performing the SET if all of the following are met for all contracts in the group or groups:
 - i. All of the contracts are either:
 - a) Single Premium Immediate Annuities;
 - b) Term Certain Payout Annuities;
 - c) Fixed payout annuities resulting from the exercise of settlement options or annuitizations of host contracts;
 - d) Supplementary contracts (such as retained asset accounts and settlements at interest);
 - e) Fixed income payment streams attributable to guaranteed living benefits associated with deferred annuity contracts once the underlying funds are exhausted;
 - f) Term Certain Payout Annuities; or
 - g) Structured Settlement Contracts
 - ii. None of the contracts are pension risk transfer annuities (PRT) or are covered under a longevity reinsurance agreement;
 - iii. Future scheduled payout benefit amounts are either level or stay within 5% of the initial payout benefit amount over time;
 - iv. There is either no or an immaterial level of policyholder options permitted within the contracts; and

Commented [CC228]: Should add valuation rate requirements in VM-V?

Commented [VM22229R228]: Edits added to address

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Commented [VM22230]: **ACLI:** This item lists Term Certain Payout Annuities as a possible group able to qualify for the exemption. Should non-life contingent annuities found in Exhibit 7 (Deposit Type Contracts) under the column labeled "Annuities Certain", as well as the column labeled "Supplementary Contracts" be a part of the Payout Annuity Exemption Reserves definition? These are separate from the life-contingent liabilities found in the Analysis of Increase in Reserves, Individual Annuities and Group Annuities pages.

Commented [VM22231]: **ACLI:** This criterion states that neither PRT nor longevity reinsurance agreement is allowed as a category possible for exemption. Certain longevity reinsurance agreements contain only contracts that would meet the remaining criteria (that is, are consistent with other "vanilla" payout annuities); a prohibition on such arrangements seems to violate consistent treatment for similar products. Further, Payout Annuity Exemption Reserves include both longevity and PRT arrangements despite not being eligible for the exclusion; it would be appropriate to remove these from the reserves contributing to the exemption. Otherwise, a company would not be able to exempt business that would otherwise meet the criteria

Commented [VM22232]: Several of our members expressed concern that Section 7.A.1.d.iii and Section 7.A.1.d.iv of the exposure may preclude application to products expected to be in scope (e.g., annuities with a fixed cost of living adjustment, 50% joint and survivor annuities, non-elective changes to contract). Such product cash flows are not impacted by changes in interest rates or current economic conditions, which appears to be the intent of the exclusion. We are suggesting two possible approaches to incorporate these edits [in the ACLI comment letter].

Additionally, we have questions about existing Section 7.A.1.d.iii. Given our proposed edits, is this criterion needed? If retained, how was the 5% developed and how does it compare to the 15% in guideline IX? Perhaps a drafting note could be included to explain the differences.

- v. The company has less than [X] of Payout Annuity Exemption Reserves, and if the company is a member of an NAIC group that includes other life insurance companies, the group has combined Payout Annuity Exemption Reserves of less than [Y] billion.
 - 1. Payout Annuity Exemption Reserves are determined as follows:
 - a) The amount reported in the prior calendar year life/health annual statement, Analysis of Increase in Reserves During the Year-Individual Annuities, Column 6 (“Life Contingent Payout (Immediate and Annuityizations)”), line 15; plus
 - b) The amount reported in the prior calendar year life/health annual statement, Analysis of Increase in Reserves During the Year-Group Annuities, Column 6 (“Life Contingent Payout (Immediate and Annuityizations)”), line 15.
- vi. A company shall file a statement of exemption certifying compliance with conditions (i) through (v) above prior to July 1 of the associated valuation year. The domiciliary commissioner may reject such statement prior to Sept. 1.
- vii. If a group of contracts that satisfies the criteria of 7.A.1.d.i to 7.A.1.d.v above for the current valuation year had been valued using the DR or SR of VM-22 for the prior year-end, the company must continue to value the contracts under the DR or SR requirements of VM-22 unless the domiciliary commissioner grants permission to value the contracts under VM-A, VM-C, and VM-V.

Commented [VM22233]: ACLI: Payout Annuity Exemption Reserves include both longevity and PRT arrangements despite not being eligible for the exclusion; it would be appropriate to remove these from the reserves contributing to the exemption. Otherwise, a company would not be able to exempt business that would otherwise meet the criteria

B. Requirement to Pass the Stochastic Exclusion Tests

Groups of contracts pass the SET if one of the following is met:

1. Stochastic Exclusion Ratio Test (SERT)—Annually within 12 months before the valuation date the company demonstrates that the groups of contracts pass the SERT defined in Section 7.C.
2. Stochastic Exclusion Demonstration Test—In the first year and at least once every three calendar years thereafter, the company provides a demonstration in the PBR Actuarial Report as specified in Section 7.D.
3. SET Certification Method—For groups of contracts that do not have guaranteed living benefits, future hedging strategies, or pension risk transfer business, in the first year and at least every third calendar year thereafter, the company provides a certification by a qualified actuary that the group of contracts is not subject to material interest rate risk, mortality and/or longevity risk, or asset return volatility risk (i.e., the risk on non-fixed-income investments having substantial volatility of returns, such as common stocks and real estate investments).

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Guidance Note: The qualified actuary should develop documentation to support the actuarial certification that presents his or her analysis clearly and in detail sufficient for another actuary to understand the analysis and reasons for the actuary’s conclusion that the group of contracts is not subject to material interest rate risk, mortality and/or longevity risk, or asset return volatility risk. Examples of methods a qualified actuary could use to support the actuarial certification include, but are not limited to:

- a) A demonstration that, for the group of contracts, reserves calculated using requirements under VM-A, VM-C, and VM-V are at least as great as the assets required to support the group of contracts and certificates using the company's cash-flow testing model under each of the 48 scenarios identified in Section 7.C.1 or alternatively each of the New York seven economic scenarios under each of the three mortality adjustment factors identified in Section 7.C.1.
- b) A demonstration that the group of contracts passed the SERT within 36 months prior to the valuation date and the company has not had a material change in its interest rate risk, mortality and/or longevity risk, or asset return volatility risk.
- c) A qualitative risk assessment of the group of contracts that concludes that the group of contracts does not have material interest rate risk, mortality and/or longevity risk, or asset return volatility. Such assessment would include an analysis of product guarantees, the company's non-guaranteed elements (NGEs) policy, assets backing the group of contracts, the company's longevity risk, and the company's investment strategy.

Commented [CC236]: Should add VM-V?

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C. Stochastic Exclusion Ratio Test

1. In order to exclude a group of contracts from the SR requirements under the stochastic exclusion ratio test (SERT), a company shall demonstrate that the ratio of (b-a)/a is less than the lesser of $x\%$ and the percentage change that would trigger the company's materiality standard, where:

- a. a = the adjusted scenario reserve described in Section 7.C.2.a below using the baseline economic scenario ("scenario 9), as described in Appendix 1.E of VM-20, and 100% as the adjustment factor for mortality.
- b. b = the largest adjusted scenario reserve described in Section 7.C.2.a below under any of the 16 economic scenarios described in Appendix 1.E of VM-20 under 95%, 100%, and 105% of anticipated experience mortality excluding margins. Because mortality variability may differ by company, if the magnitude of the company's margin for mortality exceeds 5%, then the company shall use the baseline mortality and the mortality augmented by plus and minus the company's margin for this exercise.

Commented [VM22239R238]: Edits added to address

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Commented [CC240]: Change the order for clarity as follows: "the baseline economic scenario, as described in Appendix 1.E of VM-20, and 100% as the adjustment factor for mortality."

Commented [VM22241R240]: Edits added to address

Deleted: , the baseline economic scenario, as described in Appendix 1.E of VM-20

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Guidance Note: Note that the numerator should be the largest adjusted scenario reserve, minus the adjusted scenario reserve for the baseline economic scenario and 100% as the adjustment factor for mortality. This is not necessarily the same as the biggest difference from the adjusted scenario reserve for the baseline economic scenario and 100% as the adjustment factor for mortality, or the absolute value of the biggest difference from the adjusted scenario reserve for the baseline economic scenario and 100% as the adjustment factor for mortality, both of which could lead to an incorrect test result. There are 47 (=16x3-1) combined economic and mortality scenarios that should be compared for the determination of b.

2. In calculating the ratio in Section 7.C.1 above:

- a. The company shall calculate an adjusted scenario reserve for the group of contracts for ~~each of~~ each of the 16 economic scenarios using the three levels of mortality adjustment factors that is equal to either (i) or (ii) below:
- i. The scenario reserve defined in Section 4, but with the following differences:
 - a) Using anticipated experience assumptions with no margins, with the exception of mortality factors described in Section 7.C.1.b of this section.
 - b) Using the interest rates and equity return assumptions specific to each scenario.
 - c) Using NAER and discount rates defined in Section 4 specific to each scenario to discount the cash flows.
 - d) Shall reflect future mortality improvement in line with anticipated experience assumptions.
 - e) Shall not reflect correlation between longevity and economic risks.
 - ii. The gross premium reserve developed from the cash flows from the company's asset adequacy analysis models, using the experience assumptions of the company's cash-flow analysis, but with the following differences:
 - a) Using the interest rates and equity return assumptions specific to each scenario.
 - b) Using the mortality scalars described in Section 7.C.1.b of this section.
 - c) Using the methodology to determine NAER and discount rates defined in Section 4 specific to each scenario to discount the cash flows, but using the company's cash-flow testing assumptions for default costs and reinvestment earnings.
- b. The company shall use the most current available baseline economic scenario and the 15 other economic scenarios published by the NAIC. The methodology for creating these scenarios can be found in Appendix 1 of VM-20.
- c. The company shall use assumptions within each scenario that are dynamically adjusted as appropriate for consistency with each tested scenario.
- d. The company may not group together contract types with significantly different risk profiles for purposes of calculating this ratio.
- e. If the company has reinsurance arrangements that are pro rata coinsurance and do not materially impact the interest rate risk, longevity risk, or asset return volatility in the contract, then the company may elect to conduct the stochastic exclusion ratio test on only a single basis, either pre-reinsurance-ceded or post-reinsurance-ceded.
3. If the ratio calculated in this section is less than % pre-non-proportional reinsurance, but is greater than % post-non-proportional reinsurance, the group of contracts will still pass the SERT if the company can demonstrate that the sensitivity of the adjusted

scenario reserve to economic scenarios is comparable pre- and post-non-proportional reinsurance.

Guidance Note: Further description of non-proportional reinsurance is provided in Paragraph 16 of SSAP 61R.

- a. An example of an acceptable demonstration:
- i. For convenience in notation • SERT = the ratio $(b-a)/a$ defined in Section 7.C.1 above
 - a) The pre-non-proportional reinsurance results are “gross of non-proportional,” with a subscript “gn,” so denoted $SERT_{gn}$
 - b) The post-non-proportional results are “net of non-proportional,” with subscript “nn,” so denoted $SERT_{nn}$
 - ii. If a block of business being tested is subject to one or more non-proportional reinsurance cessions as well as other forms of reinsurance, such as pro rata coinsurance, take “gross of non-proportional” to mean net of all prorata reinsurance but ignoring the non-proportional contract(s), and “net of non-proportional” to mean net of *all* reinsurance contracts. That is, treat non-proportional reinsurance as the last reinsurance in, and compute certain values below with and without that last component.
 - iii. So, if $SERT_{gn} \leq [x]\%$ but $SERT_{nn} > [x]\%$, then compute the largest percent increase in reserve (LPIR) = $(b-a)/a$, both “gross of non-proportional” and “net of non-proportional.”

$$LPIR_{gn} = (b_{gn} - a_{gn})/a_{gn}$$

$$LPIR_{nn} = (b_{nn} - a_{nn})/a_{nn}$$

Note that the scenario underlying b_{gn} could be different from the scenario underlying b_{nn} .

If $SERT_{gn} \times LPIR_{nn}/LPIR_{gn} < [x]\%$, then the block of contracts passes the SERT.
- b. Another more qualitative approach is to calculate the adjusted scenario reserves for the 48 combined economic and mortality scenarios both gross and net of reinsurance to demonstrate that there is a similar pattern of sensitivity by scenario.
4. The SERT may not be used for a group of contracts if, using the current year’s data, (i) the stochastic exclusion demonstration test defined in Section 7.D had already been attempted using the method of Section 7.D.2.a or Section 7.D.2.b and did not pass; or (ii) the qualified actuary had actively undertaken to perform the certification method in [Section 7.B.3](#) and concluded that such certification could not legitimately be made.

Commented [CC244]: For clarity, identify as Section 7.B.3

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D. Stochastic Exclusion Demonstration Test

1. In order to exclude a group of contracts from the SR requirements using the Stochastic Exclusion Demonstration Test, the company must provide a demonstration in the PBR Actuarial Report in the first year and at least once every three calendar years thereafter that complies with the following:
 - a. The demonstration shall provide a reasonable assurance that if the SR was calculated on a stand-alone basis for the group of contracts subject to the SR exclusion, the resulting stochastic reserve for those groups of contracts would not be higher than the statutory reserve determined pursuant to the applicable requirements in VM-A, VM-C, and VM-V. The demonstration shall take into account whether changing conditions over the current and two subsequent calendar years would be likely to change the conclusion to exclude the group of contracts from the SR requirements.
 - b. If, as of the end of any calendar year, the company determines the statutory reserve determined pursuant to the applicable requirements in VM-A, VM-C, and VM-V for the group of contracts no longer adequately provides for all material risks, the exclusion shall be discontinued, and the company fails the SET for those contracts.
 - c. The demonstration may be based on analysis from a date that precedes the valuation date for the initial year to which it applies if the demonstration includes an explanation of why the use of such a date will not produce a material change in the outcome, as compared to results based on an analysis as of the valuation date.
 - d. The demonstration shall provide an effective evaluation of the residual risk exposure remaining after risk mitigation techniques, such as derivative programs and reinsurance.
2. The company may use one of the following or another method acceptable to the insurance commissioner to demonstrate compliance with Section 7.D.1 above:
 - a. Demonstrate that the statutory reserve calculated in accordance with VM-A, VM-C, and VM-V is greater than the SR calculated on a stand-alone basis.
 - b. Demonstrate that the statutory reserve calculated in accordance with VM-A, VM-C, and VM-V is greater than the scenario reserve that results from each of a sufficient number of adverse deterministic scenarios.
 - c. Demonstrate that the statutory reserve calculated in accordance with VM-A, VM-C, and VM-V is greater than the SR calculated on a stand-alone basis, but using a representative sample of contracts in the SR calculations.
 - d. Demonstrate that any risk characteristics that would otherwise cause the SR calculated on a stand-alone basis to exceed the statutory reserve calculated in accordance with VM-A, VM-C, and VM-V are not present or have been substantially eliminated through actions such as hedging, investment strategy, reinsurance or passing the risk on to the contract holder by contract provision.

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E. Deterministic Certification Option

1. ~~Instead of a SR, the company may determine a Deterministic Reserve (DR) for a group of contracts using a single deterministic economic scenario, subject to the following conditions.~~
 - a. The company certifies that economic conditions do not materially influence anticipated contract holder behavior for the group of contracts and certificates. Examples of contract holder options that are materially influenced by economic conditions include surrender benefits, recurring premium payments, and guaranteed living benefits.
 - b. The company certifies that the group of contracts and certificates is not supported by a reinvestment strategy that contains future hedge purchases.
 - c. The company must perform and disclose results from the stochastic exclusion ratio test following the requirements in Section 7.C, and the company must pass the SERT when considering only the 16 economic scenarios paired with the 100% mortality scenario.
 - d. The company must disclose a description of contracts and associated features in the certification.

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2. ~~The DR for the group of contracts under the Deterministic Certification Option is determined as follows:~~
 - a. Cash flows are projected in compliance with the applicable requirements in Section 4, Section 5, Section 10, and Section 11 of VM-22 over a single economic scenario (scenario 12 found in Appendix 1 of VM-20).
 - b. ~~The DR equals the scenario reserve following the requirements for Section 4.~~

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Section 8: To Be Determined (Scenario Generation for VM-21)

Section 9: Modeling Hedges under a Non-Index Credit Future Hedging Strategy

A. Initial Considerations

1. This section applies to modeling of hedges other than situations where the company only hedges index credits. If the company clearly separates index credit hedging from other hedging, then this section only pertains to the other hedging if the index hedging follows the requirements in Section 4.A.4.b.i.
2. The appropriate costs and benefits of hedging instruments that are currently held by the company in support of the contracts falling under the scope of these requirements shall be included in the calculation of the SR, determined in accordance with Section 3.D and Section 4.D.
3. The company shall take into account the costs and benefits of hedge positions expected to be held by the company in the future along each scenario. Company management is responsible for developing, documenting, executing and evaluating the investment strategy, including the hedging strategy, used to implement the investment policy.
4. For this purpose, the investment assets refer to all the assets, including derivatives supporting covered products and guarantees. This also is referred to as the investment portfolio. The investment strategy is the set of all asset holdings at all points in time in all scenarios. The hedging portfolio, which also is referred to as the hedging assets, is a subset of the investment assets. The hedging strategy is the hedging asset holdings at all points in time in all scenarios. There is no attempt to distinguish what is the hedging portfolio and what is the investment portfolio in this section. Nor is the distinction between investment strategy and hedging strategy formally made here. Where necessary to give effect to the intent of this section, the requirements applicable to the hedging portfolio or the hedging strategy are to apply to the overall investment portfolio and investment strategy.
5. This particularly applies to restrictions on the reasonableness or acceptability of the models that make up the stochastic cash-flow model used to perform the projections, since these restrictions are inherently restrictions on the joint modeling of the hedging and non-hedging portfolio. To give effect to these requirements, they must apply to the overall investment strategy and investment portfolio.

Commented [CC249]: What if the company does not clearly separate the hedging strategies, then what? She we add a sentence such as: "If the company does not clearly separate index credit hedging from other hedging, then this section is applicable for modeling of all hedges".

Commented [A250]: ACLI: Is this meant to read as "this section only pertains"?

Commented [VM22251R250]: Edits added to address

Commented [CC252]: I believe this should say something like "then this section only pertains"

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Commented [CC254]: VM-21 has additional wording at the beginning of sentence: "If the company is following one or more future hedging strategies supporting the contracts, in accordance with an investment policy adopted by the board of directors, or a committee of board members". There is also two additional sentences about what must the investment policy include. Should these be added?

B. Modeling Approaches

1. The analysis of the impact of the hedging strategy on cash flows is typically performed using either one of two types of methods as described below. Although a hedging strategy normally would be expected to reduce risk provisions, the nature of the hedging strategy and the costs to implement the strategy may result in an increase in the amount of the SR otherwise calculated. Particular attention should be given to Section 1.B Principle 5 for the modeling of future hedging strategies.
2. The fundamental characteristic of the first type of method, referred to as the "explicit method," is that hedging positions and their resulting cash flows are included in the stochastic cash-flow model used to determine the scenario reserve, as discussed in Section 3.D, for each scenario.
3. The fundamental characteristic of the second type of method, referred to as the "implicit method," is that the effectiveness of the current hedging strategy on future cash flows is evaluated, in part or in whole, outside of the stochastic cash-flow model. There are multiple

ways that this type of modeling can be implemented. In this case, the reduction to the SR otherwise calculated should be commensurate with the degree of effectiveness of the hedging strategy in reducing accumulated deficiencies otherwise calculated.

4. Regardless of the methodology used by the company, the ultimate effect of the current hedging strategy (including currently held hedge positions) on the SR needs to recognize all risks, associated costs, imperfections in the hedges and hedging mismatch tolerances associated with the hedging strategy. The risks include, but are not limited to: basis, gap, price, parameter estimation and variation in assumptions (mortality, persistency, withdrawal, annuitization, etc.). Costs include, but are not limited to: transaction, margin (opportunity costs associated with margin requirements) and administration. In addition, the reduction to the SR attributable to the hedging strategy may need to be limited due to the uncertainty associated with the company's ability to implement the hedging strategy in a timely and effective manner. The level of operational uncertainty varies indirectly with the amount of time that the new or revised strategy has been in effect.

Guidance Note: No hedging strategy is perfect. A given hedging strategy may eliminate or reduce some but not all risks, transform some risks into others, introduce new risks, or have other imperfections.

5. A safe harbor approach is permitted for reflection of future hedging strategies supporting the contracts for those companies whose modeled hedge assets comprise only linear instruments not sensitive to implied volatility. For companies with option-based hedge strategies, electing this approach would require representing the option-based portion of the strategy as a delta-rho two-Greek hedge program. The normally modeled option portfolio would be replaced with a set of linear instruments that have the same first-order Greeks as the original option portfolio.

C. Calculation of SR (Reported)

1. The company shall calculate CTE70 (best efforts)—the results obtained when the CTE70 is based on incorporating the future hedging strategies supporting the contracts (including both currently held and future hedge positions) into the stochastic cash-flow model on a best efforts basis, including all of the factors and assumptions needed to execute the future hedging strategies supporting the contracts (e.g., stochastic implied volatility). The determination of CTE70 (best efforts) may utilize either explicit or implicit modeling techniques.
2. The company shall calculate a CTE70 (adjusted) by recalculating the CTE70 assuming the company has no future hedging strategies supporting the contracts except those to hedge interest credits, therefore following the requirements of Section 4.A.4.a and 4.A.4.b.i.

However, for a company with a future hedging strategy supporting the contracts, existing hedging instruments that are currently held by the company in support of the contracts falling under the scope of these requirements may be considered in one of two ways for the CTE70 (adjusted):

- a) Include the asset cash flows from any contractual payments and maturity values in the projection model; or
- b) No hedge positions – in which case the hedge positions held on the valuation date are replaced with cash and/or other general account assets in an amount equal to the aggregate market value of these hedge positions.

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Deleted: and hedge assets held by the company on the valuation date

Guidance Note: If the hedge positions held on the valuation date are replaced with cash, then as with any other cash, such amounts may then be invested following the company’s investment strategy.

A company may switch from method a) to method b) at any time, but it may only change from b) to a) with the approval of the domiciliary commissioner.

3. Because most models will include at least some approximations or idealistic assumptions, CTE70 (best efforts) may overstate the impact of the hedging strategy. To compensate for potential overstatement of the impact of the hedging strategy, the value for the SR is given by:

$$SR = CTE70 \text{ (best efforts)} + E \times \max[0, CTE70 \text{ (adjusted)} - CTE70 \text{ (best efforts)}]$$

4. The company shall specify a value for *E* (the “error factor”) in the range from 5% to 100% to reflect the company’s view of the potential error resulting from the level of sophistication of the stochastic cash-flow model and its ability to properly reflect the parameters of the hedging strategy (i.e., the Greeks being covered by the strategy), as well as the associated costs, risks and benefits. The greater the ability of the stochastic model to capture all risks and uncertainties, the lower the value of *E*. The value of *E* may be as low as 5% only if the model used to determine the CTE70 (best efforts) effectively reflects all of the parameters used in the hedging strategy. If certain economic risks are not hedged, yet the model does not generate scenarios that sufficiently capture those risks, *E* must be in the higher end of the range, reflecting the greater likelihood of error. Likewise, simplistic hedge cash-flow models shall assume a higher likelihood of error.
5. The company shall conduct a formal back-test, based on an analysis of the available relevant period of data (but no less than 12 months), to assess how well the model is able to replicate the hedging strategy in a way that supports the determination of the value used for *E*.
6. Such a back-test shall involve one of the following analyses:
 - a. For companies that model hedge cash flows directly (“explicit method”), replace the stochastic scenarios used in calculating the CTE70 (best efforts) with a single scenario that represents the market path that actually manifested over the selected back-testing period and compare the projected hedge asset gains and losses against the actual hedge asset gains and losses – both realized and unrealized – observed over the same time period. For this calculation, the model assumptions may be replaced with parameters that reflect actual experience during the back-testing period. In order to isolate the comparison between the modeled hedge results and actual hedge results for this calculation, the projected liabilities should accurately reflect the actual liabilities throughout the back-testing period; therefore, adjustments that facilitate this accuracy (e.g. reflecting actual experience instead of model assumptions, including new business, etc.) are permissible.

To support the choice of a low value of *E*, the company should ascertain that the projected hedge asset gains and losses are within close range of 100% (e.g., 80–125%) of the actual hedge asset gains and losses. The company may also support the choice of a low value of *E* by achieving a high R-squared (e.g., 0.80 or higher) when using a regression analysis technique.

- b. ~~Companies~~ that model hedge cash flows implicitly by quantifying the cost and benefit of hedging using the fair value of the hedged item (an “implicit method”) or

Commented [A257]: ACLI: Recommend getting rid of "for" and starting the sentence with "Companies that model..."

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“cost of reinsurance method”), **should** calculate the delta, rho and vega coverage ratios in each month over the selected back-testing period in the following manner:

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Commented [VM22260R259]: Edits added to address

- i. Determine the hedge asset gains and losses—both realized and unrealized—incurred over the month attributable to equity, interest rate, and implied volatility movements.
 - ii. Determine the change in the fair value of the hedged item over the month attributable to equity, interest rate, and implied volatility movements. The hedged item should be defined in a manner that reflects the proportion of risks hedged (e.g., if a company elects to hedge 50% of a contract’s market risks, it should quantify the fair value of the hedged item as 50% of the fair value of the contract).
 - iii. Calculate the delta coverage ratio as the ratio between (i) and (ii) attributable to equity movements.
 - iv. Calculate the rho coverage ratio as the ratio between (i) and (ii) attributable to interest rate movements.
 - v. Calculate the vega coverage ratio as the ratio between (i) and (ii) attributable to implied volatility movements.
 - vi. To support the company’s choice of a low value of E, the company should be able to demonstrate that the delta and rho coverage ratios are both within close range of 100 % (e.g., 80–125%) consistently across the back-testing period.
 - vii. In addition, the company should be able to demonstrate that the vega coverage ratio is within close range of 100 % in order to use the prevailing implied volatility levels as of the valuation date in quantifying the fair value of the hedged item for the purpose of calculating CTE70 (best efforts). Otherwise, the company shall quantify the fair value of the hedged item for the purpose of calculating CTE70 (best efforts) in a manner consistent with the realized volatility of the scenarios captured in the CTE (best efforts).
- c. Companies that do not model hedge cash flows explicitly, but that also do not use the implicit method as outlined in Section 9.C.6.b above, shall conduct the formal back-test in a manner that allows the company to clearly illustrate the appropriateness of the selected method for reflecting the cost and benefit of hedging, as well as the value used for E.

7. A company that does not have 12 months of experience to date shall set E to a value that reflects the amount of experience available, and the degree and nature of any change to the hedge program. For a material change in strategy, with less than 12 months of experience and without robust mock testing, E should be 1.0. **For a material change in strategy with less than 3 months of history, E should be 1.0. However, when a material change in hedging strategy with less than 3 months history is the introduction of hedging for a newly introduced product or newly acquired block of business and is supplemented by robust mock testing, E should instead be at least 0.3.** Moreover, with prior approval from the domestic regulator, material changes in hedge strategy with less than 3 months history but with robust mock testing may have error factors less than 1.0, though still subject to the minimum error factor specified in Section 9.C.4 and with an appropriate prudent estimate to account for additional uncertainty in anticipated hedging experience beyond that of a

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Commented [VM22264R263]: Edits added to address

robust hedging program already in existence. E may also be lower than 1.0 if the change in strategy is a minor refinement rather than a material change in strategy, though still subject to the minimum error factor specified in Section 9.C.4 and with an appropriate prudent estimate to account for any additional uncertainty associated with the refinement.

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The following examples are provided as guidance for determining the E factor when there has been a change to the hedge program:

Commented [CC267]: VM-21 also has a sentence following: "These examples are not intended to be exhaustive..." Should this sentence be added?

- The error factor should be temporarily 100% for substantial changes in hedge methodology (e.g., moving from a fair-value based strategy to a stop-loss strategy) without robust mock-testing.
- An increase in the error factor may not always be needed for minor refinements to the hedge strategy (e.g., moving from swaps to Treasury futures).

8. The company shall set the value of E reflecting the extent to which the future hedging program is clearly defined. To support a value of E below 1.0, there should be very robust documentation outlining the future hedging strategies. To the extent that documentation outlining any of the future hedging strategies is incomplete, the value of E shall be increased. In particular, the value of E shall be 1.0 if documentation is materially incomplete for any of the individual CDHS attributes (a) through (j), as listed in VM-01.

Any increases required to the value of E to reflect that documentation is not available to support that the future hedging strategies are clearly defined shall be in addition to increases to the value of E to reflect a lack of historical experience or to reflect the back-testing results, subject to an overall ceiling of 1.0 for E.

Guidance Note: Companies must use judgment both in determining an E factor and in applying this requirement in the case where there are multiple future hedging strategies, particularly where some may be CDHS and some may not be CDHS. In this case, the SR should be ensured to be no less than the CTE(70) reflecting the future hedging strategies that are CDHS and not reflecting those that are not CDHS. Companies with multiple future hedging strategies with very different levels of effectiveness or with multiple future hedging strategies that include both CDHS and non-CDHS should discuss with their domestic regulator.

D. Additional Considerations for CTE70 (best efforts)

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If the company is following one or more future hedging strategies supporting the contracts, the fair value of the portfolio of contracts falling within the scope of these requirements shall be computed and compared to the CTE70 (best efforts) and CTE70 (adjusted). If the CTE70 (best efforts) is below both the fair value and CTE70 (adjusted), the company should be prepared to explain why that result is reasonable.

For the purposes of this analysis, the SR and fair value calculations shall be done without requiring the scenario reserve for any given scenario to be equal to or in excess of the cash surrender value in aggregate for the group of contracts modeled in the projection.

E. Specific Considerations and Requirements

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1. As part of the process of choosing a methodology and assumptions for estimating the future effectiveness of the current hedging strategy (including currently held hedge positions) for

purposes of reducing the SR, the company should review actual historical hedging effectiveness. The company shall evaluate the appropriateness of the assumptions on future trading, transaction costs, other elements of the model, the strategy, the mix of business and other items that are likely to result in materially adverse results. This includes an analysis of model assumptions that, when combined with the reliance on the hedging strategy, are likely to result in adverse results relative to those modeled. The parameters and assumptions shall be adjusted (based on testing contingent on the strategy used and other assumptions) to levels that fully reflect the risk based on historical ranges and foreseeable future ranges of the assumptions and parameters. If this is not possible by parameter adjustment, the model shall be modified to reflect them at either anticipated experience or adverse estimates of the parameters.

2. A discontinuous hedging strategy is a hedging strategy where the relationships between the sensitivities to equity markets and interest rates (commonly referred to as the Greeks) associated with the guaranteed contract holder options embedded in the non-variable annuities and other in-scope products and these same sensitivities associated with the hedging assets are subject to material discontinuities. This includes, but is not limited to, a hedging strategy where material hedging assets will be obtained when the non-variable annuity and other in-scope products account balances reach a predetermined level in relationship to the guarantees. Any hedging strategy can be a discontinuous hedging strategy if implementation of the strategy permits material discontinuities between the sensitivities to equity markets and interest rates associated with the guaranteed contract holder options embedded in the non-variable annuities and other in-scope products and these same sensitivities associated with the hedging assets. There may be scenarios that are particularly costly to discontinuous hedging strategies, especially where those result in large discontinuous changes in sensitivities (Greeks) associated with the hedging assets. Where discontinuous hedging strategies contribute materially to a reduction in the SR, the company must evaluate the interaction of future trigger definitions and the discontinuous hedging strategy, in addition to the items mentioned in the previous paragraph. This includes an analysis of model assumptions that, when combined with the reliance on the discontinuous hedging strategy, may result in adverse results relative to those modeled.
3. A strategy that has a strong dependence on acquiring hedging assets at specific times that depend on specific values of an index or other market indicators may not be implemented as precisely as planned.
4. The combination of elements of the stochastic cash-flow model—including the initial actual market asset prices, prices for trading at future dates, transaction costs and other assumptions—should be analyzed by the company as to whether the stochastic cash-flow model permits hedging strategies that make money in some scenarios without losing a reasonable amount in some other scenarios. This includes, but is not limited to:
 - a. Hedging strategies with no initial investment that never lose money in any scenario and in some scenarios make money.
 - b. Hedging strategies that, with a given amount of initial money, never make less than accumulation at the one-period risk-free rates in any scenario but make more than this in one or more scenarios.
5. If the stochastic cash-flow model allows for such situations, the company should be satisfied that the results do not materially rely directly or indirectly on the use of such strategies. If the results do materially rely directly or indirectly on the use of such strategies, the strategies may not be used to reduce the SR otherwise calculated.

6. In addition to the above, the method used to determine prices of financial instruments for trading in scenarios should be compared to actual initial market prices. In addition to comparisons to initial market prices, there should be testing of the pricing models that are used to determine subsequent prices when scenarios involve trading financial instruments. This testing should consider historical relationships. For example, if a method is used where recent volatility in the scenario is one of the determinants of prices for trading in that scenario, then that model should approximate actual historic prices in similar circumstances in history.
7. The company may also consider historical experience for similar current or past hedging programs on similar products to support the error factor determined for the projection.

Section 10: Guidance and Requirements for Setting Contract Holder Behavior Prudent Estimate Assumptions

A. General

Contract holder behavior assumptions encompass actions such as lapses, withdrawals, transfers, recurring deposits, benefit utilization, option election, etc. Contract holder behavior is difficult to predict accurately, and variance in behavior assumptions can significantly affect the reserves level. In the absence of relevant and fully credible empirical data, the company should set behavior assumptions as guided by Principle 3 in Section 1.B and by Section 12.

In setting behavior assumptions, the company should examine, but not be limited by, the following considerations:

1. Behavior can vary by product, market, distribution channel, index performance, interest credited (current and guaranteed rates), time/product duration, etc.
2. Options embedded in the product may affect behavior.
3. Utilization of options may be elective or non-elective in nature. Living benefits often are elective, and death benefit options are generally non-elective.
4. Elective contract holder options may be more driven by economic conditions than non-elective options.
5. As the value of a product option increases, there is an increased likelihood that contract holders will behave in a manner that maximizes their financial interest (e.g., lower lapses, higher benefit utilization, etc.).
6. Behavior formulas may have both rational and irrational components (irrational behavior is defined as situations where some contract holders may not always act in their best financial interest). The rational component should be dynamic, but the concept of rationality need not be interpreted in strict financial terms and might change over time in response to observed trends in contract holder behavior based on increased or decreased financial efficiency in exercising their contractual options.
7. Options that are ancillary to the primary product features may or may not be significant drivers of behavior. Whether an option is ancillary to the primary product features depends on many considerations, such as:
 - a. The purpose for which the product was purchased.
 - b. Whether the option is elective or non-elective.
 - c. Whether the value of the option is well-known.
8. External influences may affect behavior.

Commented [A276]: ACLI: Think this should say "and by Section 12" in order to make it clear that Principle 3 refers only to section 1.B.

Commented [VM22277R276]: Edits added to address

Commented [A278]: ACLI: "product was purchased"

Commented [VM22279R278]: Edits added to address

Commented [CC280]: s/b "product was purchased"

Commented [VM22281R280]: Edits added to address

Commented [A282]: ACLI: "option is"

Commented [VM22283R282]: Edits added to address

Commented [CC284]: s/b "option is elective"

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B. Aggregate vs. Individual Margins

1. Prudent estimate assumptions are developed by applying a margin for uncertainty to the anticipated experience assumption. The issue of whether the level of the margin applied to the anticipated experience assumption is determined in aggregate or independently for each and every behavior assumption is discussed in Principle 3 in Section 1.B.

2. Although this principle discusses the concept of determining the level of margins in aggregate, it notes that the application of this concept shall be guided by evolving practice and expanding knowledge. From a practical standpoint, it may not always be possible to completely apply this concept to determine the level of margins in aggregate for all behavior assumptions.
3. Therefore, the company shall determine prudent estimate assumptions independently for each behavior (e.g., mortality, lapses and benefit utilization), using the requirements and guidance in this section and throughout these requirements, unless the company can demonstrate that an appropriate method was used to determine the level of margin in aggregate for two or more material behavior assumptions, if relevant to the risks in the product, and thus the approach will not understate the reserve.

C. Sensitivity Testing

The impact of behavior can vary by product, time period, etc. For any assumption that is not prescribed or stochastically modeled, the company shall use sensitivity testing to ensure that the assumption is set at the conservative end of the plausible range. The company shall sensitivity test:

- Surrenders.
- Partial withdrawals.
- Benefit utilization.
- ~~Account transfers.~~
- Future deposits.
- Other behavior assumptions if relevant to the risks in the product.

Commented [A286]: ACLI: Section 10.C and Section 12: Sections should be updated to reflect materiality language consistent with language adopted in APF 2021-11, if applicable. The list of assumptions should be updated to better reflect the material assumptions for fixed annuities; for example, remove account transfers and future deposits.

Commented [A287]: Academy: There appears to be an inconsistency with Section 10.D.2.a. Account transfers are required to be sensitivity tested yet they "might be ignored." The ARCWG suggest either eliminating the sensitivity requirement or changing the language in Section 10.D.2.a.

Sensitivity testing of assumptions is required and shall be more ~~appropriately~~ reflective of the risk of adverse deviations from the baseline assumption. For example, a base lapse assumption plus or minus X% across all contracts ~~may not achieve this objective.~~ A more appropriate sensitivity test in this example might be to devise parameters in a dynamic lapse formula to reflect more out-of-the-money contracts lapsing and/or more holders of in-the-money contracts persisting and eventually using the guarantee. The company should apply more caution in setting assumptions for behaviors where testing suggests that stochastic modeling results are sensitive to small changes in such assumptions. For such sensitive behaviors, the company shall use higher margins when the underlying experience is less than fully relevant and credible.

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Commented [A289]: Academy: The ARCWG proposes changes in this paragraph as complexity is not necessarily the goal of the sensitivity.

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The company shall examine the results of sensitivity testing to understand the materiality of prudent estimate assumptions on the modeled reserve. The company shall update the sensitivity tests periodically as appropriate, considering the materiality of the results of the tests. The company may update the tests less frequently (but no less than every 3 years) when the tests show less sensitivity of the modeled reserve to changes in the assumptions being tested or the experience is not changing rapidly. Providing there is no material impact on the results of the sensitivity testing, the company may perform sensitivity testing:

1. Using samples of the contracts in force rather than performing the entire valuation for each alternative assumption set.

2. Using data from prior periods.

D. Specific Considerations and Requirements

1. Within materiality considerations, the company should consider all relevant forms of contract holder behavior and persistency, including, but not limited to, the following:
 - a. Mortality (additional guidance and requirements regarding mortality is contained in Section 11).
 - b. Surrenders.
 - c. Partial withdrawals (systematic and elective).
 - d. Account transfers (switching/exchanges).
 - e. Resets/ratchets of the guaranteed amounts (automatic and elective).
 - f. Future deposits.
 - g. Income start date for the benefit utilization.
 - h. Commutation of benefit (from periodic payment to lump sum or vice versa.)

2. However, the company should exercise caution in assuming that current behavior will be indefinitely maintained. For example, it might be appropriate to test the impact of a shifting asset mix and/or consider future deposits to the extent they can reasonably be anticipated and increase the calculated amounts.

3. Normally, the underlying model assumptions would differ according to the attributes of the contract being valued. This would typically mean that contract holder behavior and persistency may be expected to vary according to such characteristics as (this is not an exhaustive list):

- a. Gender.
- b. Attained age.
- c. Issue age.
- d. Contract duration.
- e. Time to maturity.
- f. Tax status.
- g. Account value.
- h. Interest credited (current and guaranteed).
- i. Available indices.
- j. Guaranteed benefit amounts.
- k. Surrender charges, transaction fees or other contract charges.

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Deleted: It may be acceptable to ignore certain items that might otherwise be explicitly modeled in an ideal world, particularly if the inclusion of such items reduces the calculated provisions. ¶

For example:¶

- a. The impact of account transfers (intra-contract index “switching”) might be ignored, unless required under the terms of the contract (e.g., automatic re-allocation/rebalancing,) or if the contract provisions incentivize the contract holders to transfer between accounts. ¶
- b. Future deposits might be excluded from the model, unless required by the terms of the contracts under consideration and then only in such cases where future premiums can reasonably be anticipated (e.g., with respect to timing and amount). ¶
- c. For some non-elective benefits (nursing home benefits for example), a zero incidence rate after the surrender charge has ended, or the cash value has depleted, may be acceptable since use of a non-zero rate could reduce the modeled reserve. ¶

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I. Distribution channel.

4. Unless there is clear evidence to the contrary, behavior assumptions should be no less conservative than past experience. Margins for contract holder behavior assumptions shall assume, without relevant and credible experience or clear evidence to the contrary, that contract holders' efficiency will increase over time.

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Commented [A292]: ACLI: Should have a callout here for credibility and/or materiality. Possibly covered by the 'may' in #4 above.

5. In determining contract holder behavior assumptions, the company shall use actual experience data directly applicable to the business segment (i.e., direct data) if it is available. In the absence of direct data, the company should then look to use data from a segment that is similar to the business segment (i.e., other than direct experience), whether or not the segment is directly written by the company. If data from a similar business segment are used, the assumption shall be adjusted to reflect differences between the two segments. Margins shall reflect the data uncertainty associated with using data from a similar but not identical business segment.

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6. Where relevant and fully credible empirical data do not exist for a given contract holder behavior assumption, the company shall set the contract holder behavior assumption to reflect the increased uncertainty such that the contract holder behavior assumption is shifted towards the conservative end of the plausible range of expected experience that serves to increase the SR. If there are no relevant data, the company shall set the contract holder behavior assumption to reflect the increased uncertainty such that the contract holder behavior assumption is at the conservative end of the range. Such adjustments shall be consistent with the definition of prudent estimate, with the principles described in Section 1.B, and with the guidance and requirements in this section.

Commented [A293]: ACLI: Why is "empirical" used here? I think this can be deleted for the sake of clarity.
Commented [VM22294R293]: To keep consistent with VM-21 for now, and since this is not a material item, will retain the same wording
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7. Ideally, contract holder behavior would be modeled dynamically according to the simulated economic environment and/or other conditions. It is important to note, however, that contract holder behavior should neither assume that all contract holders act with 100% efficiency in a financially rational manner nor assume that contract holders will always act irrationally. These extreme assumptions may be used for modeling efficiency if the result is more conservative.

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E. Dynamic Assumptions

1. Consistent with the concept of prudent estimate assumptions described earlier, the liability model should incorporate margins for uncertainty for all risk factors that are not stochastically modeled.
2. The company should exercise care in using static assumptions when it would be more appropriate to use a dynamic model or other scenario-dependent formulation for behavior. With due allowance for appropriate simplifications, approximations and modeling efficiency techniques, the use of dynamic models is encouraged, but not mandatory. Static assumptions that could reasonably be expected to vary according to a stochastic process, or future states of the world (especially in response to economic drivers), may require higher margins and/or signal a need for higher margins for certain other assumptions.
3. Risk factors that are modeled dynamically should encompass the plausible range of behavior consistent with the economic scenarios and other variables in the model, including the non-scenario tested assumptions. The company shall test the sensitivity of results to understand the materiality of making alternate assumptions and follow the guidance discussed above on setting assumptions for sensitive behaviors.

F. Consistency with the CTE Level

1. All behaviors (i.e., dynamic, formulaic and non-scenario tested) should be consistent with the scenarios used in the CTE calculations (generally, the top 30% of the loss distribution). To maintain such consistency, it is not necessary to iterate (i.e., successive runs of the model) in order to determine exactly which scenario results are included in the CTE measure. Rather, in light of the products being valued, the company should be mindful of the general characteristics of those scenarios likely to represent the tail of the loss distribution and consequently use prudent estimate assumptions for behavior that are reasonable and appropriate in such scenarios. For non-variable annuities, these “valuation” scenarios would typically display one or more of the following attributes:
 - a. Declining, increasing and/or volatile index values, where applicable.
 - b. Price gaps and/or liquidity constraints.
 - c. Volatile interest rates or persistently low interest rates.
2. The behavior assumptions should be logical and consistent both individually and in aggregate, especially in the scenarios that govern the results. In other words, the company should not set behavior assumptions in isolation, but give due consideration to other elements of the model. The interdependence of assumptions (particularly those governing customer behaviors) makes this task difficult and by definition requires professional judgment, but it is important that the model risk factors and assumptions:
 - a. Remain logically and internally consistent across the scenarios tested.
 - b. Represent plausible outcomes.
 - c. Lead to appropriate, but not excessive, asset requirements.
4. The company should remember that the continuum of “plausibility” should not be confined or constrained to the outcomes and events exhibited by historic experience.
5. Companies should attempt to track experience for all assumptions that materially affect their risk profiles by collecting and maintaining the data required to conduct credible and meaningful studies of contract holder behavior.

G. Additional Considerations and Requirements for Assumptions Applicable to Guaranteed Living Benefits

Experience for contracts without guaranteed living benefits may be of limited use in setting a lapse assumption for contracts with in-the-money or at-the-money guaranteed living benefits. Such experience may only be used if it is appropriate (e.g., lapse experience on contracts without a living benefit may have relevance to the early durations of contracts with living benefits) and relevant to the business.

H. Policy Loans

If policy loans are applicable for the block of business, the company shall determine cash flows for each projection interval for policy loan assets by modeling existing loan balances either explicitly or by substituting assets that are a proxy for policy loans (e.g., bonds, cash, etc.) subject to the following:

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1. If the company substitutes assets that are a proxy for policy loans, the company must demonstrate that such substitution:
 - a. Produces reserves that are no less than those that would be produced by modeling existing loan balances explicitly.
 - b. Complies with the contract holder behavior requirements stated in Section 10.A to Section 10.G above.
2. If the company models policy loans explicitly, the company shall:
 - a. Treat policy loan activity as an aspect of contract holder behavior and subject to the requirements above in this section.
 - b. Assign loan balances either to exactly match each contract's utilization or to reflect average utilization over a model segment or sub-segments if the results are materially similar.
 - c. Model policy loan interest in a manner consistent with contract provisions and with the scenario. Include interest paid in cash as a positive policy loan cash flow in that projection interval, but do not include interest added to the loan balance as a policy loan cash flow. (The increased balance will require increased repayment cash flows in future projection intervals.)
 - d. Model policy loan principal repayments, including those that occur automatically upon death or surrender. Include policy loan principal repayments as a positive policy loan cash flow, per Section 4.A.1.h.
 - e. Model policy loan principal. Include additional policy loan principal as a negative policy loan cash flow, per Section 4.A.1.h (but do not include interest added to the loan balance as a negative policy loan cash flow).
 - f. Model any investment expenses allocated to policy loans and include them either with negative policy loan cash flows or insurance expense cash flows.

I. Non-Guaranteed Elements

Consistent with the definition in VM-01, Non-Guaranteed Elements (NGEs) are elements within a contract that affect contract costs or values and are not guaranteed or not determined at issue. NGEs consist of elements affecting contract holder costs or values that are both established and subject to change at the discretion of the insurer.

Examples of NGEs specific to non-variable annuities include but are not limited to the following: the credited rates on fixed accounts, index parameters (caps, spreads, participation rates, etc.), rider fees, rider benefit features being subject to change (rollup rates, rollup period, etc.), account value charges, and dividends under participating policies or contracts.

1. Except as noted below in Section 10.I.5, the company shall include NGE in the models to project future cash flows beyond the time the company has authorized their payment or crediting.
2. The projected NGE shall reflect factors that include, but are not limited to, the following (not all of these factors will necessarily be present in all situations):

- a. The nature of contractual guarantees.
 - b. The company's past NGE practices and established NGE policies.
 - c. The timing of any change in NGE relative to the date of recognition of a change in experience.
 - d. The benefits and risks to the company of continuing to authorize NGE.
3. Projected NGE shall be established based on projected experience consistent with how actual NGE are determined.
 4. Projected levels of NGE in the cash-flow model must be consistent with the experience assumptions used in each scenario. Contract holder behavior assumptions in the model must be consistent with the NGE assumed in the model.
 5. The company may exclude any portion of an NGE that is not based on some aspect of the contract's experience.
 6. However, if the board has guaranteed a portion of the NGE into the future, the company must model that amount. In other words, the company cannot exclude from its model any NGE that the board has guaranteed for future years, even if it could have otherwise excluded them, based on this subsection.

Drafting Note: Comments are sought for any insight into whether authorization from the board or documentation should be considered in allowing exclusion of NGEs.

7. The liability for contract holder dividends declared but not yet paid that has been established according to statutory accounting principles as of the valuation date is reported separately from the statutory reserve. The contract holder dividends that give rise to this dividend liability as of the valuation date may or may not be included in the cash-flow model at the company's option.
 - a. If the contract holder dividends that give rise to the dividend liability are not included in the cash-flow model, then no adjustment is needed to the resulting SR.
 - b. If the contract holder dividends that give rise to the dividend liability are included in the cash-flow model, then the resulting SR should be reduced by the amount of the dividend liability.
8. All projected cash flows associated with NGEs shall reflect margins for adverse deviations and estimation error in prudent estimate assumptions.

Section 11: Guidance and Requirements for Setting Prudent Estimate Mortality Assumptions

A. Overview

1. Intent

The guidance and requirements in this section apply to setting prudent estimate mortality assumptions when determining the SR. The intent is for prudent estimate mortality assumptions to be based on facts, circumstances and appropriate actuarial practice.

2. Description

Prudent estimate mortality assumptions shall be determined by first developing expected mortality curves based on either available experience or published tables. Where necessary, margins shall be applied to the experience to reflect data uncertainty. The expected mortality curves shall then be adjusted based on the credibility of the experience used to determine the expected mortality curve. Section 11.B addresses guidance and requirements for determining expected mortality curves, and Section 11.C addresses guidance and requirements for adjusting the expected mortality curves to determine prudent estimate mortality.

Finally, the credibility-adjusted tables shall be adjusted for mortality improvement (where such adjustment is permitted or required) using the guidance and requirements in Section 11.D.

3. Business Segments

For purposes of setting prudent estimate mortality assumptions, the products falling under the scope of these requirements shall be grouped into business segments with different mortality assumptions. The grouping, at a minimum, should differentiate between payout annuities or deferred annuity contracts that contain GLBs, and deferred annuity contracts with no guaranteed benefits or only GMDBs. Where appropriate, the grouping should also differentiate between segments which are known or expected to contain contract holders with sociodemographic, geographic, or health factors reasonably expected to impact the mortality assumptions for the segment (e.g., annuitants drawn from different countries, geographic areas, industry groups, or impaired lives on individually underwritten contracts such as structured settlements). The grouping should also generally follow the pricing, marketing, management and/or reinsurance programs of the company.

Guidance Note: This paragraph contemplates situations where it may be appropriate to differentiate mortality assumptions by segment or even by contract due to varying sociodemographic, geographic, or health factors. Particularly, though not exclusively, in the context of group payout annuity contracts, companies may have credible, contract-specific mortality experience data or relevant pooled data from annuitants drawn from similar industries or geographies that may be used to sub-divide inforce blocks into business segments for purposes of setting prudent estimate mortality assumptions.

For example, a company may sell group PRT contracts both to union plans in the U.S. and to private single-employer plans in another country. While both are “PRT contracts,” it would be appropriate to differentiate them for mortality assumption purposes, similar to how payout annuities vs. deferred annuities are distinguished.

4. Margin for Data Uncertainty

The expected mortality curves that are determined in Section 11.B may need to include a margin for data uncertainty. The margin could be in the form of an increase or a decrease in mortality, depending on the business segment under consideration. The margin shall be applied in a direction (i.e., increase or decrease in mortality) that results in a higher reserve. A sensitivity test may be needed to determine the appropriate direction of the provision for uncertainty to mortality. The test could be a prior year mortality sensitivity analysis of the business segment or an examination of current representative cells of the segment.

For purposes of this section, if mortality must be increased (decreased) to provide for uncertainty, the business segment is referred to as a mortality (longevity) segment.

It may be necessary, because of a change in the mortality risk profile of the segment, to reclassify a business segment from a mortality (longevity) segment to a longevity (mortality) segment to the extent compliance with this section requires such a reclassification.

B. Determination of Expected Mortality Curves

1. Experience Data

In determining expected mortality curves, the company shall use actual experience data directly applicable to the business segment (i.e., direct data) if it is available. In the absence of direct data, the company should then look to use data from a segment that is similar to the business segment (i.e., other than direct experience). See Section 11.B.2 for additional considerations. Finally, if there is no data, the company shall use the applicable table, as required in Section 11.B.3.

2. Data Other Than Direct Experience

Adjustments shall be applied to the data to reflect differences between the business segments, and margins shall be applied to the adjusted expected mortality curves to reflect the data uncertainty associated with using data from a similar but not identical business segment.

To the extent the mortality of a business segment is reinsured, any mortality charges that are consistent with the company's own pricing and applicable to a substantial portion of the mortality risk also may be a reasonable starting point for the determination of the company's expected mortality curves.

3. Little or No Data Requirements

- i. When little or no experience or information is available on a business segment, the company shall use expected mortality curves that would produce expected deaths no less than:

[2021 SOA Deferred Annuity Mortality Table] with [Projection Scale G2] for individual deferred annuities that do not contain guaranteed living benefits

$$q_x^{20XX+n} = q_x^{20XX}(1 - G2_x)^n$$

Commented [CC295]: should this table be in VM-M?

Commented [VM22296R295]: Not yet – will be determined upon settling the standard projection amount calculation, in which case it would need to be added to VM-M in the future

ii. When little or no experience or information is available on a business segment, the company shall use expected mortality curves that would produce expected deaths no greater than:

- a. [The appropriate percentage (F_x) from Table 11.1 applied to the 2012 IAM Basic Mortality Table] with [Projection Scale G2] for individual payout annuity contracts and deferred annuity contracts with guaranteed living benefits

$$q_x^{2012+n} = q_x^{2012}(1 - G2_x)^n * F_x$$

- b. [1983 Table "a"] [for structured settlements or other contracts with impaired mortality]

Commented [CC297]: should this table be in VM-M?

Commented [VM22298R297]: Not yet – will be determined upon settling the standard projection amount calculation, in which case it would need to be added to VM-M in the future

- c. [1994 GAR Table] with [Projection Scale AA] [for group annuities]

$$q_x^{1994+n} = q_x^{1994}(1 - AA_x)^n$$

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Commented [VM22300R299]: Not yet – will be determined upon settling the standard projection amount calculation, in which case it would need to be added to VM-M in the future

Table 11.1

Attained Age (x)	F_x
<=65	80.0%
66	81.5%
67	83.0%
68	84.5%
69	86.0%
70	87.5%
71	89.0%
72	90.5%
73	92.0%
74	93.5%
75	95.0%
76	96.5%
77	98.0%
78	99.5%
79	101.0%
80	102.5%
81	104.0%
82	105.5%
83	107.0%
84	108.5%
85	110.0%
86	110.0%
87	110.0%
88	110.0%
89	110.0%
90	110.0%

91	110.0%	
92	110.0%	
93	110.0%	
94	110.0%	
95	110.0%	
96	109.0%	
97	108.0%	
98	107.0%	
99	106.0%	
100	105.0%	
101	104.0%	
102	103.0%	
103	102.0%	
104	101.0%	
>=105	100.0%	

iii. For a business segment with non-U.S. insureds, when little or no experience or information is available on a business segment, an established industry or national mortality table and mortality improvement scale may be used, with approval from the domiciliary commissioner.

4. Additional Considerations Involving Data

The following considerations shall apply to mortality data specific to the business segment for which assumptions are being determined (i.e., direct data discussed in Section 11.B.1 or other than direct data discussed in Section 11.B.2).

a. Underreporting of Deaths

Mortality data shall be examined for possible underreporting of deaths. Adjustments shall be made to the data if there is any evidence of underreporting. Alternatively, exposure by lives or amounts on contracts for which death benefits were in the money may be used to determine expected mortality curves. Underreporting on such exposures should be minimal; however, this reduced subset of data will have less credibility.

b. Experience by Contract Duration

Experience of a ~~mortality~~ segment shall be examined to determine if mortality by contract duration increases materially due to selection at issue. In the absence of information, the company shall assume that expected mortality will increase by contract duration for an appropriate select period. As an alternative, if the company determines that mortality is affected by selection, the company could apply margins to the expected mortality in such a way that the actual mortality modeled does not depend on contract duration.

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c. Modification and Relevance of Data

Even for a large company, the quantity of life exposures and deaths are such that a significant amount of smoothing may be required to determine expected mortality curves from mortality experience. Expected mortality curves, when applied to the recent historic exposures (e.g., three to seven years), should not

result in an estimate of aggregate number of deaths less (greater) than the actual number deaths during the exposure period for ~~mortality~~ (longevity) segments.

In determining expected mortality curves (and the credibility of the underlying data), older data may no longer be relevant. The “age” of the experience data used to determine expected mortality curves should be documented.

d. Other Considerations

In determining expected mortality curves, consideration should be given to factors that include, but are not limited to, trends in mortality experience, trends in exposure, volatility in year-to-year A/E mortality ratios, mortality by lives relative to mortality by amounts, changes in the mix of business and product features that could lead to mortality selection.

Commented [CC303]: s/b “mortality (longevity)” segments

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C. Adjustment for Credibility to Determine Prudent Estimate Mortality

1. Adjustment for Credibility

The expected mortality curves determined in Section 11.B shall be adjusted based on the credibility of the experience used to determine the curves in order to arrive at prudent estimate mortality. The adjustment for credibility shall result in blending the expected mortality curves including margins for uncertainty with the mortality assumptions described in Section 11.B.3. The approach used to adjust the curves shall suitably account for credibility.

Guidance Note: For example, when credibility is zero, an appropriate approach should result in a mortality assumption consistent with 100% of the industry mortality assumption described in Section 11.B.3 used in the blending.

2. Adjustment of Industry Mortality for Improvement

For purposes of the adjustment for credibility, the industry mortality table for a ~~mortality~~ segment may be and the industry mortality table for a ~~longevity~~ segment must be adjusted for mortality improvement. Such adjustment shall reflect the mortality improvement scale described in Section 11.B.3 from the effective date of the respective industry mortality table to the experience weighted average date underlying the data used to develop the expected mortality curves.

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3. Credibility Procedure

The credibility procedure used shall:

- a. Produce results that are reasonable.
- b. Not tend to bias the results in any material way.
- c. Be practical to implement.
- d. Give consideration to the need to balance responsiveness and stability.
- e. Take into account not only the level of aggregate claims but the shape of the mortality curve.

f. Contain criteria for full credibility and partial credibility that have a sound statistical basis and be appropriately applied.

4. Further Adjustment of the Credibility-Adjusted Table for Mortality Improvement

The credibility-adjusted table used for ~~mortality~~ segments may be and the credibility adjusted table used for ~~longevity~~ segments must be adjusted for mortality improvement using the applicable mortality improvement scale described in Section 11.B.3 from the experience weighted average date underlying the company experience used in the credibility process to the valuation date.

Any adjustment for mortality improvement beyond the valuation date is discussed in Section 11.D.

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D. Future Mortality Improvement

The mortality assumption resulting from the requirements of Section 11.C shall be adjusted for mortality improvements beyond the valuation date if such an adjustment would serve to increase the resulting SR. If such an adjustment would reduce the SR, such assumptions are permitted, but not required. In either case, the assumption must be based on current relevant data with a margin for uncertainty (increasing assumed rates of improvement if that results in a higher reserve or reducing them otherwise).

Section 12: Other Guidance and Requirements for Assumptions

A. Overview

This section provides guidance and requirements in general for setting prudent estimate assumptions when determining either the SR or DR. It also provides specific guidance and requirements for expense assumptions.

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B. General Assumption Requirements

1. The company shall use prudent estimate assumptions for risk factors that are not stochastically modeled by applying margins to the anticipated experience assumptions if such risk factors have been categorized as material risks by following Section 1.B Principle 3 and requirements in Section 12.C.
2. The company shall establish the prudent estimate assumptions for risk factors in compliance with the requirements in Section 12 of Model #820 and must periodically review and update the assumptions as appropriate in accordance with these requirements.
3. The company shall model the following risk factors stochastically unless the company elects the stochastic exclusion test defined in Section 7:
 - a. Interest rate movements (i.e., Treasury interest rate curves).
 - b. Equity performance (e.g., Standard & Poor's 500 index [S&P 500] returns and returns of other equity investments).
4. If the company elects to stochastically model risk factors in addition to the economic scenarios, the requirements in this section for determining prudent estimate assumptions for these risk factors do not apply.

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It is expected that companies will not stochastically model risk factors other than the economic scenarios, such as contract holder behavior or mortality, until VM-22 has more specific guidance and requirements available. Companies shall discuss with domiciliary regulators if they wish to stochastically model other risk factors.

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5. The company shall use its own experience, if relevant and credible, to establish an anticipated experience assumption for any risk factor. To the extent that company experience is not available or credible, the company may use industry experience or other data to establish the anticipated experience assumption, making modifications as needed to reflect the circumstances of the company.
 - a. For risk factors (such as mortality) to which statistical credibility theory may be appropriately applied, the company shall establish anticipated experience assumptions for the risk factor by combining relevant company experience with industry experience data, tables or other applicable data in a manner that is consistent with credibility theory and accepted actuarial practice.
 - b. For risk factors (such as utilization of guaranteed living benefits) that do not lend themselves to the use of statistical credibility theory, and for risk

factors (such as some of the lapse assumptions) to which statistical credibility theory can be appropriately applied but cannot currently be applied due to lack of industry data, the company shall establish anticipated experience assumptions in a manner that is consistent with accepted actuarial practice and that reflects any available relevant company experience, any available relevant industry experience, or any other experience data that are available and relevant. Such techniques include:

- i. Adopting standard assumptions published by professional, industry or regulatory organizations to the extent they reflect any available relevant company experience or reasonable expectations.
 - ii. Applying factors to relevant industry experience tables or other relevant data to reflect any available relevant company experience and differences in expected experience from that underlying the base tables or data due to differences between the risk characteristics of the company experience and the risk characteristics of the experience underlying the base tables or data.
 - iii. Blending any available relevant company experience with any available relevant industry experience and/or other applicable data using weightings established in a manner that is consistent with accepted actuarial practice and that reflects the risk characteristics of the underlying contracts and/or company practices.
- c. For risk factors that have limited or no experience or other applicable data to draw upon, the assumptions shall be established using sound actuarial judgment and the most relevant data available, if such data exists. _____
 - d. For any assumption that is set in accordance with the requirements of Section 12.B.5.c, the qualified actuary to whom responsibility for this group of contracts is assigned shall use sensitivity testing and disclose the analysis performed to ensure that the assumption is set at the conservative end of the plausible range.
 - e. The qualified actuary, to whom responsibility for this group of contracts is assigned, shall annually review relevant emerging experience for the purpose of assessing the appropriateness of the anticipated experience assumption. If the results of statistical or other testing indicate that previously anticipated experience for a given factor is inadequate, then the qualified actuary shall set a new, adequate, anticipated experience assumption for the factor.
6. The company shall sensitivity test material risk factors that are not stochastically modeled and examine the impact on the stochastic reserve. The company shall update the sensitivity tests periodically as appropriate. The company may update the tests less frequently, but no less than every 3 years, when the tests show less sensitivity of the stochastic reserve to changes in the assumptions being tested or the experience is not changing rapidly. Providing there is no material impact on the results of the sensitivity testing, the company may perform sensitivity testing:

- a. Using samples of the contracts in force rather than performing the entire valuation for each alternative assumption set.
- b. Using data from prior periods.

Guidance Note: Sensitivity testing every risk factor on an annual basis is not required. For some risk factors, it may be reasonable, in lieu of sensitivity testing, to employ statistical measures for margins, such as adding one or more standard deviations to the anticipated experience assumption.

- 7. The company shall vary the prudent estimate assumptions from scenario to scenario within the stochastic reserve calculation in an appropriate manner to reflect the scenario-dependent risks.

C. Assumption Margins

The company shall include margins to provide for adverse deviations and estimation error in the prudent estimate assumptions for ~~all risk factors that are~~ not stochastically modeled or prescribed, subject to the following:

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- 1. The level of margin applied to the anticipated experience assumptions may be determined in aggregate or independently as discussed in Section 1.B Principle 3. It is not permissible to set a margin less toward the conservative end of the spectrum to recognize, in whole or in part, implicit or prescribed margins that are present, or are believed to be present, in other risk factors.

Risks that are stochastically modeled (e.g., interest rates, equity returns) or have prescribed margins or guardrails (e.g., assets, revenue sharing) shall be considered material risks. Other risks generally considered to be material include, but are not limited to, mortality, contract holder behavior, maintenance and overhead expenses, inflation and implied volatility. In some cases, the list of material risks may also include acquisition expenses, partial withdrawals, policy loans, annuitizations, account transfers and deposits, and/or option elections that contain an element of anti-selection.

- 2. The greater the uncertainty in the anticipated experience assumption, the larger the required margin, with the margin added or subtracted as needed to produce a larger ~~Sr or DR than would otherwise result. For example, the company shall use a larger margin when:~~

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- a. The experience data have less relevance or lower credibility.
- b. The experience data are of lower quality, such as incomplete, internally inconsistent or not current.
- c. There is doubt about the reliability of the anticipated experience assumption, such as, but not limited to, recent changes in circumstances or changes in company policies.
- d. There are constraints in the modeling that limit an effective reflection of the risk factor.

- 3. In complying with the sensitivity testing requirements in Section 12.B.6 above, greater analysis and more detailed justification are needed to determine the level

of uncertainty when establishing margins for risk factors that produce greater sensitivity on the stochastic reserve.

4. A margin is permitted but not required for assumptions that do not represent material risks.
5. A margin should reflect the magnitude of fluctuations in historical experience of the company for the risk factor, as appropriate.
6. The company shall apply the method used to determine the margin consistently on each valuation date but is permitted to change the method from the prior year if the rationale for the change and the impact on the stochastic reserve is disclosed.

D. Expense Assumptions

1. General Prudent Estimate Expense Assumption Requirements

In determining prudent estimate expense assumptions, the company:

- a. May spread certain information technology development costs and other capital expenditures over a reasonable number of years in accordance with accepted statutory accounting principles as defined in the Statements of Statutory Accounting Principles.

Guidance Note: Care should be taken with regard to the potential interaction with the inflation assumption below.

- b. Shall assume that the company is a going concern.
- c. Shall choose an appropriate expense basis that properly aligns the actual expense to the assumption. If values are not significant, they may be aggregated into a different base assumption.

Guidance Note: For example, death benefit expenses should be modeled with an expense assumption that is per death incurred.

- d. Shall reflect the impact of inflation.
- e. Shall not assume future expense improvements.
- f. Shall not include assumptions for federal income taxes (and expenses paid to provide fraternal benefits in lieu of federal income taxes) and foreign income taxes.
- g. Shall use assumptions that are consistent with other related assumptions.
- h. Shall use fully allocated expenses.

Guidance Note: Expense assumptions should reflect the direct costs associated with the block of contracts being modeled, as well as indirect costs and overhead costs that have been allocated to the modeled contracts.

- i. Shall allocate expenses using an allocation method that is consistent across company lines of business. Such allocation must be determined in a manner that is within the range of actuarial practice and methodology and consistent with applicable ASOPs. Allocations may not be done for the purpose of decreasing the stochastic reserve.
- j. Shall reflect expense efficiencies that are derived and realized from the combination of blocks of business due to a business acquisition or merger in the expense assumption only when any future costs associated with achieving the efficiencies are also recognized.

Guidance Note: For example, the combining of two similar blocks of business on the same administrative system may yield some expense savings on a per unit basis, but any future cost of the system conversion should also be considered in the final assumption. If all costs for the conversion are in the past, then there would be no future expenses to reflect in the valuation.

- k. Shall reflect the direct costs associated with the contracts being modeled, as well as an appropriate portion of indirect costs and overhead (i.e., expense assumptions representing fully allocated expenses should be used), including expenses categorized in the annual statement as “taxes, licenses and fees” (Exhibit 3 of the annual statement) in the expense assumption.
- l. Shall include acquisition expenses associated with business in force as of the valuation date and significant non-recurring expenses expected to be incurred after the valuation date in the expense assumption.
- m. For contracts sold under a new policy form or due to entry into a new product line, the company shall use expense factors that are consistent with the expense factors used to determine anticipated experience assumptions for contracts from an existing block of mature contracts taking into account:
 - i. Any differences in the expected long-term expense levels between the block of new contacts and the block of mature contracts.
 - ii. That all expenses must be fully allocated as required under Section 12.D.1.h above.

2. Margins for Prudent Estimate Expense Assumptions

The company shall determine margins for expense assumptions following Section 12.C.

Section 13: Allocation of Aggregate Reserves to the Contract Level

Section 3.F states that the aggregate reserve shall be allocated to the contracts falling within the scope of these requirements. That allocation should be done for both the pre- and post-reinsurance ceded reserves. Contracts that have passed the stochastic exclusion test as defined in Section 7.B will not be included in the allocation of the aggregate reserve; however, contracts for which the Deterministic Certification Option is elected in Section 7.E are subject to the allocation methodology described in this Section 13. Allocation calculations shall be done separately for the DR and SR, and for different reserving categories.

Under the allocation methodology described in this section, the reserve held for any contract will be no less than the cash surrender value provided under that contract, after consideration of any reinsurance. Additionally, the reserve held for a Payout Annuity contract (whether life-contingent or not) will be no less than the present value of the liability cash flows provided under the contract, after consideration of any reinsurance, discounted using the NAER described in Section 13.B.1 or 13.B.2 as applicable. The allocation methodology is a formulaic approach that is designed, generally, to allocate the excess aggregate reserves based on a measure of the risk and, therefore, to generally allocate a greater portion of the excess aggregate reserves to contracts that have greater risk. For example, an indexed annuity contract with a high benefit GLWB will typically have a larger allocated excess reserve than an otherwise identical indexed annuity contract with a low benefit GLWB or no GLWB.

A. The contract-level reserve for each contract shall be the sum of the following:

1. The contract's minimum allocation value (MAV), as defined in Section 13.C.
2. The contract's allocated excess reserve (AER), as defined in Section 13.D.

B. Scenario actuarial present value (APV)

1. For a group of contracts for which a company does not elect the Deterministic Certification Option in Section 7.E, the Scenario APV for each contract is equal to the discounted liability cash flows at the NAER, pursuant to requirements in Section 4, for the scenario that produces the aggregate scenario reserve for the group that is closest to, but not greater than the SR defined in Section 3.D.

If the Direct Iteration Method is used to satisfy the requirements in Section 4.B.1, then the company shall:

- a. Determine a path of NAER for each model segment that reflects the net general account portfolio rate in each projection interval (i.e., monthly, quarterly, annually), which will depend primarily on:
 - i. Projected net investment earnings from the portfolio of starting assets.
 - ii. Pattern of projected asset cash flows from the starting assets and subsequent reinvestment assets.
 - iii. Pattern of net liability cash flows.
 - iv. Projected net investment earnings from reinvestment assets.
- b. The company shall calculate the NAER as the ratio of net investment earnings divided by invested assets subject to the requirements in 1 through 4 below. All items reflected in the ratio are consistent with statutory asset valuation and accrual accounting, including reflection of due, accrued or unearned investment income

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where appropriate.

- i. The NAER for each projection interval is calculated in a manner that is consistent with the timing of cash flows and length of the projection interval of the related cash-flow model.
- ii. Net investment earnings include:
 1. Gross investment income plus capital gains and losses, minus prescribed default costs, and minus investment expenses.
 2. Income from derivative asset programs, subject to the requirements in Sections 4 and 9 of VM-22.
- iii. Invested assets are determined in a manner that is consistent with the timing of cash flows within the cash-flow model and the length of the projection interval of the cash-flow model.
- iv. The annual statement value of derivative instruments or a reasonable approximation thereof is in invested assets.

Drafting Note: The above NAER guidance is in line with the VM-20 NAER methodology, rather than the VM-21/VM-22 NAER methodology under an additional invested asset portfolio. During the exposure period, interested parties are encouraged to provide any feedback on the appropriateness of this approach.

2. For a group of contracts for which a company elects the Deterministic Certification Option defined in Section 7.E, the Scenario APV for each contract is equal to the discounted liability cash flows at the NAER in the single scenario used to calculate the reserve.
 3. For projecting future liability cash flows under either Section 13.B.1 or 13.B.2, as applicable, assume the same liability assumptions that were used to calculate the SR defined in Section 3.D.
- C. Minimum allocation value (MAV)
1. For Payout Annuity contracts, the MAV is equal to the greater of:
 - a. The Scenario APV for the contract, or
 - b. The cash surrender value provided under the contract, if any.
 2. For Account Value Based Annuity contracts, the MAV is equal to the cash surrender value provided under the contract, if any, otherwise zero.
- D. Allocated excess reserve (AER)
1. For each contract in a group of contracts, the AER is determined by allocating the excess, if any, of the group's aggregate reserve over the group's aggregate MAV to the contract in proportion to the excess of the Scenario APV over the MAV for such contract.

2. If the Scenario APV for any contract is less than the MAV, then the excess Scenario APV to be used for allocating the excess aggregate reserve to that contract shall be floored at zero.
 3. If all contracts in the group have an excess Scenario APV that is floored at zero, then use the MAV to allocate any excess aggregate reserve over the aggregate MAV.
 4. If a group's aggregate reserve is less than the group's aggregate MAV, that difference should be allocated to life contingent contracts in proportion to each life contingent contract's MAV to the sum of the life contingent contracts MAV.
- E. As a hypothetical example, consider a company with the results of the following eight contracts in reserving categories:

Table 13.1.A: Hypothetical Sample Allocation of Aggregate Reserve: Group A, Account Value Based Annuity Contracts

Contract	Example Product Type	CSV (1)	Scenario APV (2)	Minimum Allocation Value (MAV) (3) *	Excess	Aggregate Reserve (5)	Excess of	Allocated	Total Contract Reserve (8) = (3)+(7)
					of Scenario APV over MAV (4) = Max[(2)-(3),0]		Aggregate Reserve over Aggregate MAV (6) = Max[(5 Total) - (3 Total),0]	Excess Reserve (7) = (4) x [(6 Total)/(4 Total)]	
1	Individual annuity w/ no GLWB	95.0	91.0	95.0	-			-	95.0
2	Indexed annuity w/ low benefit GLWB	92.0	98.0	92.0	6.0			6.3	98.3
3	Indexed annuity w/ medium benefit GLWB	90.0	104.0	90.0	14.0			14.7	104.7
4	Indexed annuity w/ high benefit GLWB	88.0	111.0	88.0	23.0			24.1	112.1
Total		365.0	404.0	365.0	43.0	410.0	45.0	45.0	410.0

* MAV for Payout Annuity contracts equals Max[(1), (2)]. MAV for Account Value Based Annuity contracts equals (1) if any, otherwise zero.

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Table 13.1.B: Hypothetical Sample Allocation of Aggregate Reserve: Group B, Payout Annuity Contracts that do not have Cash Surrender Values

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Contract	Example Product Type	CSV (1)	Scenario APV (2)	Minimum Allocation Value (MAV) (3) *	Excess (floored) of Scenario APV over MAV (4) = Max[(2)-(3),0]	Aggregate Reserve CTE 70 (5)	Excess of Aggregate Reserve over Aggregate MAV (6) = Max[(5 Total) -(3 Total),0]	Allocated Excess Reserve (7) = (3) x [(6 Total)/ (3 Total)] **	Total Contract Level Reserve (8) = (3)+(7)
1	Fixed Life Contingent payout annuity	-	91.0	91.0	-			1.4	92.4
2	Fixed Life Contingent payout annuity	-	111.0	111.0	-			1.6	112.6
3	Fixed Non-life Contingent payout annuity	-	98.0	98.0	-			1.5	99.5
4	Fixed Non-life Contingent payout annuity	-	104.0	104.0	-			1.5	105.5
Total		-	404.0	404.0	-	410.0	6.0	6.0	410.0
* MAV for Payout Annuity contracts equals Max[(1), (2)]. MAV for Account Value Based Annuity contracts equals (1) if any, otherwise zero.									
** Because all contracts have an excess Scenario APV of 0, the AER is allocated in proportion to MAV.									

Guidance Note: The Scenario actuarial present value (APV) in the section above is separate from the Guarantee Actuarial Present Value (GAPV) referred to in the additional standard projection amount calculation in VM-21. The GAPV is only applicable to guaranteed minimum benefits and uses prescribed liability assumptions. In contrast, the Scenario APV in this section applies to the entire contract, irrespective of whether guaranteed benefits are attached, and uses company prudent estimate liability assumptions.

VM-V: Statutory Maximum Valuation Interest Rates for Formulaic Reserves

1. Income Annuities

A. Purpose and Scope

1. These requirements define for single premium immediate annuity contracts and other similar contracts, certificates and contract features the statutory maximum valuation interest rate that complies with Model #820. These are the maximum interest rate assumption requirements to be used in the CARVM and for certain contracts, the CRVM. These requirements do not preclude the use of a lower valuation interest rate assumption by the company if such assumption produces statutory reserves at least as great as those calculated using the maximum rate defined herein.
2. The following categories of contracts, certificates and contract features, whether group or individual, including both life contingent and term certain only contracts, directly written or assumed through reinsurance, with the exception of benefits arising from variable annuities and all contracts not passing the SET covered by Sections 1 through 13 of VM-22, are covered in VM-V:
 - a. Immediate annuity contracts issued after Dec. 31, 2017;
 - b. Deferred income annuity contracts issued after Dec. 31, 2017;
 - c. Structured settlements in payout or deferred status issued after Dec. 31, 2017;
 - d. Fixed payout annuities resulting from the exercise of settlement options or annuitizations of host contracts issued after Dec. 31, 2017;
 - e. Fixed payout annuities resulting from the exercise of settlement options or annuitizations of host contracts issued during 2017, for fixed payouts commencing after Dec. 31, 2018, or, at the option of the company, for fixed payouts commencing after Dec. 31, 2017;
 - f. Supplementary contracts, excluding contracts with no scheduled payments (such as retained asset accounts and settlements at interest), issued after Dec. 31, 2017;
 - g. Fixed income payment streams, attributable to contingent deferred annuities (CDAs) issued after Dec. 31, 2017, once the underlying contract funds are exhausted;
 - h. Fixed income payment streams attributable to guaranteed living benefits associated with deferred annuity contracts issued after Dec. 31, 2017, once the contract funds are exhausted; and
 - i. Certificates with premium determination dates after Dec. 31, 2017, emanating from non-variable group annuity contracts specified in Model #820, Section 5.C.2, purchased for the purpose of providing certificate holders benefits upon their retirement.

Guidance Note: For VM-V Section 1.A.2.d, Section 1.A.2.e, Section 1.A.2.f and Section 1.A.2.h above, there is no restriction on the type of contract that may give rise to the benefit.

3. Exemptions:

- a. With the permission of the domiciliary commissioner, for the categories of annuity contracts, certificates and/or contract features in scope as outlined in VM-V Section 1.A.2.d, Section 1.A.2.e, Section 1.A.2.f, Section 1.A.2.g or Section 1.A.2.h, the company may use the same maximum valuation interest rate used to value the payment stream in accordance with the guidance applicable to the host contract. In order to obtain such

permission, the company must demonstrate that its investment policy and practices are consistent with this approach.

4. The maximum valuation interest rates for the contracts, certificates and contract features within the scope of VM-V Section 1 supersede those described in Appendix VM-A and Appendix VM-C, but they do not otherwise change how those appendices are to be interpreted. In particular, *Actuarial Guideline IX-B—Clarification of Methods Under Standard Valuation Law for Individual Single Premium Immediate Annuities, Any Deferred Payments Associated Therewith, Some Deferred Annuities and Structured Settlements Contracts* (AG-9-B) (see VM-C) provides guidance on valuation interest rates and is, therefore, superseded by these requirements for contracts, certificates and contract features in scope. Likewise, any valuation interest rate references in *Actuarial Guideline IX-C—Use of Substandard Annuity Mortality Tables in Valuing Impaired Lives Under Individual Single Premium Immediate Annuities* (AG-9-C) (see VM-C) are also superseded by these requirements.

B. Definitions

1. The term “reference period” means the length of time used in assigning the Valuation Rate Bucket for the purpose of determining the statutory maximum valuation interest rate and is determined as follows:
 - a. For contracts, certificates or contract features with life contingencies and substantially similar payments, the reference period is the length of time, rounded to the nearest year, from the premium determination date to the earlier of: i) the date of the last non-life-contingent payment under the contract, certificate or contract feature; and ii) the date of the first life-contingent payment under the contract, certificate or contract feature, or
 - b. For contracts, certificates or contract features with no life-contingent payments and substantially similar payments, the reference period is the length of time, rounded to the nearest year, from the premium determination date to the date of the last non-life-contingent payment under the contract, certificate or contract feature, or
 - c. For contracts, certificates or contract features where the payments are not substantially similar, the actuary should apply prudent judgment and select the Valuation Rate Bucket with Macaulay duration that is a best fit to the Macaulay duration of the payments in question.

Guidance Note: Contracts with installment refunds or similar features should consider the length of the installment period calculated from the premium determination date as the non-life contingent period for the purpose of determining the reference period.

Guidance Note: The determination in VM-V Section 1.B.1.c above shall be made based on the materiality of the payments that are not substantially similar relative to the life-contingent payments.

2. The term “jumbo contract” means a contract with an initial consideration equal to or greater than \$250 million. Considerations for contracts issued by an insurer to the same contract holder within 90 days shall be combined for purposes of determining whether the contracts meet this threshold.

Guidance Note: If multiple contracts meet this criterion in aggregate, then each contract is a jumbo contract.

3. The term “non-jumbo contract” means a contract that does not meet the definition of a jumbo

contract.

4. The term “premium determination date” means the date as of which the valuation interest rate for the contract, certificate or contract feature being valued is determined.
5. The term “initial age” means the age of the annuitant as of his or her age last birthday relative to the premium determination date. For joint life contracts, certificates or contract features, the “initial age” means the initial age of the younger annuitant. If a contract, certificate or contract feature for an annuitant is being valued on a standard mortality table as an impaired annuitant, “initial age” means the rated age. If a contract, certificate or contract feature is being valued on a substandard mortality basis, “initial age” means an equivalent rated age.
6. The term “Table X spreads” means the prescribed VM-V Section 1 current market benchmark spreads for the quarter prior to the premium determination date, as published on the Industry tab of the NAIC website. The process used to determine Table X spreads is the same as that specified in VM-20 Appendix 2.D for Table F, except that JP Morgan and Bank of America bond spreads are averaged over the quarter rather than the last business day of the month.
7. The term “expected default cost” means a vector of annual default costs by weighted average life. This is calculated as a weighted average of the VM-20 Table A prescribed annual default costs published on the Industry tab of the NAIC website in effect for the quarter prior to the premium determination date, using the prescribed portfolio credit quality distribution as weights.
8. The term “expected spread” means a vector of spreads by weighted average life. This is calculated as a weighted average of the Table X spreads, using the prescribed portfolio credit quality distribution as weights.
9. The term “prescribed portfolio credit quality distribution” means the following credit rating distribution:
 - a. 5% Treasuries
 - b. 15% Aa bonds (5% Aa1, 5% Aa2, 5% Aa3)
 - c. 40% A bonds (13.33% A1, 13.33% A2, 13.33% A3)*
 - d. 40% Baa bonds (13.33% Baa1, 13.33% Baa2, 13.33% Baa3)*

*40%/3 is used unrounded in the calculations.

C. Determination of the Statutory Maximum Valuation Interest Rate

1. Valuation Rate Buckets

- a. For the purpose of determining the statutory maximum valuation interest rate, the contract, certificate or contract feature being valued must be assigned to one of four Valuation Rate Buckets labeled A through D.
- b. If the contract, certificate or contract feature has no life contingencies, the Valuation Rate Bucket is assigned based on the length of the reference period (RP), as follows:

Table 1.C-1: Assignment to Valuation Rate Bucket by Reference Period Only

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RP ≤ 5 Years	5Y < RP ≤ 10Y	10Y < RP ≤ 15Y	RP > 15Y
A	B	C	D

c. If the contract, certificate or contract feature has life contingencies, the Valuation Rate Bucket is assigned based on the length of the RP and the initial age of the annuitant, as follows:

Table 1.C-2: Assignment to Valuation Rate Bucket by Reference Period and Initial Age

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Initial Age	RP ≤ 5Y	5Y < RP ≤ 10Y	10Y < RP ≤ 15Y	RP > 15Y
90+	A	B	C	D
80-89	B	B	C	D
70-79	C	C	C	D
< 70	D	D	D	D

2. Premium Determination Dates

a. The following table specifies the decision rules for setting the premium determination date for each of the contracts, certificates and contract features listed in Section 1.A:

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Table 1.C-3: Premium Determination Dates

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Section	Item Description	Premium determination date
A.2.a	Immediate annuity	Date consideration is determined and committed to by contract holder
A.2.b	Deferred income annuity	Date consideration is determined and committed to by contract holder
A.2.c	Structured settlements	Date consideration is determined and committed to by contract holder
A.2.d and A.2.e	Fixed payout annuities resulting from settlement options or annuitizations from host contracts	Date consideration for benefit is determined and committed to by contract holder
A.2.f	Supplementary contracts	Date of issue of supplementary contract
A.2.g	Fixed income payment streams from CDAs, AV becomes 0	Date on which AV becomes 0
A.2.h	Fixed income payment streams from guaranteed living benefits, AV becomes 0	Date on which AV becomes 0

A.2.i	Group annuity and related certificates	Date consideration is determined and committed to by contract holder
-------	--	--

Guidance Note: For the purposes of the items in the table above, the phrase “date consideration is determined and committed to by the contract holder” should be interpreted by the company in a manner that is consistent with its standard practices. For some products, that interpretation may be the issue date or the date the premium is paid.

b. Immaterial Change in Consideration

If the premium determination date is based on the consideration, and if the consideration changes by an immaterial amount (defined as a change in present value of less than 10% and less than \$1 million) subsequent to the original premium determination date, such as due to a data correction, then the original premium determination date shall be retained. In the case of a group annuity contract where a single premium is intended to cover multiple certificates, certificates added to the contract after the premium determination date that do not trigger the company’s right to reprice the contract shall be treated as if they were included in the contract as of the premium determination date.

3. Statutory Maximum Valuation Interest Rate

- a. For a given contract, certificate or contract feature, the statutory maximum valuation interest rate is determined based on its assigned Valuation Rate Bucket (VM-V Section 1.C.1) and its Premium Determination Date (VM-V Section 1.C.2) and whether the contract associated with it is a jumbo contract or a non-jumbo contract.
- b. Statutory maximum valuation interest rates for jumbo contracts are determined and published daily by the NAIC on the Industry tab of the NAIC website. For a given premium determination date, the statutory maximum valuation interest rate is the daily statutory maximum valuation interest rate published for that premium determination date.
- c. Statutory maximum valuation interest rates for non-jumbo contracts are determined and published quarterly by the NAIC on the Industry tab of the NAIC website by the third business day of the quarter. For a given premium determination date, the statutory maximum valuation interest rate is the quarterly statutory maximum valuation interest rate published for the quarter in which the premium determination date falls.
- d. Quarterly Valuation Rate:

For each Valuation Rate Bucket, the quarterly valuation rate is defined as follows:

$$I_q = R + S - D - E$$

Where:

- a. R is the reference rate for that Valuation Rate Bucket (defined in VM-V Section 1.C.4);
- b. S is the spread rate for that Valuation Rate Bucket (defined in VM-V Section 1.C.5);

- c. D is the default cost rate for that Valuation Rate Bucket (defined in VM-V Section 1.C.6);
- and
- d. E is the spread deduction defined as 0.25%.

For non-jumbo contracts, the quarterly statutory maximum valuation interest rate is the quarterly valuation rate (I_q) rounded to the nearest one-fourth of one percent (1/4 of 1%).

e. Daily Valuation Rate:

For each Valuation Rate Bucket, the daily valuation rate is defined as follows:

$$I_d = I_q + C_{d-1} - C_q$$

Where:

- a. I_q is the quarterly valuation rate for the calendar quarter preceding the business day immediately preceding the premium determination date;
- b. C_{d-1} is the daily corporate rate (defined in VM-V Section 1.C.7) for the business day immediately preceding the premium determination date; and
- c. C_q is the average daily corporate rate (defined in VM-V Section 1.C.8) corresponding to the same period used to develop I_q .

For jumbo contracts, the daily statutory maximum valuation interest rate is the daily valuation rate (I_d) rounded to the nearest one-hundredth of one percent (1/100 of 1%).

4. Reference Rate

Reference rates are updated quarterly as described below:

- a. The “quarterly Treasury rate” is the average of the daily Treasury rates for a given maturity over the calendar quarter prior to the premium determination date. The quarterly Treasury rate is downloaded from <https://fred.stlouisfed.org>, and is rounded to two decimal places.
- b. Download the quarterly Treasury rates for two-year, five-year, 10-year and 30-year U.S. Treasuries.
- c. The reference rate for each Valuation Rate Bucket is calculated as the weighted average of the quarterly Treasury rates using Table 1 weights (defined in VM-V Section 1.C.9) effective for the calendar year in which the premium determination date falls.

5. Spread

The spreads for each Valuation Rate Bucket are updated quarterly as described below:

- a. Use the Table X spreads from the NAIC website for WALs two, five, 10 and 30 years only to calculate the expected spread.

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- b. Calculate the spread for each Valuation Rate Bucket, which is a weighted average of the expected spreads for WALs two, five, 10 and 30 using Table 2 weights (defined in Section 3.I) effective for the calendar year in which the premium determination date falls.

6. Default costs for each Valuation Rate Bucket are updated annually as described below:

- a. Use the VM-20 prescribed annual default cost table (Table A) in effect for the quarter prior to the premium determination date for WAL two, WAL five and WAL 10 years only to calculate the expected default cost. Table A is updated and published annually on the Industry tab of the NAIC website during the second calendar quarter and is used for premium determination dates starting in the third calendar quarter.
- b. Calculate the default cost for each Valuation Rate Bucket, which is a weighted average of the expected default costs for WAL two, WAL five and WAL 10, using Table 3 weights (defined in VM-V Section 1.C.9) effective for the calendar year in which the premium determination date falls.

7. Daily Corporate Rate

Daily corporate rates for each valuation rate bucket are updated daily as described below:

- a. Each day, download the Bank of America Merrill Lynch U.S. corporate effective yields as of the previous business day's close for each index series shown in the sample below from the St. Louis Federal Reserve website: <https://research.stlouisfed.org/fred2/categories/32348>. To access a specific series, search the St. Louis Federal Reserve website for the series name by inputting the name into the search box in the upper right corner, or input the following web address: [https://research.stlouisfed.org/fred2/series/\[replace with series name from the table below\]](https://research.stlouisfed.org/fred2/series/[replace with series name from the table below]).

Table 1.C.4: Index Series Names

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Maturity	Series Name
1Y – 3Y	BAMLC1A0C13YEY
3Y – 5Y	BAMLC2A0C35YEY
5Y – 7Y	BAMLC3A0C57YEY
7Y – 10Y	BAMLC4A0C710YEY
10Y – 15Y	BAMLC7A0C1015YEY
15Y+	BAMLC8A0C15PYEY

- b. Calculate the daily corporate rate for each valuation rate bucket, which is a weighted average of the Bank of America Merrill Lynch U.S. corporate effective yields, using Table 4 weights (defined in VM-V Section 1.C.9) effective for the calendar year in which the business date immediately preceding the premium determination date falls.

8. Average Daily Corporate Rate

Average daily corporate rates are updated quarterly as described below:

- a. Download the quarterly average Bank of America Merrill Lynch U.S. corporate effective yields for each index series shown in Section 1.C.7.a of VM-V from the St. Louis Federal Reserve website: <https://research.stlouisfed.org/fred2/categories/32348>. To access a specific series, search the St. Louis Federal Reserve website for the series name by inputting the name into the search box in the upper right corner, or input the following web address: [https://research.stlouisfed.org/fred2/series/\[replace with series name from VM-V Section 1.C.7.a\]](https://research.stlouisfed.org/fred2/series/[replace with series name from VM-V Section 1.C.7.a]).

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- b. Calculate the average daily corporate rate for each valuation rate bucket, which is a weighted average of the quarterly average Bank of America Merrill Lynch U.S. corporate effective yields, using Table 4 weights (defined in VM-V Section 1.C.9) for the same calendar year as the weight tables (i.e. Tables 1, 2, and 3) used in calculating I_t in VM-V Section 1.C.3.e.

9. Weight Tables 1 through 4

The system for calculating the statutory maximum valuation interest rates relies on a set of four tables of weights that are based on duration and asset/liability cash-flow matching analysis for representative annuities within each valuation rate bucket. A given set of weight tables is applicable to the calculations for every day of the calendar year.

In the fourth quarter of each calendar year, the weights used within each valuation rate bucket for determining the applicable valuation interest rates for the following calendar year will be updated using the process described below. In each of the four tables of weights, the weights in a given row (valuation rate bucket) must add to exactly 100%.

Weight Table 1

The process for determining Table 1 weights is described below:

- a. Each valuation rate bucket has a set of representative annuity forms. These annuity forms are as follows:
- i. Bucket A:
 - a) Single Life Annuity age 91 with 0 and five-year certain periods.
 - b) Five-year certain only.
 - ii. Bucket B:
 - a) Single Life Annuity age 80 and 85 with 0, five-year and 10-year certain periods.
 - b) 10-year certain only.
 - iii. Bucket C:
 - a) Single Life Annuity age 70 with 0 and 15-year certain periods.
 - b) Single Life Annuity age 75 with 0, 10-year and 15-year certain periods.
 - c) 15-year certain only.
 - iv. Bucket D:

- a) Single Life Annuity age 55, 60 and 65 with 0 and 15-year certain periods.
- b) 25-year certain only.
- b. Annual cash flows are projected assuming annuity payments are made at the end of each year. These cash flows are averaged for each valuation rate bucket across the annuity forms for that bucket using the statutory valuation mortality table in effect for the following calendar year for individual annuities for males (ANB).
- c. The average daily rates in the third quarter for the two-year, five-year, 10-year and 30-year U.S. Treasuries are downloaded from <https://fred.stlouisfed.org> as input to calculate the present values in Step d.
- d. The average cash flows are summed into four time period groups: years 1–3, years 4–7, years 8–15 and years 16–30. (Note: The present value of cash flows beyond year 30 are discounted to the end of year 30 and included in the years 16–30 group. This present value is based on the lower of 3% and the 30-year Treasury rate input in Step c.)
- e. The present value of each summed cash-flow group in Step d is then calculated by using the Step c U.S. Treasury rates for the midpoint of that group (and using the linearly interpolated U.S. Treasury rate when necessary).
- f. The duration-weighted present value of the cash flows is determined by multiplying the present value of the cash-flow groups by the midpoint of the time period for each applicable group.
- g. Weightings for each cash-flow time period group within a valuation rate bucket are calculated by dividing the duration weighted present value of the cash flow by the sum of the duration weighted present value of cash flow for each valuation rate bucket.

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Weight Tables 2 through 4

Weight Tables 2 through 4 are determined using the following process:

- i. Table 2 is identical to Table 1.
- ii. Table 3 is based on the same set of underlying weights as Table 1, but the 10-year and 30-year columns are combined since VM-20 default rates are only published for maturities of up to 10 years.
- iii. Table 4 is derived from Table 1 as follows:
 - a) Column 1 of Table 4 is identical to column 1 of Table 1.
 - b) Column 2 of Table 4 is 50% of column 2 of Table 1.
 - c) Column 3 of Table 4 is identical to column 2 of Table 4.
 - d) Column 4 of Table 4 is 50% of column 3 of Table 1.
 - e) Column 5 of Table 4 is identical to column 4 of Table 4.
 - f) Column 6 of Table 4 is identical to column 4 of Table 1.

10. Group Annuity Contracts

For a group annuity purchased under a retirement or deferred compensation plan (VM-V Section 1.A.2.i), the following apply:

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- a. The statutory maximum valuation interest rate shall be determined separately for each certificate, considering its premium determination date, the certificate holder's initial age, the reference period corresponding to its form of payout and whether the contract is a jumbo contract or a non-jumbo contract.

Guidance Note: Under some group annuity contracts, certificates may be purchased on different dates.

- b. In the case of a certificate whose form of payout has not been elected by the beneficiary at its premium determination date, the statutory maximum valuation interest rate shall be based on the reference period corresponding to the normal form of payout as defined in the contract or as is evidenced by the underlying pension plan documents or census file. If the normal form of payout cannot be determined, the maximum valuation interest rate shall be based on the reference period corresponding to the annuity form available to the certificate holder that produces the most conservative rate.

Guidance Note: The statutory maximum valuation interest rate will not change when the form of payout is elected.

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Page 5: [1] Commented [A26] Author

ACLI: Some of our members have expressed concerns over the VM-22 draft's proposed exemption amount being set too low at \$0.5 billion in reserves. The Draft Note in the exposure indicated the original proposal of \$3 billion for a company and \$6 billion for a group was revised downward, but these higher levels may cover the vast majority of annuity reserves held (not only those subject to VM-22) and would be more appropriate. The Life PBR Exemption uses a \$300/600 million life premium limit; creating a parallel for annuities looking at reserves would inherently be greater than the proposed \$0.5/1.0 billion limits. We would request that the NAIC consider researching and consider implementing "equivalency" between life premiums and annuity reserves. Our hope is that exemption levels will be set so that small annuity writers are not included within the scope of PBR requirements.

Page 5: [2] Commented [VM2227R26] VM-22 Subgroup 4/3/2023 1:07:00 PM

VM-22 Subgroup voted on an initial level of \$1 billion.

Page 5: [3] Commented [A28] Author

Academy: The ARCWG proposes that the exemption limits here and in Section 7.A.1.d.v be based on amounts gross of reinsurance. It is possible that a carrier could have material liability gross of reinsurance and an immaterial liability, ignoring counterparty risk, net of reinsurance.

Page 17: [4] Commented [CC116] Craig Chupp 10/13/2022 1:23:00 PM

This entire subsection needs renumbered and there is no "DR"

Page 17: [5] Commented [VM22117R116] VM-22 Subgroup 11/28/2022 1:00:00 PM

DR added for clarification in 7.E

Findings from Regulator Reviews of Company Filings for Actuarial Guideline 53

Fred Andersen, FSA, MAAA

8/11/2023

Notice Regarding Confidentiality

AG 53 provides uniform guidance for the asset adequacy testing, and is effective for reserves reported with respect to the Dec. 31, 2022, and subsequent annual statutory financial statements. A statement of actuarial opinion on the adequacy of the reserves and assets supporting reserves after the operative date of the Valuation Manual is required under Section 3B of the NAIC Standard Valuation Law (#820) and VM-30 of the Valuation Manual. Section 14A of Model #820 provides that actuarial opinions and related documents, including an asset adequacy analysis, are confidential information, while Section 14B provides that such confidential information may be shared with other state regulatory agencies and the NAIC. The asset adequacy analyses required under AG 53 reviewed in the preparation of this report were shared with the Valuation Analysis (E) Working Group and the NAIC in accordance with these requirements, and continue to remain confidential in nature.

Data Limitations

- Asset information shown in the slides that follow rely on data submitted by companies in their AG 53 templates. The NAIC took steps to review the data for reasonableness. However, the accuracy and reliability of the results are ultimately dependent on the quality of participant submissions.
- Some of the submitted data was adjusted to make it useable and help ensure greater consistency of reporting across companies. For example: 1) units were changed from dollars to millions where necessary; 2) asset types were mapped to those listed in the standard AG 53 template for companies that substituted different asset descriptions; 3) aggregated initial asset summary templates were created for companies that provided templates by segment but not in total; 4) templates submitted as PDFs were converted to Excel.
- Some companies did not submit AG 53 templates or did not complete all of the AG 53 template tabs.

Summary

1. AG 53 background
2. AG 53 review activities
3. Net yield assumption findings
4. Upcoming review steps



AG 53 Background

- Actuarial Guideline 53 was adopted in 2022
- Main purpose: help ensure claims paying ability even if complex assets do not perform as expected
- Requires disclosures and asset-related information for most life insurers over a size threshold
 - An opportunity for companies to tell their stories regarding:
 - Their complex assets & associated risks
 - How their cash-flow testing models address those risks
- First submissions were due April 2023



AG 53 provides uniform guidance for the asset adequacy testing applied to life insurers and is effective for reserves reported with respect to the Dec. 31, 2022, and subsequent annual statutory financial statements. A statement of actuarial opinion on the adequacy of the reserves and assets supporting reserves after the operative date of the Valuation Manual is required under Section 38 of the NAIC Standard Valuation Law (#820) and VM-30 of the Valuation Manual. Section 14A of Model #820 provides that actuarial opinions and related documents, including an asset adequacy analysis, are confidential information, while Section 14B provides that such confidential information may be shared with other state regulatory agencies and the NAIC. The asset adequacy analyses required under AG 53 reviewed in the preparation of this report were shared with the Valuation Analysis (E) Working Group and the NAIC in accordance with these requirements and continue to remain confidential in nature.

5

AG 53 Reviews - activity to date

Done:

- ✓ AG 53 filings received from 246 life insurers
- ✓ AG 53 Review Group (within the Valuation Analysis Working Group) formed
 - Team of actuaries, investment experts, and other financial staff to perform reviews
- ✓ Review process started with company prioritization, based on prior knowledge and template information

In Progress:

- AG 53 Review Group meeting frequently, with various state regulators presenting their review findings
- Identifying companies with outlier net yield assumptions
- Engaging with domestic regulators with the goal of decreasing highest net yield assumptions to remove companies from outlier list



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6

Implications of Higher Investment Net Yield Assumptions

- More favorable asset adequacy analysis results
- Lower amounts of assets needed for reserves to be considered adequate
 - A signal that more money could be released (dividends or other)
- Concern is, if risk is understated and assets underperform, reserves will turn out to be inadequate and that previously released money may have been needed

Amount to fund \$1 Billion liability in 15 years

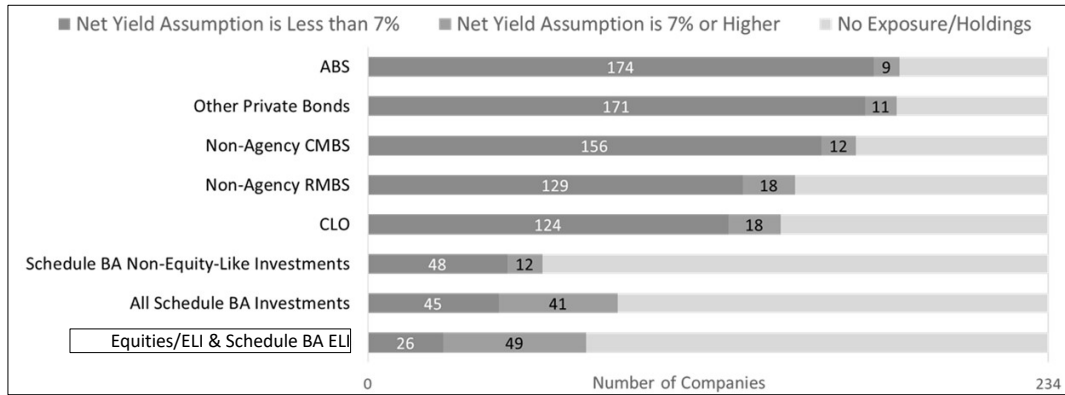
Company assumption type	Assumed net yield for high- yield assets	Adequate reserve per company's CFT	Adequate reserve per average conservative company's CFT	Amount (in excess of adequate reserve) available to be released per company's CFT
Most conservative	4.5%	\$ 520,000,000	\$ 520,000,000	\$ -
Moderately conservative	5.8%	\$ 430,000,000	\$ 520,000,000	\$ 90,000,000
Fairly aggressive	6.5%	\$ 390,000,000	\$ 520,000,000	\$ 130,000,000
Outlying / aggressive	7.8%	\$ 320,000,000	\$ 520,000,000	\$ 200,000,000

Range of Practice for Net Yield Assumptions

- Some companies are assuming outlier levels of high net yield assumptions. Reducing those outlying assumptions could result in:
 1. Less reliance on sustained high levels of investment returns (e.g., 8% for 30 years) in order to:
 - a. Make reserves adequate
 - b. Pay claims
 2. Not encouraging more companies to assume unreasonably high net yield assumptions to compete
- A vast majority of life insurers have reasonable net yield assumptions



Net Yield Assumptions A majority of companies assumed Net Yields < 7% for Initial Assets, but a sizable number of companies assumed Net Yields ≥ 7%



ELI = Equity-Like Investments/Instruments
*The Equities or ELI asset type and the Schedule BA ELI asset type were aggregated so that, for each company, the maximum yield among the two categories is reflected.



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9

Net Yield Assumptions For many asset types, a majority of companies assumed Net Yields < 5%

Net Yield for Initial Assets	ABS	Other Private Bonds	Non-Agency CMBS	Non-Agency RMBS	CLO	Schedule BA Non-ELI	All Schedule BA	Equities/ELI & Schedule BA ELI*
Less than 5%	134	129	124	103	58	26	24	12
5%-5.99%	27	31	18	17	38	17	14	6
6%-6.99%	13	11	14	9	28	5	7	8
7%-7.99%	6	4	6	8	9	2	9	16
8%-9.99%	1	5	6	6	7	10	24	23
10%+	2	2	0	4	2	0	8	10

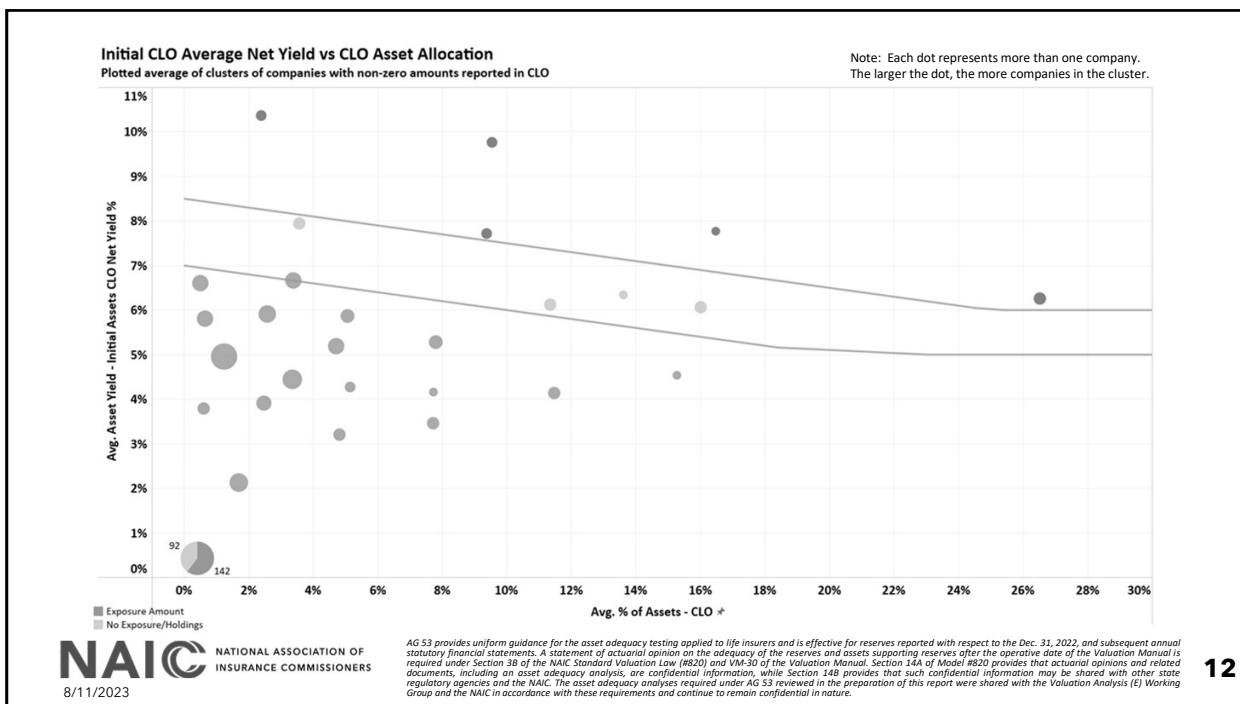
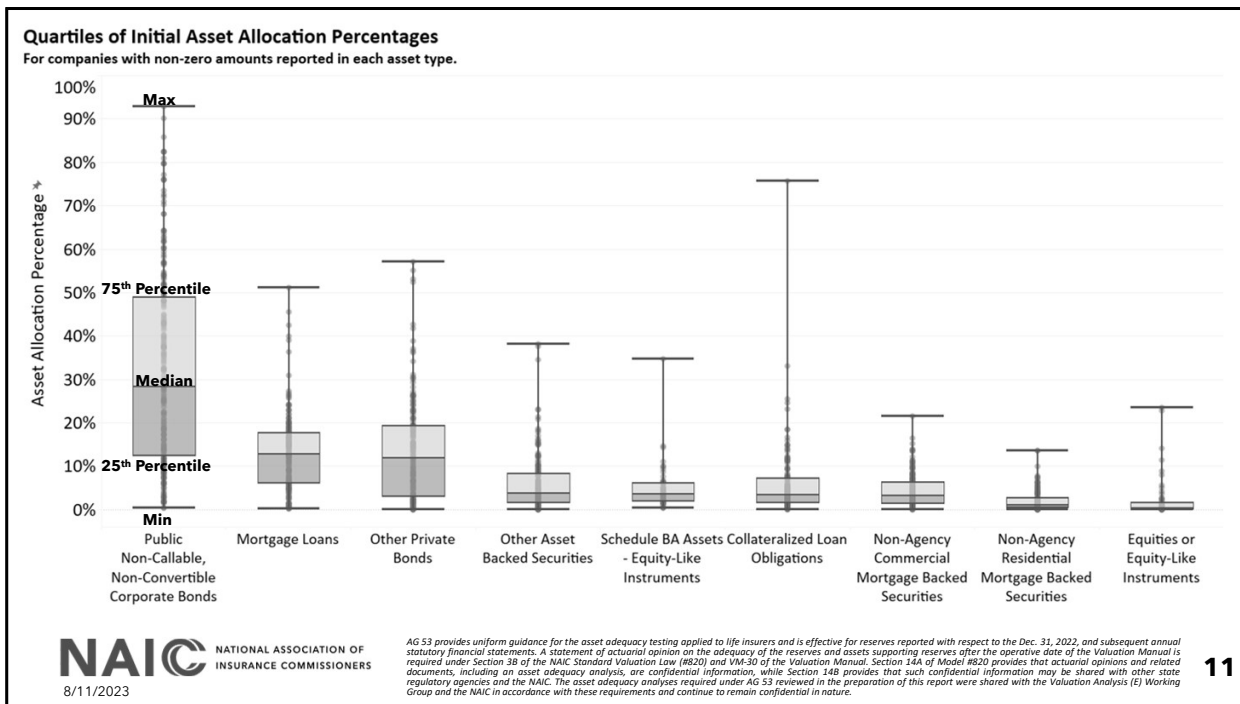
Net Yield for Reinvestments	ABS	Other Private Bonds	Non-Agency CMBS	Non-Agency RMBS	CLO	Schedule BA Non-ELI	All Schedule BA	Equities/ELI & Schedule BA ELI*
Less than 5%	28	129	26	25	11	26	1	1
5%-5.99%	39	31	29	24	21	17	5	2
6%-6.99%	30	11	13	6	14	5	6	4
7%-7.99%	1	4	11	0	17	2	1	6
8%-9.99%	1	5	0	0	8	10	10	16
10%+	0	2	0	0	4	0	3	4

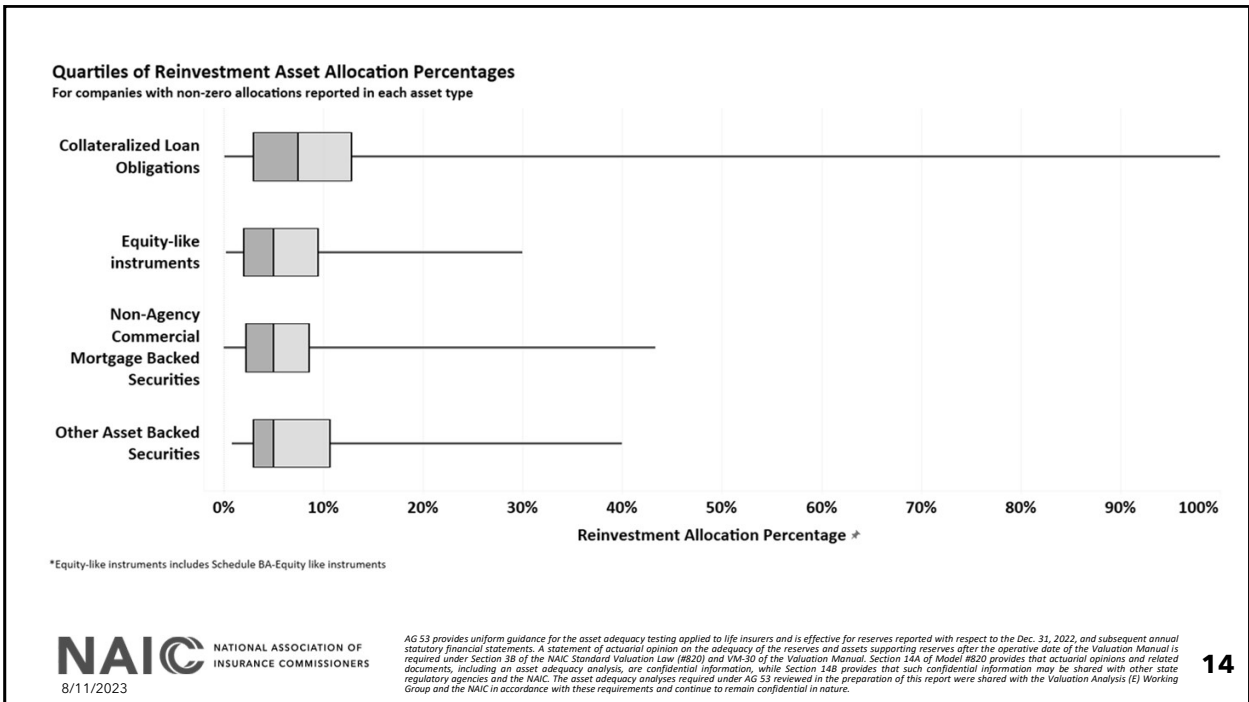
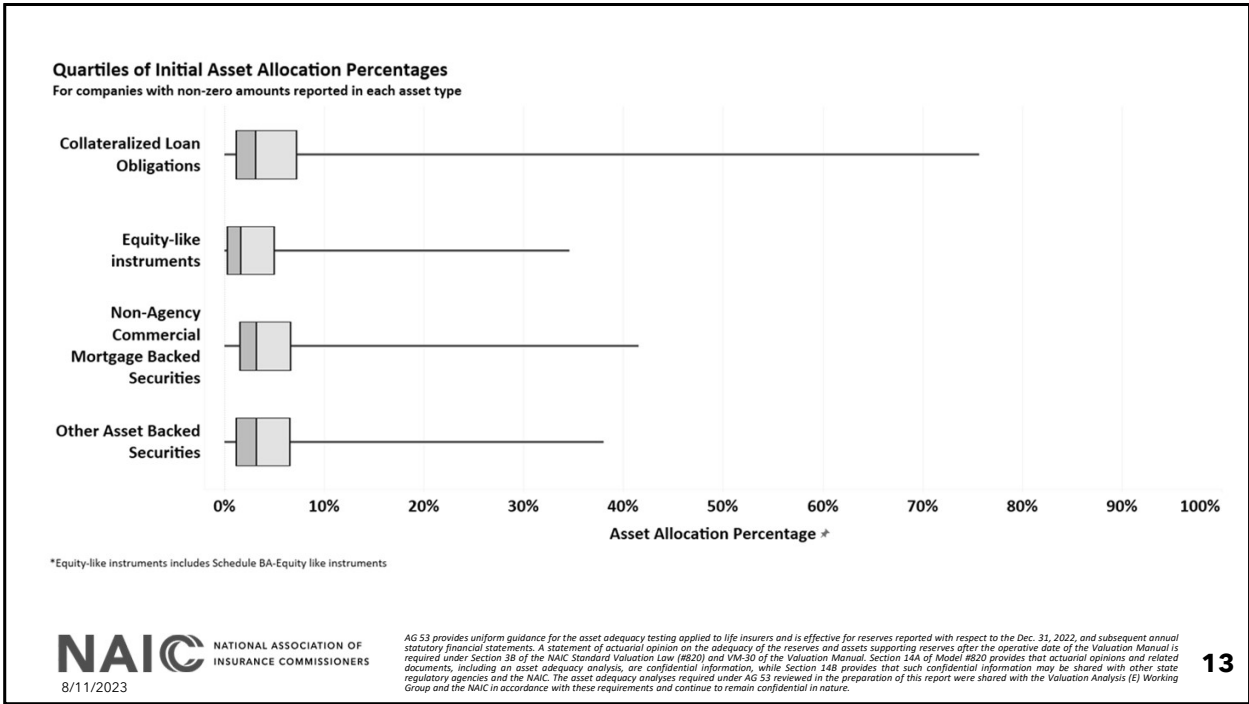
ELI = Equity-Like Investments/Instruments
*The Equities or ELI asset type and the Schedule BA ELI asset type were aggregated so that, for each company, the maximum yield among the two categories is reflected.



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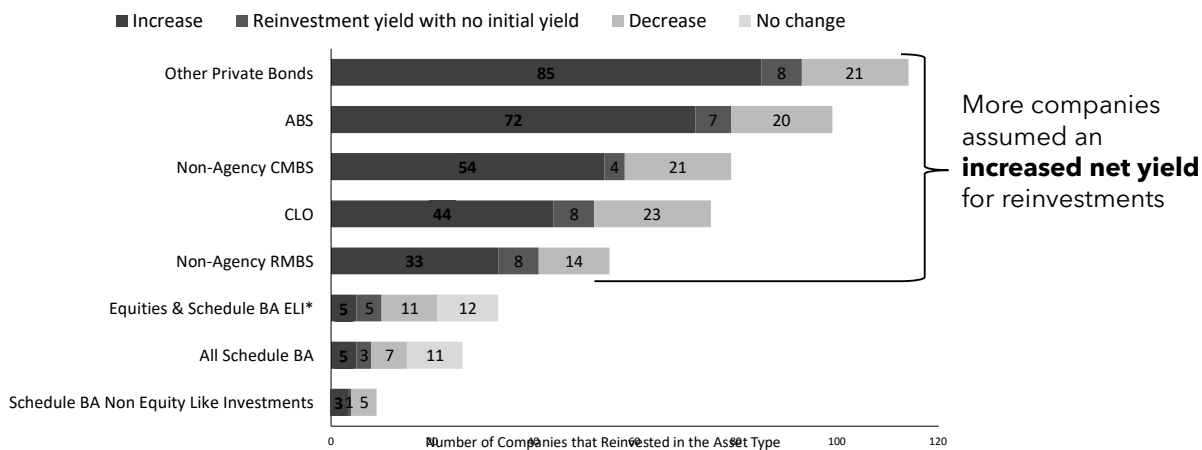
10







Reinvestment Net Yield compared to Initial Asset Net Yield



ELI = Equity-Like Investments/Instruments
*The Equities or ELI asset type and the Schedule BA ELI asset type were aggregated so that, for each company, the maximum yield among the two categories is reflected.



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15

Attribution of Guideline Excess Spreads for Initial Assets

- Beyond **Credit Risk** and **Illiquidity Risk**, a wide array of descriptions were used to identify the risk components related to the Guideline Excess Spread
- Risks identified as **other components** included:
 - Spread Widening
 - Call / Prepayment
 - Complexity
 - Convexity
 - Structure
 - Volatility
 - Interest Rate



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16



Examples of range of general practices

- **Assumptions in 30-year+ cash-flow testing projection:**

- | | |
|---|---|
| <ul style="list-style-type: none"> • Company 1 (reflective of most companies) <ul style="list-style-type: none"> • High performance will <u>continue for a short time</u> • Narrative: as markets increase in efficiency, <u>yields will decline over time</u> • <u>Excess returns</u> over market risk/return expectations <u>not reflected</u> in reinvestment assets | <ul style="list-style-type: none"> • Company 2 (reflective of small number of companies with outlying assumptions) <ul style="list-style-type: none"> • High performance will <u>continue throughout the projection</u> with little downside risk • <u>Little explanation</u> in narrative, <u>risks “too complicated to model”</u> • Attribution analysis: illiquidity or complexity are described as <u>reasons for excess returns</u> • Future <u>reinvestments</u> are projected to continue to have <u>high performance</u> |
|---|---|



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Regulator reactions to outlying practices

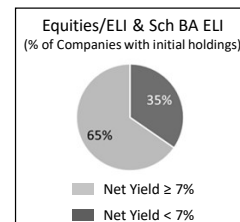
- Work with Company 2 types
 - Plan A: a soft touch - encourage adding conservatism to assumptions
 - Plan B: firmer tone - highly recommend adding conservatism
 - Plan C (if company resists Plans A and B): exercise regulatory authority as appropriate
- Domestic regulator is typically the point person
- If regulators are concerned about more widespread practice:
 - Typically work with LATF for potential consideration of rulemaking
 - Cash-flow testing of equity return assumptions may fit this category



AG 53 provides uniform guidance for the asset adequacy testing applied to life insurers and is effective for reserves reported with respect to the Dec. 31, 2022, and subsequent annual statutory financial statements. A statement of actuarial opinion on the adequacy of the reserves and assets supporting reserves after the operative date of the Valuation Manual is required under Section 38 of the NAIC Standard Valuation Law (#820) and VM-30 of the Valuation Manual. Section 144 of Model #820 provides that actuarial opinions and related documents, including an asset adequacy analysis, are confidential information, while Section 148 provides that such confidential information may be shared with other state regulatory agencies and the NAIC. The asset adequacy analyses required under AG 53 reviewed in the preparation of this report were shared with the Valuation Analysis (E) Working Group and the NAIC in accordance with these requirements and continue to remain confidential in nature.

Equity return assumptions

- For other asset types, above 7% assumed net returns are bordering on being an outlier
- For equities, it's more common for life insurers to assume returns in excess of 7%
 - While fixed-income securities are subject to interest rate scenarios, equities are typically modeled simplistically, with the return assumed to be the same each year
 - Other standards impacting life insurer products require reflection of volatility
 - e.g., VM-20, VM-21
- Even a small allocation to equities grows to be a substantial allocation over time if equities are assumed to earn excess returns in all scenarios
- Consideration for future LATF discussion - guardrails on assumed equity returns in asset adequacy analysis



Q&A on Reviews of Net Yields



AG 53 Next steps - Reinsurance collectability risk

- Requests for additional information from ceding companies are being sent in targeted situations:
 - Particularly if assuming company does not submit a VM-30 actuarial memorandum to a state
 - Inquiry:
 - Description and reason for significant reinsurance ceded transactions
 - Process and metrics used to evaluate the counterparty's asset risk and financial health
 - Reasons for review:
 - Help ensure future claims are paid and the US insurer's balance sheet is accurate
 - Are significant risks associated with reinsurance ceded appropriately addressed in the actuarial memorandum?
 - A US ceding company should not act like they've wiped their hands and balance sheet of the risk if the assuming company will be some combination of weakly capitalized, under-reserved, or with risky assets supporting reserves.
 - Bottom line: are there enough quality assets at the reinsurer to pay reinsurance claims in moderately adverse conditions?



AG 53 provides uniform guidance for the asset adequacy testing applied to life insurers and is effective for reserves reported with respect to the Dec. 31, 2022, and subsequent annual statutory financial statements. A statement of actuarial opinion on the adequacy of the reserves and assets supporting reserves after the operative date of the Valuation Manual is required under Section 38 of the NAIC Standard Valuation Law (#820) and VM-30 of the Valuation Manual. Section 144 of Model #820 provides that actuarial opinions and related documents, including an asset adequacy analysis, are confidential information, while Section 148 provides that such confidential information may be shared with other state regulatory agencies and the NAIC. The asset adequacy analyses required under AG 53 reviewed in the preparation of this report were shared with the Valuation Analysis (E) Working Group and the NAIC in accordance with these requirements and continue to remain confidential in nature.

21

AG 53 Next steps - Guidance Document

- Guidance Document for year-end 2023
 - Add clarification / fill in gaps identified during reviews of year-end 2022 filings, including:
 - Sensitivity test for currently-held equities
 - Structured asset information by tranche and related to payments in kind
 - Information about asset allocations in future projection years
 - Help ensure less volatility in classification as a projected high net yield asset
 - Template clarification and updates



AG 53 provides uniform guidance for the asset adequacy testing applied to life insurers and is effective for reserves reported with respect to the Dec. 31, 2022, and subsequent annual statutory financial statements. A statement of actuarial opinion on the adequacy of the reserves and assets supporting reserves after the operative date of the Valuation Manual is required under Section 38 of the NAIC Standard Valuation Law (#820) and VM-30 of the Valuation Manual. Section 144 of Model #820 provides that actuarial opinions and related documents, including an asset adequacy analysis, are confidential information, while Section 148 provides that such confidential information may be shared with other state regulatory agencies and the NAIC. The asset adequacy analyses required under AG 53 reviewed in the preparation of this report were shared with the Valuation Analysis (E) Working Group and the NAIC in accordance with these requirements and continue to remain confidential in nature.

22

AG 53 Reviews - "Phases"

- Transition to "Phase 2" reviews
 - Phase 1 focused on active companies with outlying net yield assumptions
 - Phase 2 will be other issues:
 - Incomplete documentation
 - Focus on narrative answers
 - Identify best / outlying practices (e.g., determination of fair value of internally-valued assets)

Mortality Improvements Life Working Group (MILWG): 2023 HMI and FMI Scale Update



Academy Mortality Improvements Life Work Group (MILWG)
SOA Mortality and Longevity Oversight Advisory Council (MLOAC)

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PRESENTED ON Life Actuarial Task Force (LATF) Call—7/20/23

Revisit Smoothing Process



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Review Smoothing Approach

	Current Method	Recommendation
1. Ages 0-15 (juvenile)	Use adult average (18-84) x 1.5	Use 0-20 average
2. Ages 16-20	Linear interpolation from juvenile rate to adult rate at age 21	Use 0-20 average
3. Ages 21-84	Use Adult Average 18-84	Break into more detailed age groups: 0-20 25-40 45-60 65-85 Linear interpolation between groups.
4. Ages 85-94	Linear interpolation from adult rate to .0025 per year ultimate level at age 95	Linear interpolation from 65-85 average to .001 per year ultimate level at age 95 (use .001 due to COVID considerations)
5. Ages 95 and later	Use constant .0025 (used .001 for 2022 due to COVID impact considerations)	Use constant .001 due to COVID considerations

3



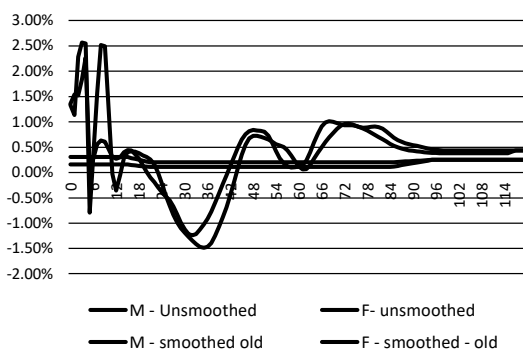
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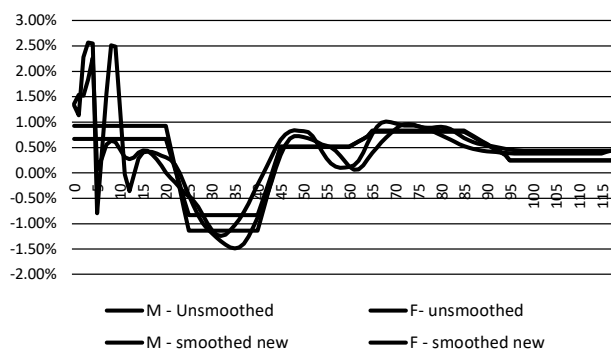
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Comparison of Smoothing Approaches

Smoothing—OLD



2023 Recommended HMI scale Smoothing—NEW



4



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COVID-19 Impact—2023 Approach



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COVID-19 Impact

COVID-19 Impact considerations

- Ensuring COVID-19 impact is considered
- Some companies with high credibility will use their best estimate mortality (including implied historical improvement) for long periods before grading to industry
 - Creates potential disconnect between HMI and the recommended industry FMI scale

Recommendation: COVID impact will be included in the first few years of the FMI scale for 2023 (similar to approach for 2022 scale work)



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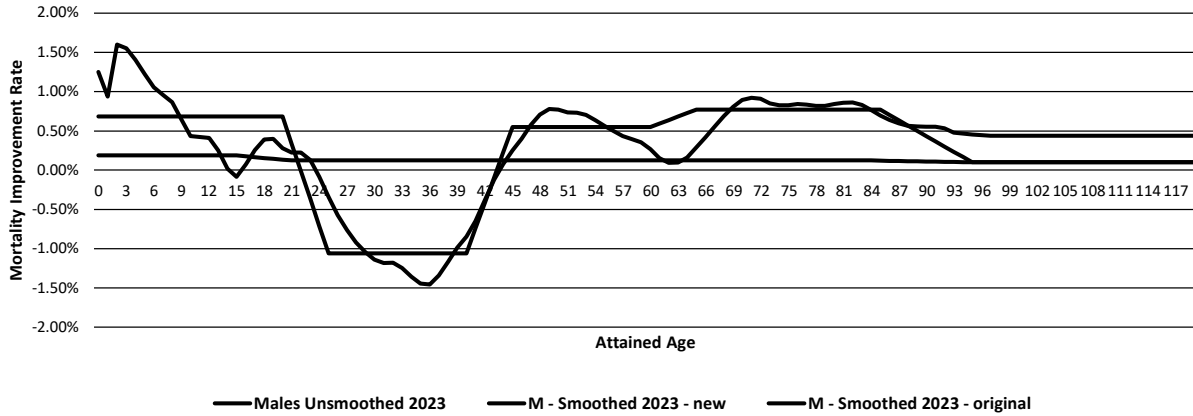
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Slide 6

DJNO Added -19

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HMI 2023 Recommendation Male, Mortality Improvement Rates



7

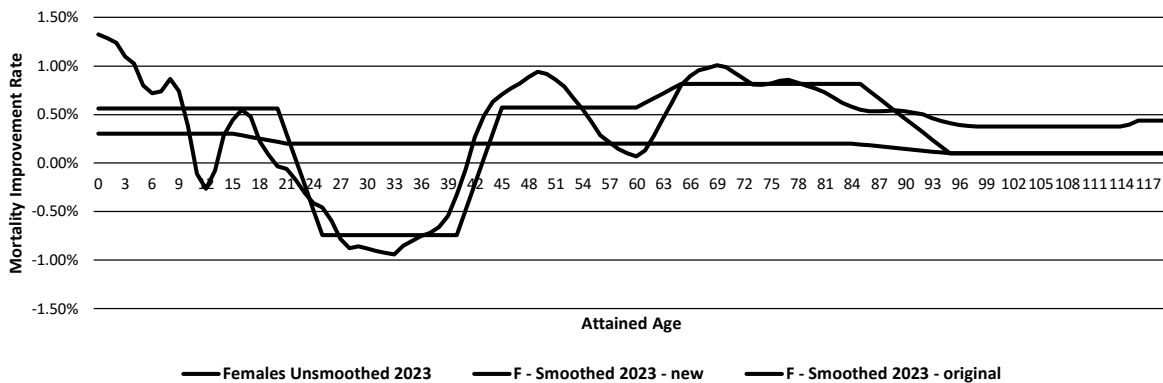


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HMI 2023 Recommendation Female, Mortality Improvement Rates



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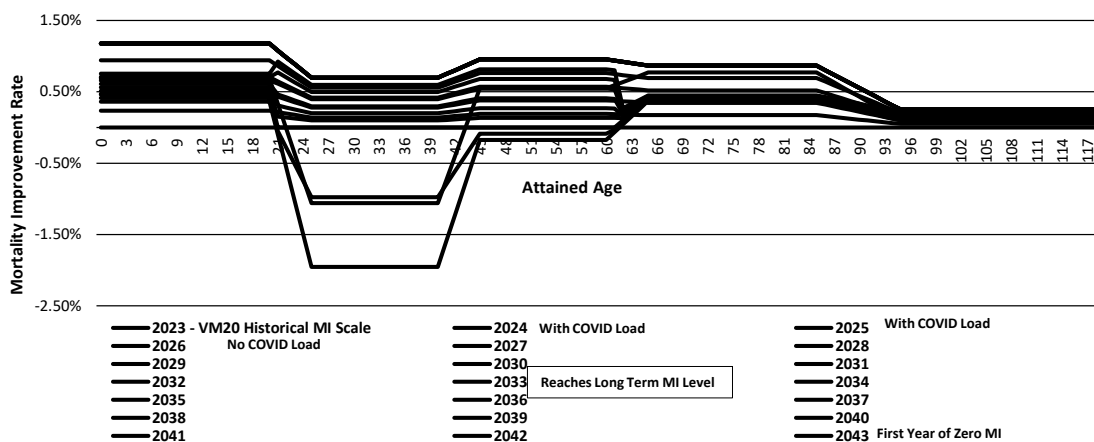


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FMI 2023 Recommendation—Basic Scale Male, Future Mortality Improvement Rates

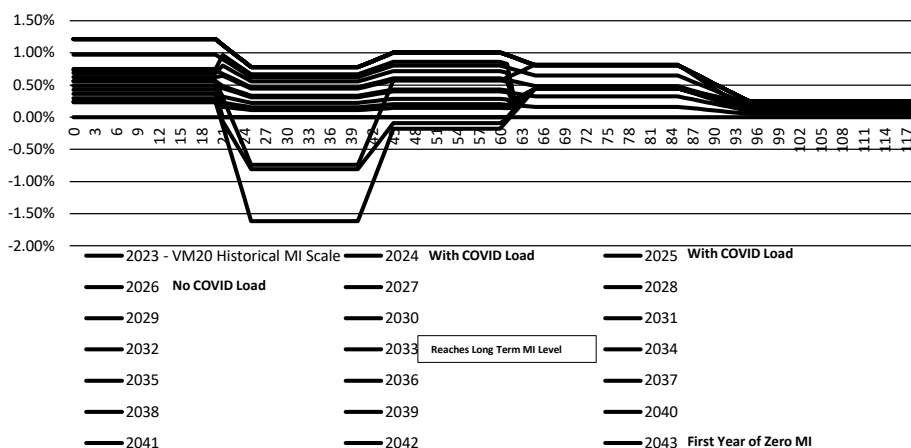


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FMI 2023 Recommendation—Basic Scale Female, Future Mortality Improvement Rates



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Questions?

11



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Life MI Subgroup Members

Marianne Purushotham, FSA, MAAA (Chair)

Cynthia Edwalds, FSA, MAAA

Sam Gutterman, FSA, MAAA

Tim Hoxha, FSA, MAAA

Mary Simmons, FSA, MAAA

Jean-Marc Fix, FSA, MAAA

Larry Stern, FSA, MAAA

Mark Rosa, FSA, MAAA

Cynthia MacDonald, FSA, MAAA

Members available to provide supplementary information and explanation as needed.



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SEATTLE

NAIC

2023 SUMMER
NATIONAL MEETING

NAIC Model Office Considerations

Scott O’Neal FSA, MAAA

August 11, 2023

NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

2023 SUMMER NATIONAL MEETING
NAIC

NAIC Model Office

ULSG

Universal Life with Secondary Guarantees (ULSG) model—long-duration product, larger potential for reserve reduction

- Model office and assumptions same as used in the yearly renewable term (YRT) representative model analysis
- Lifetime shadow account secondary guarantee
- No reinsurance in the model

Component	Values
Issue ages	Decennial issue ages 30 – 70
Gender	Male Female
Risk classes	Preferred non-tobacco Standard non-tobacco Standard tobacco
Face bands	Low (\$250,000) High (\$1,000,000)

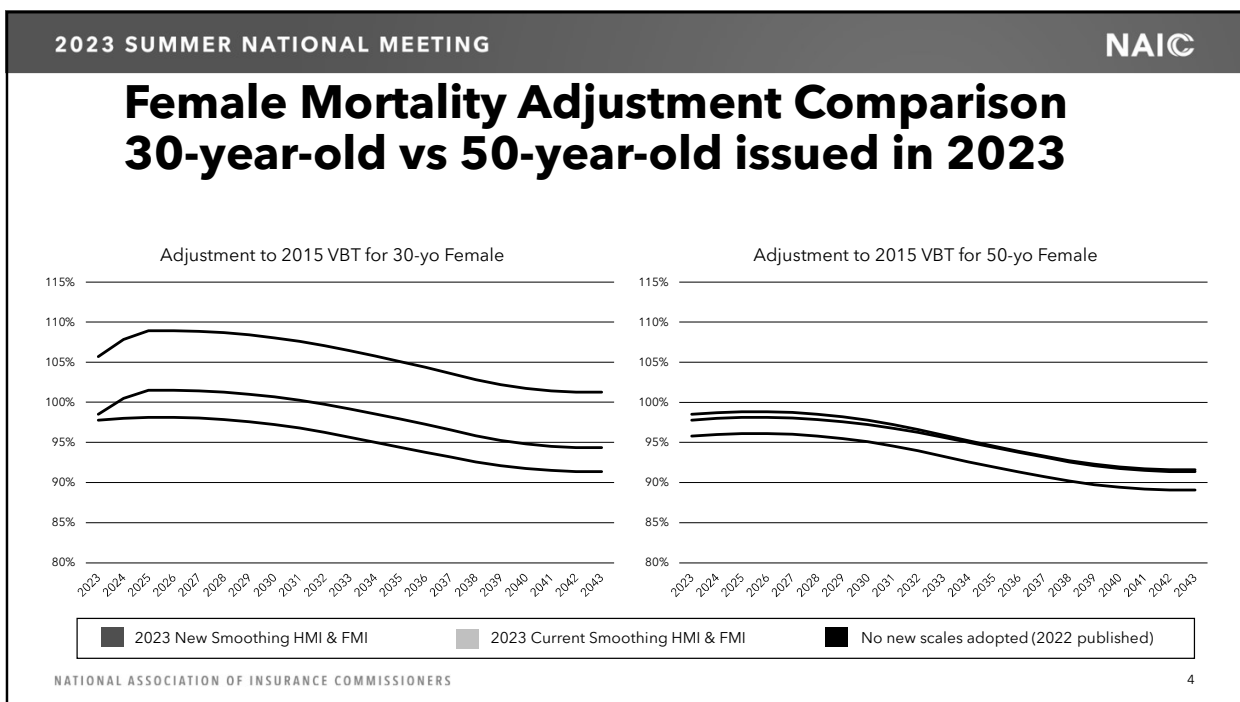
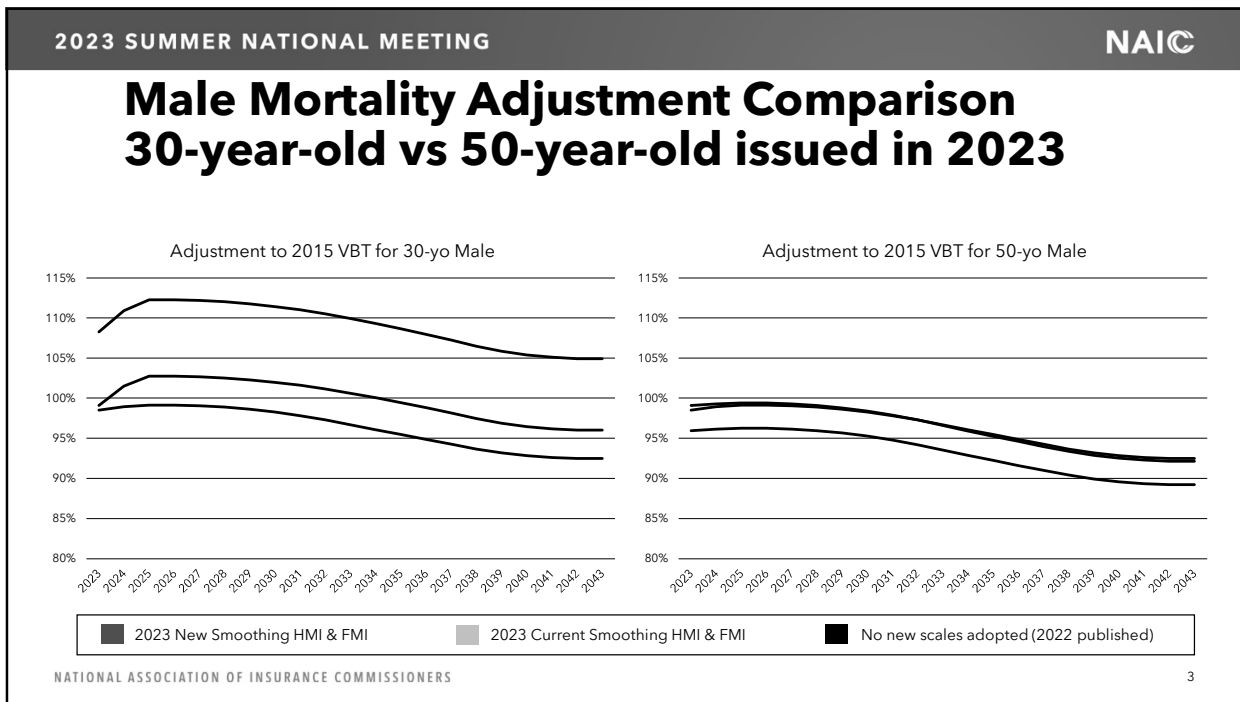
Term

Term Life Insurance Product with 10- and 20-year level premium periods

- Model office and assumptions same as used in the YRT representative model analysis
- Mature at age 95
- 100% shock lapse at end of level term period

Component	Values
Issue ages	Decennial issue ages 20 – 60
Gender	Male Female
Risk classes	Preferred non-tobacco Standard non-tobacco Standard tobacco
Face bands	Low (\$250,000) High (\$1,000,000)
Term lengths	10 year 20 year

NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS
2



NAIC Model Office Considerations

- Model office has an equal weight of each issue age, risk class, gender, face amount which may not be representative of the industry.
- For YE 2023, the scalar applied to the model office: $(1-HMI)^{7.5}$ (6/2015 to 12/2023)
 - The proposed HMI has deterioration for the proposed smoothing method for ages 25-40: **1.08** for a 30-yo male
 - The proposed HMI has slight improvement to mortality for ages 45-60: **0.96** for a 50-yo male
- We apply the HMI factors to both industry and company mortality in the model office, though companies that have highly credible data may not use the HMI to adjust the company mortality.
- GOES Field Test Participation:
 - Term: About half the GOES Field Test Participants for VM-20 had negative Term DR
 - ULSG: All baseline DR was positive

Next Steps

- Compare Term and ULSG model office results to understand the new HMI smoothing methodology impact to reserves
- Analyze model office results of a cohort with mortality deterioration and a cohort with mortality improvement cohorts to illustrate the new smoothing impact to reserves
 - 30-year-olds represent mortality deterioration
 - 50-year-olds represent mortality improvement
- Present findings after summer national meeting

Life Actuarial (A) Task Force/ Health Actuarial (B) Task Force Amendment Proposal Form*

1. Identify yourself, your affiliation and a very brief description (title) of the issue.

Identification:

Rachel Hemphill, FSA, FCAS, MAAA, Ph.D.

Title of the Issue:

Add guidance on consistency of HMI and FMI rates.

2. Identify the document, including the date if the document is “released for comment,” and the location in the document where the amendment is proposed:

VM-20 Section 9.C.2.h

January 1, 2023 NAIC Valuation Manual

3. Show what changes are needed by providing a red-line version of the original verbiage with deletions and identify the verbiage to be deleted, inserted or changed by providing a red-line (turn on “track changes” in Word®) version of the verbiage. (You may do this through an attachment.)

See attached.

4. State the reason for the proposed amendment? (You may do this through an attachment.)

For the last two years, the SOA has been restricted in the form of the historical and future mortality improvement rates that they are able to recommend, as the *Valuation Manual* pairs the industry future mortality improvement with both company-specific historical mortality improvement as well as industry historical mortality improvement. Therefore, the SOA’s future mortality improvement recommendation has not been able to assume a specific treatment of any considerations, such as COVID, in the historical mortality improvement.

Rather than continuing this restricted form of recommendations, this APF proposes to require that companies ensure that they are applying historical mortality improvement rates that are consistent with any considerations specifically identified by the SOA, adopted by LATF, and published along with the mortality improvement factors (e.g., COVID).

Also, because mortality improvement may be negative, the requirement should be that HMI “shall” be applied to the company mortality rates not “may” be applied.

* This form is not intended for minor corrections, such as formatting, grammar, cross-references or spelling. Those types of changes do not require action by the entire group and may be submitted via letter or email to the NAIC staff support person for the NAIC group where the document originated.

NAIC Staff Comments:

Dates: Received	Reviewed by Staff	Distributed	Considered
7/20/23	SO		
Notes: 2023-09			

VM-20 9.C.2.h

h. Mortality improvement shall not be incorporated beyond the valuation date in the company experience mortality rates. However, historical mortality improvement from the central point of the underlying company experience data to the valuation date ~~may~~ shall be incorporated. The company shall ensure that any specific considerations identified by the SOA, adopted by the Life Actuarial (A) Task Force, and published on the SOA website, at [link/reference to SOA site TBD] are reflected in the development of the company's historical mortality improvement assumption.

Guidance Note: Mortality improvement may be positive or negative (i.e., deterioration).

Interest Rates— Update on proposed Acceptance Criteria

Jason Kehrberg, MAAA, FSA
Chairperson, Economic Scenario Generator Subcommittee (ESGS)

Link Richardson, MAAA, FSA, CERA
Member, Economic Scenario Generator Subcommittee (ESGS)

National Association of Insurance Commissioners (NAIC)
Life Actuarial (A) Task Force (LATF)—August 12, 2023

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Agenda—Acceptance criteria for simulated interest rates 2

1. Background
2. Changes to previously proposed criteria
3. Newly proposed criteria
4. Discussion and Q&A
5. Appendix 1—Slides from Academy's 12/11/2022 presentation on interest rates

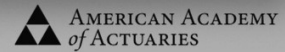
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1.

Background

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Background

LATF asked the Academy to deliver a series of presentations focused on proposing qualitative **Stylized Facts** and quantitative **Acceptance Criteria** for the three major components of an ESG used for statutory reporting purposes: **Interest Rates, Equity Returns, and Corporate Bond Fund Returns.**

This presentation provides an update on the Academy’s work to propose **Acceptance Criteria for Interest Rates**, including both newly developed criteria and minor changes to previously proposed criteria.

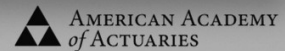
Prior presentations in this series:

- A Framework for Working with ESGs (8/8/22)
- ESG Governance Considerations (8/8/22)
- Equity Returns—Stylized Facts (8/9/22)
- Corporate Credit & Bond Fund Returns—Stylized Facts, Acceptance Criteria, and a Simplified Model (10/27/22)
- Interest Rates—Stylized Facts and Acceptance Criteria (12/11/22)

This and future presentations in this series:

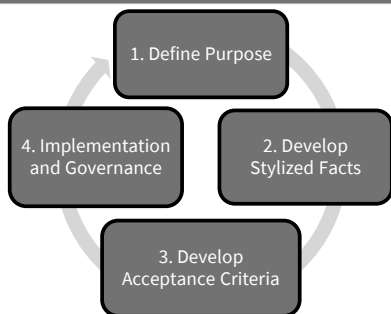
- **Interest Rates—Update on Proposed Acceptance Criteria (8/12/22)**
- Equity Returns—Acceptance criteria, including criteria for the joint distribution of equity returns and interest rates (TBD)

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A framework for developing, implementing, and evaluating ESGs and the scenario sets they produce

5



- 1. Define Purpose:** The intended purpose of the ESG informs the economic variables to be simulated and the relative importance of their “stylized facts.”
- 2. Develop Stylized Facts:** Stylized facts describe properties of the economic variables to be simulated. They are based on historical market data and economic theory and are prioritized relative to the defined purpose at hand. The establishment of stylized facts is critical for selecting candidate ESG models and a key prerequisite for the development of acceptance criteria.
- 3. Develop Acceptance Criteria:** A set of quantitative metrics or target values at different time horizons or in different economic conditions that provide a simplified framework for ensuring sets of scenarios produced by the ESG are consistent with key stylized facts.
- 4. Implementation and Governance:** ESG models are selected based on their ability to reflect the stylized facts, then calibrated in accordance with acceptance criteria. Validation reports are produced on each candidate scenario set generated by the ESG. These reports compare scenario set statistics to acceptance criteria and contain other charts and tables useful for evaluation and signoff, which is ultimately a matter of judgement (no automatic “pass” or “fail” based only on acceptance criteria). Implementation is an iterative process. It is important to periodically review and recalibrate the ESG as market conditions change over time.

“Statistical criteria are important in assessing the quality of an ESG. Statistical calibration criteria are usually numerically specified but can also be qualitative in nature. Statistical criteria belong to one of two broad categories: qualitative features and quantitative measures. The issues one must address in both categories are not amenable to a checklist approach, however, and expert judgment plays a role.”
(quote from p. 96 of the 2020 CAS/Conning research paper on ESGs)

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2.

6

Changes to previously proposed criteria

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Rate level
Criteria for the distribution of steady state interest rates

7

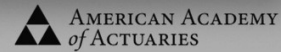
Percentile	20Y Criteria	1Y Criteria	"Buffers" can provide guidance on "too extreme"
99 th	> 13.55%	> 13.86%	[275 bps]
95 th	> 9.35%	> 9.02%	[250 bps]
85 th	> 7.54%	> 6.22%	[225 bps]
50 th	> 3.35% and < 4.88%	> 1.31% and < 3.34%	n/a
15 th	< 2.31%	< 0.16%	[70 bps]
5 th	< 1.78%	< 0.10%	[80 bps]
1 st	< 1.15%	< 0.07%	[90 bps]

- Criteria are based on 15-year half-life PEWs calculated from 1953.04 to 2021.12.
- Scenarios should be "plausibly more extreme" than the PEWs; however, scenarios that exceed the PEWs by more than a "buffer" may be "too extreme".
- Note, the range for the 50th percentile (Median) is based on the [40th] and [60th] PEW.
- Note, other categories of criteria cover rate dynamics in initial periods.

Changes from 12/11/2022 presentation:

- Min/Max criteria moved to new criteria focused on bounds and worse-than-history events.
- Removed 30th/70th percentile criteria.
- Steady state period changed from month [600] to months [961 through 1200] (years [80 through 100]).

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Rate volatility
Criteria for the standard deviation of monthly yield changes

8

Bucket	Yield Level (BOM)	1Y volatility		20Y volatility	
		Historical Stat	Desired range for scenario stat	Historical Stat	Desired range for scenario stat
Low	[≤ 3%]	0.59%	0.30% to 0.89%	0.61%	0.31% to 0.92%
Medium	[> 3%, ≤ 8%]	1.16%	0.58% to 1.73%	0.74%	0.37% to 1.12%
High	[> 8%]	3.32%	1.67% to 5.02%	1.54%	0.78% to 2.33%

Notes:

- The relevant statistic is the annualized standard deviation of monthly yield changes across all scenarios, bucketed by the rate level at the beginning of month (BOM).
- Desired ranges use a [50%] buffer on either side of the historical statistic.

Changes from 12/11/22 presentation:

- Steady state period changed from months [600] to months [961] through [1200] (years [80] through [100]). Initial period remains the first [10] years.
- A specific buffer of [50%] has been illustrated.

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Yield curve slope

Criteria for the shape of the yield curve

9

Percentiles of [20Y]-[1Y]	Bucketed by level of [20Y] rate		
	<=[3%]	>[3%] to <=[8%]	>[8%]
99 th	2.81% to 3.31%	4.06% to 4.56%	2.76% to 3.26%
95 th	2.64% to 3.14%	3.71% to 4.21%	2.41% to 2.91%
90 th	2.52% to 3.02%	3.44% to 3.94%	2.05% to 2.55%
85 th	2.28% to 2.78%	3.23% to 3.73%	1.94% to 2.44%
15 th	-0.01% to 0.49%	-0.56% to -0.06%	-1.46% to -0.96%
10 th	-0.11% to 0.39%	-0.71% to -0.21%	-1.79% to -1.29%
5 th	-0.23% to 0.27%	-0.97% to -0.47%	-2.06% to -1.56%
1 st	-0.32% to 0.18%	-1.73% to -1.23%	-3.43% to -2.93%

Changes from 12/11/22 presentation:

- Added percentiles further out in the tails.
- Steady state period changed from months 600 to months 961 through 1200 (years 80 through 100). Initial period remains the first 10 years.

Notes:

- Based on historical percentiles using data from [1953.04 to 2021.12] and a [50 bps] buffer.
- Historical statistics are in black.

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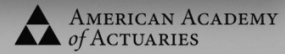
Newly proposed criteria

Description of new categories of acceptance criteria

11

- Criteria for upper and lower bounds and worse-than-history frequencies for rate and slope levels
- Criteria for reversion of median rate and slope levels
- Low-for-long criteria

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Criteria for upper and lower bounds and worse-than-history frequencies for rate and slope levels

12

	Bucket	Lower Bound	Upper Bound	Historical Min and Max (for reference) ¹	Worse-Than-History Frequencies ²
Rates:					
1Y	n/a	-0.5% to -1%	20% to 24%	0.05% & 16.97%	0.5% to 1.5%
20Y	n/a	0% to 0.5%	17% to 20%	0.95% & 15.78%	0.5% to 1.5%
Slopes:					
20Y-1Y	20Y <= 3%	-0.5% to -1.5%	3% to 4%	0.02% & 2.85%	0.5% to 2%
20Y-1Y	3% < 20Y <= 8%	-2% to -3.5%	4.5% to 6%	-1.38% & 4.15%	0.5% to 2%
20Y-1Y	8% < 20Y	-4% to -5%	3.5% to 5.5%	-3.36% & 2.90%	0.5% to 2%

¹ Historical Min and Max determined using monthly observations from 1953.04 to 2021.12.
² The same Worse-Than-History frequency ranges are proposed for both the left and right tail.
³ These criteria are applied to the steady state period, i.e., months [961] through [1200] (years [80] through [100])

eh0

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Slide 12

eh0 Where is fn 3 referrer ?
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JK0 0 The 3rd footnote applies to the entire slide.
Jason Kehrberg, 2023-08-07T17:50:36.810

Criteria for reversion of median rate and slope levels

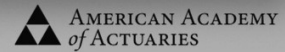
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Proposed criteria for interim rate levels is expressed in terms of the length of time it takes for initial rates and slopes to revert 50% of the way to their steady state levels (e.g., half-lives).

The Academy is currently using reference models to further explore potential additional interim criteria.

	Proposed range for half-life of median reversion
Rates:	
1Y	[10] to [20] years
20Y	[10] to [20] years
Slopes:	
20Y-1Y	[2] to [8] years

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Low-for-long criteria for steady state interest rate levels

14

- Proposed *additional, steady state, low-for-long* criteria uses the concept of “sojourn length,” i.e., the number of years an interest rate stays within a defined corridor.
 - Criteria for [1Y] rate: During months [961 to 1200] (years [80 to 100]), the 1Y rate stays below [0.5%] for at least [5] consecutive years in at least [X%] of scenarios.
 - Criteria for [20Y] rate: During months [961 to 1200] (years [80 to 100]), the 20Y rate stays below [2%] for at least [5] consecutive years in at least [X%] of scenarios.
- This steady state low-for-long criteria can be combined with the NAIC’s current initial period low-for-long criteria to ensure desired low-for-long behavior throughout the simulation. DB0
- Reference models can and should be used to refine the numbers in brackets.

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Slide 14

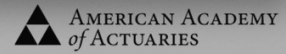
DB0 I just want to make sure that we want to use this spelling?
Devin Boerm, 2023-08-02T19:59:21.526

JK0 0 I'd go with "behavior" since intended for US audience
Jason Kehrberg, 2023-08-07T17:51:52.423

4.

Discussion and Q&A

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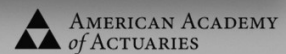


Thank You

Contact:

Amanda Barry-Moilanen, Life Policy Analyst,
barrymoilanen@actuary.org

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5.

Appendix 1 – Slides from Academy’s 12/11/2022 presentation on Interest Rates

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Interest Rates— Stylized Facts and Acceptance Criteria

Jason Kehrberg, MAAA, FSA
Chairperson, Economic Scenario Generator Work Group (ESGWG)

Link Richardson, MAAA, FSA, CERA
Member, Economic Scenario Generator Work Group (ESGWG)

National Association of Insurance Commissioners (NAIC) Life Actuarial (A) Task Force (LATF)
December 11, 2022

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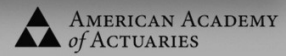


Agenda—Interest rates

19

1. Background
2. Stylized Facts
3. Acceptance Criteria
4. Discussion and Q&A

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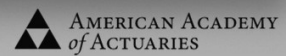


1.

20

Background

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Background

21

LATF asked the Academy to deliver a series of presentations focused on proposing qualitative **Stylized Facts** and quantitative **Acceptance Criteria** for the three major components of an ESG used for statutory reporting purposes: **Interest Rates, Equity Returns, and Corporate Bond Fund Returns**.

This presentation proposes **Stylized Facts** and **Acceptance Criteria** for Interest Rates that (a) are independent of any specific ESG model, (b) can be used to identify and evaluate candidate ESG models, and (c) can be used to evaluate a set of stochastic scenarios.

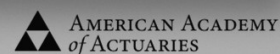
Prior presentations in this series:

- A Framework for Working with ESGs (8/8/22)
- ESG Governance Considerations (8/8/22)
- Equity Returns—Stylized Facts (8/9/22)
- Corporate Credit & Bond Fund Returns—Stylized Facts, Acceptance Criteria, and a Simplified Model (10/27/22)

This and future presentations in this series:

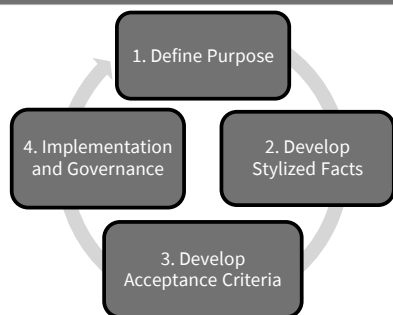
- **Interest Rates—Stylized Facts and Acceptance Criteria**
- Equity Returns—Acceptance Criteria

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A framework for developing, implementing, and evaluating ESGs and the scenario sets they produce

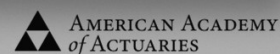
22



“Statistical criteria are important in assessing the quality of an ESG. Statistical calibration criteria are usually numerically specified but can also be qualitative in nature. Statistical criteria belong to one of two broad categories: qualitative features and quantitative measures. The issues one must address in both categories are not amenable to a checklist approach, however, and expert judgment plays a role.”
(quote from p. 96 of the 2020 CAS/Conning research paper on ESGs)

1. **Define Purpose:** The intended purpose of the ESG informs the economic variables to be simulated and the relative importance of their “stylized facts.”
2. **Develop Stylized Facts:** Stylized facts describe properties of the economic variables to be simulated. They are based on historical market data and economic theory and are prioritized relative to the defined purpose at hand. The establishment of stylized facts is critical for selecting candidate ESG models and a key prerequisite for the development of acceptance criteria.
3. **Develop Acceptance Criteria:** A set of quantitative metrics or target values at different time horizons or in different economic conditions that provide a simplified framework for ensuring sets of scenarios produced by the ESG are consistent with key stylized facts.
4. **Implementation and Governance:** ESG models are selected based on their ability to reflect the stylized facts, then calibrated in accordance with acceptance criteria. Validation reports are produced on each candidate scenario set generated by the ESG. These reports compare scenario set statistics to acceptance criteria and contain other charts and tables useful for evaluation and signoff, which is ultimately a matter of judgement (no automatic “pass” or “fail” based only on acceptance criteria). Implementation is an iterative process. It is important to periodically review and recalibrate the ESG as market conditions change over time.

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Excerpts from the 2020 Casualty Actuarial Society (CAS)/Conning research paper on ESGs

23

High-level features of a good ESG:

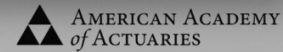
- “It produces simulation results that reflect the economic view of the risk manager.
- Scenarios are consistent with **realistic market dynamics**.
- A large simulation should produce some **extreme but plausible results** (i.e., the simulation covers and moderately exceeds the benchmark stylized facts).
- Component models and architecture must have sufficient flexibility to serve in multiple roles.

If one discusses the essential features of a good ESG with a diverse group of ESG experts, those experts’ lists of features and the relative importance of those features will vary. However, they will set forth a common core of ideas that can serve as a checklist of best practices.”

A good ESG:

1. “has a solid methodological foundation for the way the models are built and the way the variables are interrelated, and models are parsimonious, practical, and comprehensive.
2. provides a comprehensive suite of macroeconomic and financial variables and a multi-economy capability.
3. can accommodate many types of calibration views across a wide range of benchmarks.
4. produces simulation results that reflect a relevant view.
5. produces some extreme but plausible outcomes.
6. embeds realistic market dynamics.
7. is computationally efficient and numerically stable.
8. has fast and robust recalibration capabilities.
9. meets the requirements of regulators and auditing firms.
10. produces sufficient simulation detail for extensive validation.”

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The NAIC presented LATF with preliminary goals for interest rates on 12/3/20 and preliminary boundary guidance on 2/17/22

24

Preliminary goal

1. The model’s starting yield curve should fit the actual starting yield curve as closely as possible.
2. The model should produce a variety of yield curve shapes, and they should change over time.
3. Interest rates can be negative.

Preliminary boundary guidance

- Yield curve fit and Yield curve shape (priority 4)*
- a) Review initial actual vs. fitted spot curve differences for a sampling of 5 dates representing different shapes and rate levels for the entire curve and review fitted curves qualitatively to confirm they stylistically mimic the different actual yield curve shapes
 - b) The frequency of different yield curve shapes in early durations should be reasonable considering the shape of the starting yield curve (e.g., a flatter yield curve leads to more inversions).
 - c) The steady state curve has normal shape (not inverted for short maturities, longer vs shorter maturities, or between long maturities)
- Negative rates (priority 3)*
- a) All maturities could experience negative interest rates
 - b) Interest rates may remain negative for multi-year time periods
 - c) Rates should generally not be lower than -1.5%

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The NAIC presented LATF with preliminary goals for interest rates on 12/3/20 and preliminary boundary guidance on 2/17/22 (continued)²⁵

Preliminary goal	Preliminary boundary guidance
4. The model should be capable of producing a reasonable range of results for very long simulations.	<p><i>High rates (priority 2)</i></p> <p>a) The scenario set should reasonably reflect history, with some allowance for more extreme high and low interest rate environments</p> <p>b) Upper Bound:</p> <p>i. 20% is >= 99th percentile on the 3M yield fan chart, and no more than 5% of scenarios have 3M yields that go above 20% in the first 30 years</p> <p>ii. 20% is >= 99th percentile on the 10Y yield fan chart, and no more than 5% of scenarios have 10Y yields that go above 20% in the first 30 years</p>
5. The ESG should be capable of producing low interest rates for an extended period of time.	<p><i>Low for long (priority 1)</i></p> <p>a) For scenarios generated as of 12/31/20, at least 10% of scenarios should have a 10-year geometric average of the 20-year US Treasury yield that is below its current level (e.g., 1.45% at 12/31/20)</p> <p>b) For scenarios generated as of 12/31/20, at least 5% of scenarios should have a 30-year geometric average of the 20-year US Treasury yield that is below its current level (e.g., 1.45% at 12/31/20)</p>

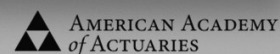
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The NAIC presented LATF with preliminary goals for interest rates on 12/3/20 and preliminary boundary guidance on 2/17/22 (continued)²⁶

Preliminary goal	Preliminary boundary guidance
6. The model should produce interest rate levels that fluctuate significantly over long periods.	<p><i>Volatility (no priority given)</i></p> <p>Preliminary boundary guidance not specified</p>
7. The interest rate generator should be arbitrage free.	<p><i>Arbitrage free (priority 3)</i></p> <p>No longer considered an explicit requirement in the 2/17/22 preliminary boundary guidance since the NAIC's ESG Drafting Group was proposing the use of a generalized fractional floor.</p>
8. The ESG should be calibrated using an appropriate historical period.	<p><i>Historical calibration period (no priority given)</i></p> <p>Preliminary boundary guidance not specified</p>

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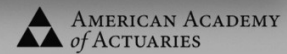


27

2.

Stylized Facts

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28

Groupings for stylized facts about interest rates

Stylized Facts have been grouped into the following three categories:

1. Level of Interest Rates
2. Volatility of Interest Rates
3. Term Structure of Interest Rates (shape of yield curve)

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*Stylized Facts***1. Level of Interest Rates**

29

The level of interest rates (the cost of borrowing money) changes due to a variety of complex and interrelated factors (e.g., supply of and demand for financing, business cycle, GDP, inflation, central bank actions to stimulate the economy or control inflation).

- a. Short-term rates (which the Fed has more control of) have generally fallen within a range of 0% to 20% and have most often been within the lower part of that range. Long-term rates have generally been within 300 bps of short-term rates.
- b. Negative interest rates are possible (have been observed outside the U.S.) but unlikely due to structural and market differences between the U.S. and other economies.
- c. Interest rates can exhibit multi-year trends (e.g., up, down, low-for-long). Interest rates can stay at very low levels for several years. Short-term rates can stay very near their lower bound for several years while higher long-term rates continue to fluctuate.

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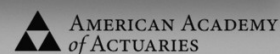
*Stylized Facts***2. Volatility of Interest Rates**

30

The volatility of interest rates varies over time, with periods of both high and low volatility.

- a. Monthly changes in interest rates are generally limited in size (less than 80 bps) but changes tend to be greater when the level of interest rates is higher.
- b. Monthly changes in short-term rates tend to be larger than monthly changes in long-term rates when short-term rates are not near their lower bound, but the opposite relationship tends to hold when short-term rates are near their lower bound.
- c. Volatility tends to increase in stressed markets.

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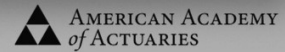
*Stylized Facts***3. Term Structure of Interest Rates (shape of yield curve)**

31

The yield curve embodies the term structure of interest rates and takes a variety of shapes.

- a. The normal yield curve shape is upward sloping (long-term rates greater than short-term rates) and concave downward. Normal yield curve shapes can persist for extended periods of time.
- b. Non-normal yield curve shapes include inversions (downward sloping), humps, and valleys. Inversions (and other non-normal yield curve shapes) are often associated with key points in the business cycle (e.g., recession indicator) but generally don't persist for extended periods of time.
- c. The slope of the yield curve tends to be lower (even negative/inverted) when short-term rates are at relatively high levels.

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32

3.

Acceptance Criteria

Unless otherwise specified, tables and charts on the following slides are based on two primary data sources:

1. Historical U.S. Treasury yields from the "Historical Curves" tab of the August 2022 Academy Interest Rate Generator (AIRG) located at <https://soa.org/resources/tables-calcs-tools/research-scenario/>
2. Simulated U.S. Treasury yields from "10000_Path_Set_1a_Conning_GFF_Baseline_Equity_123121" located at <https://naic.conning.com/scenariofiles>

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This section discusses acceptance criteria around four key properties of interest rates identified in the stylized facts 33

1. Rate level

- Includes criteria around high, low, and negative rates.
- Only **steady state** criteria is being proposed at this point. **Interim** rate level criteria, which depend heavily on initial conditions, are being developed and will be proposed later.

2. Rate volatility

- Criteria varies by rate level (applies to interim and steady state).

3. Yield curve shape

- Criteria varies by rate level (applies to interim and steady state).

4. Low-for-long

- Although the ESGWG has not finalized its proposal for this key property of interest rates, we present our qualitative understanding of low-for-long for discussion and feedback.

Acceptance criteria provide a simplified framework for validating key scenario properties but are only part of a larger validation exercise that includes other charts, statistics, and of course, judgment.

Criteria were developed with the following principles in mind:

- The scenario set should include some extreme but plausible scenarios.
- Pathwise behavior is as important as point-in-time distributions.
- Scenarios should be consistent with realistic market dynamics over both short- and long-term horizons.

"The importance of pathwise model behavior is that it is the simulated path that represents the way an insurance company will experience the evolution of the economy. In other words. The pathwise behavior is the only thing of interest when we want to investigate simulation dynamics. If the overall distribution of returns for an asset class is correct but the pathwise behavior does not correspond to the nature of the fluctuations that we see in the historical record, then there is a potential model issue." (p. 107)

"A good ESG will be capable of being calibrated to coherent targets across multiple simulation horizons." (p. 106)

(quotes from the 2020 CAS/Conning research paper on ESGs)

Rate level

Historical PEWs (see appendix for additional information on PEWs) 34

- Selected 15-year half-life “Percentiles Exponentially Weighted” (PEWs) on historical month-end interest rates are proposed as steady state acceptance criteria for rate level (high, low, and negative).
 - *Ideally, corresponding percentiles on scenario sets are “plausibly more extreme” than the PEWs.*
- Calculated using data from April 1953, but unlike typical percentiles where data is weighted equally, PEWs give exponentially less weight to older data.
- PEWs are defined by their “half-life.” A half-life of 15 years means data that is 15 years older receives half the weight.
- A half-life of 15 years is suggested to give more weight to recent data while not overreacting to short-term fluctuations.

“Stability versus responsiveness: As a common trade-off and concern in general actuarial work, it is important to consider where the happy medium is between a long period of data (enhancing stability) and a recent shorter data period (that promotes responsiveness to more recent conditions).”
(quote from p. 129 of the 2020 CAS/Conning research paper on ESGs)

15-year half-life PEWs at 12/31/21	20Y	1Y
Max	15.52%	16.97%
99 th PEW	13.55%	13.86%
95 th PEW	9.35%	9.02%
85 th PEW	7.54%	6.22%
70 th PEW	5.77%	4.88%
60 th PEW	4.88%	3.34%
50 th PEW	4.33%	2.11%
40 th PEW	3.35%	1.31%
30 th PEW	2.83%	0.49%
15 th PEW	2.31%	0.16%
5 th PEW	1.78%	0.10%
1 st PEW	1.15%	0.07%
Min	0.98%	0.05%

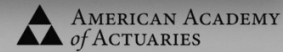
Rate level
Criteria for the distribution of steady state interest rates

35

	20Y Criteria	1Y Criteria	"Buffers" could provide guidance on "too extreme"
Max	> 15.52%	> 16.97%	[300 bps]
99 th Percentile	> 13.55%	> 13.86%	[275 bps]
95 th Percentile	> 9.35%	> 9.02%	[250 bps]
85 th Percentile	> 7.54%	> 6.22%	[225 bps]
70 th Percentile	> 5.77%	> 4.88%	[200 bps]
50 th Percentile	> 3.35% and < 4.88%	> 1.31% and < 3.34%	n/a
30 th Percentile	< 2.83%	< 0.49%	[60 bps]
15 th Percentile	< 2.31%	< 0.16%	[70 bps]
5 th Percentile	< 1.78%	< 0.10%	[80 bps]
1 st Percentile	< 1.15%	< 0.07%	[90 bps]
Min	< 0.98%	< 0.05%	[100 bps]

- Criteria is based on 15-year half-life PEWs.
- Scenarios should be "plausibly more extreme" than the PEWs.
- But scenarios that exceed the PEWs by more than a "buffer" may be "too extreme".
- Test statistics:
 - Percentiles of the [20Y] and [1Y] rate distributions at month [600] (year [50]).
 - Max and Min of the [20Y] and [1Y] rate distributions are from projection months [480] through [720] (years [40] through [60]).
- Note, the range for the 50th percentile (Median) is based on the 40th and 60th PEW.

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Rate level
Illustrative application of criteria to field test scenario set #1a

36

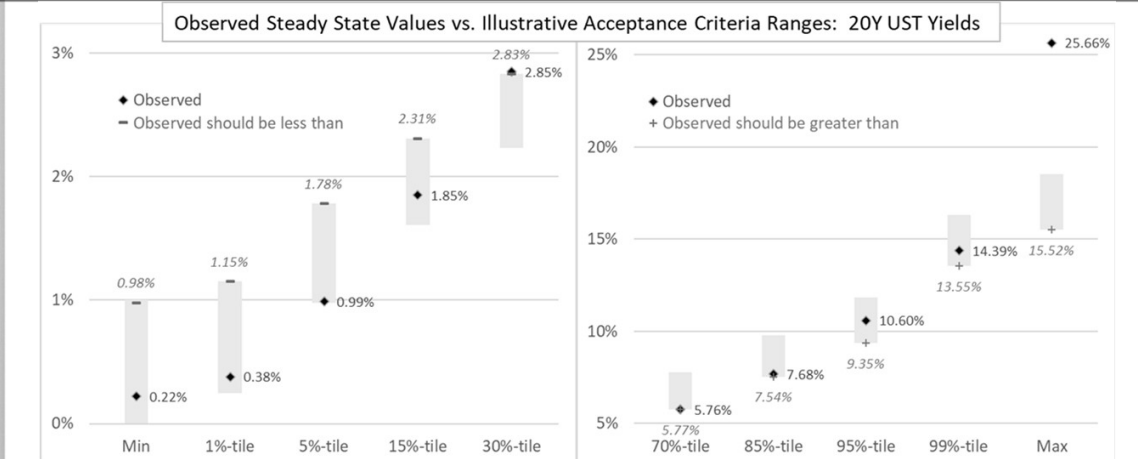
	20Y Criteria	1Y Criteria	Buffers	20Y Stat	20Y Result	1Y Stat	1Y Result
Max	> 15.52%	> 16.97%	[300 bps]	25.66%	> Buffer (714 bps)	29.60%	> Buffer (963 bps)
99 th Percentile	> 13.55%	> 13.86%	[275 bps]	14.39%	In range	15.40%	In range
95 th Percentile	> 9.35%	> 9.02%	[250 bps]	10.60%	In range	11.09%	In range
85 th Percentile	> 7.54%	> 6.22%	[225 bps]	7.68%	In range	7.41%	In range
70 th Percentile	> 5.77%	> 4.88%	[200 bps]	5.76%	< PEW (1 bp)	4.71%	< PEW (17 bps)
50 th Percentile	> 3.35% and < 4.88%	> 1.31% and < 3.34%	n/a	4.20%	In range	2.35%	In range
30 th Percentile	< 2.83%	< 0.49%	[60 bps]	2.85%	> PEW (2 bps)	0.40%	In range
15 th Percentile	< 2.31%	< 0.16%	[70 bps]	1.85%	In range	0.07%	In range
5 th Percentile	< 1.78%	< 0.10%	[80 bps]	0.99%	In range	-0.26%	In range
1 st Percentile	< 1.15%	< 0.07%	[90 bps]	0.38%	In range	-0.53%	In range
Min	< 0.98%	< 0.05%	[100 bps]	0.22%	In range	-0.79%	In range

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Rate level

Illustrative application of criteria to field test scenario set #1a (continued) 37

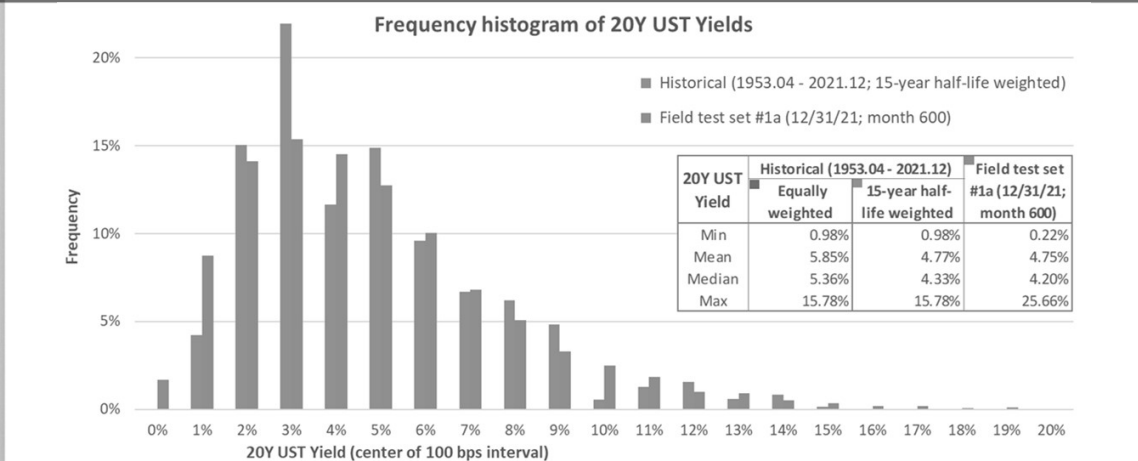


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Rate level

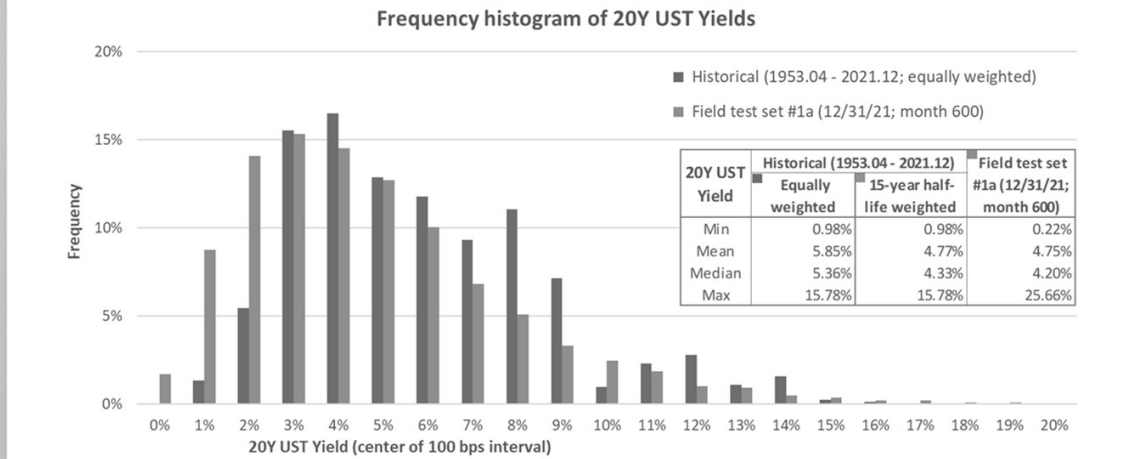
Supplemental chart for evaluating rate levels on consistent basis with PEWs 38



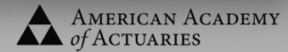
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Rate level
Supplemental chart for evaluating rate levels on consistent basis with PEWs 39

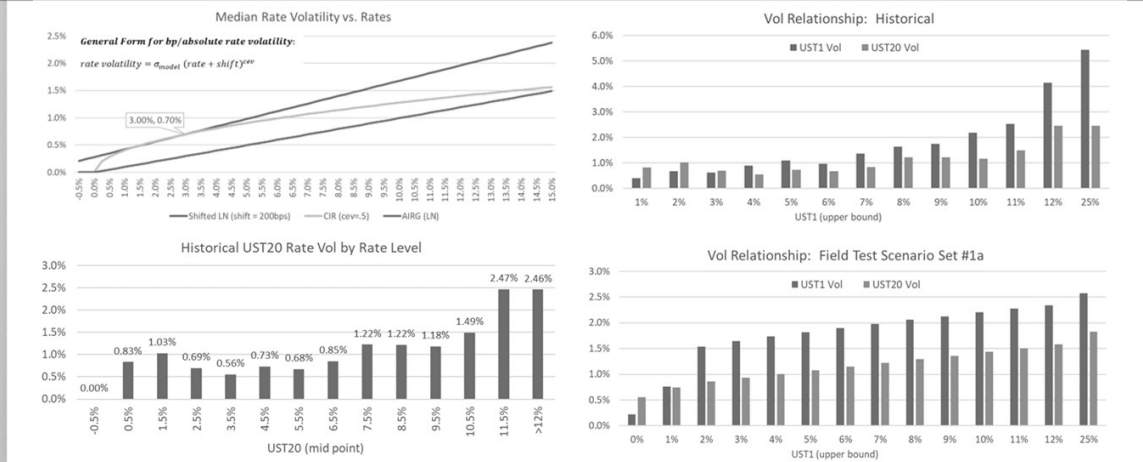


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Rate volatility
Background

40



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Rate volatility
Historical statistics and Criteria

41

Historical volatility statistics

Annualized standard deviation of monthly yield changes from 1953.04 to 2021.12, bucketed by yield level at beginning of month (BOM):

Bucket	Yield Level (BOM)	1Y	20Y
Low	[≤ 3%]	0.59%	0.61%
Medium	[> 3%, ≤ 8%]	1.16%	0.74%
High	[> 8%]	3.32%	1.54%

Note that short (1Y) rate volatility tends to exceed long (20Y) rate volatility, except when rates are low.

Volatility criteria

- » For the relevant test statistics on the candidate scenario set, calculate the annualized standard deviation of monthly yield changes across all scenarios, bucketed by the rate level at the BOM.
 - Calculate the above test statistics for both the first [10] years and steady state, e.g., years [40] to [60].
- » The above test statistics should be “reasonably close” to the historical volatility statistics in the table to the left.
 - For example, the above test statistics should be within [X]% of historical volatility statistics.

Rate volatility
Illustrative application of rate volatility criteria to field test scenario set #1a

42

Tabular comparison of annualized standard deviation of 1Y and 20Y UST rates to history

	Bucket	Yield Level (BOM)	History	First [10] years		Steady state*	
				Simulated	Difference	Simulated	Difference
1Y UST	Low	[≤ 3%]	0.59%	1.06%	47 bps above	1.05%	46 bps above
	Medium	[> 3%, ≤ 8%]	1.16%	1.88%	72 bps above	1.85%	69 bps above
	High	[> 8%]	3.32%	2.31%	101 bps below	2.31%	101 bps below
20Y UST	Low	[≤ 3%]	0.61%	0.66%	5 bps above	0.68%	7 bps above
	Medium	[> 3%, ≤ 8%]	0.74%	1.00%	26 bps above	1.11%	37 bps above
	High	[> 8%]	1.54%	1.61%	7 bps above	1.69%	15 bps above

* Years [40] to [60]

Rate volatility

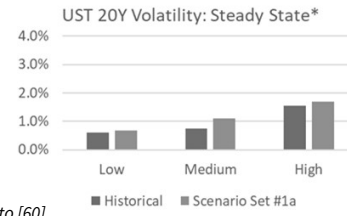
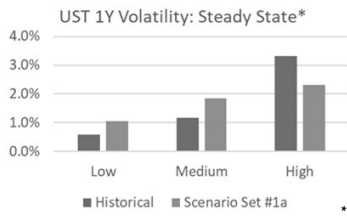
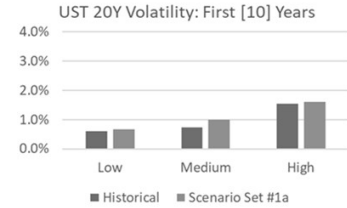
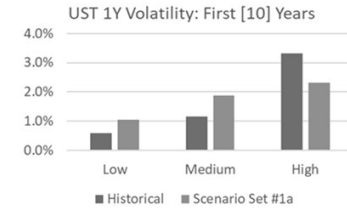
Illustrative application of rate volatility criteria to field test scenario set #1a

43

Graphical comparison of annualized standard deviation of 1Y and 20Y UST rates to history

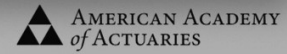
Observations on Set #1a:

- Initial and steady state volatility are similar
- Volatility is generally higher than history
- In the Low bucket:
 - 1Y volatility roughly double history
 - 20Y volatility roughly equal to history



*Years [40] to [60]

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**Yield curve slope
Historical statistics**

44

Historical yield curve slope statistics

Selected percentiles on the distribution of slope (month-end [20Y] less month-end [1Y] yields) from 1953.04 to 2021.12, bucketed by [20Y] rate:

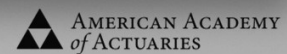
Bucket	Yield Level (BOM)	% Inverted	Min	5%	15%	30%	Median	70%	85%	95%	Max
Low	[≤ 3%]	0%	0.0%	0.3%	0.5%	1.1%	1.6%	2.0%	2.3%	2.6%	2.9%
Medium	[> 3%, ≤ 8%]	17%	-1.4%	-0.5%	-0.1%	0.4%	0.9%	1.8%	3.3%	3.8%	4.3%
High	[> 8%]	25%	-3.4%	-1.5%	-0.8%	0.3%	1.2%	1.8%	2.1%	2.7%	3.9%

Criteria

- For the test statistics on the candidate scenario set, calculate selected percentiles on the distribution of slope ([20Y] less [1Y] yield) across all scenarios, bucketed by the level of the [20Y] yield level.
 - Calculate above for both the first [10] years and steady state, e.g., years [40] to [60].
- The [15th] and [85th] percentiles should be “plausibly more extreme” than history.

Historical data indicates the distribution of curve shapes (particularly inversions) varies by rate level.

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Yield curve slope

Illustrative application of criteria to field test scenario set #1a

45

Historical

Bucket	Inv %	Min	5%	15%	30%	Median	70%	85%	95%	Max
Low	0%	0.0%	0.3%	0.5%	1.1%	1.6%	2.0%	2.3%	2.6%	2.9%
Medium	17%	-1.4%	-0.5%	-0.1%	0.4%	0.9%	1.8%	3.3%	3.8%	4.3%
High	25%	-3.4%	-1.5%	-0.8%	0.3%	1.2%	1.8%	2.1%	2.7%	3.9%

Field test #1a (first [10] years)

Bucket	Inv %	Min	5%	15%	30%	Median	70%	85%	95%	Max
Low	6%	-4.5%	-0.2%	0.6%	1.0%	1.3%	1.6%	1.9%	2.2%	3.1%
Medium	35%	-9.2%	-2.6%	-1.3%	-0.3%	0.7%	1.5%	2.3%	3.0%	4.5%
High	62%	-10.0%	-5.2%	-3.4%	-2.0%	-0.7%	0.5%	1.3%	2.2%	3.7%

Difference (field test #1a less historical)

Bucket	Inv %	Min	5%	15%	30%	Median	70%	85%	95%	Max
Low	6%	-4.6%	-0.5%	0.1%	-0.2%	-0.3%	-0.5%	-0.4%	-0.4%	0.2%
Medium	18%	-7.9%	-2.1%	-1.2%	-0.6%	-0.3%	-0.3%	-1.0%	-0.8%	0.3%
High	37%	-6.7%	-3.7%	-2.5%	-2.3%	-1.9%	-1.3%	-0.8%	-0.5%	-0.2%

Notes:

- Slope = [20Y] less [1Y] yield
- Bucketed by [20Y] yield
- Buckets:
 - Low [≤ 3%]
 - Medium [> 3%, ≤ 8%]
 - High [> 8%]
- The [15th] percentile is more extreme than history if the difference is negative.
- The [85th] percentile is more extreme than history if the difference is positive.

Yield curve slope

Illustrative application of criteria to field test scenario set #1a

46

Historical

Bucket	Inv %	Min	5%	15%	30%	Median	70%	85%	95%	Max
Low	0%	0.0%	0.3%	0.5%	1.1%	1.6%	2.0%	2.3%	2.6%	2.9%
Medium	17%	-1.4%	-0.5%	-0.1%	0.4%	0.9%	1.8%	3.3%	3.8%	4.3%
High	25%	-3.4%	-1.5%	-0.8%	0.3%	1.2%	1.8%	2.1%	2.7%	3.9%

Field test #1a (steady state, e.g., years [40] to [60])

Bucket	Inv %	Min	5%	15%	30%	Median	70%	85%	95%	Max
Low	4%	-4.5%	0.3%	0.9%	1.2%	1.6%	2.0%	2.3%	2.6%	3.1%
Medium	19%	-10.5%	-2.0%	-0.4%	0.7%	1.7%	2.5%	3.1%	3.5%	4.6%
High	39%	-11.3%	-3.6%	-1.8%	-0.5%	0.6%	1.5%	2.2%	2.8%	4.2%

Difference (field test #1a less historical)

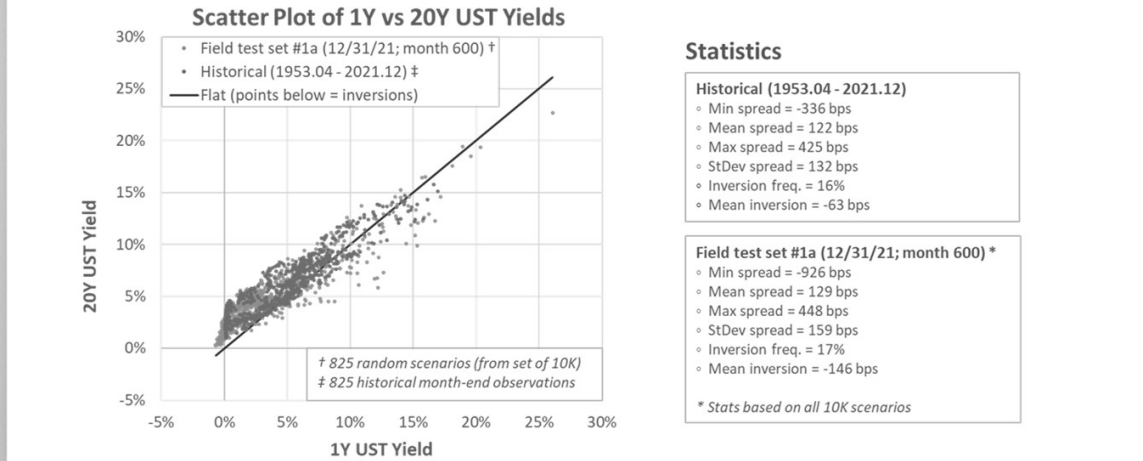
Bucket	Inv %	Min	5%	15%	30%	Median	70%	85%	95%	Max
Low	4%	-4.5%	0.0%	0.4%	0.1%	0.0%	0.0%	0.0%	0.0%	0.2%
Medium	2%	-9.2%	-1.5%	-0.3%	0.4%	0.8%	0.8%	-0.2%	-0.3%	0.4%
High	14%	-8.0%	-2.0%	-1.0%	-0.8%	-0.6%	-0.3%	0.1%	0.1%	0.3%

Notes:

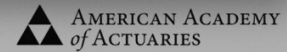
- Slope = [20Y] less [1Y] yield
- Bucketed by [20Y] yield
- Buckets:
 - Low [≤ 3%]
 - Medium [> 3%, ≤ 8%]
 - High [> 8%]
- The [15th] percentile is more extreme than history if the difference is negative.
- The [85th] percentile is more extreme than history if the difference is positive.

Yield curve slope
 Supplemental chart for evaluating rate yield curve slope

47

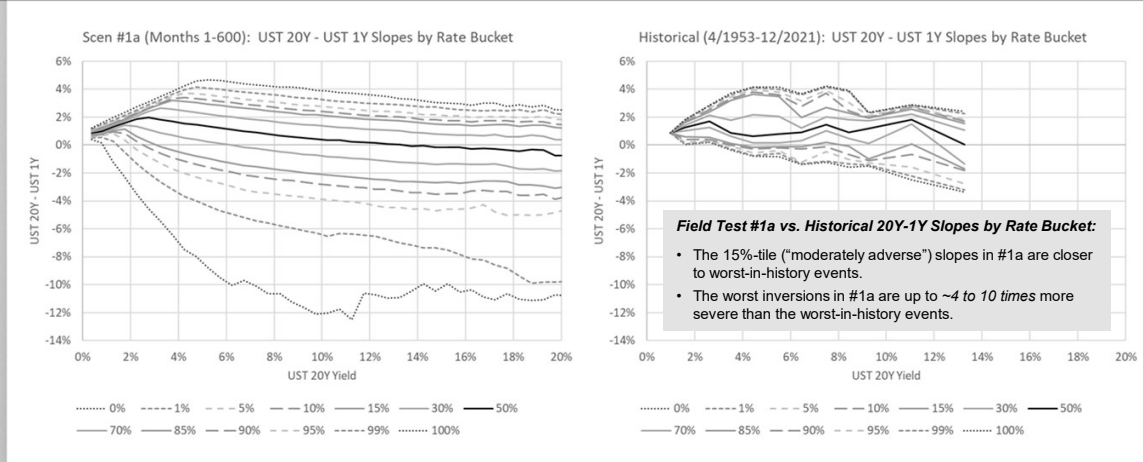


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Yield curve slope
 Supplemental chart for evaluating rate yield curve slope

48



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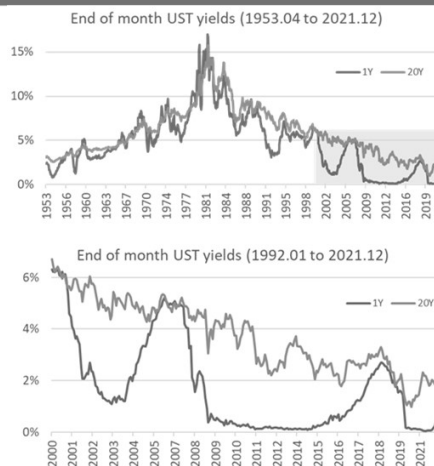
4. Low-for-long Qualitative understanding

49

Although the ESGWG has not finalized its proposal for this key property of interest rates, we present our qualitative understanding of low-for-long for discussion and feedback.

Historical observations on low-for-long interest rate behavior:

1. (a) The long rate [20Y] stays below a threshold [3%] for an extended period of time [5+ years]. (b) During this time, the long rate continues to fluctuate as usual.
2. (a) The short rate [1Y] is “stuck” in a very narrow range [50bps] above zero. (b) During this time, short rate volatility (which normally exceeds long rate volatility) drops to near zero.
3. Low-for-long is a relatively recent phenomenon (post-2000 in the US; limited historical data).



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4.

50

Discussion and Q&A

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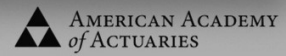
Thank You

51

Contact:

- Amanda Barry-Moilanen, Life Policy Analyst, barrymoilanen@actuary.org

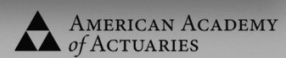
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52

Appendix

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PEWs

Additional information on Percentiles Exponentially Weighted (PEWs)

53

The development of historical statistics for economic variables such as interest rates and equity rates involves subjective decisions such as how much history to include. One way to make use of all available data, but to focus more heavily on more recent data, is to develop exponentially weighted averages and percentiles.

An AWE is an Average Weighted Exponentially, with parameter Alpha. The most recent historical period, typically a month, gets an initial weight of 100%. Each prior historical period gets (1- α) times the weight of the next most recent period. Based on the number of historical periods of available data, the weights are then normalized so that their sum is 100%. The AWE is simply the weighted average of all the available or selected data. The "half-life" is then the period of time for which the cumulative weight reaches 50%.

PEWs apply the same concept to develop exponentially weighted percentiles. The historical values are unchanged, but their relative weight is dependent on when they occurred. Values are rank-ordered, with percentiles based on the sum of the relative weights up to the particular value. It may be desirable to assign percentiles at the center of each value's weight range, especially if extreme values are important or statistical distributions will be fitted to the percentiles.

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PEWs

Historical UST 20Y PEWs at different half-lives (12/31/2021)

54

	Equally Weighted	20Yr Half-Life	15Yr Half-Life	10Yr Half-Life	5Yr Half-Life
Maximum	15.52 %	15.52 %	15.52 %	15.52 %	15.52 %
99th PEW	13.92 %	13.63 %	13.55 %	12.49 %	8.11 %
95th PEW	11.70 %	10.44 %	9.35 %	8.59 %	5.78 %
85th PEW	8.48 %	7.94 %	7.54 %	6.47 %	4.47 %
70th PEW	7.09 %	6.20 %	5.77 %	4.87 %	3.08 %
50th PEW	5.36 %	4.64 %	4.33 %	3.31 %	2.66 %
30th PEW	4.06 %	3.05 %	2.83 %	2.63 %	2.20 %
15th PEW	2.95 %	2.47 %	2.31 %	2.08 %	1.85 %
5th PEW	2.31 %	1.85 %	1.78 %	1.45 %	1.23 %
1st PEW	1.43 %	1.18 %	1.15 %	1.05 %	1.05 %
Minimum	0.98 %	0.98 %	0.98 %	0.98 %	0.98 %
Max minus Min	14.54 %	14.54 %	14.54 %	14.54 %	14.54 %
99th minus 1st	12.48 %	12.45 %	12.40 %	11.44 %	7.06 %
95th minus 5th	9.39 %	8.59 %	7.57 %	7.14 %	4.55 %
85th minus 15th	5.53 %	5.47 %	5.23 %	4.39 %	2.62 %
70th minus 30th	3.03 %	3.15 %	2.94 %	2.24 %	0.88 %

* Historical 20 year Treasury rates are from: 1) 1953.04 - 1977.01 - monthly average rates from Fed H15 monthly history report;
2) 1977.02 - 1993.09 - estimated month-end 20 year rates by averaging 10 year and 30 year; 3) 1993.10 - current: actual month end rates.

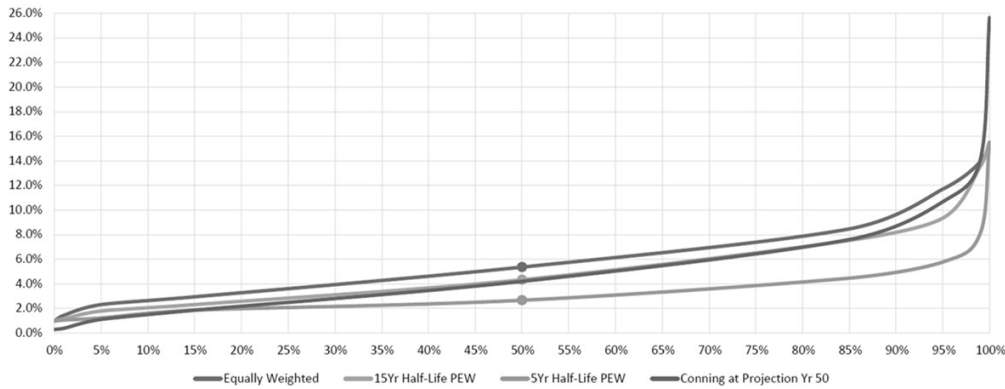
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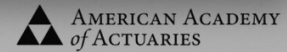
PEWs
Chart of UST 20Y PEWs at different half-lives (12/31/2021)

55

20Yr Treasury Cumulative Distribution Function
1953.04 - 2021.12



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PEWs
Historical movement in 15-year half-life PEWs

56

	PEWs from April 1953 through:						
	1971.12	1991.12	2001.12	2011.12	2016.12	2020.12	2021.12
	(50 years ago)	(30 years ago)	(20 years ago)	(10 years ago)	(5 years ago)	(1 year ago)	Current
Maximum	7.34 %	15.52 %	15.52 %	15.52 %	15.52 %	15.52 %	15.52 %
99th PEW	7.24 %	14.32 %	14.03 %	13.88 %	13.63 %	13.55 %	13.55 %
95th PEW	6.85 %	13.28 %	12.48 %	11.45 %	10.64 %	10.04 %	9.35 %
85th PEW	6.18 %	11.19 %	9.18 %	8.34 %	8.01 %	7.60 %	7.54 %
Mean (AWE)	4.60 %	8.03 %	7.38 %	6.24 %	5.46 %	4.91 %	4.77 %
50th PEW	4.20 %	8.11 %	7.05 %	5.68 %	4.91 %	4.47 %	4.33 %
15th PEW	3.30 %	4.25 %	5.46 %	4.19 %	2.77 %	2.49 %	2.31 %
5th PEW	2.86 %	3.49 %	3.96 %	3.61 %	2.31 %	1.78 %	1.78 %
1st PEW	2.60 %	2.80 %	2.93 %	2.66 %	1.90 %	1.15 %	1.15 %
Minimum	2.57 %	2.57 %	2.57 %	2.57 %	1.78 %	0.98 %	0.98 %
99th minus 1st	4.64 %	11.52 %	11.10 %	11.22 %	11.73 %	12.40 %	12.40 %
95th minus 5th	3.99 %	9.79 %	8.52 %	7.84 %	8.33 %	8.26 %	7.57 %
85th minus 15th	2.88 %	6.94 %	3.72 %	4.15 %	5.24 %	5.11 %	5.23 %

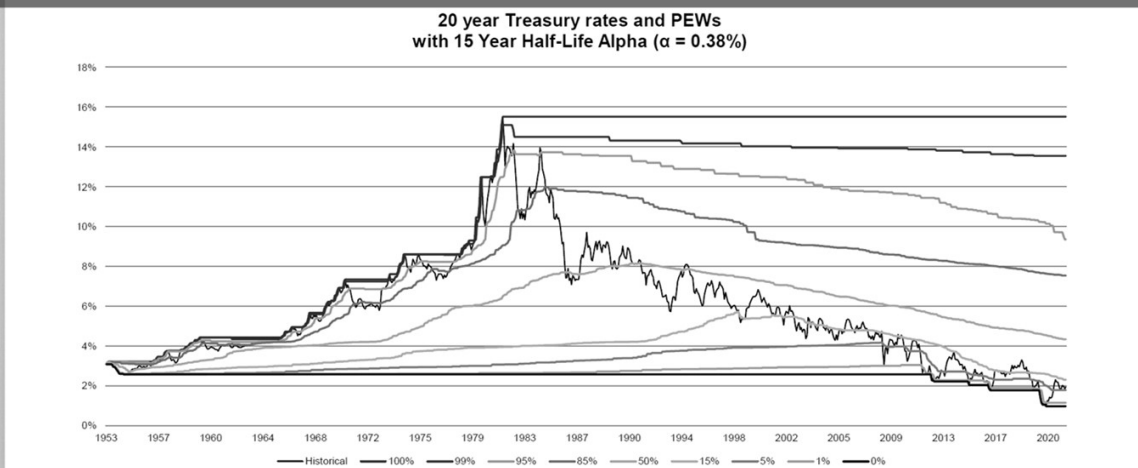
* Percentiles Exponentially Weighted (PEW) are determined by the specified alpha
* Historical 20 year Treasury rates are from: 1) 1953.04 - 1977.01 - monthly average rates from Fed H15 monthly history report;
2) 1977.02 - 1993.09 - estimated month-end 20 year rates by averaging 10 year and 30 year; 3) 1993.10 - current: actual month end rates.

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PEWs
Chart of historical movement in 15-year half-life PEWs

57

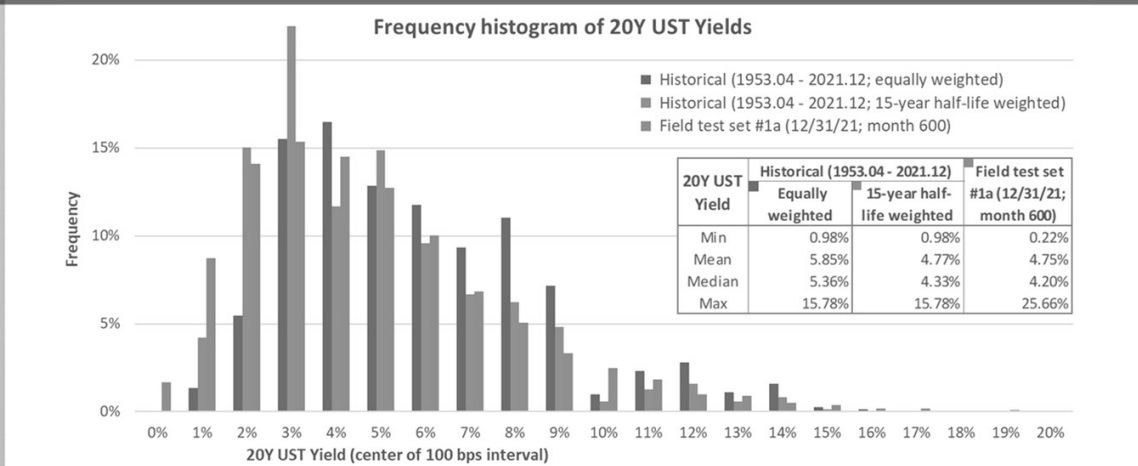


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Rate level
Supplemental chart for evaluating rate levels on consistent basis with PEWs

58



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Yield curve slope (bucketed by 20Y rate) Historical Slope Data (4/1953 - 12/2020)

Observations:

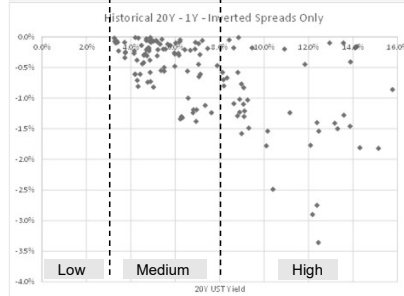
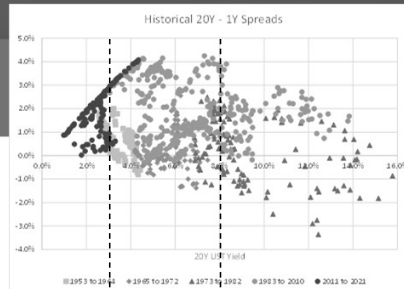
- No inversions for UST 20-year yields below 3%
- Severity of inversions generally increases with rate levels
- Other variations in curve steepness by rate level
- Recommend slope criteria based on simplified Low / Medium / High 20Y yield buckets to capture historical dynamics while not being overly constraining
- Also considers alignment with volatility buckets

ALL Spreads

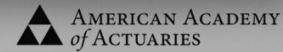
Rate Bucket (20Y)	Inverted Months	Total Months	% Inverted	Min Spread	15%	50%	85%	Max Spread	Avg Spread
[0%, 1%]	0	1	0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
[1%, 2%]	0	23	0%	0.0%	0.6%	1.3%	1.6%	1.8%	1.2%
[2%, 3%]	0	107	0%	0.2%	0.5%	1.7%	2.4%	2.9%	1.6%
[3%, 4%]	11	102	11%	-0.3%	0.1%	0.9%	3.2%	3.7%	1.4%
[4%, 5%]	32	146	22%	-0.6%	-0.2%	0.6%	3.6%	4.1%	1.2%
[5%, 6%]	18	89	20%	-0.8%	-0.1%	0.6%	3.5%	4.2%	1.3%
[6%, 7%]	18	93	19%	-1.4%	-0.1%	0.9%	2.0%	3.7%	0.9%
[7%, 8%]	10	82	12%	-1.2%	0.2%	1.5%	2.7%	4.3%	1.5%
[8%, 9%]	14	79	18%	-1.6%	-0.1%	0.8%	2.3%	3.8%	1.1%
[9%, 10%]	7	29	24%	-1.5%	-1.0%	1.2%	1.9%	2.3%	0.8%
> 10%	24	74	32%	-3.4%	-1.5%	1.4%	2.2%	2.8%	0.7%
All	134	826	16%	-3.4%	-0.1%	1.1%	2.7%	4.3%	1.2%

INVERTED Spreads Only

Rate Bucket (20Y)	Inverted Months	Total Months	% Inverted	Most Negative Spread	15%	50%	85%	Least Negative Spread	Avg Spread
[0%, 1%]	0	1	0%	n/a	n/a	n/a	n/a	n/a	n/a
[1%, 2%]	0	23	0%	n/a	n/a	n/a	n/a	n/a	n/a
[2%, 3%]	0	107	0%	n/a	n/a	n/a	n/a	n/a	n/a
[3%, 4%]	11	102	11%	-0.3%	-0.3%	-0.1%	-0.1%	0.0%	-0.1%
[4%, 5%]	32	146	22%	-0.8%	-0.6%	-0.2%	-0.1%	0.0%	-0.3%
[5%, 6%]	18	89	20%	-0.8%	-0.5%	-0.2%	-0.1%	0.0%	-0.3%
[6%, 7%]	18	93	19%	-1.4%	-1.3%	-0.4%	-0.1%	0.0%	-0.7%
[7%, 8%]	10	82	12%	-1.2%	-1.0%	-0.5%	-0.1%	-0.1%	-0.5%
[8%, 9%]	14	79	18%	-1.6%	-1.2%	-0.7%	-0.2%	0.0%	-0.8%
[9%, 10%]	7	29	24%	-1.5%	-1.3%	-1.1%	-0.8%	-0.2%	-1.0%
> 10%	24	74	32%	-3.4%	-3.4%	-2.2%	-1.4%	-0.1%	-1.4%
All	134	826	16%	-3.4%	-1.3%	-0.4%	-0.1%	0.0%	-0.6%



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Yield curve slope (bucketed by 1Y rate) Historical Slope Data (4/1953 - 12/2020)

Observations:

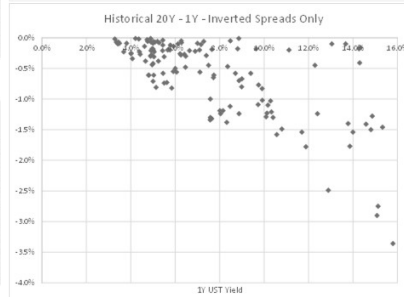
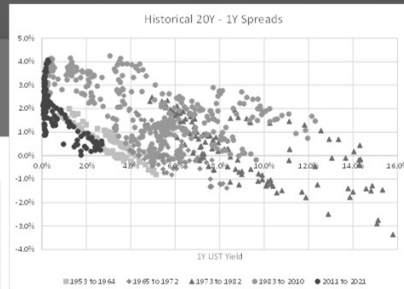
- No inversions for UST 1-year yields below 3%
- Severity of inversions generally increases with rate levels
- Other variations in curve steepness by rate level
- Recommend slope criteria based on simplified Low / Medium / High yield buckets to capture historical dynamics while not being overly constraining
- May bucket by 20Y instead of 1Y yields based on preference

ALL Spreads

Rate Bucket (1Y)	Inverted Months	Total Months	% Inverted	Min Spread	15%	50%	85%	Max Spread	Avg Spread
[0%, 1%]	0	123	0%	0.5%	1.6%	2.5%	3.6%	4.1%	2.3%
[1%, 2%]	0	69	0%	0.0%	1.0%	1.6%	3.6%	4.2%	2.1%
[2%, 3%]	0	71	0%	0.1%	0.4%	0.9%	3.0%	3.6%	1.3%
[3%, 4%]	8	103	8%	-0.2%	0.2%	0.8%	2.8%	4.3%	1.2%
[4%, 5%]	22	89	25%	-0.6%	-0.2%	0.5%	1.7%	3.9%	0.8%
[5%, 6%]	26	116	22%	-0.8%	-0.1%	0.9%	1.8%	3.0%	0.8%
[6%, 7%]	12	76	16%	-0.6%	0.0%	1.2%	1.9%	2.5%	1.1%
[7%, 8%]	14	56	25%	-1.3%	-0.3%	0.7%	1.9%	2.9%	0.6%
[8%, 9%]	13	30	34%	-1.4%	-0.9%	0.5%	1.9%	2.6%	0.5%
[9%, 10%]	7	26	27%	-1.1%	-0.7%	1.5%	2.1%	2.5%	0.9%
> 10%	32	53	60%	-3.4%	-1.6%	-0.4%	1.5%	2.0%	-0.3%
All	134	826	16%	-3.4%	-1.3%	-0.4%	-0.1%	2.7%	4.3%


INVERTED Spreads Only

Rate Bucket (1Y)	Inverted Months	Total Months	% Inverted	Most Negative Spread	15%	50%	85%	Least Negative Spread	Avg Spread
[0%, 1%]	0	123	0%	n/a	n/a	n/a	n/a	n/a	n/a
[1%, 2%]	0	69	0%	n/a	n/a	n/a	n/a	n/a	n/a
[2%, 3%]	0	71	0%	n/a	n/a	n/a	n/a	n/a	n/a
[3%, 4%]	8	103	8%	-0.2%	-0.1%	-0.1%	-0.1%	0.0%	-0.1%
[4%, 5%]	22	89	25%	-0.6%	-0.4%	-0.2%	0.0%	0.0%	-0.2%
[5%, 6%]	26	116	22%	-0.8%	-0.7%	-0.3%	-0.1%	0.0%	-0.3%
[6%, 7%]	12	76	16%	-0.6%	-0.5%	-0.3%	-0.1%	0.0%	-0.3%
[7%, 8%]	14	56	25%	-1.3%	-1.3%	-0.5%	-0.1%	-0.1%	-0.6%
[8%, 9%]	13	36	34%	-1.4%	-1.2%	-0.8%	-0.2%	0.0%	-0.8%
[9%, 10%]	7	26	27%	-1.1%	-1.0%	-0.8%	-0.5%	-0.2%	-0.7%
> 10%	32	53	60%	-3.4%	-1.8%	-1.4%	-0.3%	-0.1%	-1.3%
All	134	826	16%	-3.4%	-1.3%	-0.4%	-0.1%	0.0%	-0.6%



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**NAIC Economic Scenario
Generator Field Test:
C3 Phase I Quantitative
Results**

Scott O’Neal, FSA, MAAA

August 11, 2023

NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

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Agenda

1. Background and Purpose
2. Limitations
3. Field Test Participation
4. High-Level Observations
5. Quantitative Results
 - A. Baseline Comparisons
 - B. Valuation Date Comparisons
 - C. Additional Metrics
6. Next Steps

Appendix: Field Test Run Descriptions

NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS 2



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Background and Purpose

- The purpose of this presentation is to summarize quantitative information from the C3 Phase I field test participants to:
 - Understand the impact on capital,
 - Review the range of results across field test participants,
 - Compare the stability of results over time,
 - Evaluate the use of alternative metrics, and
 - Inform regulator decision-making on model and calibration choices.

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3

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C3 Phase I Background

Calculation Details

- Cash flow models that are used for asset adequacy analysis (or other consistent models) are used. The greatest present value of a deficiency at any point in the projection is calculated for each scenario.
- 50 or 12 interest rate scenarios generated from an older version of the Academy Interest Rate Generator (AIRG) are used in the calculations. The 50 or 12 scenarios are selected from a larger 200 set and are meant to contain the most adverse scenarios so that a tail measure metric can be calculated with a smaller number of scenarios.
- This version of the AIRG has a 6.55% interest rate mean reversion parameter (MRP) which does not change, compared with the current version of the AIRG which has a dynamic MRP that resets annually based on a weighted average of past interest rate levels.
- From the 50-scenario set, a weighted average centered around the 95th percentile scenario is determined, and that is the C3 RBC amount.
- In the C3 Phase I RBC worksheet, the scenario level and final results are also shown as a "C3 Factor" percentage, which is the capital amount divided by the statutory reserve at the start of the projection.

Product Scope

Deferred and Immediate Annuities

Guaranteed Separate Accounts*

Guaranteed Investment Contracts

Single Premium Life

Excludes Indexed and Variable Products

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* excluding guaranteed indexed separate accounts following a Class II investment strategy 4



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Limitations

- The NAIC took steps to review the quantitative results for reasonableness, including reviewing qualitative survey responses, sending questions to participants, and asking participants to confirm that the NAIC compilations matched their intended result submission. However, the accuracy and reliability of the results are ultimately dependent on the quality of participant submissions.
- The field test analytics (average C3 Factors, range of impacts, etc.) can be strongly dependent on a subset of the participants. Results shown today for the different field test runs will include varying numbers of participants corresponding to the levels of participation for that run. The lack of participation in some of the runs will limit their applicability to the overall industry.
- There are two basic types of comparisons of the field test results in this presentation; 1) comparisons of field test runs to their respective baseline run, and 2) comparisons of field test runs across the two tested valuation dates. These comparisons are limited to the participation of whichever run had the least participation. For example, as Baseline 2 (as of 12/31/19 + 200 BP) had significantly lower participation than run 2A, many of the 2A results will not be included in the baseline comparison.
- Some participants mentioned that they would assess the need for changes to their assumptions prior to implementation of the new Generator of Economic Scenarios (GOES) but had not done so for the field test.
- The C3 Phase I portion of the qualitative survey did not ask companies to specifically comment on the drivers of their results as was done for VM-21/C3 Phase II. Most participants did not comment on the drivers of their results.
- Detailed information on the products included in the C3 Phase I results was not asked for in the qualitative survey data. Therefore, it is not fully understood exactly what products were included in each participant's C3 Phase I submission.

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5

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Field Test Participation

- Looking at overall numbers for the industry, at the end of 2021 there were 752 legal entities that reported using the Life RBC blank. Of those 752, 613 legal entities reported industry C3 Phase I capital (line 33, LR027) less than or equal to \$1. That group of 613 companies includes both legal entities that are in scope for C3 Phase I (and determined their C3 Phase I capital to be zero) as well as companies that do not have products that are in scope for C3 Phase I.
- The total amount of industry C3 Phase I capital was approximately \$3 billion at the end of 2021. The largest ten legal entities (by C3 Phase I capital amount) accounted for over \$2 billion of this total. Of those ten legal entities, two of them participated in the field test.
- The chart below shows the number of legal entities that submitted C3 Phase I GOES Field Test results. It also shows the share of the 12/31/21 total industry C3 Phase I capital (line 33, LR027) that is reflective of the participation in each field test.
- C3 Phase I results will be shown for 24 legal entities that represent approximately 19% of the industry when looking at their share of the 2021 industry C3 Phase I capital.

C3 Phase I RBC Statistics (2021)

Total # of Life RBC Blank Filers	752
Life RBC Filers with Line 33 of LR027 <= \$1	613
Total Industry Amount of C3 Phase I Capital	~\$3 billion
Total C3 Phase I Capital: Top Ten Filers	~\$2 billion
# of Top Ten Filers that Participated in GOES Field Test	2/10

Category	Baseline 1*	Baseline 2	1A*	1B*	2A*	2B*	7
Number of Participants (Legal Entities)	24	10	24	22	22	22	16
Share of Industry C3 Phase I Capital	19%	13%	19%	19%	19%	19%	14%

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Valuation Dates: 12/31/21 12/31/19 + 200 BP *Required Run
6



2023 SUMMER NATIONAL MEETING NAIC

High-Level Observations

- The field test results for the scenario sets produced from the Conning economic scenario generator (1A, 2A, 1B, 2B) showed significant increases on average compared to the respective 12/31/21 or 12/31/19 + 200 BP baseline. However, many of the field test participants held little to no C3 Phase I capital in their baseline runs.
- The participant results for field test 7 (200 scenarios from the latest version of the AIRG prescribed in VM-20 and VM-21) were mixed, with increases for some companies mostly offset by decreases for others.
- When producing capital results using a limited number of scenarios, outlier scenarios that are included in the scenario sets can have an outsized impact on the results - particularly with scenario sets that have increased volatility/broader distributions (e.g. 1A, 2A).

NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS 7

12/31/21 Baseline Comparisons

8



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Field Test 1A: US Treasury Overview

- Field Test 1A (as of 12/31/21) included a recalibration of the Conning GEMS® US Treasury model that was designed to meet the acceptance criteria related to low for long, the prevalence of high interest rates, upper and lower bounds, initial yield curve fit, and yield curve shape. The frequency and severity of negative interest rates were controlled using a generalized fractional floor.
- The 1A UST scenario set as of 12/31/21 had a much higher prevalence of low UST rates, including negative interest rates, compared to the scenarios produced by the C3 Phase I Generator.
- The 1A UST scenario set included a frequency and severity of high 1-yr UST rates that was comparable at certain percentiles and projection periods but deviated in others. The limited number of scenarios typically used among field test participants for B1 and 1A may not be fully reflective of the distribution produced by either scenario generator with a greater number of scenarios.

Baseline 1 (B1): 50 C3 Phase I AIRG 1-yr UST Scenarios: Percentiles by Projection Month						1A: 200 Conning w/ GFF 1-yr UST Scenarios: Percentiles by Projection Month						1A – B1					
Percentile	12	60	120	240	360	Percentile	12	60	120	240	360	Percentile	12	60	120	240	360
Min	0.42%	0.39%	0.40%	0.62%	0.65%	Min	-0.20%	-0.58%	-0.72%	-0.69%	-0.75%	Min	-0.62%	-0.97%	-1.12%	-1.31%	-1.40%
1%	0.43%	0.40%	0.43%	0.64%	0.71%	1%	-0.19%	-0.54%	-0.58%	-0.36%	-0.40%	1%	-0.62%	-0.94%	-1.01%	-1.00%	-1.11%
10%	0.47%	0.48%	0.59%	1.65%	1.37%	10%	0.07%	-0.16%	-0.21%	-0.10%	-0.04%	10%	-0.40%	-0.65%	-0.80%	-1.75%	-1.41%
25%	0.52%	1.00%	0.89%	2.90%	3.17%	25%	0.24%	0.11%	0.09%	0.20%	0.32%	25%	-0.28%	-0.89%	-0.81%	-2.70%	-2.85%
50%	0.81%	2.19%	2.86%	4.61%	5.05%	50%	0.62%	0.75%	1.14%	1.62%	1.83%	50%	-0.19%	-1.45%	-1.72%	-2.99%	-3.22%
75%	1.49%	4.27%	5.69%	6.98%	7.92%	75%	1.70%	2.95%	3.42%	4.34%	4.44%	75%	0.22%	-1.32%	-2.27%	-2.64%	-3.47%
95%	3.04%	6.88%	7.94%	10.06%	12.61%	95%	3.09%	5.59%	9.28%	9.10%	8.98%	95%	0.05%	-1.29%	1.34%	-0.96%	-3.64%
99%	3.30%	7.60%	8.67%	12.58%	14.26%	99%	3.72%	7.50%	11.93%	10.35%	13.72%	99%	0.42%	-0.09%	3.26%	-2.23%	-0.54%
Max	3.44%	7.98%	9.04%	13.98%	14.35%	Max	4.29%	14.36%	14.57%	15.71%	14.39%	Max	0.85%	6.38%	5.53%	1.73%	0.04%

NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS 9

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Field Test 1B: US Treasury Overview

- Field Test 1B (as of 12/31/21) included a calibration of the Conning GEMS® US Treasury model that was designed to meet regulator acceptance criteria but placed additional emphasis on maintaining realistic term premiums throughout the projection. Towards that end, there was a significantly lower frequency of inversions (e.g. ~5% of 1B scenarios had 10 year/2year UST inversions at the end of year 30 compared to ~12% seen in 1A). The average level of inversion was also significantly lower (e.g. in 1B 10 year/2 year UST inversions average ~30 BP at the end of year 30, compared to ~90 BP average inversion level for 1A).
- The 1B UST scenario set as of 12/31/21 had a much higher prevalence of low UST rates, including negative interest rates, compared to the scenarios produced by the C3 Phase I Generator.
- The 1B UST scenario set included a frequency and severity of high 1-yr UST rates that was typically lower than that produced by the C3 Phase I scenario generator.

Baseline 1 (B1): 50 C3 Phase I AIRG 1-yr UST Scenarios: Percentiles by Projection Month						1B: 200 Alternative w/ Shadow Floor 1-yr UST Scenarios: Percentiles by Projection						1B – B1					
Percentile	12	60	120	240	360	Percentile	12	60	120	240	360	Percentile	12	60	120	240	360
Min	0.42%	0.39%	0.40%	0.62%	0.65%	Min	-0.33%	-0.80%	-0.69%	-0.85%	-0.95%	Min	-0.75%	-1.19%	-1.09%	-1.47%	-1.60%
1%	0.43%	0.40%	0.43%	0.64%	0.71%	1%	-0.08%	-0.48%	-0.54%	-0.58%	-0.78%	1%	-0.52%	-0.88%	-0.97%	-1.22%	-1.49%
10%	0.47%	0.48%	0.59%	1.65%	1.37%	10%	0.22%	-0.01%	-0.08%	-0.03%	0.08%	10%	-0.25%	-0.50%	-0.67%	-1.68%	-1.29%
25%	0.52%	1.00%	0.89%	2.90%	3.17%	25%	0.41%	0.30%	0.30%	0.34%	0.57%	25%	-0.11%	-0.70%	-0.60%	-2.57%	-2.60%
50%	0.81%	2.19%	2.86%	4.61%	5.05%	50%	0.63%	0.67%	0.74%	0.84%	1.37%	50%	-0.18%	-1.53%	-2.12%	-3.78%	-3.68%
75%	1.49%	4.27%	5.69%	6.98%	7.92%	75%	0.82%	0.98%	1.87%	2.38%	3.55%	75%	-0.67%	-3.29%	-3.82%	-4.60%	-4.36%
95%	3.04%	6.88%	7.94%	10.06%	12.61%	95%	1.61%	3.16%	4.20%	6.24%	7.25%	95%	-1.43%	-3.72%	-3.74%	-3.82%	-5.37%
99%	3.30%	7.60%	8.67%	12.58%	14.26%	99%	2.02%	4.15%	5.39%	7.93%	10.13%	99%	-1.28%	-3.44%	-3.28%	-4.65%	-4.13%
Max	3.44%	7.98%	9.04%	13.98%	14.35%	Max	2.34%	5.62%	9.36%	10.24%	14.31%	Max	-1.10%	-2.36%	0.32%	-3.74%	-0.04%

NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS 10



2023 SUMMER NATIONAL MEETING **NAIC**

Field Test 7: US Treasury Overview

- Field Test 7 (as of 12/31/21) was a C3 Phase I specific test designed to use the current version of the AIRG (prescribed in VM-20 and VM-21) to understand what the impact would be of moving to the latest version of the AIRG with a mean reversion parameter that is dynamic based upon historical data. For 12/31/21, the latest version of the AIRG had a mean reversion parameter of 3.25% compared to 6.55% for the C3 Phase I ESG.
- The field test 7 UST scenario set as of 12/31/21 had a much higher prevalence of low UST rates, but the current version of the AIRG has a soft floor of 1 BP, effectively eliminating negative interest rates.
- The field test 7 UST scenario set included a frequency and severity of high 1-yr UST rates that was much lower than those produced by the C3 Phase I generator, particularly at the later projection periods.

Baseline 1 (B1): 50 C3 Phase I AIRG 1-yr UST Scenarios: Percentiles by Projection Month						7: 200 VM-20 AIRG 1-yr UST Scenarios: Percentiles by Projection Month						7 - B1					
Percentile	12	60	120	240	360	Percentile	12	60	120	240	360	Percentile	12	60	120	240	360
Min	0.42%	0.39%	0.40%	0.62%	0.65%	Min	0.01%	0.17%	0.01%	0.01%	0.17%	Min	-0.41%	-0.22%	-0.39%	-0.61%	-0.49%
1%	0.43%	0.40%	0.43%	0.64%	0.71%	1%	0.01%	0.40%	0.28%	0.57%	0.32%	1%	-0.42%	0.00%	-0.16%	-0.07%	-0.39%
10%	0.47%	0.48%	0.59%	1.65%	1.37%	10%	0.25%	0.71%	0.77%	1.02%	1.06%	10%	-0.22%	0.23%	0.19%	-0.63%	-0.31%
25%	0.52%	1.00%	0.89%	2.90%	3.17%	25%	0.43%	0.89%	1.22%	1.55%	1.41%	25%	-0.09%	-0.11%	0.32%	-1.35%	-1.76%
50%	0.81%	2.19%	2.86%	4.61%	5.05%	50%	0.69%	1.23%	1.65%	2.04%	2.07%	50%	-0.12%	-0.96%	-1.21%	-2.57%	-2.98%
75%	1.49%	4.27%	5.69%	6.98%	7.92%	75%	0.90%	1.72%	2.31%	2.79%	2.95%	75%	-0.59%	-2.55%	-3.37%	-4.19%	-4.96%
95%	3.04%	6.88%	7.94%	10.06%	12.61%	95%	1.24%	2.27%	3.35%	3.98%	4.69%	95%	-1.81%	-4.61%	-4.59%	-6.08%	-7.92%
99%	3.30%	7.60%	8.67%	12.58%	14.26%	99%	1.54%	2.97%	4.27%	5.39%	5.99%	99%	-1.75%	-4.62%	-4.40%	-7.19%	-8.27%
Max	3.44%	7.98%	9.04%	13.98%	14.35%	Max	1.57%	4.01%	5.28%	7.45%	6.95%	Max	-1.87%	-3.97%	-3.76%	-6.53%	-7.40%

NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS 11

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Change in Capital Amount by Legal Entity - 12/31/21

Field Test	B1	1A	1B	7
Wtd. Average C3 Phase I Factor	0.14%	1.29%	0.92%	0.17%
Average % Change*		817%	512%	15%
# of Participants	24	24	22	16

- For the 12/31/21 Baseline 1 (B1) field test run, approximately half of the participants had C3P1 RBC amounts (C3 factor * statutory reserve) close to zero. The 75th percentile for the Baseline 1 C3 factor was 0.23%, and the average C3 factor (weighted by statutory reserve) was 0.14%.
- For each of the 12/31/21 field test runs shown, there was an increase to the average C3 factor, with 1A (Conning calibration with GFF) coming in at the highest followed by the 1B (Alternative with Shadow Floor).
- Both 1A and 1B saw a larger proportion of the field test participants with non-zero C3 Factors.
- Field test run 7 (200 Scenario VM-20 AIRG) had a small average C3 factor increase, with some participants seeing higher, lower, or no changes at all to their capital.

C3 Phase I Factor: Range and Percentile Statistics

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*Note, each of the Average % Change value is specific to the cohort that completed both the baseline and the respective field test run. 12



12/31/19 + 200 BP Baseline Comparisons

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13

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Field Test 2A: US Treasury Overview

- Field Test 2A (as of 12/31/19 + 200 BP) used the same calibration as 1A (Conning Calibration with a Generalized Fractional Floor) but with a 12/31/19 starting yield curve modified using a 200 BP increase across all maturities.
- Compared to the C3 Phase I generator with a 12/31/19 + 200 BP starting interest environment, the 2A scenario set has a much greater frequency and severity of low (and negative) UST rates. The 2A scenario set has a comparable severity of high 1-yr UST rates at the 95th percentile, but somewhat higher 1-yr UST rates at the 99th percentile.

Baseline 2 (B2): 50 C3 Phase I AIRG 1-yr UST Scenarios: Percentiles by Projection Month						2A: 200 Conning w/ GFF 1-yr UST Scenarios: Percentiles by Projection Month						2A – B2					
Percentile	12	60	120	240	360	Percentile	12	60	120	240	360	Percentile	12	60	120	240	360
Min	0.81%	0.67%	0.73%	0.59%	0.64%	Min	-0.01%	-0.72%	-0.50%	-0.74%	-0.70%	Min	-0.82%	-1.39%	-1.23%	-1.33%	-1.34%
1%	0.85%	0.69%	0.78%	0.60%	0.70%	1%	0.30%	-0.10%	-0.30%	-0.56%	-0.57%	1%	-0.55%	-0.79%	-1.08%	-1.16%	-1.27%
10%	1.90%	1.38%	1.61%	1.75%	2.35%	10%	1.48%	0.26%	-0.01%	0.02%	-0.02%	10%	-0.42%	-1.12%	-1.63%	-1.73%	-2.37%
25%	3.23%	2.69%	2.76%	3.06%	3.85%	25%	2.47%	0.76%	0.42%	0.49%	0.37%	25%	-0.76%	-1.93%	-2.34%	-2.56%	-3.48%
50%	3.82%	3.81%	3.94%	4.42%	5.49%	50%	3.53%	2.89%	2.68%	2.48%	2.51%	50%	-0.29%	-0.93%	-1.26%	-1.95%	-2.98%
75%	4.64%	4.80%	6.30%	5.81%	7.77%	75%	4.65%	5.30%	5.45%	5.59%	5.29%	75%	0.01%	0.50%	-0.86%	-0.22%	-2.48%
95%	5.81%	7.46%	9.29%	8.88%	10.14%	95%	6.55%	8.68%	10.02%	11.22%	10.88%	95%	0.74%	1.22%	0.73%	2.35%	0.74%
99%	6.03%	11.09%	11.53%	9.85%	11.39%	99%	7.68%	10.55%	12.97%	14.28%	13.77%	99%	1.66%	-0.54%	1.44%	4.43%	2.38%
Max	6.18%	12.29%	13.42%	9.91%	11.88%	Max	9.12%	12.16%	14.50%	15.29%	23.43%	Max	2.94%	-0.13%	1.08%	5.38%	11.55%

NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS 14



2023 SUMMER NATIONAL MEETING
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Field Test 2B: US Treasury Overview

- Field Test 2B (as of 12/31/19 + 200 BP) used the same calibration as 1A (Conning Calibration with a Generalized Fractional Floor) but with a 12/31/19 starting yield curve modified using a 200 BP increase across all maturities
- Compared to the C3 Phase I generator with a 12/31/19 + 200 BP starting interest environment, the 2B scenario set has a much greater frequency and severity of low (and negative) UST rates. The 2B scenario set has a comparable severity of high 1-yr UST rates at the 95th percentile but has higher or lower severity depending on the projection period at the 99th percentile level.

Baseline 2 (B2): 50 C3 Phase I AIRG 1-yr UST Scenarios: Percentiles by Projection Month

Percentile	12	60	120	240	360
Min	0.81%	0.67%	0.73%	0.59%	0.64%
1%	0.85%	0.69%	0.78%	0.60%	0.70%
10%	1.90%	1.38%	1.61%	1.75%	2.35%
25%	3.23%	2.69%	2.76%	3.06%	3.85%
50%	3.82%	3.81%	3.94%	4.42%	5.49%
75%	4.64%	4.80%	6.30%	5.81%	7.77%
95%	5.81%	7.46%	9.29%	8.88%	10.14%
99%	6.03%	11.09%	11.53%	9.85%	11.39%
Max	6.18%	12.29%	13.42%	9.91%	11.88%

2B: 200 Conning w/ GFF 1-yr UST Scenarios: Percentiles by Projection Month

Percentile	12	60	120	240	360
Min	0.34%	-0.10%	-0.25%	-0.30%	-0.49%
1%	0.70%	0.23%	-0.07%	-0.27%	-0.40%
10%	1.44%	0.71%	0.47%	0.32%	0.34%
25%	2.22%	1.32%	0.92%	0.90%	0.93%
50%	3.25%	2.76%	2.78%	2.57%	2.54%
75%	4.04%	4.36%	4.60%	5.28%	5.41%
95%	5.53%	6.58%	9.26%	9.50%	9.61%
99%	6.28%	7.74%	11.19%	10.58%	13.54%
Max	6.93%	10.41%	12.18%	18.69%	19.49%

2B - B2

Percentile	12	60	120	240	360
Min	-0.47%	-0.77%	-0.98%	-0.89%	-1.13%
1%	-0.15%	-0.47%	-0.85%	-0.87%	-1.10%
10%	-0.46%	-0.67%	-1.15%	-1.44%	-2.01%
25%	-1.01%	-1.37%	-1.84%	-2.16%	-2.92%
50%	-0.57%	-1.05%	-1.16%	-1.85%	-2.96%
75%	-0.60%	-0.45%	-1.70%	-0.53%	-2.36%
95%	-0.28%	-0.88%	-0.03%	0.63%	-0.53%
99%	0.25%	-3.35%	-0.34%	0.73%	2.15%
Max	0.75%	-1.88%	-1.24%	8.78%	7.61%

NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS 15

2023 SUMMER NATIONAL MEETING
NAIC

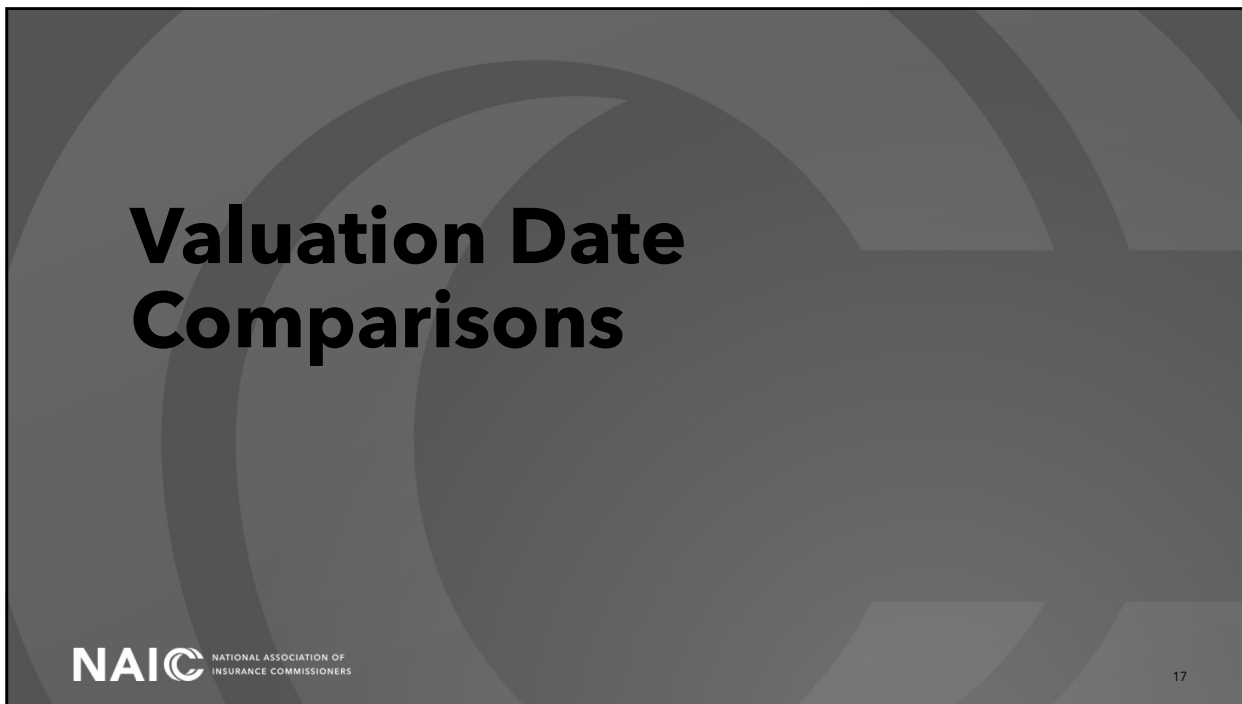
Change in Capital Amount by Legal Entity - 12/31/19 + 200 BP

Field Test	B2	2A	2B
Wtd. Average C3 Phase I Factor	0.46%	1.50%	0.93%
Average % Change		226%	103%
# of Participants	10	10	10

C3 Phase I Factor: Range and Percentile Statistics

- There was more limited participation for the optional Baseline 2 run.
- For the 12/31/19 + 200 BP Baseline 2 (B2) field test run, approximately half of the participants had C3P1 RBC amounts (C3 factor * statutory reserve) close to zero. The 75th percentile for the Baseline 2 C3 factor was 0.87%, and the average C3 factor (weighted by statutory reserve) was 0.46%.
- A similar pattern to the 12/31/21 field test runs holds for the 12/31/19 + 200 BP field test baseline comparisons, where the Conning Calibration w/ GFF (2A) has the largest increase to capital from the baseline with the Alternative Calibration with a Shadow Floor (2B) representing a significant but smaller increase.
- Both 2A and 2B saw a larger proportion of the field test participants with non-zero C3 Factors.

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2023 SUMMER NATIONAL MEETING NAIC

Change in Capital Amount by Legal Entity - 12/31/19 + 200 BP compared to 12/31/21

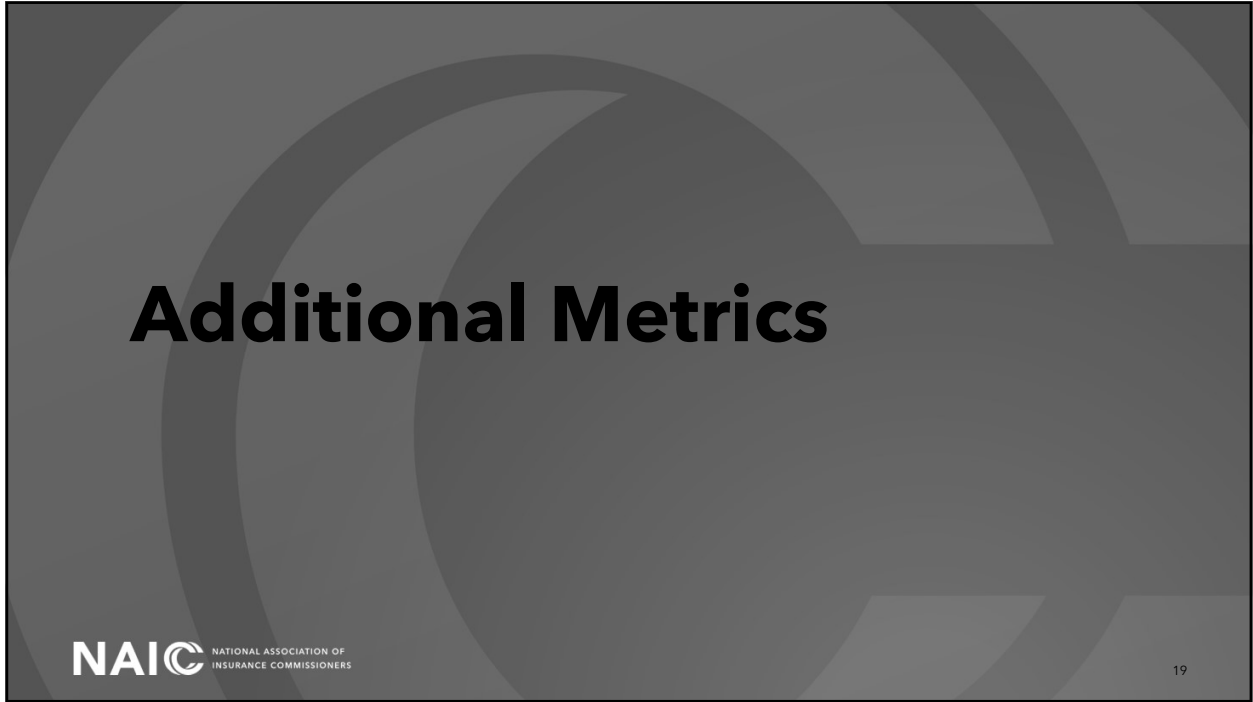
Field Test	B1	B2	1A	2A	1B	2B
Wtd. Average C3 Phase I Factor	0.14%	0.46%	1.35%	1.72%	1.01%	1.15%
Average % Change		229%		28%		15%
# of Participants	10	10	22	22	20	20

C3 Phase I Factor: Range and Percentile Statistics

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- For each of the valuation date comparisons, the average C3 Factor increased from 12/31/21 (low interest environment) to 12/31/19 + 200 BP (higher interest environment).
- There was more limited participation for the optional Baseline 2 run, limiting the comparison between valuation dates. The average % change in the C3 Factor between valuation dates was the greatest for the baseline runs.
- Of the field test runs, the Conning calibration w/ GFF showed a higher average % change between valuation dates (28%), compared to the smaller (15%) change for the alternative calibration with shadow floor.
- Because of the large difference in legal entity cohorts between the baseline and field test runs, it is hard to conclude that the field test scenario sets produce more stable results than the C3 Phase I generator used in the baseline runs.

18



2023 SUMMER NATIONAL MEETING **NAIC**

Additional C3 Phase I Metrics

- The table below shows the range statistics and weighted average of the legal entity results for C3 Phase I factors (C3 Phase I Capital Amount/Statutory Reserve) computed using different metrics.
- The results for the "C3 Phase I Weighted Average" are for 24 legal entities, whereas the results shown for the other metrics are only for 23 legal entities. One of the legal entities was removed due to one scenario out of their C3 Phase I calculation producing a very large C3 Phase I factor (e.g. 3,000%) that distorted the metrics. This scenario result was not included in the C3 Phase I weighted average or the range statistics.
- Once the outlier was removed, the CTE 90 metric had very similar results to the C3 Phase I metric. However, the 25% * (CTE 98 - CTE 70) metric produced smaller C3 Factors overall.

Range Statistic/Average	C3 Phase I Metric		CTE90		Mean Factor		Max Factor		25% * (CTE98 - CTE70)	
	B1	1A	B1	1A	B1	1A	B1	1A	B1	1A
Minimum	-0.49%	0.00%	-0.34%	0.00%	-0.62%	-0.62%	0.00%	0.00%	0.00%	0.00%
25 th Percentile	0.00%	0.11%	0.00%	0.02%	0.00%	0.00%	0.00%	0.33%	0.00%	0.02%
Median	0.00%	0.87%	0.00%	1.14%	0.00%	0.13%	0.13%	3.56%	0.04%	0.67%
75 th Percentile	0.23%	3.18%	0.36%	3.09%	0.15%	0.85%	1.27%	4.60%	0.15%	0.68%
Maximum	10.78%	17.32%	10.80%	17.82%	10.52%	15.85%	11.09%	29.91%	0.70%	0.80%
Wtd. Average Factor	0.14%	1.29%	0.20%	1.39%	0.08%	0.63%	0.62%	8.35%	0.03%	0.40%

(a) For the 50 scenario set, the C-3 scores are multiplied by the following series of weights:


C3 Phase I Metric →

----- Weighting Table -----

Scenario Rank:	17	16	15	14	13	12	11	10	9	8	7	6	5	20
Weight:	0.02	0.04	0.06	0.08	0.10	0.12	0.16	0.12	0.10	0.08	0.06	0.04	0.02	


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2023 SUMMER NATIONAL MEETING


Next Steps

- The Generator of Economic Scenarios (GOES) (A) Subgroup will develop recommendations to LATF for reserve and capital framework-specific implementation issues and a GOES model governance framework.
- A more comprehensive set of GOES acceptance criteria will be reviewed by regulators and exposed in September. Once regulators decide on a new set of acceptance criteria, additional candidate scenario sets will be produced that are designed to meet the acceptance criteria.
- Regulators and the NAIC are considering how model office testing can supplement and/or replace components of industry field testing to efficiently evaluate the new scenario sets. A second-round industry field test of the new scenarios would occur no sooner than Spring of 2024.



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22



Appendix: Field Test Run Descriptions


NAIC NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

23

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Field Test Run Descriptions		Note: Bold = Required Run
Run #	Description	Purpose of Run
Baseline #1	Scenario set(s) the company used for 12/31/21 statutory reporting	Baseline used as comparative basis for 12/31/21 runs
Baseline #2	ESG the company used for 12/31/21 statutory reporting of reserves and RBC, but modified to produce scenario sets with a 12/31/19 yield curve modified using a 200 BP increase across all maturities	Baseline used as comparative basis for 12/31/19 + 200 BP runs
Test #1a	GEMS Baseline Equity and Corporate model scenarios as of 12/31/21, and Conning Treasury model calibration with generalized fractional floor as of 12/31/21	Tests Conning Treasury model w/ GFF and Baseline Equity at YE 2021
Test #1b	Same as Test #1a, but with Alternative Treasury model calibration with shadow floor as of 12/31/21	Tests Alternative Treasury model with shadow floor and Baseline Equity at YE 2021
Test #2a	Same as Test #1a, but with Equity, Corporate, and Treasury models with a 12/31/19 starting yield curve modified using a 200 BP increase across all maturities. All other initial market conditions are unchanged. The Equity model parameters would be adjusted from #1a so that the year 30 median Large Cap Equity gross wealth factors remain consistent with #1a.	Stresses the starting Treasury rates using the same calibration as 1a to evaluate whether the model produces appropriate results in different economic environments
Test #2b	Same as Test #2a, but with the Alternative Treasury model calibration with shadow floor instead of the Conning Treasury model calibration with generalized fractional floor	Same as 2a, but designed to stress the 1b calibration
Test #7	12/31/21 scenarios from the ESG prescribed in VM-20 with a Mean Reversion Parameter (MRP) set to 3.25%	Attribution analysis to understand the impact of moving from the current C3 Phase I MRP of 6.55% to a lower MRP that incorporates recent UST history.

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24



**SOCIETY OF ACTUARIES
RESEARCH UPDATE TO
LATF**

August 12, 2023

Cindy MacDonald, FSA, MAAA
Senior Director, Experience Studies



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SOA Experience Studies Regulator Input on Prioritization

3

Experience Studies Pro

In 2021, LIMRA and the SOA Research Institute entered into a partnership to support the industry with a **comprehensive program of industry experience studies**.

This program will provide timely, consistent, and comprehensive releases of industry experience data — providing you with the necessary tools for addressing **product development, pricing, and regulatory** strategies.



Together, We have Unmatched Breadth & Depth of Experience

Expertise

We are both associations dedicated to this industry, with a long history of conducting large data-intensive efforts

Trust

Strong reputation for unbiased research, analysis, and industry relationships

Value

Together we provide unparalleled value while delivering cost-effective insights



Benefits to the Industry



Credible, robust, benchmarking, and strong industry representation:
70% market participation is typical

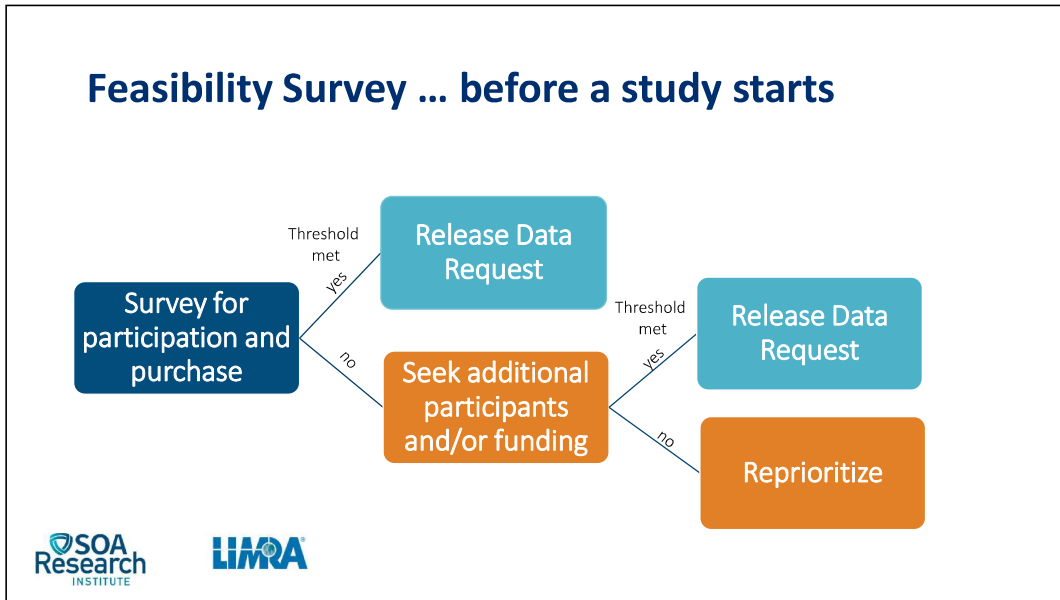


Comprehensive and timely: updates of industry data on a regularly published schedule





Detailed and deeper analytics: to support product development, inform management, reserving, and growth strategies





Studies at Risk for Participation and Funding

Product	Contingency Studied	Funding Concerns
Long-term care	claim incidence, claim termination, claim utilization, active life lapse and mortality	Blocks in run-off; complicated study/higher cost
Individual disability	claim incidence, claim termination	Few carriers; complicated study/higher cost
Group annuity	mortality	Few carriers; niche line of business
Structured settlements	mortality	Few carriers; niche line of business



Results Regulator Interest Survey - LATF	Experience Study	
	Individual Payout Annuity – mortality	★
	Individual Fixed Indexed Annuity – premium deposits, withdrawals, surrenders	★
	Individual Variable Annuity – premium deposits, withdrawals, surrenders	★
	Individual Life – mortality	★
	Individual Fixed Deferred Annuity – surrenders	★
	Individual Universal Life – premium persistency	★
	Individual Universal Life – lapse, surrender	★
	Individual Term Life – post level term lapse and mortality	
	Individual Term Life – term conversion, lapse, mortality	
	Individual Fixed Deferred Annuity – mortality	★
	Group Life – mortality	★
	Group Annuity – mortality	
	Structured Settlement Annuity – mortality	

SOA Research INSTITUTE

Results Regulator Interest Survey - LATF

Tables/Projects

Individual Payout Annuity – mortality
Individual Life – mortality
Individual Fixed Deferred Annuity – mortality
Group Annuity – mortality
Structured Settlement Annuity – mortality



Comments

- LATF
 - Surrender information following a rise in rates will be available for the first time in decades.
 - A "return to normal" (or not) will be indicated by mortality data.
 - Guaranteed Issue Life Mortality - not a high priority but in the middle.



What can regulators do to help?

For studies, tables, project desired by regulators

- Help us clarify the prioritization
- Support/encourage voluntary participation in Experience Study Pro studies
- Support/encourage potential funding through NAIC, where funding through direct sales is not feasible



Discussion





Experience Studies

Project Name	Objective	Link/Expected Completion Date
COVID-19 Individual Life Mortality Study - Experience Study Report - 2022 Q2	Complete a mortality study assessing the impact of COVID-19 on Individual Life Insurance.	https://www.soa.org/resources/research-reports/2023/ind-life-covid-mort-finding/
COVID-19 Reported Claims Study - 4Q 2022 Update	Draft a research study reviewing Covid-19 reported deaths by quarter.	https://www.soa.org/49c0c12/globalassets/files/resources/research-report/2023/covid-reported-claims-analysis-o4.pdf
Economic Scenario Generator - 2023 Update	Update the AAA Economic Scenario Generator Annually.	https://www.soa.org/resources/tables-calcs-tools/research-scenarios/
Group Life COVID-19 Mortality Survey Update - through December 2022	Complete an update on a mortality study assessing the impact of COVID-19 on Group Life Insurance.	https://www.soa.org/resources/experience-studies/2022/group-life-covid-19-mortality-12-2022/
COVID-19 Individual Life Mortality Study - Experience Study Report - 2022 Q3	Complete a mortality study assessing the impact of COVID-19 on Individual Life Insurance.	7/27/2023
2019-20 Fixed Indexed Annuity Study - Report	Examine lapse and the utilization of guaranteed living withdrawal benefit options on fixed index annuity policies under a Joint SOA/LIMRA project and release Tableau visualizations with the observations from the study.	8/8/2023
COVID-19 Cause of Death Study - 2022 Q1 Update	Publish a semi-annual cause of death study for individual life insurance.	8/15/2023
COVID-19 Individual Life Mortality Study - Experience Study Report - 2022 Q4	Complete a mortality study assessing the impact of COVID-19 on Individual Life Insurance.	8/15/2023
COVID-19 Reported Claims Study - 1Q 2023 Update	Reviews Covid-19 reported deaths by quarter.	8/15/2023
2009-2015 Individual Life Experience Committee Lapse and Mortality Study	Study mortality and lapse experience in the database of 2009-2015 individual life experience data and release a report with the findings.	8/30/2023
GRET for 2024	Develop the Generally Recognized Expense Table (GRET) for 2024.	9/15/2023
2019 Quintile Analysis	Ranks individual company experience into quintiles.	9/28/2023
2023 Life Mortality Improvement	Develop AG38 mortality improvement assumptions for YE 2023.	9/29/2023
2019-21 Variable Annuity Guaranteed Living Benefit Utilization Study - Report	Examine the utilization of guaranteed living benefit options on variable annuity policies under a Joint SOA/LIMRA project.	9/30/2023

Practice Research & Data Driven In-house Research

Project Name	Objective	Link/Expected Completion Date
Reimagining Pharmacy	18/11 Style Gathering to discuss pharmacy.	https://www.soa.org/resources/research-reports/2023/reimagining-pharmacy-finance/
International Comparison of Regulatory Requirements Study Note; 2021.08	Capital Adequacy Regulatory Requirements in Life Insurance across 4 key models in the US, Canada, EU and Bermuda.	6/30/2023
Expert Opinion on Impact of COVID-19 on Future Mortality - Survey 2	Survey panel of experts on short and mid term thoughts on future population and insured mortality.	8/15/2023
Maternal Mortality	Study maternal mortality in US and compare to other countries.	8/15/2023
Mortality and Race	Summarize available literature on mortality and race and discuss actuarial aspects.	8/15/2023
Unhealthy Longevity	Examine differences in mortality/longevity between impaired vs healthy lives.	8/15/2023
Accelerated Underwriting Survey and Impact of COVID in Underwriting	Update prior survey and explore the way insurers have adapted their underwriting practices.	8/31/2023
Challenges with Defining Fairness for Life Insurance	Summarize the challenges and complexities with defining and measuring fairness for life insurance products and processes.	8/31/2023
2023 Living to 100	Produce body of research to help with old age mortality modeling and projection and research to support the needs of an increasing aging population.	9/15/2023





The Evolution of the FSA Pathway

NAIC presentations

Stuart Klugman, FSA, CERA, PhD
SOA Senior Staff Fellow

August 2023



We've heard your feedback

FSA candidates encounter significant challenges along the pathway

Lack of flexibility or customization

Less relevant to global markets

Little guidance on what to study



Slow grading process

No exam feedback

Difficult source materials that lack focus



Introducing a range of improvements for a better candidate experience



3

Regulatory Material Shift

Current Challenge

- In-depth U.S. and Canadian regulatory material lacks relevance to global markets



SOA Shift

- Detailed local regulatory material moved outside of the current FSA requirements
- Fundamental regulatory principles and frameworks will still be covered in the FSA pathway
- FSA will qualify actuaries to sign General Statements of Actuarial Opinion

CERTIFICATES:



- Stand-alone, optional regulatory certificates will be offered. Certificates can be taken when needed.
- The SOA is collaborating with regulatory bodies to develop the certificates



4



Flexible Pathway

Current Challenge

- Forced track structure lacks flexibility and customization
- Highly specialized tracks are less relevant for developing markets



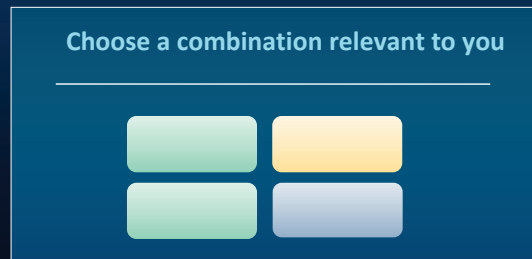
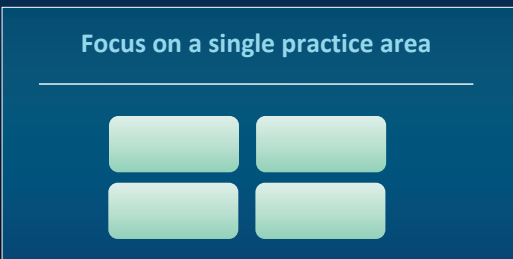
SOA Shift

- Shifting from “tracks” to a flexible pathway
- Flexibility to focus on a single practice area or create a combination of courses relevant to you
- 5 courses required:
 - 4 Technical courses (one must build on another)
 - 1 Decision Making and Communications (DMAC) Course
 - + Fellowship Admissions Course (FAC)

5



Choose from About 20 Courses



6



Life Practice Council Update

Ben Slutsker, MAAA, FSA
Vice President, Life Practice Council
Amanda Barry-Moilanen
Policy Analyst, Life

Life Actuarial Task Force (LATF) Meeting
August 12, 2023

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Academy Webinars and Events

2

- Recent
 - [PBR Bootcamp: Liability Assumption Development](#)—June 21
 - PBR Bootcamp: Liability—July 26
- Upcoming
 - [Holy Moly, Let's Talk COLI](#)—August 29
 - Non-Variable Annuity PBR Framework Updates—September 6
 - PBR Bootcamp: Hedge Modeling—September 20
 - PBR Bootcamp: Reinsurance—October 18
 - Additional PBR webinars in 2023

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Recent Activity

3

- Created a new group, the Investment Analysis Subcommittee
 - Will engage in NAIC issues related to investment disclosures, financial statement classifications, and credit ratings.
- Released a [Resource and Discussion Guide](#) on an actuarial review of investments in actuarial modeling.
- Delivered [comments](#) to the Life Actuarial (A) Task Force on the Interest Maintenance Reserve (IMR) Template.
 - Delivered [comments](#) to the Statutory Accounting Principles Working Group on 2023 Net Negative (Disallowed) Interest Maintenance Reserve (INT 23-01T).

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Recent Activity

4

- Delivered [comments](#) to the Risk-Based Capital Investment Risk and Evaluation (E) Working Group on Exposure 2023-09-IRE—Interim Residual Tranche Factor.
- Delivered [comments](#) to the ILVA Subgroup of the Product Standard Committee Interstate Insurance Product Regulation Commission on 2023 Compact Requirements for ILVA Products.

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Ongoing Activity

5

- Developed education on economic scenario generators and acceptance criteria for the Life Actuarial (A) Task Force
- Engaging in the discussions on a fixed annuity principle-based reserving framework in the VM-22 (A) Subgroup
- Revisiting the covariance methodology in life risk-based capital
- Updating the asset adequacy analysis practice note
- Developing practice note on non-guaranteed elements

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Thank you

6

Questions?

- For more information, please contact the Academy's life policy analyst, Amanda Barry-Moilanen, at barrymoilanen@actuary.org.

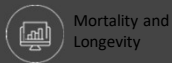
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2024 GRET Recommendation

Tony Phipps, FSA, MAAA
Chair SOA Research Institute Committee on Life Insurance Expenses
August 12, 2023



Mortality and
Longevity

Agenda

- Methodology
- Recommendation
- Comparison to Prior Years
- Information on Companies in Study



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3

Methodology

1. Calculate Actual to Expected Expenses
 - Gather data points from company Annual Statement submissions provided by NAIC
 - Seed factors used to calculate expected expenses.
2. Determine Distribution Channel
 - Survey sent by SOA Research Institute to companies to determine primary distribution channel.
 - This channel is used or the historical distribution channel for those companies that did not respond.
3. Remove outlier companies
4. Analyze data to derive unit expense factors by those Distribution Channels



4

Seed Values

Expenses allocated to acquisition and maintenance categories using the same seeds as has been previously used:

- Acquisition/Policy: \$200.00
- Acquisition/Face Amount: \$1.10
- Acquisition/Premium: 50%
- Maintenance/Policy: \$60.00



Recommendation for 2024 GRET Factors

Proposed 2024 GRET Factors Based on Average of 2021/2022 Data					
Description	Acquisition per Policy	Acquisition per Unit	Acquisition per Premium	Maintenance per Policy	Company Count
Independent	\$198	\$1.10	50%	\$59	140
Career	206	1.10	52%	62	90
Direct Marketing	217	1.20	54%	65	23
Niche Marketing	132	0.70	33%	40	31
Other*	162	0.90	41%	49	95
					379

* Includes companies that did not respond to this or prior year surveys

Current 2023 GRET Factors Based on Average of 2020/2021 Data					
Description	Acquisition per Policy	Acquisition per Unit	Acquisition per Premium	Maintenance per Policy	Company Count
Independent	\$180	\$1.00	45%	\$54	141
Career	203	1.10	51%	61	84
Direct Marketing	197	1.10	49%	59	21
Niche Marketing	147	0.80	37%	44	30
Other*	153	0.90	39%	46	106
					382

* Includes companies that did not respond to this or prior year surveys



Comparison to Prior Years

Acquisition per Policy					
Description	2023	Percentage Change	2022	Percentage Change	2021
Independent	\$198	10%	\$180	-2%	\$183
Career	206	1%	203	-4%	212
Direct Marketing	217	10%	197	-2%	200
Niche Marketing	132	-10%	147	-3%	151
Other*	162	6%	153	10%	139

* Includes companies that did not respond to this or prior year surveys

Acquisition per Unit					
Description	2023	Percentage Change	2022	Percentage Change	2021
Independent	\$1.10	10%	\$1.00	0%	\$1.00
Career	1.10	0%	1.10	-8%	1.20
Direct Marketing	1.20	9%	1.10	0%	1.10
Niche Marketing	0.70	-13%	0.80	-11%	0.90
Other*	0.90	0%	0.90	13%	0.80

* Includes companies that did not respond to this or prior year surveys



Comparison to Prior Years

Acquisition per Premium					
Description	2023	Percentage Change	2022	Percentage Change	2021
Independent	50%	11%	45%	-2%	46%
Career	52%	2%	51%	-4%	53%
Direct Marketing	54%	10%	49%	-2%	50%
Niche Marketing	33%	-11%	37%	0%	37%
Other*	41%	5%	39%	11%	35%

* Includes companies that did not respond to this or prior year surveys

Maintenance per Policy					
Description	2023	Percentage Change	2022	Percentage Change	2021
Independent	\$59	9%	\$54	-2%	\$55
Career	62	2%	61	-5%	64
Direct Marketing	65	10%	59	-2%	60
Niche Marketing	40	-9%	44	-2%	45
Other*	49	7%	46	10%	42

* Includes companies that did not respond to this or prior year surveys



Survey Results

- Percent of survey respondents that that responded that GRET factors are used for individual life sales illustration purposes:

Percentage of Companies that use GRET Factors	
Survey Year	Percentage
2022	44%
2022	35%
2021	31%
2020	29%
2019	26%
2018	28%
2017	30%
2016	26%

- We believe variation is a result of the mix of respondents and the limited number of responses



Information on Companies in Study

- NAIC Data extracts included:
 - 2022: 749 companies
 - 2021: 766 companies
- Total ordinary policies issued saw a decrease of 8.45% (850k) in 2022 after seeing an increase of 3.1% (312k) in the previous year.
- The final companies used in the GRET calculation was 379 in 2022, a decrease of 3 from the previous year after seeing an increase of 7 in the previous year.
- This year's survey, a record of 44% of respondents indicated they use GRET factors for individual life sales illustration purposes, continuing the increasing trend.



Questions?





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TO: Rachel Hemphil, FFA, FCAS, MAAA, PHD, Chair, Life Actuarial (A) Task Force

FROM: Pete Miller, ASA, MAAA, Experience Study Actuary, Society of Actuaries (SOA) Research Institute
Tony Phipps, Chair, SOA Research Institute Committee on Life Insurance Company Expenses

DATE: August 4, 2023

RE: 2024 Generally Recognized Expense Table (GRET) – SOA Research Institute Analysis

Dear Ms. Hemphill:

As in previous years, the Society of Actuaries Research Institute expresses its thanks to NAIC staff for their assistance and responsiveness in providing Annual Statement expense and unit data for the 2024 GRET analysis for use with individual life insurance sales illustrations. The analysis is based on expense and expense-related information reported on each company's 2021 and 2022 Annual Statements. This project has been completed to assist the Life Actuarial Task Force (LATF) in considering potential revisions to the GRET that could become effective for the calendar year 2024. This memo describes the analysis and resultant findings.

NAIC staff provided Annual Statement data for life insurance companies for calendar years 2021 and 2022. This included data from 766 companies in 2021 and 749 companies in 2022. This decrease resumes the trend of small decreases from year to year. Of the total companies, 379 were in both years and passed the outlier exclusion tests and were included as a base for the GRET factors (382 companies passed similar tests last year).

APPROACH USED

The methodology for calculating the recommended GRET factors based on this data is similar to that in the last several years. The methodology was last altered in 2015. The changes made then can be found in the recommendation letter sent to LATF on July 30, 2015.

To calculate updated GRET factors, the average of the factors from the two most recent years (2021 and 2022 for those companies with data available for both years) of Annual Statement data was used. For each company, an actual-to-expected ratio was calculated. Companies with ratios that fell outside predetermined parameters were excluded. This process was completed three times to stabilize the average rates. The boundaries of the exclusions have been modified from time to time; however, there were no adjustments made this year. Unit expense seed factors (the seeds for all distribution channel categories are the same), as shown in Appendix B, were used to compute total expected expenses. Thus, these seed factors were used to implicitly allocate expenses between acquisition and maintenance expenses, as well as among the three acquisition expense factors (on a direct of ceded reinsurance basis).

Companies were categorized by their reported distribution channel (four categories were used as described in Appendix A included below). There remain a significant number of companies for which no distribution channel was provided, as no responses to the annual surveys have been received from those companies. The characteristics of these companies vary significantly, including companies not currently writing new business or whose major line of business is not individual life insurance. Any advice or assistance from LATF in future years to increase the response rate to the surveys of companies that submit Annual Statements to reduce the number of companies in the "Other" category would be most welcomed.



The intention is to continue surveying the companies in future years to enable the enhancement of this multiple distribution channel information.

Companies were excluded from the analysis if in either 2021 or 2022, (1) their actual to expected ratios were considered outliers, often due to low business volume, (2) the average first year and single premium per policy were more than \$40,000, (3) they are known reinsurance companies or (4) their data were not included in the data supplied by the NAIC. To derive the overall GRET factors, the unweighted average of the remaining companies' actual-to-expected ratios for each respective category was calculated. The resulting factors were rounded, as shown in Table 1.

THE RECOMMENDATION

The above methodology results in the proposed 2024 GRET values shown in Table 1. To facilitate comparisons, the current 2023 GRET factors are shown in Table 2. Further characteristics of the type of companies represented in each category are included in the last two columns in Table 1, including the average premium per policy issued and the average face amount (\$000s) per policy issued.

To facilitate comparisons, the current 2023 GRET factors are shown in Table 2. Further characteristics of the type of companies represented in each category are included in the last two columns in Table 2, including the average premium per policy issued and the average face amount (\$000s) per policy issued.

TABLE 1

PROPOSED 2024 GRET FACTORS, BASED ON AVERAGE OF 2021/2022 DATA

DESCRIPTION	Acquisition per Policy	Acquisition per Unit	Acquisition per Premium	Maintenance per Policy	Companies Included	Average Premium Per Policy Issued During Year	Average Face Amt (000) Per Policy Issued During Year
Independent	\$198	\$1.10	50%	\$59	140	3,433	222
Career	206	1.10	52%	62	90	2,325	196
Direct Marketing	217	1.20	54%	65	23	767	122
Niche Marketing	132	0.70	33%	40	31	347	10
Other*	162	0.90	41%	49	95	917	80
* Includes companies that did not respond to this or prior year surveys					379		

TABLE 2

CURRENT 2023 GRET FACTORS, BASED ON AVERAGE OF 2020/2021 DATA

Description	Acquisition per Policy	Acquisition per Unit	Acquisition per Premium	Maintenance per Policy	Companies Included	Average Premium Per Policy Issued During Year	Average Face Amt (000) Per Policy Issued During Year
Independent	\$180	\$1.00	45%	\$54	141	3,073	204
Career	203	1.10	51%	61	84	2,296	197
Direct Marketing	197	1.10	49%	59	21	899	57
Niche Marketing	147	0.80	37%	44	30	507	14
Other*	153	0.90	39%	46	106	853	72
* Includes companies that did not respond to this or prior year surveys					382		



In previous recommendations, an effort was made to reduce volatility in the GRET factors from year to year by limiting the yearly change in GRET factors to about ten percent of the prior value. The changes from the 2023 GRET were reviewed to ensure that a significant change was not made in this year's GRET recommendation.

All GRET factors for the Independent and the Direct Marketing distribution channel experienced changes greater than ten percent, so the factors for these lines were capped at the ten percent level (or slightly above/below 10% due to rounding of the factor) from the corresponding 2023 GRET values. The volatility occurred due to an increasing median actual-to-expected ratio for each distribution channel, which allowed for additional companies with higher actual-to-expected ratios to be included in the calculation that were previously dropped. The driving force behind the notable increase in median actual-to-expected ratios for Independent and Direct Marketing were several significant outlier companies. Niche Marketing experienced the opposite, with lower median actual-to-expected ratios allowing several additional companies with lower actual-to-expected ratios, and the factors need to be capped at a ten percent drop.

USAGE OF THE GRET

This year's survey, responded to by each company's Annual Statement correspondent, included a question regarding whether the 2023 GRET table was used in its illustrations by the company. Last year, 35% of the responders indicated their company used the GRET for sales illustration purposes, with similar percentage results by company size; this contrasted with about 31% in 2021. This year, 44% of responding companies indicated they used the GRET in 2023 for sales illustration purposes. The range covered all distribution methods, including 48% for Independent, 32% for Career, 40% for Niche Marketers, and 60% for Direct Marketing. Based on the information received over the last several years, the variation in GRET usage appears to be in large part due to the relatively small sample size and different responders to the surveys.

We hope LATF finds this information helpful and sufficient for consideration of a potential update to the GRET. If you require further analysis or have questions, please contact Pete Miller at 847-706-3566.

Kindest personal regards,

A handwritten signature in black ink that reads "Peter J. Miller".

Pete Miller, ASA, MAAA
Experience Studies Actuary
Society of Actuaries Research Institute

A handwritten signature in black ink that reads "Tony Phipps".

Tony Phipps, FSA, MAAA
Chair, SOA Research Institute Committee on
Life Insurance Company Expenses



APPENDIX A -- DISTRIBUTION CHANNELS

The following is a description of distribution channels used in the development of recommended 2023 GRET values:

1. Independent – Business written by a company that markets its insurance policies through an independent insurance agent or insurance broker not primarily affiliated with any one insurance company. These agencies or agents are not employed by the company and operate without an exclusive distribution contract with the company. These include most PPGA arrangements.
2. Career – Business written by a company that markets insurance and investment products through a sales force primarily affiliated with one insurance company. These companies recruit, finance, train, and often house financial professionals who are typically referred to as career agents or multi-line exclusive agents.
3. Direct Marketing – Business written by a company that markets its own insurance policies direct to the consumer through methods such as direct mail, print media, broadcast media, telemarketing, retail centers and kiosks, internet, or other media. No direct field compensation is involved.
4. Niche Marketers – Business written by home service, pre-need, or final expense insurance companies as well as niche-market companies selling small face amount life products through a variety of distribution channels.
5. Other – Companies surveyed were only provided with the four options described above. Nonetheless since there were many companies for which we did not receive a response (or whose response in past years' surveys confirmed an "other" categorization (see below), values for the "other" category are given in the tables in this memo. It was also included to indicate how many life insurance companies with no response (to this survey and prior surveys) and to indicate whether their exclusion has introduced a bias into the resulting values.



APPENDIX B – UNIT EXPENSE SEEDS

The expense seeds used in the 2014 and prior GRETs were differentiated between branch office and all other categories, due to the results of a relatively old study that had indicated that branch office acquisition cost expressed on a per Face Amount basis was about double that of other distribution channels. Due to the elimination of the branch office category in the 2015 GRET, non-differentiated unit expense seeds have been used in the current and immediately prior studies.

The unit expense seeds used in the 2024 GRET and the 2023 GRET recommendations were based on the average of the 2006 through 2010 Annual SOA expense studies. These studies differentiated unit expenses by type of individual life insurance policy (term and permanent coverages). As neither the GRET nor the Annual Statement data provided differentiates between these two types of coverage, the unit expense seed was derived by judgment based this information. The following shows the averages derived from the Annual SOA studies and the seeds used in this study. Beginning with the 2020 Annual Statement submission this information will become more readily available.

2006-2010 (AVERAGE) CLICE STUDIES:

	Acquisition/ Policy	Acquisition/ Face Amount (000)	Acquisition/ Premium	Maintenance/ Policy
Term				
Weighted Average	\$149	\$0.62	38%	\$58
Unweighted Average	\$237	\$0.80	57%	\$76
Median	\$196	\$0.59	38%	\$64
Permanent				
Weighted Average	\$167	\$1.43	42%	\$56
Unweighted Average	\$303	\$1.57	49%	\$70
Median	\$158	\$1.30	41%	\$67

CURRENT UNIT EXPENSE SEEDS:

	Acquisition/ Policy	Acquisition/ Face Amount (000)	Acquisition/ Premium	Maintenance/ Policy
All distribution channels	\$200	\$1.10	50%	\$60

August XX, 2023

To: Members of the Life Actuarial (A) Task Force

From: NAIC Staff

RE: Guidance on Allocating Negative IMR (PIMR) In VM-20, VM-21, and VM-30

Executive Summary

While the potential admittance of some portion of negative Interest Maintenance Reserve (IMR) is being considered by the Statutory Accounting Practices (E) Working Group (SAPWG), continued guidance on the proper practice for allocating IMR for principles-based reserving (PBR) and asset adequacy testing purposes may be helpful for companies in the near term.

Background

LATF issued guidance on November 17, 2022 (Attachment A) on allocating negative IMR (PIMR) in VM-20, VM-30, VM-31. Since then, SAPWG has continued to discuss the potential admittance of some portion of negative IMR. In light of these ongoing discussions, continued guidance is needed to ensure consistent treatment for negative IMR in PBR and asset adequacy testing. Due to the timing of Valuation Manual updates, the earliest that such guidance can practically be added to the Valuation Manual is for year-end 2025. Therefore, LATF is issuing additional guidance for 2023 and 2024.

Recommendation

In order to assist state regulators and companies in achieving uniform outcomes for year-end 2023 and 2024, we have the following recommendation: the allocation of IMR in VM-20, VM-21, and VM-30 should be principle-based, “appropriate”, and “reasonable”. Companies are not required to allocate any non-admitted portion of IMR (or PIMR, as applicable) for purposes of VM-20, VM-21, and VM-30, as being consistent with the asset handling for the non-admitted portion of IMR would be part of a principle-based, reasonable and appropriate allocation. However, any portion of negative IMR that is an admitted asset, should be allocated for purposes of VM-20, VM-21, and VM-30, as again a principle-based, reasonable and appropriate IMR allocation would be consistent with the handling of the IMR asset.

This recommended guidance is for year-end 2023 and 2024, to address the current uncertainty and concerns with the “double-counting” of losses. This recommended guidance will help ensure consistency between states and between life insurers in this volatile rate environment. This guidance is expected to be incorporated in the 2025 Valuation Manual.

Attachment A

November 17, 2022

To: Members of the Life Actuarial (A) Task Force

From: NAIC Staff

RE: Guidance on Allocating Negative IMR (PIMR) In VM-20, VM-21, and VM-30

Executive Summary

With the rapidly rising interest rate environment, companies selling fixed income assets for a loss are seeing their Interest Maintenance Reserve (IMR) balances decrease or even become negative. Current statutory accounting treatment makes negative IMR a non-admitted asset. While a longer-term evaluation of IMR is being considered by the Statutory Accounting Practices (E) Working Group (SAPWG), additional guidance on the proper practice for allocating IMR for Asset Adequacy Testing and Principle-based Reserving purposes may be helpful for companies in the near term.

Background

The letter to SAPWG from the American Council of Life Insurers (ACLI) (Attachment 1) notes that "...with the inclusion of a negative IMR balance in asset adequacy testing, the disallowance of a negative IMR can result in double counting of losses (i.e., through the disallowance on the balance sheet and the potential AAT-related reserve deficiency)." There are several sections of the Valuation Manual and RBC instructions where IMR is referenced in the letter. Some of these references contemplate allocating negative IMR (or pre-tax IMR (PIMR), as applicable) at the level of business that is being analyzed/reserved for. However, these references do not detail what to do when the total company IMR balance is negative – and therefore a non-admitted asset under current statutory guidance.

Other references do provide additional insight as to the allocation of IMR when the total company balance is negative/disallowable. VM-20 Section 7.D.7.b notes that "...the company shall use a reasonable approach to allocate any portion of the total company balance that is disallowable under statutory accounting procedures (i.e., when the total company balance is an asset rather than a liability)." Question 22 of the AAA's Asset Adequacy Practice Note (Attachment 2) states that "... a negative IMR is not an admitted asset in the annual statement. So, some actuaries do not reflect a negative value of IMR in the liabilities used for asset adequacy analysis." However, Question 22 also notes a 2012 survey data that showed varying practices across companies, including some companies that allocated negative IMR.

Recommendation

In order to assist state regulators and companies in achieving uniform outcomes for year-end 2022, we have the following recommendation: the allocation of IMR in VM-20, VM-21, and VM-30 should be principle-based, "appropriate", and "reasonable". Companies are not required to allocate any non-admitted portion of IMR (or PIMR, as applicable) for purposes of VM-20, VM-21, and VM-30, as being consistent with the asset handling for the non-admitted portion of IMR would be part of a principle-based, reasonable and appropriate allocation. However, if a company was granted a permitted practice to admit negative IMR as an asset, the company should allocate the formerly non-admitted portion of negative IMR, as again a principle-based, reasonable and appropriate IMR allocation would be consistent with the handling of the IMR asset. This recommended guidance is for year-end 2022, to address the current uncertainty and concerns with the "double-counting" of losses. This recommended guidance will help ensure consistency between states and between life insurers in this volatile rate environment. Refinement of this guidance may be considered beyond year-end 2022.

Attachment 1

**Mike Monahan**

Senior Director, Accounting Policy
202-624-2324 t
mikemonahan@acli.com

Paul Graham

Senior Vice President, Chief Actuary
202-624-2164 t
paulgraham@acli.com

October 31, 2022

Mr. Dale Bruggeman, Chairman
Statutory Accounting Principles Working Group
National Association of Insurance Commissioners
1100 Walnut Street, Suite 1500
Kansas City, MO 64106-2197

Dear Mr. Bruggeman:

Re: Proposal for the NAIC to Fulfill the Original Intent of the Interest Maintenance Reserve

The American Council of Life Insurers (ACLI) would like to request urgent action on an issue that was never fully resolved by the NAIC and has become a pressing matter for the industry due to the rapid rise in interest rates—the allowance of a net negative Interest Maintenance Reserve (IMR) balance.

The ACLI proposes the allowance of a negative IMR balance in statutory accounting. Negative IMR balances are expected to become more prevalent in a higher interest rate environment and their continued disallowance will only serve to project misleading optics on insurers' financial strength (e.g. inappropriate perception of decreased financial strength through lower surplus and risk-based capital even though higher rates are favorable to an insurer's financial health) while creating uneconomic incentives for asset-liability management (e.g. discourage prudent investment transactions that are necessary to avoid mismatches between assets and liabilities just to avoid negative IMR).

ACLI believes the necessary changes can be implemented quickly and with minimal changes to the annual statement reporting instructions.

American Council of Life Insurers | 101 Constitution Ave, NW, Suite 700 | Washington, DC 20001-2133

The American Council of Life Insurers (ACLI) is the leading trade association driving public policy and advocacy on behalf of the life insurance industry. 90 million American families rely on the life insurance industry for financial protection and retirement security. ACLI's member companies are dedicated to protecting consumers' financial wellbeing through life insurance, annuities, retirement plans, long-term care insurance, disability income insurance, reinsurance, and dental, vision and other supplemental benefits. ACLI's 280 member companies represent 94 percent of industry assets in the United States.

acli.com

The remainder of this letter expands upon these points.

Historical Context and Background

The IMR, first effective in statutory accounting in 1992, requires that a realized fixed income gain or loss, attributable to changes in interest rates (but not gains or losses that are credit related), be amortized into income over the remaining term to maturity of the fixed income investments (and related hedging programs) sold rather than being reflected in income immediately.

Since statutory accounting practices for life insurance companies are the primary determinant of obtaining an accurate picture for assessing solvency, it was imperative that the accounting practices be consistent for assets, liabilities, and income and that they be reported on a financially consistent basis. If assets and liabilities were not reported on a financially consistent basis, then the financial statements would not be useful in determining an accurate assessment of solvency or whether there were sufficient assets to pay contractual obligations when they become due.

Amortized cost valuation of fixed income investments reflects the outlook at the time of purchase and amortization reflects the yields available at time of purchase. Policy reserve liabilities are established at the same time, and the interest rate assumptions are consistent with the yields at that time. But if fixed income investments are sold, with the proceeds reinvested in new fixed income investments, a new amortization schedule is established which may be based on an entirely different yield environment, which may be inconsistent with the reserve liabilities when they were established.

IMR was created to prevent the timing of the realization of gains or losses on fixed income investments, related to interest rates changes, to affect the immediate financial performance of the insurance company. This recognized that the gains and losses were transitory without any true economic substance since the proceeds would be reinvested at offsetting lower or higher interest rates.

For example, without the IMR, if a company sold all bonds in a declining interest environment (e.g., from 4% to 2%), and reinvested in new bonds, surplus would increase through significant realized gains. The increased surplus would inappropriately reflect increased financial strength that is illusory, due to a now lower yielding portfolio, as there would be no change to the income needed to support the liabilities.

Likewise, if a company sold all bonds in an increasing interest rate environment (e.g., from 2% to 4%), and reinvested in new bonds, surplus would decrease through significant realized losses. The decreased surplus would inappropriately reflect decreased financial strength that is similarly illusory due to the reinvestment at higher yields relative to when the bonds were originally purchased.

A net negative IMR is currently disallowed in statutory accounting. This handling is contrary to its original intent which recognized that interest related gains and losses are both transitory without any true economic substance since the proceeds would be reinvested at offsetting lower or higher interest rates, respectively. See attachment I to this letter that illustrates the financially consistent

treatment of assets, liabilities, and income and how IMR is needed to achieve that objective for both realized gains and losses.

That IMR should conceptually apply to both realized gains and losses was recognized by the NAIC during and after IMR development. The below is a quote from a 2002 report by the NAIC AVR/IMR Working Group to the E-Committee:

*“The basic rationale for the IMR would conclude that neither a maximum nor a minimum is appropriate. If the liability values are based on the assumption that the assets were purchased at about the same time as the liabilities were established, then there should be no bounds to the reserve which corrects for departures from that assumption; **if a company has to set up a large reserve because of trading gains, it is in no worse position that if it had held the original assets. As for negative values of the IMR, the same rationale applies. However, the concept of a negative reserve in the aggregate has not been adopted.**”*

While realized losses can offset realized gains in IMR, the IMR instructions require the disallowance of a net negative IMR balance (e.g., as noted in the last sentence of the aforementioned quote). See attachment II to this letter, which includes the pertinent IMR instructions where negative IMR balances are currently disallowed and in need of amendment.

When IMR was originally developed, it was intended to achieve its purpose in both a declining and rising interest rate environment. The originally adopted disallowed status of a negative IMR was expected to be addressed in subsequent years. However, over time with the persistent declining interest rates, the issue lost urgency since a negative IMR would not have been a significant issue for any company. The NAIC AVR/IMR Working Group ultimately disbanded without ever addressing this longstanding item on their agenda.

With a rising interest rate environment, it is important that the allowance of a negative IMR be addressed to fulfill its original purpose. In general, rising interest rates are favorable to the financial health of the insurance industry as well as for policyowners.

Without a change, the rising interest rate environment will give the inappropriate perception of decreased financial strength through lower surplus and risk-based capital and worse, create incentives for insurance companies to take action, or not take actions, to prevent uneconomic surplus impacts where the actions (or lack thereof) themselves may be economically detrimental.

Symmetrical treatment of a negative IMR (i.e., the allowance of a negative IMR balance) would appropriately not change surplus as a sale and reinvestment would not affect the underlying insurance company liquidity, solvency, or claims paying ability, just like with a positive IMR. See attachment III to this letter that illustrates that the sale of a fixed income investment, and reinvestment in a new fixed income investment, has no bearing on a life insurance company's liquidity, solvency, or claims paying ability.

As it was initially recognized by the NAIC that IMR should apply to both gains and losses, adequate safeguards were already built into the IMR instructions for asset adequacy, risk-based capital, and troubled companies.

Negative IMR – Reserve Adequacy and Risk-Based Capital

When IMR was developed, it was anticipated that a negative IMR balance would be reflected in asset adequacy analysis. This inclusion ensures that the assets, with the appropriate allocation from the IMR (whether negative or positive), would be adequate to fund future benefit obligations and related expenses of the company.

From the standpoint of reserve adequacy, the inclusion of a negative IMR balance appropriately reduces the investment income in asset adequacy testing. Without the inclusion of negative IMR, reserve inadequacies would potentially not be recognized.

Further, with the inclusion of a negative IMR balance in asset adequacy testing, the disallowance of a negative IMR can result in double counting of losses (i.e., through the disallowance on the balance sheet and the potential AAT-related reserve deficiency). The Actuarial Opinion that covers asset adequacy analysis requires the appropriate assessment of negative IMR in its analysis.

If a negative IMR balance is used in the asset adequacy analysis, its allowance is appropriate. Likewise, if only a portion of a company's negative IMR balance is reflected in the asset adequacy analysis, only the allowance for that portion of the negative IMR balance reflected is appropriate. If a negative IMR balance is disallowed, it would be inappropriate to include in asset adequacy analysis. It is imperative there is symmetry between both reserving and accounting considerations, and there is already precedent in the asset adequacy analyses for inclusion of IMR.

Below are the current references to IMR in the valuation manual and risk-based capital calculations.

Regulation	Use	IMR references
Actuarial Opinion and Memorandum Regulation (VM-30)	Asset adequacy analysis for annual reserve opinion	An appropriate allocation of assets in the amount of the IMR, whether positive or negative, shall be used in any asset adequacy analysis.
Life principle-based reserves (VM-20)	Calculation of deterministic reserve	Calculate the deterministic reserve equal to the actuarial present value of benefits, expenses, and related amounts less the actuarial present value of premiums and related amounts, less the positive or negative pre-tax IMR balance at the valuation date allocated to the group of one or more policies being modeled
Life principle-based reserves (VM-20)	Calculation of stochastic reserve	Add the CTE amount (D) plus any additional amount (E) less the positive or negative pre-tax IMR balance allocated to the group of one or more policies being modeled
Variable annuities principle-based reserves (VM-21)	Reserving for variable annuities	The IMR shall be handled consistently with the treatment in the company's cash-flow testing, and the amounts should be adjusted to a pre-tax basis.
C3 Phase 1 (Interest rate risk capital)	RBC for fixed annuities and single premium life	IMR assets should be used for C3 modeling.

Additional IMR Safeguards

The IMR instructions do provide additional safeguards in situations where it would be appropriate to recognize interest-rate related gains and losses immediately rather than be included in the IMR.

They were established to prevent situations where the liability the IMR supports, no longer exists. Examples noted in the annual statement instructions include:

- Major book-value withdrawals or increases in policy loans occurring at a time of elevated interest rates.
- Major book value withdrawals resulting from a “run on the bank” due to adverse publicity.

As a result, the IMR instructions include an IMR Exclusion whereby all gains or losses which arise from the sale of investments related to “Excess Withdrawal Activity” are to be excluded from IMR and reflected in net income. In short, Excess Withdrawal Activity is defined as 150% of the product of the lower of the withdrawal rate in the preceding or in the next preceding year calendar year times the withdrawal reserves at the beginning of the year.

Summary

With a rising interest rate environment, it is important that the allowance of a negative IMR be addressed to fulfill its original purpose. In general, rising interest rates are favorable to the financial health of the insurance industry as well as for policyowners. Without a change, the rising interest rate environment will give the inappropriate perception of decreased financial strength through lower surplus and risk-based capital.

The inability to recognize negative IMR could also impact the rating agency view of the industry, or worse, incentivize companies to avoid prudent investment transactions that are necessary to avoid mismatches between assets and liabilities. Furthermore, there are adequate safeguards in place to ensure that allowing a negative IMR does not cause any unrecognized reserve or capital inadequacies or any overstatement of claims paying ability.

Current statutory accounting guidance creates two equally objectionable alternatives for insurers and their policyowners. Following the current statutory guidance will improperly reflect financial strength through understating surplus, so additional surplus may need to be retained. Alternatively, one could take steps to manage the current situation by limiting trading of fixed income investments and related hedging programs, which would diminish significant economic value for policyowners, as well as create a mismatch between assets and liabilities.

Both scenarios encourage short-term non-economic activity not in the best long-term interest of the insurance company’s financial health or its policyowners. For insurers with diminishing IMR balances due to the rapid increase in interest rates, this dilemma is either here or fast approaching and can only be resolved now with certainty of the appropriate treatment of IMR by the NAIC.

The ACLI looks forward to urgently working with the NAIC toward fulfilling the original intent of IMR. It is imperative that insurers receive relief for year-end 2022.

If you have any questions regarding this letter, please do not hesitate to contact us.

Sincerely,

A handwritten signature in black ink that reads "Mike Monahan". The signature is written in a cursive style with a large, sweeping initial "M".

Mike Monahan
Senior Director, Accounting Policy

A handwritten signature in black ink that reads "Paul A. Dunham". The signature is written in a cursive style with a large, sweeping initial "P".

Paul Graham
Senior Vice President, Chief Actuary

Attachment I

Simplified Example – Need for Reporting Assets, Liabilities, and Income on a Consistent Basis:

- This example shows the appropriate interrelationship of IMR on assets, reserve liabilities, and income.
- Assume a bond is held with the following characteristics:
 - Par Value: \$1,000
 - Coupon: 3%
 - Term-to-maturity: 10 years
- Assume the bond is then sold at “time zero” and the proceeds are immediately reinvested in a bond with the same characteristics (e.g., term-to maturity, credit quality, coupon equivalent to market rate, etc.).
- Assume a simplified example with no existing IMR balance, where the bond supports a fixed insurance liability with the same duration as the original bond, as well as a present value of \$1,000.

Table 1: Market Interest Rate Scenario			
	Same	Lower	Higher
Market interest rate	3%	2%	4%
Bond’s market value	\$1,000	\$1,090	\$919
Realized gain/(loss) if sold	\$0	\$90	(\$81)*

Realized gain/(loss) deferred to balance sheet IMR and amortized into income over remaining life of bond sold (i.e., 10 years).

Table 2: Statutory Investment Income			
IMR amortization	\$0	\$9	(\$8)
Interest income on new bond	\$30	\$21	\$38
Total annual stat income	\$30	\$30	\$30

On average, future income is approximately the same in each interest rate scenario as the IMR gets reduced through amortization to income.

Table 3: Statutory Balance Sheet			
Balance Sheet Bonds	\$1,000	\$1,090	\$919
IMR	\$0	(\$90)	\$0*
Stat assets net of IMR	\$1,000	\$1,000	\$919*
Reserves	\$1,000	\$1,000	\$1,000
Surplus	\$0	\$0	(\$81)*

Even though the sale of the bond (and subsequent reinvestment) is non-economic, and the same income is being produced to support the liability, a negative surplus position makes it appear there is now a deficiency. Allowing the negative IMR appropriately would show no surplus impact, as is shown when a gain occurs, as there is no change in reported reserve liabilities. Appropriately consistent financial results require the allowance of negative IMR

***The negative IMR balance is currently disallowed and directly reduces surplus. This treatment is not supported by theoretical rationale and gives a distorted view of solvency.**

Attachment II

Pertinent Annual Statement Instructions

Line 6 – Reserve as of December 31, Current Year

Record any positive or allowable negative balance in the liability line captioned “Interest Maintenance Reserve” on Page 3, Line 9.4 of the General Account Statement and Line 3 of the Separate Accounts Statement. A negative IMR balance may be recorded as a negative liability in either the General Account or the Separate Accounts Statement of a company only to the extent that it is covered or offset by a positive IMR liability in the other statement.

If there is any disallowed negative IMR balance in the General Account Statement, include the change in the disallowed portion in Page 4, Line 41 so that the change will be appropriately charged or credited to the Capital and Surplus Account on Page 4. If there is any disallowed negative IMR balance in the Separate Accounts Statement, determine the change in the disallowed portion (prior year less current year disallowed portions), and make a direct charge or credit to the surplus account for the “Change in Disallowed Interest Maintenance Reserve” in the write -in line, in the Surplus Account on Page 4 of the Separate Accounts Statement.

The following information is presented to assist in determining the proper accounting:

General Account IMR Balance	Separate Account IMR Balance	Net IMR Balance
Positive	Positive	Positive (see rule a)
Negative	Negative	Negative (see rule b)
Positive	Negative	Positive (see rule c)
Positive	Negative	Negative (see rule d)
Negative	Positive	Positive (see rule e)
Negative	Positive	Negative (see rule f)

Rules:

- a. If both balances are positive, then report each as a liability in its respective statement.
- b. If both balances are negative, then no portion of the negative balances is allowable as a negative liability in either statement. Report a zero for the IMR liability in each statement and follow the above instructions for handling disallowed negative IMR balances in each statement.
- c. If the general account balance is positive, the separate accounts balance is negative and the combined net balance is positive, then all of the negative IMR balance is allowable as a negative liability in the Separate Accounts Statement.
- d. If the general account balance is positive, the separate account balance is negative, and the combined net balance is negative, then the negative amount not covered by the positive amount is not allowable. Report only the allowable portion as a negative liability in the Separate Accounts Statement and follow the above instructions for handling the disallowed portion of negative IMR balances in the Separate Accounts Statement.
- e. If the general account balance is negative, the separate account balance is positive, and the combined net balance is positive, then all of the negative IMR balance is allowable as a negative liability in the General Account Statement.
- f. If the general account balance is negative, the separate account balance is positive, and the combined net balance is negative, then the negative amount not covered by the positive amount is not allowable. Report only the allowable portion as a negative liability in the General Account Statement and follow the above instructions for handling the disallowed portion of negative IMR balances in the General Account Statement.

Attachment III

IMR Illustration – Liquidity, Solvency and Claims Paying Ability

Essentially, a negative IMR balance from an individual trade represents the present value of the future positive interest rate differential, from the new investment compared to the old investment, that puts one in the same economic position, when compared to before the trade, including total liquid assets available to pay claims.

This phenomenon can be illustrated in the following table where a 10-year bond is sold, one year after purchase, and immediately reinvested in another 10-year bond with equivalent credit quality in an interest rate environment where market interest rates increased from 2% to 4% in the intervening year.

	Coupon Rate of Bond	Market Interest Rate @ Purchase	Par Value of Bond	Fair Value @ Purchase	Fair Value @ Time of Sale	Loss on Sale	Claims Paying Liquidity
Old Bond	2%	2%	100	100	85.13	14.87	85.13
New Bond	4%	4%	85.13	85.13	85.13	N/A	85.13

The short-term acceleration of negative IMR to surplus (e.g., its disallowance) is strictly a timing issue and not a true loss of financial strength or claims paying liquidity, but it does present a temporary and inappropriate optics issue in surplus/financial strength until the IMR is fully amortized.

This phenomenon can further be illustrated by comparing two separate hypothetical companies. Assume Company A and B both have the exact same balance sheets. Then assume Company A keeps the old bond and Company B affects the trade mentioned above.

With the disallowance of a negative IMR balance, Company B now has a balance sheet that shows a relative decline of financial strength of \$14.87. This weakened balance sheet contrasts with both the principle behind the development of IMR, the relative actual economic financial strength, and claims paying ability of the two entities.

There is no difference in balance sheet economics of the two entities. The negative IMR balance for Company B essentially represents the difference between cost and fair value of the investment sold, that is already embedded on Company A's balance sheet based on the existing interest rate environment. The negative IMR balance should be recognized as there is no change in economics pre and post trade (or in this instance between Company A and Company B) which is consistent with the overall principle behind IMR.

Attachment 2

Some actuaries test the option risk in assets (e.g., calls) by assuming an immediate drop in the discount rate used in the GPV. The drop test is often set as severe as needed to represent a drop in earned rate that would occur if all options were exercised.

Q22. The AOMR states that the interest maintenance reserve (IMR) should be used in asset adequacy analysis. Why?

The IMR is part of the total reported statutory reserves. The IMR typically defers recognition of the portion of realized capital gains and losses resulting from changes in the general level of interest rates. These gains and losses are amortized into investment income over the expected remaining life of the investments sold, rather than being recognized immediately. This amortization is after tax.

The purpose of the IMR usually is to maintain the original matching between assets and liabilities that might be weakened by the sale of an asset. Originally, it was anticipated that the IMR would be allowed to become negative, as long as the asset adequacy analysis showed that the total statutory reserves, including the negative IMR, were sufficient to cover the liabilities. However, a negative IMR is not an admitted asset in the annual statement. So, some actuaries do not reflect a negative value of IMR in the liabilities used for asset adequacy analysis.

In the 2012 survey of appointed actuaries, more than 80 percent of the respondents indicated they include the IMR in their testing. Some actuaries use a starting IMR of zero if IMR is negative. Other actuaries use negative IMR to adjust starting assets and therefore model future lower asset yields than if zero IMR were assumed. Half of the respondents who indicated they used IMR in testing also indicated they lower assets by the absolute value of a negative IMR balance; the other half indicated they use a value of zero for the starting IMR if it is negative at the beginning of the projection period. There is no prohibition regarding the use of negative IMR within asset adequacy analysis. So, a number of actuaries allow the IMR to fall below zero within the testing period. About 60 percent of actuaries responding to the survey indicated they do not have to deal with a negative IMR.

Q23. How does the actuary determine which portion of the IMR can be used to support certain products? How is the portion of the IMR used?

If the actuary allocates the assets and IMR by line, then one possible approach is line of business-level inclusion of starting assets in the amount of the unamortized portion of the IMR relating to those assets that were owned by the line prior to being sold. Another possible approach is the allocation of company-level IMR proportionately to starting assets. An advantage of this second approach is that it is generally simpler, while a disadvantage is that longer liabilities probably have longer assets, which usually produce higher capital gains when sold, after a given drop in interest rates, than shorter assets do,

Life Actuarial (A) Task Force/ Health Actuarial (B) Task Force Amendment Proposal Form*

1. Identify yourself, your affiliation and a very brief description (title) of the issue.

Identification:

Rachel Hemphill, FSA, FCAS, MAAA, Ph.D.

Title of the Issue:

Clarifying guidance for allocation of negative IMR.

2. Identify the document, including the date if the document is “released for comment,” and the location in the document where the amendment is proposed:

VM- 20 Section 7.D.7, VM-30 Section 3.B.5

January 1, 2023 NAIC Valuation Manual

3. Show what changes are needed by providing a red-line version of the original verbiage with deletions and identify the verbiage to be deleted, inserted or changed by providing a red-line (turn on “track changes” in Word®) version of the verbiage. (You may do this through an attachment.)

See attached.

4. State the reason for the proposed amendment? (You may do this through an attachment.)

Clarify allocation of negative IMR for VM-20 and VM-30; in particular, non-admitted IMR is excluded. Note that VM-21 Section 4.A.7 currently requires a treatment consistent with VM-30, and so additional guidance is not needed for VM-21.

* This form is not intended for minor corrections, such as formatting, grammar, cross-references or spelling. Those types of changes do not require action by the entire group and may be submitted via letter or email to the NAIC staff support person for the NAIC group where the document originated.

NAIC Staff Comments:

Dates: Received	Reviewed by Staff	Distributed	Considered
<u>05/22/23</u>	<u>SO</u>		
Notes: <u>APF 2023-08</u>			

VM-20 7.D.7

7. Under Section 7.D.1, any PIMR balance allocated to the group of one or more policies being modeled at the projection start date is included when determining the amount of starting assets and is then subtracted out, under Section 4 and Section 5, as the final step in calculating the modeled reserves. The determination of the PIMR allocation is subject to the following:

- a. The amount of PIMR allocable to each model segment is the approximate statutory interest maintenance reserve liability that would have developed for the model segment, assuming applicable capital gains taxes are excluded. The allocable PIMR may be either positive or negative.
- b. In performing the allocation to each model segment, ~~the company shall use a reasonable approach to allocate~~ any portion of the total company IMR balance that is ~~disallowable not admitted~~ under statutory accounting procedures ~~(i.e., when the total company balance is an asset rather than a liability)~~ shall first be removed. The company shall use a reasonable approach to allocate the total company balance, after removing any non-admitted portion thereof, between PBR and non-PBR business and then allocate the PBR portion among model segments in an equitable fashion.
- c. The company may use a simplified approach to allocate the PIMR, if the impact of the PIMR on the minimum reserve is minimal.

VM-30 Section 3.B.5

5. An appropriate allocation of assets in the amount of the IMR, whether positive or negative, shall be used in any asset adequacy analysis. In performing the allocation, any portion of the total company IMR balance that is not admitted under statutory accounting procedures shall first be removed. Analysis of risks regarding asset default may include an appropriate allocation of assets supporting the asset valuation reserve; these AVR assets may not be applied for any other risks with respect to reserve adequacy. Analysis of these and other risks may include assets supporting other mandatory or voluntary reserves available to the extent not used for risk analysis and reserve support.

In addition to providing general feedback on the IMR Template and Instructions, commenters are requested to address the following questions:

1. Does there need to be any disclosure about C3 Phase 1 and C3 Phase 2? If responding affirmatively, please suggest specific disclosures.
2. Are there any summary tables that may be useful standard documentation for the free-form responses on excess withdrawals or bond sales?

The template contained in this spreadsheet is part of the company's PBR Actuarial Report and/or Actuarial Memorandum. The PBR Actuarial Report and Actuarial Memorandum are considered to be confidential information under Section 14A of the Standard Valuation Law (Model #820), and may only be disclosed by a commissioner pursuant to Section 14B of Model #820.

General Instructions for Completing Optional IMR Template

- 1) Instructions for specific fields are provided on tab "Instructions Template IMR". Please review all instructions. Then complete the template in this workbook.
- 2) Fields that must be completed are shaded in blue.
- 3) Do not add, remove, or move rows or columns.
- 4) Use the Comments column if further explanation is needed.
- 5) This template is part of the PBR Actuarial Report and/or Actuarial Memorandum. Although this workbook is formatted for printing, templates must be provided in [Excel](#) format.

**Instructions for Completing Optional AOM and PBR Actuarial Report Template IMR
Supplemental IMR Reporting**

IMR and Relevant Annual Statement Reporting

Column	Instructions
1	General Account IMR "Interest Maintenance Reserve" on Annual Statement Page 3, Line 9.4 of the General Account Statement.
2	Separate Account IMR "Interest Maintenance Reserve" on Annual Statement Page 3, Line 3 of the Separate Accounts Statement.
3	RBC RBC ratio, where the denominator is the authorized control level. Reporting entities with a 300% or lower RBC are not permitted to admit net negative (disallowed) IMR.
4	General Account Capital and Surplus General account capital and surplus, as required to be shown on the statutory balance sheet of the reporting entity for its most recently filed statement with the domiciliary state commissioner adjusted to exclude any net positive goodwill, EDP equipment and operating system software, net deferred tax assets and admitted net negative IMR. This amount should reconcile to the note disclosure for IMR included with the annual statement.
5	Admitted negative (disallowed) IMR Reported as a write-in to miscellaneous other-than-invested asset, named as "Disallowed IMR" and included in special surplus. Should be entered as a positive amount. This amount should reconcile to the note disclosure for IMR included with the annual statement.
6	Comments Any additional commentary needed to explain the entries in Columns 1-5.

Automatic Verifications

- RBC Flag**
If the RBC is under 300%, it is expected that the Admitted negative (disallowed) IMR will be 0. Provide an explanation if this is not the case.
- Capital and Surplus Flag**
The Admitted negative (disallowed) IMR is limited to 5% of General Account Capital and Surplus. Provide an explanation if this is not the case.

IMR and Relevant 9/30 Statement Reporting (to be completed if 9/30 data is used for AAT)

Repeats Columns 1-6 above, but as of 9/30. Automatic verifications are repeated for the 9/30 table. This table only needs to be completed if 9/30 data is used for AAT.

Reflection of IMR in Asset Adequacy Testing and Principle-Based Reserving

Column	Instructions
1	Reporting Basis All potential reporting bases for the template are listed. Columns 2-7 should be completed for all rows for which the company has business.
2	As of Quarter Enter Q3 for 9/30 data or Q4 for 12/31 data.
3	Amount of IMR Allocated Enter the total amount of IMR that is allocated and included in starting assets (after being adjusted to a pre-tax basis for PBR) for the given reporting basis. Report IMR, not PIMR.
4	Amount of negative (disallowed) IMR Allocated Enter the amount of net negative (disallowed) IMR that is allocated and included in starting assets (after being adjusted to a pre-tax basis for PBR) for the given reporting basis. Should be entered as a positive amount. Report IMR, not PIMR.
5	IMR Allocation Basis Enter the allocation basis used to allocate IMR for AAT or PBR. For example, this may be proportional based on starting assets or may be specific to the assets included in the reserving or testing.
6	Included in Starting Assets? (Y/N) Verify whether the allocated admitted net negative (disallowed) IMR was reflected in the starting assets, thereby reducing the amount of starting assets.
7	Allocated IMR generates future income? (Y/N) Verify that the allocated admitted net negative (disallowed) IMR included in the starting assets does not generate future income.
8	Comments Any additional commentary needed to explain the entries in Columns 1-7. In particular, if reserves are not modeled, and so allocated IMR is not reflected via starting assets, explain how IMR is reflected in the calculation. For the AAT line, if a book value projection was used to evaluate reserve adequacy, disclose whether ending surplus was adjusted for any remaining negative IMR (i.e., reduced surplus).

Automatic Verification

- AAT IMR Flag**
If the amount of negative (disallowed) IMR reflected in AAT is less than the amount of admitted negative (disallowed) IMR, provide an explanation why the admitted IMR is not fully reflected in AAT.

Excess Withdrawals

SAPWG's referral to LATF included a request with assistance "Ensuring that excessive withdrawal considerations are consistent with actual data." Input is appreciated on how LATF could best respond to this portion of the referral. To date, feedback has suggested that A/E analysis on withdrawals would be an appropriate actuarial item responsive to this request.

Bond Sales

SAPWG has proposed a restriction on the types of sales that may generate admitted net negative (disallowed) IMR. At this point, it is unclear what responsive information could be requested to verify this restriction. ACLI has suggested that this item is more suited for a CFO attestation and should not be included with the other actuarial items. Input is requested on whether this item should be included in this template and whether there is information that could be provided by actuaries to support this item or if an alternate verification should be suggested to SAPWG.

Optional AOM and PBR Actuarial Report Template IMR
Supplemental IMR Reporting
 (All dollar amounts in thousands.)

Company Name:
 NAIC Company Code:
 Valuation Year:

IMR and Relevant Annual Statement Reporting

1 General Account IMR	2 Separate Account IMR	3 RBC	4 General Account Capital and Surplus	5 Admitted negative (disallowed) IMR	6 Comments
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

RBC Flag:
 Capital and Surplus Flag:

IMR and Relevant 9/30 Statement Reporting (to be completed if 9/30 data is used for AAT)

1 General Account IMR	2 Separate Account IMR	3 RBC	4 General Account Capital and Surplus	5 Admitted negative (disallowed) IMR	6 Comments
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

RBC Flag:
 Capital and Surplus Flag:

Reflection of IMR in Asset Adequacy Testing and Principle-Based Reserving

1 Reporting Basis	2 As of Quarter	3 Amount of IMR Allocated	4 Amount of negative (disallowed) IMR Allocated	5 IMR Allocation Basis	6 Included in Starting Assets? (Y/N)	7 Allocated IMR generates future income? (Y/N)	8 Comments
VM-20 (AAT)							
VM-Z1							
VM-20: Term Reserving Category							
VM-20: ULISG Reserving Category							
VM-20: All Other Reserving Category							

Automatic Verification

AAT IMR Flag:

Admitted negative (disallowed) IMR should not reflect asset sales due to excess withdrawals, either historical excess withdrawals or anticipated future excess withdrawals (where the company anticipates future withdrawals that are "excess" as defined by IMR instructions - above 150% of the prior two years). First, discuss and support with Actual to Expected analysis the level of historical excess withdrawals and anticipated future excess withdrawals. This discussion may be supplemented by other analysis and A/E's, such as for lapse data. Second, please confirm and support that any admitted net negative IMR is not due to asset sales related to excess withdrawals. Note that if the company cannot provide strong support, then the Admitted Negative (disallowed) IMR shall be 0.

(Enter summary here, and attach additional documentation as necessary.)

Admitted negative (disallowed) IMR is limited to IMR generated from losses incurred from the sale of bonds, or other qualifying fixed income investments, that were reported at amortized cost prior to the sale, and for which the proceeds of the sale were immediately used to acquire bonds, or other qualifying fixed income investments, that will be reported at amortized cost. Please confirm and support that any admitted net negative IMR is generated by losses that satisfy that requirement. Note that if the company cannot provide strong support, then the Admitted Negative (disallowed) IMR shall be 0.

(Enter summary here, and attach additional documentation as necessary.)

**Brian Bayerle**

Chief Life Actuary

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July 28, 2023

Rachel Hemphill

Chair, NAIC Life Actuarial (A) Task Force (LATF)

Craig Chupp

Vice-Chair, NAIC Life Actuarial (A) Task Force (LATF)

Re: LATF Interest Maintenance Reserve (IMR) Template

Dear Chair Hemphill,

The American Council of Life Insurers (ACLI) appreciates the opportunity to comment on the IMR Template which was exposed by LATF during their meeting on June 15, 2023, and we are especially appreciative of the changes to the template made by regulators to date. ACLI members have a few questions and suggested edits for consideration that would go a long way towards making the Template as meaningful and effective as possible for both industry and regulators alike.

The template will need to be updated to be consistent with the work Statutory Accounting Principles (E) Working Group (SAPWG) is doing on this topic. The July 5th SAPWG exposure had significant updates. Notably, the 5% limit has increased to 10% (with adjustments), which will need to be reflected on the "Instructions Template IMR" and "Template IMR" tabs. Additionally, "Bond Sales" (rows 69-70) on the "Instructions Template IMR" and "Template IMR" tabs may no longer be necessary given the most recent SAPWG exposure. We would also request that LATF adjust the template (particularly the free response questions) to remove any data and questions that are already being captured by SAPWG (e.g., the attestation requirements).

American Council of Life Insurers | 101 Constitution Ave, NW, Suite 700 | Washington, DC 20001-2133

The American Council of Life Insurers (ACLI) is the leading trade association driving public policy and advocacy on behalf of the life insurance industry. 90 million American families rely on the life insurance industry for financial protection and retirement security. ACLI's member companies are dedicated to protecting consumers' financial wellbeing through life insurance, annuities, retirement plans, long-term care insurance, disability income insurance, reinsurance, and dental, vision and other supplemental benefits. ACLI's 280 member companies represent 94 percent of industry assets in the United States.

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General Comments/Confidentiality Tab:

- The template combines concepts from both PBR and the Actuarial Opinion and Memorandum (AOM).
 - The parts relevant for PBR would be in the purview of the Qualified Actuary, but the PBR Report is not due until 4/1.
 - Further, the information requested in lines 45 and 60 is not currently the responsibility of the Appointed Actuary and should be collected elsewhere. It does not seem appropriate for this piece to be part of the AOM. Further, it does not seem appropriate to include this information before the audited financial statements are completed.
 - If the template were considered part of the AOM, how is it referenced? AG 53 was attached to the memorandum as an appendix and was separately provided to domestic regulators as a request. To work similarly to that process the template could be due at or the same time the Regulatory Asset Adequacy Issue Summary (RAAIS) is due.
- ACLI requests that IMR template submissions not be due on 2/28 and are deferred until after the RAAIS and PBR Report are submitted.
- Is it the intent that the file is on record at the company and is available upon request?

Instructions Template IMR Tab:

- The instructions reference a “note disclosure for IMR.” We request clarification on what this wording entails as some members have expressed confusion. There is no IMR Note or IMR Disclosure but there is a form for calculating IMR; is this last item what regulators intended companies to use?

Template IMR Tab:

- Row 16: For column 3, RBC, consider including reference to the following annual statement items for the RBC ratio (= TAC/Authorized Control Level RBC)
 - TAC: Five-Year Historical Data, Line 30, Column 1
 - Authorized Control Level RBC: Five-Year Historical Data, Line 31, Column 1
- Row 16: For column 4, General Account Capital and Surplus,
 - Consider including references to the location in the annual statement for each item in the adjusted amount:
 - General Account Capital and Surplus: Page 3, Line 38
 - Net Positive Goodwill: <location>
 - EDP Equipment and operating system software: Page 2, Line 20, Column 3
 - Net deferred tax assets: Page 2, Line 18.2, Column 3
 - Admitted net negative IMR: <location>
- For column 5, Admitted negative (disallowed) IMR, how does this item differ, if at all, from “admitted net negative IMR” referenced in column 4, General Account Capital and Surplus?
- For column 7, Allocated IMR generates future income? (Y/N)?, consider re-stating the instructions to read as follows: Does the allocated admitted net negative (disallowed) IMR included in the starting assets generate future income? The current language is open to interpretation.
- The following cells do not allow for a zero entry:

- Cell E16 – Admitted negative (disallowed) IMR in Annual Statement
- Cell E26 – Admitted negative (disallowed) IMR in 9/30 Quarterly Statement
- The following cells do not allow for a free-form text entry:
 - Cell E35 (IMR Allocation Basis – VM-30)
 - Cell E36 (IMR Allocation Basis – VM-21)
 - Cell E37 (IMR Allocation Basis – VM-20 Term)
 - Cell E38 (IMR Allocation Basis – VM-20 ULSG)
 - Cell E39 (IMR Allocation Basis – VM-20 All Other)

Thank you once again for your consideration of our comments and we look forward to discussing the IMR Template at a future session of LATF.

Sincerely,



Colin Masterson

cc: Scott O'Neal, NAIC



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July 21, 2023

Rachel Hemphill
Chair, NAIC Life Actuarial (A) Task Force (LATF)

Re: APF 2023-08 and the NAIC Staff Memo on Interest Maintenance Reserve (IMR)

Dear Chair Hemphill:

The American Council of Life Insurers (ACLI) appreciates the opportunity to submit comments on the two LATF exposures from the June 1st meeting related to IMR: APF 2023-08 and the NAIC Staff Memorandum on Allocating Negative IMR (PIMR) In VM-20, VM-21, and VM-30. Overall, ACLI has no objections to the language and proposals presented in the exposures.

ACLI would like to clarify whether the regulators' intention is to require that all admitted negative IMR be fully allocated in PBR and AAT, including admitted negative IMR arising from assets in a segmented surplus portfolio. ACLI notes that positive IMR amounts arising from assets in a segmented surplus portfolio are not allocated in PBR and AAT.

Thank you very much for the consideration of our request for clarification and we look forward to further discussion on these exposures at a future LATF session.

Sincerely,

Two handwritten signatures in cursive script. The first signature is 'B Bayerle' and the second is 'Colin Masterson'.

cc: Scott O'Neal, NAIC

American Council of Life Insurers | 101 Constitution Ave, NW, Suite 700 | Washington, DC 20001-2133

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HEALTH INSURANCE AND MANAGED CARE (B) COMMITTEE

Health Insurance and Managed Care (B) Committee Aug. 14, 2023, Minutes	6-2
Health Insurance and Managed Care (B) Committee June 29, 2023, Minutes (Attachment One)	6-7
Consumer Information (B) Subgroup May 25, 2023, Minutes (Attachment Two)	6-11
Consumer Information (B) Subgroup April 25, 2023, Minutes (Attachment Two-A).....	6-14
Medicaid Redeterminations State Insurance Regulator Guide (Attachment Two-A1)	6-15
Consumer Information (B) Subgroup April 17, 2023, Minutes (Attachment Two-B).....	6-18
Health Innovations (B) Working Group Aug. 13, 2023, Minutes (Attachment Three)	6-20

Draft: 8/22/23

Health Insurance and Managed Care (B) Committee
Seattle, Washington
August 14, 2023

The Health Insurance and Managed Care (B) Committee met in Seattle, WA, Aug. 14, 2023. The following Committee members participated: Anita G. Fox (MI), Chair; Jon Pike, Co-Vice Chair (UT); Mike Kreidler, Co-Vice Chair (WA); Trinidad Navarro represented by Jessica Luff (DE); John F. King (GA); Dean L. Cameron (ID); Kathleen A. Birrane (MD); Grace Arnold (MN); Mike Chaney represented by Bob Williams (MS); D.J. Bettencourt (NH); Glen Mulready (OK); Andrew R. Stolfi (OR); Michael Humphreys (PA); and Allan L. McVey represented by Erin K. Hunter (WV). Also participating were: Paul Lombardo (CT); LeAnn Crow (KS); Troy Downing (MT); Eric Dunning and Martin Swanson (NE); and Scott A. White (VA).

1. Adopted its June 29 and Spring National Meeting Minutes

The Committee met June 29 and March 23. During its June 29 meeting, the Committee took the following action: 1) heard presentations on the Maryland, Michigan, and Nebraska state appeal programs; and 2) received an update on the Consumer Information (B) Subgroup's work to educate consumers on their claim appeal rights.

Williams made a motion, seconded by Commissioner King, to adopt the Committee's June 29 (Attachment One) and March 23 (*see NAIC Proceedings – Spring 2023, Health Insurance and Managed Care (B) Committee*) minutes. The motion passed unanimously.

2. Adopted its Subgroup, Working Group, and Task Force Reports

Williams made a motion, seconded by Commissioner King, to adopt the following reports: 1) the Consumer Information (B) Subgroup, including its May 25 minutes (Attachment Two); 2) the Health Innovations (B) Working Group, including its Aug. 14 minutes (Attachment Three); 3) the Health Actuarial (B) Task Force; 4) the Regulatory Framework (B) Task Force; and 5) the Senior Issues (B) Task Force. The motion passed unanimously.

3. Discussed Referrals to the Health Actuarial (B) Task Force

Director Fox said the Committee received a referral from the Financial Analysis (E) Working Group, asking the Committee to engage in a discussion with the federal Centers for Medicare & Medicaid Services (CMS) about state insurance regulators' concerns with how the risk adjustment formula impacts the current or prospective financial solvency position of new health insurers entering the health insurance marketplaces. She said that from the NAIC groups under the Committee, the Health Actuarial (B) Task Force is the group best suited to work on this referral. She said that assuming the Committee agrees to refer this issue to the Task Force, the referral will ask the Task Force to: 1) reach out to the CMS to discuss the issue; and 2) identify the changes, if any, in the formula to address the issue identified in the Working Group's referral to the Committee.

Director Fox said the second referral to the Health Actuarial (B) Task Force concerns how possible changes to the cost-sharing reduction subsidy, such as changes to silver loading, could impact plan options and costs to consumers. She said the Task Force has already heard from the American Academy of Actuaries (Academy) and other actuarial groups that silver loading has created odd incentives in the market. Because of this, Director Fox said she believes it would be beneficial for the Committee to know more about how changes in state silver loading policies or other changes, such as the elimination of the enhanced subsidies in 2026, could affect consumer

choices and the affordability of coverage. She said assuming the Committee agrees to this referral, the Committee would be asking the Task Force to review this issue and report its findings to the Committee.

Commissioner Stolfi made a motion, seconded by Commissioner King, to refer the issues identified in the Financial Analysis (E) Working Group referral letter to the Committee and the issue on how possible changes to the cost-sharing reduction subsidy could impact plan options and costs to consumers to the Health Actuarial (B) Task Force. The motion passed unanimously.

4. Received an Update on Market Regulation and Consumer Affairs (D) Committee Work of Interest to the Committee

Director Fox said that in accordance with the Committee's charge to coordinate with appropriate Market Regulation and Consumer Affairs (D) Committee groups, as necessary, on health benefit plan and producer enforcement issues, she asked Commissioner Pike, chair of the Market Regulation and Consumer Affairs (D) Committee, to provide an update on the work of that Committee of interest to this Committee. Commissioner Pike asked Swanson to provide an update on the work of the Improper Marketing of Health Insurance (D) Working Group concerning revisions to the *Unfair Trade Practices Act* (#880). Swanson said that after several meetings and numerous discussions, during its meeting on Aug. 14, the Working Group adopted revisions to Model #880 to address regulatory and enforcement issues with health insurance lead generators.

5. Received an Update on the Consumer Information (B) Subgroup's Work Related to Educating Consumers on Claim Appeal Rights

Crow provided an update on the work of the Consumer Information (B) Subgroup related to educating consumers on their claim appeal rights. She said the Subgroup's small drafting subgroup, which the Subgroup established to review the Subgroup's previous work in 2021 on claims, has met three times since the Committee's July 29 meeting and plans to meet again after the Summer National Meeting. She said the small drafting group includes an array of stakeholders, including state insurance regulators and consumer representatives. She said the small drafting group decided to update its series of consumer guides on claims: 1) codes and claims; 2) explanation of benefits; 3) filing health insurance claims; 4) how to appeal a denied claim; and 5) understanding medical necessity. She said the 2021 version of these guides are available on the Subgroup's webpage on the NAIC website under the "Documents" tab.

Crow said the Subgroup hopes to have updated versions of the guides completed within the next few months. She said the Subgroup's goal is to create content that allows states to incorporate it into their own materials and to use it as-is with no additional configuration needed. The Subgroup is also considering ways to break the content into pieces that can be used in social media posts or in videos. She said that for the updated complete guides, the Subgroup wants to make them more interactive rather than the static PDF format. Crow said the NAIC Communications Division staff have been participating in the small drafting group meetings. She said the Subgroup plans to use their expertise and assistance in making the guides attractive and more accessible to consumers.

Crow said that as mentioned during her update to the Committee during its June 29 meeting, the Subgroup recognizes that developing documents like the guides is only one part of engaging consumers with health insurance issues. Consumers will only find its documents if they seek them out or if they come across communication from a state insurance department that engages them and inspires them to learn more. She said the Subgroup encourages the Committee and the NAIC to consider additional strategies for building knowledge among consumers and establishing state departments of insurance (DOIs) as a go-to source for assistance and education on health insurance.

Williams asked if the Subgroup’s consumer guides could be shared with the Mississippi Insurance Department to possibly supplement the information it currently has on its website about health insurance. Crow said she would share this information with him. Director Fox agreed that one of the main goals of the Consumer Information (B) Subgroup’s work is to be able to share the guides with state DOIs to better assist them with helping their consumers.

6. Heard a Panel Discussion on Preventive Services

Carl Schmid (HIV + Hepatitis Policy Institute), Amy Killelea (Killelea Consulting), and Anna Howard (American Cancer Society Cancer Action Network—ACS CAN) gave a panel presentation on preventive services from a consumer-focused perspective. The presentation also discussed the methodology, findings, and recommendations included in the recently issued NAIC consumer representatives’ report, *Preventive Services and Coverage and Cost-Sharing Protections Are Inconsistently and Inequitably Implemented: Considerations for Regulators*. Schmid provided an overview of the federal Affordable Care Act’s (ACA’s) preventive service requirements and the recent court case, *Braidwood v. Becerra*, challenging those requirements. He also discussed the health equity implications of increasing access to preventive services. Schmid cited the four preventive services examined in the NAIC consumer representatives’ report that have such health equity implications: 1) smoking cessation; 2) pre-exposure prophylaxis (PrEP) for the prevention of human immunodeficiency virus (HIV); 3) colorectal cancer screening; and 4) postpartum depression screening. He explained that the NAIC consumer representatives commissioned the report because despite the ACA preventive care requirements for coverage and no cost-sharing for such services, compliance with such requirements has been a challenge for certain preventive services, particularly with respect to HIV preventive care services, including prescription drugs needed to manage the virus.

Killelea discussed the NAIC consumer representatives’ preventive services report’s methodology and findings. She said the report found that: 1) consumer-facing documents lack comprehensive preventive services descriptions; 2) plan formularies did not always describe zero-dollar cost-sharing preventive medications clearly and accurately; and 3) payer guidance documents that inform claims adjudication policies were often incomplete. She provided examples for each of these findings. She also explained why payer guidance matters because incomplete, unarticulated specific coverage payer policies that fail to inform claims adjudication policies for providers lead to arbitrary coverage decisions.

Howard discussed the recommendations included in the report for state insurance regulators to address the issues in the report’s findings, which include using data calls and market conduct examinations to assess compliance, ensuring continued preventive protections with state legislative and regulatory action, establishing uniform billing and coding standards, and holding plans accountable for educating consumers and providers on preventive services requirements.

Schmid asked if the Consumer Information (B) Subgroup has developed materials on preventive services, and if not, if the Subgroup would consider developing such materials. Crow said that the Subgroup has not developed specific materials on preventive services, but because the Subgroup also believes this is an important consumer issue, she would ask the Subgroup to develop consumer education materials on it.

7. Heard an Update on the Medicaid Redetermination Process

Miranda Motter (America’s Health Insurance Plans—AHIP) provided a status update on the Medicaid redetermination process following the end of the COVID-19 public health emergency (PHE). She discussed key findings from the first batch of Medicaid redeterminations data the CMS reported last month in accordance with the federal Consolidated Appropriations Act, 2023. She said that as of April 2023, based on 14 states, more than 2 million people have gone through the full renewal process. Of those, nearly half (45.5%) were successfully

reenrolled in Medicaid and Children’s Health Insurance Program (CHIP), and more than half (55%) of those renewed were done automatically. She said that approximately, one-third (32.2%) lost their Medicaid and/or CHIP coverage and within that group, 79% of those terminations were for procedural reasons. Motter said that it is anticipated that the next CMS update will provide data on coverage transitions for those who were determined no longer eligible for Medicaid.

Motter discussed updated state renewal timelines. She also discussed new state flexibilities the U.S. Department of Health and Human Services (HHS) recently announced to help keep Americans covered as states resume Medicaid and CHIP renewals. She also provided information on federal, state, and health industry resources for consumers and employers to assist them with transitioning through the renewal process and maintaining coverage. She highlighted AHIP’s Medicaid redetermination toolkit designed to assist consumers transitioning from Medicaid coverage because of redetermined ineligibility for such coverage to other types of coverage, such as employer-based health insurance and health insurance marketplace plans. She also discussed the work of the Connecting to Coverage Coalition (Coalition), which is a coordinating community for stakeholders working to minimize disruptions in coverage associated with Medicaid redeterminations. She said the Coalition includes broad representation from seniors, disability groups, patient groups, provider associations, employer-related organizations, consumer advocacy groups, and Medicaid trade associations.

8. Received an Update on the Work of the Special (EX) Committee on Race and Insurance Health Workstream

Commissioner Arnold and Commissioner Birrane provided an update on the Special (EX) Committee on Race and Insurance Health Workstream work since its last update to the Committee.

Commissioner Arnold said that after the Spring National Meeting, the Workstream met in a regulator-only session to discuss its activities and meetings for 2023, during which, the Workstream decided to: (1) continue its education on benefit design relating to specific areas of focus, such as preventative care and mental health coverage beyond pure parity; (2) explore the evolution of the ACA section 1332 waivers and innovative uses of them that can be implemented to lower the uninsured rate in states; and (3) continue to provide a forum for sharing innovative programs and initiatives that states are doing that are designed to promote health equity. She said the Workstream met July 24 to hear presentations focusing on preventative care and lowering barriers to such care, particularly with respect to chronic diseases. The presentations discussed the impact of lowering barriers to such care in increasing health equity and reducing disparities. The Workstream plans to hold a follow up meeting on this topic sometime in October or early November. Commissioner Arnold said the Workstream plans to meet sometime in late September or early October to hear presentations on initiatives and programs to reduce mental health disparities. The Workstream hopes to hear from a variety of stakeholders, including industry and consumers.

Commissioner Birrane said the Workstream plans to meet Sept. 19 to hear presentations on innovative uses for ACA section 1332 waivers and other market reforms, aimed toward lowering the uninsured rate in the states. She said during this meeting, the Workstream will hear from states that have found success in amending their state benchmark plans, what they changed, and what that process looked like. Further, the Workstream will hear from states that have implemented other market reforms to make health insurance more accessible. She said the Workstream looks forward to hearing what has proven successful, what challenges arose, and what recommended best practices emerged as these efforts were undertaken to assist the uninsured population in respective states.

Commissioner Arnold said the Workstream is also piloting a new collaboration space on the NAIC Connect platform to allow Workstream members and other NAIC members to discuss issues related to health equity and other related topics. She said this effort will provide a platform that Workstream members can use to share the information that has and will be captured during its past and future meetings on removing barriers to health insurance for historically disadvantaged communities with each other and other NAIC members. She said the

Workstream's NAIC Connect page will be a living resource for the NAIC membership on which the Workstream can continue to build content and resources for states seeking to address the equity gap in health insurance access and utilization.

Commissioner Arnold said that due to the hard work of the NAIC Member Services Division, the Workstream's NAIC Connect platform page is scheduled to go live within the next few weeks as part of the initial pilot rollout along with the Innovation, Cybersecurity, and Technology (H) Committee. She encouraged anyone interested to visit the Workstream's page and test it out during the pilot phase. The Workstream has planned a meeting on Sept. 21 to walk Workstream members through the features and content on the page.

Lastly, Commissioner Birrane said that the Workstream has been working in collaboration with the Committee and the Big Data and Artificial Intelligence (H) Working Group to prepare a survey of artificial intelligence (AI) use by health insurers. She said Maryland has been doing the initial coordination of this work with the assistance of the Johns Hopkins Bloomberg School of Health. She said Maryland expects to have a draft survey form soon to share with the collaborating groups as it finalizes a draft to share with the industry for refinement. She said Maryland's goal is to solicit participating states and have the survey out this year.

Having no further business, the Health Insurance and Managed Care (B) Committee adjourned.

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Draft: 8/1/23

Health Insurance and Managed Care (B) Committee
Virtual Meeting
June 29, 2023

The Health Insurance and Managed Care (B) Committee met June 29, 2023. The following Committee members participated: Anita G. Fox, Chair, and Laura Hall (MI); Jon Pike, Co-Vice Chair (UT); Mike Kreidler, Co-Vice Chair, represented by Jane Beyer and Ned Gaines (WA); Trinidad Navarro (DE); John F. King (GA); Dean L. Cameron represented by Shannon Hohl (ID); Kathleen A. Birrane and Louis Butler (MD); Grace Arnold represented by Julia Dreier (MN); Chris Nicolopoulos represented by Jason Dexter (NH); Glen Mulready (OK); Michael Humphreys (PA); and Allan L. McVey (WV). Also participating were: LeAnn Crow (KS); Troy Downing (MT); Maggie Reinert (NE); and Larry D. Deiter (SD).

1. Heard Presentations on State Appeals Programs

Director Fox said that during the Committee's meeting at the Spring National Meeting, it heard a presentation from the Kaiser Family Foundation (KFF) on findings from its issue brief "Claims Denials and Appeals in ACA Marketplace Plans in 2021." She said one piece of data from the presentation raising the Committee members' attention was that consumers rarely appeal claim denials. She said that because of that, the Committee wanted to have a broader discussion on: 1) what support the states offer to consumers in this area and how they are raising awareness to consumers of their options to appeal; and 2) what more the Committee and the groups reporting to it can do as well to raise consumer awareness.

Director Fox said that during today's meeting, the Committee would hear from Maryland, Nebraska, and Michigan on their work to raise consumer awareness of their claim appeal rights.

Butler discussed Maryland's work, including statistics supporting the KFF's findings about the low percentage of consumer claim appeals. He said the Maryland Insurance Administration (MIA) has a dedicated unit, the Consumer Education and Advocacy Unit (Unit), whose mission is to educate Maryland residents about various insurance products and explain to consumers their rights and obligations under the terms of their insurance policies. The Unit travels to fairs, trade shows, and other events across the state to provide educational materials to consumers. It answers questions on various insurance issues, including health insurance and the right of consumers to appeal claim denials.

Butler noted that based on questions during these events, it is shocking the low number of consumers who are aware of the MIA and their right to appeal claim denials. He said many consumers, who may know of their claim appeal rights, do not file internal appeals with their insurer because of a fear of retaliation. Butler explained how the Unit will walk a consumer through the process of filing an internal appeal with their insurer. He also discussed Maryland's external independent review process.

Reinert discussed Nebraska's work to educate and assist consumers in appeals of claim denials focusing on its external review program. She provided a history of the program and its steps toward implementation, including developing denial letter templates and working with major medical carriers on the language that the carriers must include in the appeals and grievances sections in their policies and certificates to ensure consumers have notice of their internal and external appeal rights.

This information is also posted on the Nebraska Department of Insurance's (DOI's) website.

Reinert also discussed the Nebraska DOI's best practices with respect to external appeals, including recommending that consumers assign their doctor to be their authorized representative because provider participation is a vital part of the appeal process.

Reinert provided an overview of the Nebraska DOI's Health Division's efforts to raise consumer awareness of their appeal rights, including highlighting information on its website detailing the steps consumers can take to appeal claim denials first internally through their insurer and then, if necessary, externally through an independent reviewer. She said that in addition, the Nebraska DOI Health Division conducts an annual "road show" during which it holds community meetings and makes presentations throughout the state to educate consumers on an array of insurance issues, including a consumer's right to appeal claim denials.

Reinert also discussed the Nebraska DOI Health Division's use of social media—Facebook and LinkedIn—to educate consumers and increase awareness. Reinert highlighted the Nebraska external review program's successes. She said that since 2014, 786 internal claim denials were overturned. She said that in the past five years, Nebraska has consistently averaged about 250 external appeal cases per year. From that number, approximately 47% of eligible cases were overturned, and about 23% of those cases were not eligible for external review.

Hall discussed Michigan's efforts to educate and increase consumer awareness of their right to appeal claim denials beginning with changes to the Michigan DOI's website to make it more consumer-friendly. She said it was hard for consumers to find information on the old website, and the information on it was highly technical and hard for the average consumer to understand. She said the new website resolves these challenges. It has a modern look and feel and is mobile-friendly. She said the new website includes a step-by-step guide at a 7th-grade reading level with links for consumers to use and follow to appeal claim denials.

Hall also discussed the Michigan DOI's proactive outreach efforts. She said the Michigan DOI plans to continue these efforts and access other means to educate consumers, such as leveraging social media, public service announcements, and sharing information with stakeholders.

Director Fox asked the presenters about their consumer outreach efforts, including how it evaluates the success of those efforts and keeps track of what works. Butler said the MIA's Unit travels around the state to various events, which in many cases, it does not create, but it piggybacks on already planned events. He said the MIA recently did a podcast on medical necessity. He said that following that podcast, the MIA saw an increase in the number of appeals filed, which he believes is a direct correlation to the podcast's airing. He said that in addition, the MIA saw an increase in telephone calls from consumers asking for more information about their claim denial appeal rights and the internal and external appeal processes. He also noted that the MIA is on all the social media platforms, including Nextdoor.

Reinert said that to increase awareness of planned events during its annual roadshow, the Nebraska DOI places advertisements in local newspapers and on the radio, and it posts information on social media. She said the Nebraska DOI has found that posting on Facebook produces the most engagement from the public, particularly if it does paid pushes that target certain areas in the state where it plans to host an event. She said the Nebraska DOI also reaches out to industry, such as the Independent Insurance Agents & Brokers of America (IIABA) and the National Association of Health Underwriters (NAHU). In addition, it sends out an email blast to insurers.

Hall discussed how Michigan evaluates its success in reaching out to consumers. She said Michigan tracks the number of attendees at its in-person events and has great participation in its virtual events. She noted that

because of the COVID-19 pandemic, in-person events were eliminated for a few years, but in-person attendance is beginning to increase since it has recently restarted those events. She said that Michigan has experienced the most success in reaching consumers by using air media—local news station reporters and radio stations—interviews with Director Fox during which she discusses various insurance issues, including consumer appeal rights.

Commissioner Birrane discussed additional approaches the MIA uses to reach consumers. She described the MIA's LinkedIn platform profile. She also discussed the MIA's creation of an emoji character called MIA that it uses to interact with the public on Facebook and, as appropriate, other social media platforms.

Commissioner Birrane also noted that the MIA gives more than 600 presentations a year and specifically emphasizes to the public that the MIA is available 24 hours a day, seven days a week to assist consumers, providers, and other stakeholders. She also noted the MIA's high reversal rate related to medical necessity determinations due to its involvement in assisting the consumer in navigating the appeals process.

2. Received an Update from the Consumer Information (B) Subgroup on its Work Related to Consumer Education on Claim Appeal Rights

Crow discussed the Consumer Information (B) Subgroup's work related to educating consumers on their appeal rights. She said that after the Committee's discussion of the issue at the Spring National Meeting, the Subgroup accelerated its work in this area. She said the Subgroup's most recent meetings have been devoted to this topic. Based on the discussions during these meetings, the Subgroup formed a small drafting subgroup to review the Subgroup's previous work related to this issue to determine whether the Subgroup needs to develop additional resources on the issue. She said that in 2021, the Subgroup developed a series of consumer guides on claims. The five guides were: 1) codes and claims; 2) explanation of benefits; 3) filing health insurance claims; 4) how to appeal a denied claim; and 5) understanding medical necessity.

Crow said the small drafting subgroup has met three times since the Spring National Meeting. During these meetings, the small drafting subgroup started reviewing the guides to see if additional content should be added. She said the small drafting subgroup is also interested in changing the format of the guides from a PDF document to a format that is more interactive for consumers. Crow explained that one example of such interactive content is the Subgroup's "How to Understand Your Insurance Card" document. She said that because of its interactive format, the document has been well received. Crow said the Subgroup has also been working with the NAIC Communications Division as it develops ideas for making the content of the guides more user-friendly. She said as Maryland, Michigan, and Nebraska discussed during their presentations, the Subgroup is exploring ways to leverage social media to let the public know about these resources.

Crow noted that the Subgroup's charge from the Committee is to develop information or resources that would be helpful to state insurance regulators and others in assisting consumers to better understand health insurance. She said it might be useful for the Committee to consider additional strategies for engaging consumers on claims and appeals and possibly other health topics. She said she would be happy to provide an update to the Committee on the Subgroup work during the Committee's meeting at the Summer National Meeting.

Director Fox said that with respect to letting the public know about the guides and other resources the Subgroup has developed, the Subgroup could consider developing a tool kit with this information and making it available to NAIC members for them to use in their states because many NAIC members do not know this information exists.

Carl Schmid (HIV+Hepatitis Policy Institute) said the NAIC consumer representatives suggested that the Committee invite the KFF to present its findings to the Committee at the Spring National Meeting because they felt it was important for the Committee hear those findings. He said the NAIC consumer representatives believe this issue is of the utmost importance. Reflecting its importance, he said the NAIC consumer representatives have established a subgroup of NAIC consumer representatives focusing on prior authorization, medical necessity, and appeals and denials. The subgroup is developing recommendations for the Committee to consider addressing the low number of consumer appeals of claim denials and other issues related to prior authorization and medical necessity.

Having no further business, the Health Insurance and Managed Care (B) Committee adjourned.

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Draft: 6/14/23

Consumer Information (B) Subgroup
Virtual Meeting
May 25, 2023

The Consumer Information (B) Subgroup of the Health Insurance and Managed Care (B) Committee met May 25, 2023. The following Subgroup members participated: LeAnn Crow, Chair (KS); Anthony L. Williams (AL); Debra Judy (CO); Randy Pipal (ID); Alex Peck (IN); Judith Watters (ME); Joy Hatchette (MD); Carrie Couch (MO); Susan Brown (MT); Rebecca Ross (OK); Jill Kruger (SD); Scott McAnally (TN); and Christina Keeley (WI). Also participating was: Cynthia Cisneros (NM).

1. Adopted its April 25 and April 17 Minutes

The Subgroup met April 17 to discuss a guide on Medicaid redeterminations, titled *Resuming Medicaid Redeterminations: State Insurance Regulator Guide*, and it adopted the guide during an e-vote that concluded April 25.

Couch made a motion, seconded by Keeley, to adopt the Subgroup's April 25 (Attachment Two-A) and April 17 minutes (Attachment Two-B). The motion passed unanimously.

2. Discussed Consumer Assistance on Claim Denials and Appeals

Crow said the Health Insurance and Managed Care (B) Committee had asked the Subgroup to look into claim denials and appeals in response to a recent KFF report on the subject. She said the Subgroup had last addressed appeals in 2021 when it developed a guide for consumers on appealing denied claims.

Crow asked Subgroup members how departments of insurance (DOIs) assist consumers with appeals, how consumers find out about the assistance available, and what barriers prevent consumers from appealing. She also asked about the 2021 guide and whether states use it, including the template letter to request an appeal. Crow said that in Kansas, consumers must first appeal internally. She said most insurers include contact information for the DOI in denial letters. She said many consumers do not believe it is worth it to appeal. She said working with providers and asking them to encourage patients to appeal is one route Kansas has used. Couch said Missouri does not require exhaustion of internal appeals before external review and does not have time limits. She said Missouri also faces obstacles in making consumers aware that assistance is available from the Missouri Department of Commerce and Insurance. She said information in denial letters is one way they find out. Watters said Maine has a similar process to Missouri. She said a consumer advocacy group (Maine Consumers for Affordable Health Care) also provides information and assistance to consumers in filing appeals.

Harry Ting (Health Consumer Advocate) questioned whether all states require explanations of benefits to include contact information for DOIs. He said the 2021 guide is written with medical necessity denials in mind, but denials occur for many other reasons, including missed premium payments and late billing by providers. He suggested that the guide include language to address other denial reasons.

Lucy Culp (The Leukemia & Lymphoma Society—LLS) said consumers should also be directed to their employers when they have employer-sponsored coverage. She said consumer representatives had originally requested that the Health Insurance and Managed Care (B) Committee consider the KFF report. They have formed their own ad hoc group to examine denial and appeals issues. She said the consumer group would be willing to partner with the Subgroup on any work in this area.

Crow said consumers need assistance navigating complicated processes, so it is important to develop a document that is usable and easy to understand. She said the 2021 guide is a good start. She said consumers often do not understand what type of plan they are enrolled in or whether they are eligible for state-based external review.

Crow said the guide could be revised into two separate documents, one shorter and one longer. Bonnie Burns (California Health Advocates—CHA) said many consumers struggle with written communications and do not know how to respond to a denial letter. She said shorter and longer versions would be helpful. She said help should be provided in a very simple way, and when possible, consumers should be connected with an organization like the one in Maine to assist.

Eric Ellsworth (Consumers' Checkbook) said consumers may not know anything about their medical bills. He said the Subgroup should consider the first communication consumers receive that tells them about denials or other forms of nonpayment. He said there is a need for better billing information earlier in the process, including explanations of benefits.

Brenda J. Cude (University of Georgia) said the existing guide makes assumptions, such as that consumers know what denial means. She said a more basic piece could help consumers understand what to look for to know that a claim is denied. She said one basic question for the Subgroup is whether it will develop a formatted guide or content that states can take and use to develop their own materials. Crow said she liked the idea of taking it back to the basics.

Keeley said having two versions would allow more examples and images. She said the term "grievance" should be included, as well as a link to the NAIC glossary. Brown said Montana performs a triage before a consumer files an appeal to ensure an appeal is appropriate or whether a coding issue means the consumer should go back to the biller. She said there are things consumers can do before an appeal to get things corrected.

Culp said her organization assists consumers in navigating care and coverage, and it often takes significant work to uncover the problem, which could be a denial or something else. She said there is high engagement with denial questions on social media and suggested that in addition to shorter and longer guides, bite-sized pieces geared toward social media may be helpful.

Crow said the Subgroup should consider a series of documents that starts pre-denial and walks consumers through the process.

Ellsworth said about 15% of claims face some kind of rejection, including denials and other types. He said over half of rejected claims are eligible for additional work but are not reworked. He asked whether states have authority over contracts that influence billing practices. Brown said it is beyond the insurance department's scope of authority, but they can refer consumers out for consumer protection from the attorney general's office.

Crow said the Subgroup should include something on prior authorization requests, as well as denials. She said the Subgroup may want to update all the documents in its series on claims from 2021. She asked for volunteers to identify gaps in the series and develop revised versions. Brown said the appeals guide may not need to be updated significantly, but all the documents should be reviewed at once.

Hatchette said the Subgroup should not think only about a written document. She said departments should meet consumers where they are with videos and social media. She said the key point to make is that there is somewhere to go for help and that consumers have a right to appeal. Dr. Cude said the first step should remain considering

what consumers need to know. Crow said the Subgroup should figure out its message first and potentially work with the NAIC's communications department to develop videos or other materials like snippets for social media.

Dr. Ting said no document will be as useful as assistance from the staff of an insurance department or State Health Insurance Assistance Program (SHIP). He said increasing the awareness of insurance departments, in general, should also be pursued.

Having no further business, the Consumer Information (B) Subgroup adjourned.

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Draft: 5/8/23

Consumer Information (B) Subgroup
E-Vote
April 25, 2023

The Consumer Information (B) Subgroup of the Health Insurance and Managed Care (B) Committee conducted an e-vote that concluded Apr. 25, 2023. The following Subgroup members participated: LeAnn Crow, Chair (KS); Anthony L. Williams (AL); Randy Pipal (ID); Judith Watters (ME); Carrie Couch (MO); Nichole Faulkner (NC); David Buono (PA); Vickie Trice (TN); Shelley Wiseman (UT); and Christina Keely (WI).

1. Adopted a Guide on Medicaid Redeterminations

The Subgroup conducted an e-vote to consider adoption of the document titled *Resuming Medicaid Redeterminations: State Insurance Regulator Guide* (Attachment Two-A1). The guide is a resource for department of insurance (DOI) staff in understanding the return of eligibility redeterminations in Medicaid. The motion passed unanimously.

Having no further business, the Consumer Information (B) Subgroup adjourned.

SharePoint/NAIC Support Staff Hub/Committees/B Committee/National Meetings/2023 Summer National Meeting/Final Minutes/Cons Info 4.25 evote.docx

Resuming Medicaid Redeterminations

State Insurance Regulator Guide

Background

In March of 2020, and as part of the Families First Coronavirus Response Act, Congress created an incentive for state Medicaid programs to keep consumers continuously enrolled during the COVID-19 pandemic. As a result, states suspended redeterminations of eligibility and Medicaid now covers over 20 million more people than it did in 2019. On December 29, 2022, President Biden signed into law the Consolidated Appropriations Act, 2023 (CAA), which put an end to the Medicaid continuous enrollment provision on March 31, 2023. The CAA allows for states to resume redetermining the eligibility of Medicaid enrollees and to take up to 14 months to complete redeterminations. It also provides for a phased down approach for enhanced Medicaid funding for the States. When redeterminations resume, many Medicaid enrollees will remain eligible, but some will be disenrolled and need to find other coverage from an employer, a Marketplace plan, Medicare, or another source. Many will be eligible for other state or federal assistance with costs, such as premium tax credits or a Medicare Savings Program.

The NAIC's Consumer Information (B) Subgroup developed this resource to help state insurance regulators and their Departments plan for the impact of resumed Medicaid redeterminations. The information and answers below may also be helpful in responding to questions and concerns consumers may have, particularly those who have recently lost Medicaid coverage and are shopping for health insurance for themselves and their family.

State-specific Information on Medicaid Redeterminations

What is happening in my state and when?

- [Unwinding Medicaid Continuous Coverage](#) (Georgetown University)
 - Use this page to find information and resources, including a [50-State Unwinding Tracker](#) with [links to state plans, FAQs, and communications toolkits](#).
- [State Approaches to the Unwinding Period, January 2023](#) (KFF & Georgetown University)
 - KFF lists the timeframe for each state to begin and complete redeterminations.
- [Anticipated 2023 State Timelines for Initiating Unwinding-Related Renewals As of February 24, 2023](#) (CMS)

How many people may be impacted in my state?

- [The Impact of the COVID-19 Public Health Emergency Expiration on All Types of Health Coverage](#)
 - This Urban Institute report provides national estimates and state tables in Appendix B.
- [Coverage Transition Modeling Dashboard](#) (.xlsx file)

- With funding from AHIP, NORC at the University of Chicago developed estimates for each state of the number of people expected to transition to other coverage sources. Methodology is discussed in [a companion report](#).

Messages and Advice for Consumers

How can my department assist consumers if they receive notice they are losing Medicaid coverage?

- Many individuals who leave Medicaid or CHIP will be eligible for employer coverage. Deadlines for electing employer coverage have been extended. Those who lose Medicaid coverage before July 10, 2023, will have a special enrollment right to elect employer plans until September 8, 2023. After that, the standard special enrollment period of 60 days from the loss of other coverage will apply.
- Shopping for coverage
 - Marketplace. Some consumers may already be aware of the Marketplace; however, there may be some consumers who will need guidance on how to access the Marketplace. Marketplace plans or ACA plans on healthcare.gov are guaranteed issued. Some plans will have \$0 premium after tax credits. Most will have either copays or deductibles.
 - A number of special enrollment periods (SEPs) for Marketplace coverage may be relevant for consumers leaving Medicaid.
 - The SEP for loss of minimum essential coverage (including Medicaid and CHIP) has been extended from 60 days before through 90 days after the coverage loss.
 - A separate SEP is available for those who lose Medicaid or CHIP through July 31, 2024.
 - Individuals with income less than 150% of the federal poverty level may enroll in Marketplace plans in any month.
 - <https://www.healthcare.gov/medicaid-to-marketplace/>
 - Agents, brokers, navigators, and assisters are available to assist consumers.
 - Confirm that the agent is licensed to sell the product.
 - Use [Find Local Help](#) for help with Marketplace plans.
 - NAIC [Health Insurance Shopping Tool](#)
- Tips to offer to consumers (taken from the 2019 "[What to ask when Shopping for Health Insurance](#)" document)
 - Is it a Short-Term, Limited Duration plan, a Sharing Ministry plan, or other limited-coverage plan? Is it sold through an association that requires a membership fee? If so, it could cover less than Marketplace plans.
 - Is the person selling the plan licensed in [STATE]? If so, ask for his/her state license number and contact [STATE DOI] at [phone number] to confirm.
 - What is the insurance company and is it licensed in [STATE]?
 - Does the plan require enrollment in an association or as a limited partner?
 - Does the plan cover your pre-existing conditions? Does it cover your medications?
 - What are the deductibles? There may be different deductibles for different services.
 - Does the plan set a limit on how much I have to pay out of pocket in a year (maximum out of pocket or MOOP)?

- What services DOESN'T the plan cover? Always ask about Exclusions and Limitations on non-ACA policies and whether a claim can be denied or not paid after the fact.
- For services that ARE covered, how much will the plan actually pay? Is there a limit on the total amount the plan will pay per person, per service, or per year?
- How long will the coverage last? Will you be able to keep or renew your coverage if you get sick?
- Does the plan have a provider network? If yes, how do you access the directory of providers and can you review the directory before signing up? Is your doctor or hospital in the network? If not, will doctors and providers agree not to bill for amounts above what the plan pays?

What messages are federal agencies using and recommending related to Medicaid redeterminations?

- [Medicaid and CHIP Continuous Enrollment Unwinding – Toolkit](#)
 - This toolkit includes key messages, drop-in articles, social media and outreach products, call center scripts, and more. A .zip file contains [supporting materials and graphics](#). Materials are available in languages in addition to English on the [CMS Unwinding page](#).

Medicare Issues

Where can I find a review of Medicare enrollment considerations for those losing Medicaid?

- ADvancing States published [a brief guide](#) for counseling Medicare-eligible individuals whose Medicaid benefits changed due to the end of the continuous coverage requirement.

Can states assist individuals who missed a period of guaranteed issue for Medicare supplement coverage while they were enrolled in Medicaid?

- A number of states (including [Alaska](#), [Delaware](#), [Idaho](#), [Kentucky](#), [Maryland](#), [New Hampshire](#), and [Oklahoma](#)) have issued bulletins to direct issuers to offer guaranteed issue of Medicare supplement plans for those who exhausted their open enrollment period as a result of their continued enrollment in Medicaid and who experience a change in Medicaid eligibility.

Additional Resources

- [Connecting to Coverage Coalition](#) has issued a set of resources.
 - The Coalition has compiled resources on redeterminations, including information on [fraud prevention](#), [guidance on texting consumers](#) from the Federal Communications Commission, and [How Health Insurance Providers Are Supporting Americans Through Medicaid Unwinding](#)
- [Unwinding and Returning to Regular Operations after COVID-19](#) (CMS)
 - CMS guidance and resources
- [Unwinding resources for American Indians and Alaska Natives](#) (CMS)

SharePoint/NAIC Support Staff Hub/Committees/B Committee/National Meetings/2023 Summer National Meeting/Final Minutes/ci-medicare-redet-guide-5.23.docx

Draft: 5/8/23

Consumer Information (B) Subgroup
Virtual Meeting
April 17, 2023

The Consumer Information (B) Subgroup of the Health Insurance and Managed Care (B) Committee met April 17, 2023. The following Subgroup members participated: LeAnn Crow, Chair (KS); Anthony L. Williams (AL); Randy Pipal (ID); Alex Peck (IN); Mary Kwei (MD); Carrie Couch (MO); Cuc Nguyen (OK); David Buono (PA); Jill Kruger (SD); Shelley Wiseman (UT); and Christina Keeley (WI). Also participating were: Susan Brown (MT); and Cynthia Cisneros (NM).

1. Adopted its March 2 Minutes

The Subgroup met March 2 to discuss potential Subgroup activities for the year.

Couch made a motion, seconded by Pipal, to adopt the Subgroup's March 2 minutes (*see NAIC Proceedings – Spring 2023, Health Insurance and Managed Care (B) Committee, Attachment One*). The motion passed unanimously.

2. Discussed a Regulator Guide on Medicaid Redeterminations

Crow said the Subgroup identified a guide on Medicaid redeterminations as a top priority during its March 2 meeting. She said millions of people will leave Medicaid in 2023 and need to find new coverage. She said a small group met to draft a guide for state insurance regulators to aid in understanding the resumption of redeterminations. She said many other groups have developed materials aimed at consumers.

Crow said the guide focuses on providing links to existing useful tools. Couch said the guide is a good resource for those who take calls from consumers. She said the draft guide lacks information on navigators and assisters.

Bonnie Burns (California Health Advocates—CHA) said she applauds the group for developing the document. She said people dropped from Medicaid may not know they remain eligible for Medicare Savings Programs or other state-based assistance with health costs. She recommended that the guide refer readers to State Health Insurance Assistance Programs (SHIPs) to check into other programs that may offer benefits. Harry Ting (Health Care Consumer Advocate) agreed that SHIPs should be referenced and provided a suggested resource for assisting Medicare-eligible individuals.

Crow said other emailed suggestions included adding references to enrolling in employer-sponsored plans. Kris Hathaway (AHIP) also recommended adding information on employer coverage. Burns said individuals who lose Medicaid after a redetermination may not have a total loss of assistance due to eligibility for other benefits. She added that not all insurance departments have SHIPs within their departments, so it would be useful to link to them.

Crow asked whether the guide should mention coverage of preexisting conditions since it is not an issue under plans under the federal Affordable Care Act (ACA), but it is for other plans. Subgroup members agreed that there should be information on preexisting condition exclusions.

3. Discussed Other Matters

Crow said the Health Insurance and Managed Care (B) Committee had discussed statistics on claim denials and appeals. She said they showed that consumers appeal very few denials. She said the Subgroup may wish to consider how to assist consumers in understanding denials and making appeals. She reminded the Subgroup that it has already produced a guide for consumers on how to appeal denied claims.

Dr. Ting said it would be a good idea to refresh the denials guide and also to encourage consumers to appeal denials because there is a good chance that a denial would be overturned. He said communications outreach around the value of appealing would be useful in addition to updating the guide. Couch said social media can be a good avenue for reaching consumers.

Cisneros said overall health insurance literacy is also important and that the appeals guide could be part of a larger set of resources. Crow said the Subgroup had put out a more comprehensive guide to using insurance in the past. Buono said Pennsylvania uses a similar comprehensive guide.

Katie Dzurec (Regulatory Insurance Advisors) said information on coverage for preventive services may be useful for state insurance regulators and consumers after the recent *Braidwood* decision.

Crow asked Subgroup members and interested parties to suggest over email other topics for the Subgroup to take up.

Having no further business, the Consumer Information (B) Subgroup adjourned.

SharePoint/NAIC Support Staff Hub/Committees/B Committee/National Meetings/2023 Summer National Meeting/Final Minutes/Cons Info 4.17.docx

Draft: 8/29/23

Health Innovations (B) Working Group
Seattle, Washington
August 13, 2023

The Health Innovations (B) Working Group of the Health Insurance and Managed Care (B) Committee met in Seattle, WA, Aug. 13, 2023. The following Working Group members participated: Nathan Houdek, Chair, and Jennifer Stegall (WI); Amy Hoyt, Vice Chair (MO); Sarah Bailey (AK); Jimmy Gunn (AL); Debra Judy (CO); Andria Seip (IA); Alex Peck (IN); Julie Holmes and Craig VanAalst (KS); Jamie Sexton (MD); Marti Hooper (ME); Chad Arnold and Sarah Wohlford (MI); Chrystal Bartuska (ND); Paige Duhamel (NM); Daniel Bradford (OH); TK Keen (OR); Rachel Bowden (TX); Mike Kreidler and Ned Gaines (WA); and Joylynn Fix and Erin K. Hunter (WV). Also participating were: Michael Muldoon (NE); and D.J. Bettencourt (NH).

1. Adopted its 2023 Spring National Meeting Minutes

Keen made a motion, seconded by Peck, to adopt the Working Group's March 22 minutes (*see NAIC Proceedings – Spring 2023, Health Insurance and Managed Care (B) Committee, Attachment Two*). The motion passed unanimously.

2. Heard Presentations on Prior Authorizations

Commissioner Houdek said health plans are using new methods to review prior authorizations, and providers are calling for more consistency and certainty in the process. He said gold-carding allows plans to recognize providers with a high rate of successful prior authorizations and reduce prior authorization requirements for them. He said some states have adopted gold card programs in law.

Bowden presented on Texas' gold card law and its implementation. She said Texas passed its gold card law in 2021. She said the law applies to state-regulated health plans and state employee plans. She said health plans are obligated to provide an exemption from prior authorization to providers who receive approval more than 90% of the time. Plans are required to evaluate and provide exemptions even without a request from a provider. She said many providers believed they would qualify, but often they did not meet the threshold of providing the same service five times in a six-month period under a state-regulated plan.

Bowden said Texas conducted a survey of prior authorization practices before and after the law took effect. She said three out of four providers who met the evaluation threshold received exemptions. However, because many providers did not meet the threshold, only 3% of providers received an exemption.

Bowden said the law's impact could be increased by extending the evaluation period, aggregating services, or looking to claims across all affiliated entities, not just state-regulated plans. Bowden said the law does not carve out any types of providers or services. She said services are defined at the Current Procedural Terminology (CPT) code level, so it is very granular. Also, providers are defined based on the billing National Provider Identifier (NPI) number.

Bowden said that once an exemption is issued, a plan may not deny claims for medical necessity. However, retrospective reviews are permitted, which can impact the provider's exemption. Plans may rescind exemptions, but providers may request independent reviews of rescissions.

Commissioner Houdek asked if providers may appeal a plan's decision not to grant an exemption. Bowden said providers may complain to both the plan and the Texas Department of Insurance (DOI) in such cases.

Duhamel asked how many staff are dedicated to the program in Texas. Bowden said no additional staff were assigned under the law. She said the number of requests so far has not significantly affected workloads, and existing staff handled an ad hoc data call and reporting on it.

Houdek asked about stakeholders' views on the law. Bowden said health plans did not support passage of the bill and needed to make complicated updates to their systems to comply. She said providers are disappointed by the limited impact.

Gaines asked whether information on exemptions appears in provider directories. Bowden says it does not, and such information may not be helpful for consumers because the exemption only applies to particular services, not all services delivered by a provider.

Fix presented on West Virginia's prior authorization laws, one passed in 2019 and an update in 2023. She said West Virginia requires prior authorization on episodes of care rather than specific services. She said the initial law required all insurance companies to create online portals for prior authorization, and the updated law requires providers to use the electronic portal for all prior authorization requests. She said the portal must stay updated with the current status of the request. The law also sets timelines for insurers to respond to requests. She said West Virginia has a gold-carding program. She said gold cards are available when a provider averages 30 procedures per year and achieves 90% success in prior authorization requests. Fix said the initial law required 100% prior authorization success, but the state found no providers qualified and the threshold was reduced to 90%. She said there is a procedure for revoking gold cards if warranted. Fix said insurers must report quarterly on prior authorization statistics, broken down by provider. She said one staff member works on prior authorization implementation, and a contractor collects quarterly report filings.

Miranda Motter (AHIP) presented on prior authorization. She said AHIP has partnered with doctors, hospitals, and pharmacies to reduce the administrative burden. She said a 2018 consensus statement with the American Medical Association (AMA) and hospital and pharmacy groups recognizes that prior authorization can be burdensome for all involved. The statement also notes variation in medical practice and adherence to evidence-based practice standards. The statement identified five areas for improvement in prior authorization.

Motter said the industry has taken many steps since the 2018 statement, including increasing the adoption of electronic prior authorization. AHIP launched Fast PATH, a program to place technology in provider offices to streamline prior authorization. She said low quality care can increase costs and can harm patients. She said a 2020 study showed about 10% of physicians provided care inconsistent with evidence-based standards.

Motter said AHIP surveyed its members on prior authorization in 2022. She said the survey asked about gold-carding due to recent laws and proposals. She said the survey showed more plans are using more evidence-based resources to guide their prior authorization programs. She said the services most subject to prior authorization include genetic testing and specialty drugs. The survey also showed plans streamlined prior authorization in a variety of ways, including using electronic prior authorization. She said barriers to electronic prior authorization include providers using systems that do not have electronic prior authorization functionality and compatibility between systems. She said the use of gold-carding has increased since the last survey in 2019, and 62% of members have gold card programs. Motter said health plans have refined their gold card programs to target the

right services and the right providers, so they do not have negative impacts for patients. She said opportunities for further improvement include moving to electronic prior authorization and value-based relationships.

Duhamel asked how reliably plans apply their own clinical review criteria and provided an example of a plan asking providers for three years of history on infants in order to receive a certain benefit. She said failures of inter-rater reliability cause frustration. She also asked how plans can comply with mental health parity laws if gold card programs only apply to physical health services. Motter said there is a huge opportunity in electronic prior authorization to reduce burden on providers. She said gold card programs have the most impact when there is consistent review.

Commissioner Houdek said providers continue to complain that getting prior authorization is more challenging than it has ever been and asked how that aligns with the improvements cited in the presentation. Motter said plans continue to evaluate where prior authorization is warranted. She said new drugs and therapies require prior authorization reviews. She said prior authorization also serves as a touch point for communication between plans and providers. She said utilization management techniques like prior authorization are reduced when providers enter into value-based arrangements where they are accountable for the quality of care they provide.

3. Heard a Presentation from ArrayRx on Multistate Prescription Drug Purchasing

Trevor Douglass (ArrayRx) presented on his organization's purpose and development. He said ArrayRx is operated for states, by states and has long incorporated transparency into its practices. He said the organization began in 2003, before Medicare Part D existed, to provide seniors with discounts on prescription drugs. The Northwest Prescription Drug Consortium (NW Consortium) grew from an intergovernmental agreement between Washington and Oregon. The Consortium wanted to provide its benefits to other states, so it has expanded, changed its name to ArrayRx, and now can serve any state or public entity. He said Nevada is also a member, and Connecticut is in the process of joining.

Douglass said ArrayRx is an expert in the field of prescription drugs and public servants. He said other states can trust that their values align with the organization. He said the organization is committed to accountability and auditability and requires contractors to allow audits to the claim level. He said public sector experts in the pharmacy space are the ones who create contract terms.

Douglass said ArrayRx oversees the entire contract process and works with state Departments of Justice (DOJ) to review terms and conditions of contracts. He said ArrayRx provides states with predictability, transparency, and auditability. He said the organization's goal is to work with the rest of the states. It does not impose one solution but works with states to mold solutions to meet their needs. He said ArrayRx does not capture or allow spread pricing and does not charge a fee to its partner states.

Douglass said pharmacy benefit managers (PBMs) usually capture spread prices, but ArrayRx's contracts have allowed it to avoid \$155 million in such costs and generated about \$100 million per year in rebates. He said public programs have struggled with PBMs capturing spread, but ArrayRx's terms and conditions protect its partners. He said the organization allows states to leverage best practices from other states and modern technology from contractors. He said the PBM status quo is not useful, and his organization is pushing for innovations.

Duhamel asked about incorporating point-of-sale (POS) rebate reimbursement into member cost sharing. Douglass said he has not worked on this previously but would be happy to engage with New Mexico on the issue.

Seip asked about the process for purchasing drugs and distributing them to pharmacies. Douglass said ArrayRx does not make bulk purchases. Instead, it contracts with a PBM under its own specific terms.

4. Heard a Presentation from PhRMA on Health Equity Efforts

Courtney Christian (Pharmaceutical Researchers and Manufacturers of America—PhRMA) presented on the organization's efforts to advance health equity in clinical trials. She defined equity as the absence of avoidable, unfair, and remediable differences, such as everyone having a fair opportunity to achieve their full health potential. She said PhRMA has 800 drugs in development that are intended to treat diseases that disproportionately affect racial and ethnic minorities. She said common conditions, as well, have a disproportionate impact on black communities.

Christian said PhRMA is working to increase diverse representation in clinical trials. She shared statistics on representation in current trials, which showed lower participation from minority communities. She said structural racism underlies social determinants of health and drives inequities in health care. She said income and education, the digital divide, and environmental factors are all social determinants of health. She described barriers to equity in health care.

Christian said one way to improve access is to share drug rebates directly with patients. She said reducing patient costs by sharing rebates can improve their adherence to medications.

Christian said the drug industry is not immune to systemic racism. She said PhRMA's work for solutions includes clinical trial diversity, health equity, and talent in member companies. In clinical trial diversity, PhRMA is seeking to stay invested in communities, providing resources to providers, and setting up a network of community ambassadors to encourage participation in clinical trials. Other solutions include grants to historically Black schools of medicine and grants to community-based projects on the treatment of chronic disease and access to COVID-19 vaccines. Christian said PhRMA developed a Pathways to Success Summit to help diverse students discover career pathways within the industry.

Christian shared statistics on the savings available from reducing disparities and improving health outcomes, including \$3.8 trillion from reducing the effects of chronic conditions.

Sylvia Yee (Disability Rights Education and Defense Fund—DREDF) asked about efforts to include people with disabilities in clinical trials. Christian said PhRMA is working to provide materials in accessible formats to attract a broader universe of individuals into clinical trials.

Having no further business, the Health Innovations (B) Working Group adjourned.

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HEALTH ACTUARIAL (B) TASK FORCE

Health Actuarial (B) Task Force Aug. 12, 2023, Minutes	6-25
Long-Term Care Actuarial (B) Working Group Aug. 12, 2023, Minutes (Attachment One).....	6-27
Long Term Care Actuarial (B) Working Group July 19, 2023, Minutes (Attachment One-A)	6-33
Colorado Division of Insurance Comments on the Long-Term Care Insurance Multistate Rate Review Framework (LTCI MSA Framework) (Attachment One-A1)	6-37
Texas Department of Insurance (DOI) Comments on the LTCI MSA Framework (Attachment One-A2)	6-37
American Council of Life Insurers (ACLI) and America’s Health Insurance Plans (AHIP) Comments on the LTCI MSA Framework (Attachment One-A3).....	6-43
Long-Term Care Actuarial (B) Working Group June 7, 2023, Minutes (Attachment One-B)	6-50
Revised Ideas on the Improved Multistate Actuarial (MSA) Approach (Attachment One-B1).....	6-52
Utah Insurance Department Methodology for MSA (Attachment One-B2).....	6-54
ACLI and AHIP June 2, 2023, Comment Letter (Attachment One-B3)	6-56
Virginia Bureau of Insurance Comments (Attachment One-B4).....	6-59
Long-Term Care Actuarial (B) Working Group May 1, 2023, Minutes (Attachment One-C).....	6-62
Colorado Division of Insurance Comments on the LTCI MSA Framework (Attachment One-C1)	6-64
American Academy of Actuaries (Academy) Comments on the LTCI MSA Framework (Attachment One-C2)	6-65
ACLI and AHIP Comments on the LTCI MSA Framework (Attachment One-C3)	6-67
LTCI MSA Framework Draft Principles (Attachment One-C4)	6-72
Referral to the Health Actuarial (B) Task Force and Long-Term Care Valuation (B) Subgroup for <i>Actuarial Guideline LI—The Application of Asset Adequacy Testing to Long-Term Care</i> <i>Insurance Reserves (AG 51)</i> (Attachment Two).....	6-74
FTI Consulting Presentation, “An LTC Industry Update: Public/Private Collaborations” (Attachment Three)	6-76
Society of Actuaries (SOA) Research Update to the Health Actuarial (B) Task Force (Attachment Four)	6-81
SOA Presentation on “The Evolution of the FSA Pathway” (Attachment Five).....	6-90
Academy Health Practice Council Summer 2023 Updates (Attachment Six)	6-94

Draft: 8/21/23

Health Actuarial (B) Task Force
Seattle, Washington
August 12, 2023

The Health Actuarial (B) Task Force met Aug. 12, 2023. The following Task Force members participated: Andrew N. Mais, Chair, represented by Paul Lombardo (CT); Anita G. Fox, Vice Chair, represented by Kevin Dyke (MI); Mark Fowler represented by Sanjeev Chaudhuri (AL); Gordon I. Ito represented by Kathleen Nakasone (HI); Dean L. Cameron represented by Weston Trexler (ID); Amy L. Beard represented by Scott Shover (IN); Vicki Schmidt represented by Nicole Boyd (KS); Timothy N. Schott represented by Marti Hooper (ME); Grace Arnold represented by Fred Andersen (MN); Eric Dunning represented by Michael Muldoon (NE); D.J. Bettencourt represented by Jennifer Li (NH); Justin Zimmerman represented by Seong-min Eom (NJ); Judith L. French represented by Craig Kalman (OH); Glen Mulready represented by Andrew Schallhorn (OK); Michael Humphreys represented by Jodi Frantz (PA); Cassie Brown represented by Aaron Hodges (TX); Jon Pike represented by Ryan Jubber (UT); and Mike Kreidler represented by Lichiou Lee (WA). Also participating was: Anna Krylova (NM).

1. Adopted its Spring National Meeting Minutes

Muldoon made a motion, seconded by Trexler, to adopt the Task Force's March 21 minutes (*see NAIC Proceedings – Spring 2023, Health Actuarial (B) Task Force*). The motion passed unanimously.

2. Adopted the Report of the Long-Term Care Actuarial (B) Working Group

Andersen said the Working Group met Aug. 12 and took the following action: 1) adopted its July 19, June 7, and May 1 minutes; 2) discussed drafting changes to VM-25, Health Insurance Reserves Minimum Reserve Requirements, of the *Valuation Manual* to add tables from the American Academy of Actuaries (Academy) and Society of Actuaries (SOA) Research Institute's final *Long-Term Care Insurance Mortality and Lapse Study*; 3) discussed a referral from the Health Risk-Based Capital (E) Working Group regarding *Actuarial Guideline LI—The Application of Asset Adequacy Testing to Long-Term Care Insurance Reserves* (AG 51); 4) heard a presentation on public/private long-term care (LTC) funding solutions; and 5) heard an update on a single long-term care insurance (LTCL) multistate rate review approach.

Andersen made a motion, seconded by Trexler, to adopt the report of the Long-Term Care Actuarial (B) Working Group (Attachment One), including its July 19, June 7, and May 1 minutes. The motion passed unanimously. Note that the July 19, June 7, and May 1 minutes will be referenced in the Working Group's August 12 minutes.

3. Heard an Update on SOA Research Institute Activities

Cindy MacDonald (SOA) gave an update (Attachment Four) on SOA Research Institute activities. Lombardo said he is concerned that the results of the SOA's state insurance regulator interest survey indicate that the studies regulators have given the highest priority to are the ones that are the most difficult to get industry support for participation and funding. He said he and Dyke would like to meet with the SOA and LTCL industry representatives to discuss industry difficulties with providing study data and to determine if there is anything regulators can do to assist them.

4. Heard a Presentation on SOA Education Redesign

Stuart Klugman (SOA) gave a presentation (Attachment Five) on changes to the educational pathway to attaining the Fellow, SOA designation. Lombardo asked if the SOA can give a more detailed presentation of changes to the educational pathway during a future Task Force meeting. Klugman said the SOA will do so.

5. Heard an Update from the Academy Health Practice Council

Matthew Williams (Academy) gave an update (Attachment Six) on Academy Health Practice Council activities.

6. Heard an Update on Academy Professionalism

Dyke said the Actuarial Standards Board (ASB) currently has 18 Actuarial Standards of Practice (ASOPs) open for revision. He said of the 18, there are two general, four casualty, two enterprise risk management, three health, two life, three pension, and two multipractice. He said the ASB has begun work on a diversity, equity, and inclusion (DE&I) initiative and has developed a statement of the importance of DE&I to the ASB. He said the statement is available on the ASB website. He said the ASB has an initiative underway to determine if current ASOPs are sufficient to cover the use of general and generative artificial intelligence (AI) in actuarial practice.

Dyke said the following ASOPs are currently or will soon be exposed for comment: ASOP No.7, Analysis of Life, Health, or Property/Casualty Insurer Cash Flows; ASOP No. 12, Risk Classification (for All Practice Areas); ASOP No. 28, Statements of Actuarial Opinion Regarding Health Insurance Assets and Liabilities; ASOP No. 41, Actuarial Communications; ASOP No. 45, The Use of Health Status Based Risk Adjustment Methodologies; and ASOP No. 49, Medicaid Managed Care Capitation Rate Development and Certification. He said a proposed ASOP for reinsurance pricing for life and health insurance is being developed, and work is being done to determine if health insurance should be included.

Shawna Ackerman (California Earthquake Authority—CEA) said the Actuarial Board for Counseling and Discipline (ABCD) has two primary functions. She said the first is to respond to member requests for guidance on professional or ethical issues they face at work. She said the second is to consider complaints of alleged violations of the Academy's Code of Professional Conduct. She said the ABCD receives about 100 requests for guidance each year, and approximately 30 of these each year are related to health practice issues. She said requests for guidance typically center on Precept 1: An actuary shall act honestly, with integrity and competence, and in a manner to fulfill the profession's responsibility to the public and to uphold the reputation of the actuarial profession. She said another issue requests for guidance are received for is qualification standards.

7. Discussed an Inadequate Risk Adjustment Issue

Jubber said the Utah Insurance Department was recently approached by two insurers that claim the risk adjustment formula used for federal Affordable Care Act (ACA) marketplace plans is inadequate, particularly in specialty drug prescriptions. He said the insurers stated that insureds taking these drugs do not receive a risk score that adequately reflects the high cost to the insurers for the drugs. He said he would like to discuss what other states have experienced with this issue. Lombardo said a meeting will be scheduled for Task Force members and interested state insurance regulators to discuss the issue.

Having no further business, the Health Actuarial (B) Task Force adjourned.

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Draft: 8/21/23

Long-Term Care Actuarial (B) Working Group
Seattle, Washington
August 12, 2023

The Long-Term Care Actuarial (B) Working Group of the Health Actuarial (B) Task Force met in Seattle, WA, Aug. 12, 2023. The following Working Group members participated: Paul Lombardo, Co-Chair (CT); Fred Andersen, Co-Chair (MN); Sanjeev Chaudhuri (AL); Thomas Reedy (CA); Wes Trexler (ID); Nicole Boyd (KS); Marti Hooper (ME); Kevin Dyke (MI); William Leung (MO); Michael Muldoon (NE); Jennifer Li (NH); Anna Krylova (NM); Michael Cebula (NY); Craig Kalman (OH); Andrew Schallhorn (OK); Jim Laverty (PA); Aaron Hodges and R. Michael Markham (TX); and Tomasz Serbinowski (UT).

1. Adopted its July 19, June 7, and May 1 Minutes

Lombardo said the Working Group met July 19, June 7, and May 1. During these meetings, the Working Group took the following action: 1) discussed comments received on a request for comments on various long-term care insurance (LTCI) rate increase review methodologies; 2) discussed comments received on exposures of ideas for a single LTCI rate increase review methodology for use in multistate actuarial (MSA) filing reviews; and 3) discussed comments received on proposals to revise the Nationally Coordinated LTCI Rate Increase Review Checklist and comments received on an exposure of the Minnesota and Texas LTCI rate increase review methodologies.

Dyke made a motion, seconded by Schallhorn, to adopt the Working Group's July 19 (Attachment One-A), June 7 (Attachment One-B) and May 1 (Attachment One-C) minutes. The motion passed unanimously.

2. Discussed Drafting Changes to VM-25

Lombardo said drafting changes to VM-25, Health Insurance Reserves Minimum Reserve Requirements, of the *Valuation Manual* to add tables from the American Academy of Actuaries (Academy) and Society of Actuaries (SOA) Research Institute's final Long-Term Care Insurance Mortality and Lapse Study were last discussed during the Working Group's Oct. 17, 2022, meeting. Serbinowski said he has begun drafting language for VM-25 and Appendix A-010, Minimum Reserve Standards for Individual and Group Health Insurance Contracts of the *Accounting Practices and Procedures Manual* (AP&P Manual) to incorporate the tables. He said the Working Group will schedule a meeting soon to discuss this draft language and work towards exposing changes to incorporate the tables from the Academy and SOA Study into VM-25 and Appendix A-010.

3. Discussed a Referral from the Health Risk-Based Capital (E) Working Group

Lombardo said the Working Group has received a referral (Attachment Two) through the Health Actuarial (B) Task Force from the Health Risk-Based Capital (E) Working Group regarding *Actuarial Guideline LI—The Application of Asset Adequacy Testing to Long-Term Care Insurance Reserves* (AG 51). He said the Health Risk-Based Capital (E) Working Group is developing criteria for insurers that file their annual statements on Life/Accident/Health & Fraternal Blanks to potentially file on Health Blanks in the future, and concerns were raised that it needs to be made clear that a move to the Health Blank does not remove an insurer's obligation to submit an AG 51 filing if the criteria for filing under AG 51 is still met. He said the Working Group will discuss the referral at its next meeting.

4. Heard a Presentation on Public/Private LTC Funding Solutions

Steve Schoonveld (FTI Consulting) gave a presentation (Attachment Three) on public/private collaborations to increase consumer access to long-term care (LTC) financing, services, and support.

5. Heard an Update on a Single LTCI Multistate Rate Review Approach

Andersen said the Working Group has discussed developing a single LTCI rate increase review methodology for use in MSA filing reviews at its past few meetings. He said the MSA Team does not want to continue to use the Texas and Minnesota approaches if they produce illogical results and result in untimely rate increase approvals, and the Working Group wants to have a single methodology in use soon. He said Serbinowski provided a draft of a proposed methodology that builds on the Minnesota approach structure that allows an insurer to receive a rate increase in earlier product years that gets the insurer closer to its original economic expectations, and then in later product years ensures that policyholders do not pay more than the value of their expected claims and related expenses. He said the proposed methodology would diverge from an increase that returns the insurer to its original expectations more quickly than the Minnesota approach, and it would result in a lower rate increase. He said he modeled modifications to the Minnesota approach that will produce higher rate increases than it yields as is but does not grade down from the insurer's original expectations as quickly as Serbinowski's proposal. He said the MSA Team examined the Texas approach and found that it does not work well for older blocks of business, especially those that have had rate increases that predate the use of the Texas approach.

Andersen said members of the MSA Team agree that older policyholders that have experienced past rate increases should have lower future rate increases than shorter-duration policyholders that have not experienced as many rate increases. He said large rate increases for older policyholders do not seem appropriate, as they have fewer remaining premiums to be paid than younger policyholders, and the effect of large increases on few remaining premiums does not create much of a financial impact on the insurer.

Andersen said he wants the Working Group to discuss the following issues, which need to be addressed in order to develop a single methodology to present to the Long-Term Care Insurance (EX) Task Force in a timely fashion: 1) whether adjustments to the Minnesota approach's cost-sharing formula can result, generally, in older age/higher duration/higher past rate increase policyholders having their future rate increases be more limited than under the current approach; 2) whether such an adjusted Minnesota approach would align with key principles such that it could be considered a candidate for the single actuarial approach; and 3) whether interest rate history and expectations should be a part of a single actuarial approach like it is with the Minnesota approach.

Andersen asked if members of the Working Group, interested state regulators, or interested parties share the concern for a need for limiting future rate increases for older age/higher duration/higher past rate increase policyholders. Lombardo said he and Connecticut, and he imagines all of the states, do not have an expectation that a policyholder who has paid 20 to 25 years of premium already and is not expected to pay a significant number of future premiums should receive as high of a rate increase as a policyholder who is expected to pay future premiums for 25 to 30 more years. He said he understands that different insurers have different distributions of policyholder attained ages within their blocks, and any formula to reduce increases for older policyholders would depend on these distributions. Trexler said he agrees with Lombardo, and he wants to see if such a formula can be integrated into Serbinowski's proposal.

Serbinowski asked how a closed block of policies should be defined. He asked if a block is considered closed after the last policyholder dies or lapses, or if it is when a specified percentage of total premiums have been paid. He said with few remaining policyholders, a 50% rate increase may only result in a loss ratio decrease of 0.1%. He said his proposal for a single approach does not require there to be a definition of when a block is closed.

Lombardo said he has seen a growing support from insurance department commissioners for the use of a single approach in MSA reviews. He said a single approach is easier to explain, and more supportable. The weighting of the Minnesota and Texas approaches that varies depending on characteristics of the block does not translate well to commissioners. He said he believes having a single approach will allow the MSA Team to reach better outcomes more quickly than with the current blending of approaches.

Birny Birnbaum (Center for Economic Justice—CEJ) said the CEJ supports a single approach. He said it may be better to consider the dynamics of small, closed blocks of business rather than differences within a block. He asked how likely it is that a particular block of policies will have age differences of 30 years, as well as how many blocks of business and consumers will be affected. He asked how the age where rate increases would be reduced will be determined, whether it will be a specified age or if the age would be determined based on a percentage impact on premium. Lombardo said the Working Group has been considering these issues as they relate to how a single approach will treat reduced increases for older policyholders. Birnbaum asked if the reduction in increase formula will be applied consistently from state to state and if there is a risk of legal action being taken for unfair discrimination against certain classes of policyholders. Andersen said he does not believe there is a risk of legal action, as the adjustment will only be a change to the slope of rates by attained age. He said ideally, all states will apply the formula consistently, but the final rate increase determination is at each state's discretion.

Jan Graeber (American Council of Life Insurers—ACLI) said any single approach recommendation needs to be grounded in actuarial science. She said ACLI members believe modifications to rate increases based on attained age and duration cannot be a one-size-fits-all solution due to the variance in block characteristics. She said the ACLI asserts that rate increases at older attained ages affect insurers' financial status. She said the ACLI reviewed a rate increase filing for a block with over 3,000 policyholders and grouped the seriatim data by whether a policyholder was on the claim, of policy issue age, and attained the age at the time of the claim. She said the ACLI found that almost 50% of premiums were attributable to policyholders over age 80, and roughly 25% of premiums were attributable to those over age 85. She said the present values of future premiums were calculated for attained ages 80 and 85. She said some of these policyholders may pay premiums for only two years, but some may pay premiums for seven to 10 more years. She said there was a 100-year-old active policyholder who was still paying premiums. She said many policyholders continue to pay premiums after a rate increase because they realize there is a potential benefit that is far greater than the cost of increased rates. She said the ACLI has concerns that administering rate increases that vary by attained age will be burdensome for insurers, as systems for policies that were sold on an issue-age basis will need to be modified to use attained age-based rating.

Ray Nelson (America's Health Insurance Plans—AHIP) said he agrees with Graeber that a one-size-fits-all approach is not appropriate.

Andersen said the Working Group will schedule a meeting dedicated to the discussion of the attained age rate increase modification issue. He said information that Graeber said the ACLI found for premiums attributable to older issue ages will be helpful for this discussion, as will similar information from any other interested parties. He said the Working Group will schedule another meeting to address removing the cost-sharing component of the Minnesota approach for consideration in using a modified Minnesota approach as a basis for the single approach.

Lombardo said there is a great sense of urgency in developing a single approach, and the Working Group is willing to dedicate a significant amount of time over the next few months to developing a single approach.

Having no further business, the Long-Term Care Actuarial (B) Working Group adjourned.

Meetings/Member Meetings/BCMTE/HATF/2023_Summer/8-12-23 HATF_ NM/HATF_Minutes_08-12-23

Draft: 8/2/23

Long-Term Care Actuarial (B) Working Group
Virtual Meeting
July 19, 2023

The Long-Term Care Actuarial (B) Working Group of the Health Actuarial (B) Task Force met July 19, 2023. The following Working Group members participated: Paul Lombardo, Co-Chair (CT); Fred Andersen, Co-Chair (MN); Ahmad Kamil (CA); Lilyan Zhang (FL); Weston Trexler (ID); Nicole Boyd (KS); Marti Hooper (ME); Kevin Dyke (MI); William Leung (MO); Michael Muldoon (NE); Jennifer Li (NH); Anna Krylova (NM); Bill Carmello (NY); Craig Kalman (OH); Jim Laverty (PA); Andrew Dvorine (SC); Aaron Hodges and R. Michael Markham (TX); and Tomasz Serbinowski (UT).

1. Discussed Comments Received on a Request for Comments on Various LTCI Rate Increase Review Methodologies

Andersen said the Working Group exposed a request for comments on the Minnesota and Texas approaches, as described in the Long-Term Care Insurance Multistate Rate Review Framework (LTCI MSA Framework) and the Utah proposal for an alternative approach to LTCI rate increase reviews. He said the comments received will be discussed in the context of developing a single actuarial approach to multistate long-term care insurance (LTCI) rate increase reviews and that the Working Group will continue this discussion during its Aug. 12 meeting. He said the Utah proposal reflects adjustments to the Minnesota approach, with the primary adjustments being the absence of an explicit cost-sharing provision and a faster grading by duration of the lower if-knew premium from the higher make-up premium during the blending process. He said initial informal testing of the Utah proposal indicates higher rate increases early in a product's life and lower increases later when compared to the Minnesota and Texas approaches.

Andersen said comments were received from the Colorado Division of Insurance (Attachment One-A1), the Texas Department of Insurance (DOI) (Attachment One-A2), and the American Council of Life Insurers (ACLI) and America's Health Insurance Plans (AHIP) (Attachment One-A3). Markham gave an overview of the Texas DOI comments.

Jan Graeber (ACLI) gave an overview of the ACLI/AHIP comments. Lombardo said that if a single actuarial approach is ultimately adopted, there will still be flexibility to modify it in the future if state insurance regulators and interested parties determine it needs to be. Andersen said any proposed single approach will need to be adopted by the Working Group and the Long-Term Care Insurance (EX) Task Force before it will be implemented as part of the LTCI MSA Framework. Serbinowski said he is concerned that adequacy of premiums may be given too much weight in assessing an actuarial approach and that by using this as a criterion, rate increases may be denied due to the inadequacy of resulting premiums. He said that rate adequacy can be achieved by increasing active life reserves for the block of policies. Leung said that if what is considered an excessive premium cannot be objectively defined, applying whether a premium is excessive as an evaluation criterion will be difficult. Andersen said the Minnesota approach, and he assumes the Texas approach, verifies that the total of premiums paid over time do not exceed the expected benefits and expenses to be paid over time. Lombardo said there should never be a situation where potential benefits paid are less than potential premiums. He said there needs to be a mechanism in any approach used that lessens the increase for policyholders at later policy durations, as they have likely paid more in cumulative rate increases than policyholders at earlier durations. Andersen said it is possible to modify the Minnesota approach to account for this by increasing the cost sharing for insurers for policies at later durations and decreasing insurer cost sharing at earlier durations. He said the Working Group will discuss this further during

its Aug. 12 meeting. Serbinowski said the Working Group should also discuss the impact of waiver of premium and the interest rate to be used in the approach.

Having no further business, the Long-Term Care Actuarial (B) Working Group adjourned.

Meetings/Member Meetings/B CMTE/HATF/2023_Summer/07-19-23 LTCAWG/Minutes_LTCAWG_07-19-23.docx

From: [Brady, Sean](#)
To: [King, Eric](#)
Cc: [Unger, Eric](#)
Subject: Re: Long-Term Care Actuarial (B) Working Group –xposure - Comments due July 10
Date: Monday, July 10, 2023 3:26:08 PM
Attachments: [image001.png](#)
[image002.png](#) [image003.png](#)
[image004.png](#) [image005.png](#)

CAUTION: This email originated from outside of the organization. Do not click links or open attachments unless you recognize the sender and know the content is safe.

Colorado's responses in **Bold**:

Please provide comments on the following:

The Minnesota and Texas approaches, as described in the Long-Term Care Insurance Multistate Rate Review Framework [MSA Framework Final Adopted 2022](#).

No comment.

The Utah Proposal for an Alternative Approach to LTCI Rate Increase Reviews [LTC –ncrease - Utah](#).

At this time, we do not have a complete response. We should have a response available by next Monday if that is acceptable.

Among the options for the form of comments being sought are:

A scorecard assessing the approaches' success in meeting key principles. These principles can be from the list provided on June 2, 2023 by ACLI / AHIP [Final ACLI-AHIP Comment Letter June 2, 2023](#), or as developed or thought of by the commenter.

Agree with ACLI that principles should be established for evaluation but the guidelines presented seem too generic to be useful in evaluating LTC approaches (MN, TX and the suggested Utah method).

Disagree with ACLI regarding differing analysis if filing is pre- or post-rate stability. The same method should be applied to pre- or post-rate stability filings. Propose that rate increases be determined on best estimate assumptions for both pre and post-rate stability.

Also disagree with principle #8: The approach should not apply subjective, arbitrary, or discretionary caps, factors, or limitations. At some point, limitations should exist especially if policyholders are 80+ and have had substantial past rate increases.

Assessment of the rate increase amounts resulting from the approaches, including for various types of situations, e.g., older and newer business, blocks with short or lengthy rate increase histories.

On Thu, Jun 8, 2023 at 4:53 PM King, Eric <EKing@naic.org> wrote:

To: Long-Term Care Actuarial (B) Working Group Members, Interested Regulators, and Interested Parties

Please provide comments on the following:

The Minnesota and Texas approaches, as described in the Long-Term Care Insurance Multistate Rate Review Framework [MSA Framework Final Adopted 2022](#).

The Utah Proposal for an Alternative Approach to LTCI Rate Increase Reviews [LTC –ncrease - Utah](#).

Among the options for the form of comments being sought are:

A scorecard assessing the approaches' success in meeting key principles.

These principles can be from the list provided on June 2, 2023 by ACLI / AHIP [Final ACLI-AHIP Comment Letter June 2, 2023](#), or as developed or thought of by the commenter.

Assessment of the rate increase amounts resulting from the approaches, including for various types of situations, e.g., older and newer business, blocks with short or lengthy rate increase histories.

Comments should be submitted to [Eric King](#) by Monday, July 10.

Thanks,

Eric J. King, FSA, MAAA

Senior Health Actuary **M:** 816-708-7982 **O:** 816-783-8234 **W:** Research & Actuarial Services

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Sean Brady FSA FLMI

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From: [King, Eric](#)
To: [King, Eric](#)
Subject: TX LTC Working Group Comments
Date: Wednesday, July 19, 2023 7:15:47 AM

From: R Michael Markham <R.Michael.Markham@tdi.texas.gov>
Sent: Friday, July 14, 2023 1:18 PM
To: Andersen, Frederick14ulie14ick<frederick.andersen@state.mn.us>; Lombardo, Paul <Paul.Lombardo@ct.gov>; Tomasz Serbinowski (tserbinowski@utah.gov) <tserbinowski@utah.gov> **Cc:** Eric King (EKing@naic.org) <eking@naic.org>
Subject: RE: LTC Working Group Comments

Can I have my comments from the June 7th email below included in the discussion related to a combined approach for LTC rate review discussion?

Also comments that I sent to the MSA Team in the May 4th email may also be relevant; particularly shortcomings in the MN and TX Approaches, copied below:

TX PPV Formulas

Description

The TX PPV formulas compare differences in the Contract Reserves between the old and new assumptions, holding contract reserves fixed at the point of valuation and distributing any deficit over the remaining available future premium. The method ensures the block is profitable using 58/85 for rate stabilized block and 60/80 pre-rate stabilized prospectively assuming contract reserves were held at a responsible level using the prior assumptions. Interest rates are set at the conservative Statutory Valuation Rate which supports larger rate increases and requires insurers to bear the interest rate risk. By bearing the interest rate risk, insurers are permitted to gain additional profits when yields exceed the statutory valuation rate which is almost always the case, but may suffer loss if the yields fall below the statutory valuation rate or if the company assumed a higher yield in pricing.

The PPV formulas ignores the impact of the historical lapse, though in both cases this is favorable to insurers:

- If lapses are higher, the company can retain the additional profits
- If lapses are lower than assumed, the increase in projected benefits is passed to the consumers via the increase in required contract reserves.

The TX Method by focusing on contract reserve deficiency and taking a prospective approach filters historic losses.

Issues with this Method

- Impact of shock lapses, non-forfeiture lapse, and benefit buydowns from the prior rate increase is not considered in the formulas
- Policyholders are required to bear the full brunt of any contract reserve deficiency without any cost sharing from the company
In the later durations, the formulas will justify excessive rate increases
- Using the Statutory Valuation Rate permits the company to sustain additional profits when yields exceed the statutory valuation rate.
The formulas do not give relief to insurers when the yields fall below the statutory valuation rate or assumed pricing yield.

One additional note, approving a rate increase in excess of that permitted by the PPV formulas permit insurers to realize an immediate profit by releasing contract reserves.

MN Approach

Description

The MN Approach is different from the TX Approach in that this method looks at the Lifetime Loss Ratio. The method determines an “IF-Knew” rate increase based on original target loss ratio, and calculates an additional “Make Up” increase to permit insurers to share the costs of prior losses and contract reserve deficiencies with policyholders, though requiring insurers to bear some of the loss. Deficiencies are spread across remaining available premium. By looking on historical performance, this method does adjust for favorable historical experience including shock lapses, benefit buydowns, and nonforfeiture lapses. The MN Method also assumes the Statutory Valuation Rate.

Issues with this Method

- By not adjusting the gross premium to net premium when reviewing historical experience, companies are permitted recoup non-existent historical expense losses* in both the “IF – Knew” and “Make-up” tables
- Companies are permitted to recoup historical losses
- Using this Statutory Valuation Rate historically permits companies to aggregate the losses when the yield falls between the pricing and the statutory yield
- Using the Statutory Valuation Rate historically and prospectively, the company would be permitted a rate increase at issue reflecting the difference between the pricing and statutory yield
- In the later durations, the formulas will justify excessive rate increases
- When the MN Method “justifies” a rate increase above the TX Method, companies are permitted an immediate profit by the release of contract reserves.

* - Historical administrative expenses such as acquisition costs and commissions are based on the premium and do not need to be recouped.

Finally, I want to address a legitimate concern regarding the TX Method in Utah's Comments.

A criticism of the TX method, especially when applied to legacy blocks with prior rate increases, was that it may result in counterintuitive results, and reliance on Original Pricing Assumptions.

- Contract Reserves are required to be calculated based on original pricing assumptions by Health Insurance Reserves Model Regulation (MDL-10)- Section 4 with the following exceptions.
 - a. One-Year Preliminary Term,
 - b. Mandated low statutory interest rate, and
 - c. Lapse restriction on the decrement calculation.

These assumptions should not change over the lifetime of the contracts. This includes morbidity, changes in underlying assumptions are addressed in the annual adequacy test (i.e. Gross Premium Valuation)

- Adequacy of Contract Reserves are required to be reviewed annually also by Health Insurance Reserves Model Regulation (MDL-10)- Section 4 – D using current assumptions.

The Texas PPV Formulas by definition pass any deficiency in contract reserves to the policyholders over the available future premium, with the exception that insurers are required to bear the interest rate risk.

- If the full rate increase as authorized by the prior assumptions are not given, “counterintuitive” results may result.

These factors must be taken into account, when reviewing subsequent rate increases.

Some concluding comments on LTC in general

- The sustainability of LTC blocks is dependent on the level and sustainability of contract reserves
- The Texas PPV Formulas takes a prospective approach focusing directly on contract reserve adequacy at the time of valuation.
The Texas method assumes current rates reflect the most recent assumptions which may not be the case
- The MN Approach takes a lifetime loss ratio approach but is highly dependent on the assumed discount rate.
- The MN Approach does not consider the current level of contract reserves.

An underlying issue regarding LTC, is the unsustainability of LTC policies with inflation protection.

Texas would prefer a LTC product that is sustainable over the lifetime of the contract with proper oversight and management of contract reserves including rate increases as needed to contain the premiums particularly in the later durations.

Thanks,

R. Michael Markham, FSA MAAA
Senior Actuary, Director
Life and Health Division - Life and Health Actuarial Office
512-676-6622

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From: R Michael Markham
Sent: Wednesday, June 07, 2023 2:19 PM
To: Frederick Andersen (Frederick.Andersen@state17ulie17ickfrederick.andersen@state.mn.us); Lombardo, Paul (Paul.Lombardo@ct.gov); Tomasz Serbinowski (tserbinowski@utah.gov)
<tserbinowski@utah.gov>
Cc: Eric King (EKing@naic.org) <eking@naic.org>
Subject: LTC Working Group Comments

Good Afternoon,

Some comments related to developing a combined approach for LTC rate review.

The TX PPV Approach takes a prospective view of rate and contract reserves adequacy and would benefit from taking a lifetime view of the block of business that the MN Approach presents.

I would like to present some topics that would be obstacles to TX approving a combined approach

Contract Reserve Adequacy – The sustainability of Long Term Care blocks is dependent on having sufficient contract reserves. The TX approach focuses on contract reserves and the strengthening of contract reserves. The TX PPV formulas basically set a cap on rate increases based on contract reserve levels using prior assumptions. When the TX PPV formulas produce a negative value and when rate increases exceed the TX PPV “justified” rate increase, the company would experience an immediate profit from the rate increase.

Skewness when Low Interest Rates are assumed – The MN method by assuming a discount rate below market yields “justify” excessive rate increases. The MN method is also volatile based on yields assumed prospectively. Setting historical yields equal to a standard such as the Moody’s Corp Avg Yield would remove this distortion historically. The prospective yield is more tricky, but setting this yield equal to the company’s pricing yield would be consistent.

I am reluctant to considering interest rates, because I fear that it will generally work against the industry. Though consideration due to the historical low yields may be temporarily appropriate.

Distortion from Waiver of Premium – The TX Approach only considers active premium paying lives which removes the waiver of premium distortion. For disabled lives, companies using the “Total Claims” approach consider non-existent premium offset by “lost” premium resulting in an additional 100% loss ratio claim.

The disabled life reserve set up at the time of incident can contain a component for recovery addressing the contract which must be set up upon recovery.

The MN Approach appears to depart from the 58/85 requirement of Rate

Stabilization – This is inconsistent with requirements of the LTC Model Regulation (MDR 641). For states that have adopted rate stabilization, this would make the rate increase out of compliance. It would also make MSA recommended rate increases out of compliance with recommended NAIC regulations.

Inflation Protection – Automatic inflation protection policies which is required in compliance LTC Model Regulation is a major contributor to the large rate increases we are seeing with LTC blocks. Inflation protection can result in exponential growth of expected liabilities (claims) while available premium is shrinking as the block ages. This is perhaps the greatest challenge we face in order to stabilizing the costs of LTC contracts. One potential solution is to permit an optional annual adjustment to premium based on the age at the time of inflation adjusted benefit (I can elaborate in another email).

Addressing Inflation Protection would also require revisions in the LTC Model Regulation. Texas also has inflation protection consistent with MDR 641 in our code.

The Guiding Principles presented by ACLI appear consistent with TX objectives. Texas has no objection to accepting these principles.

Finally there are practical considerations when utilizing the TX PPV formulas such as reliance on initial and prior assumptions as well as the cumulative rate increases. Though initial assumptions are required by Health Insurance Reserves Model Regulation (MDL-10) (and Texas Code) in order to determine statutory contract reserves, many companies simply do not have them. There are also legitimate industry concerns when prior rate increases are below TX PPV formula recommendations. It is a reality that we face when reviewing rates particularly for older blocks. TX addresses these issues as they arise on a case-by-case basis.

Out of respect for time, I don't want to press these issues, but am available to discuss as needed.

Thanks,

R. Michael Markham, FSA MAAA

Senior Actuary, Director

Life and Health Division - Life and Health Actuarial Office

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July 10, 2023

Paul Lombardo, Co-Chair, NAIC Long-Term Care Actuarial (B) Working Group
Fred Andersen, Co-Chair, NAIC Long-Term Care Actuarial (B) Working Group

Dear Paul and Fred,

The American Council of Life Insurers (ACLI)¹ and the America's Health Insurance Plans (AHIP)² appreciate the progress the working group has made with respect to evaluating appropriate methods for determining actuarially justified rate increases on long-term care blocks of business.

We have analyzed the three actuarial approaches under discussion in light of the overarching principles proposed in our June 2nd letter. In our analysis, we considered the fact that two of the methods are familiar to companies and regulators. These two methods have been the topic of significant discussion at the NAIC and are currently used by the multistate actuarial (MSA) team in reviewing filings through the MSRR process.

The attached chart highlights advantages and challenges associated with each method. The comments contained in the chart are applicable only to filings submitted through the Long-Term Care Insurance Multistate Rate Review (MSRR) Framework for the purpose of recommending a long-term care national premium rate schedule as described in the MSRR Framework adopted by the NAIC on April 8, 2022. The comments are not applicable to rate increase filings made with an individual state and outside of the MSRR process.

In evaluating the extent to which each method aligns with the principles, we recognized that in certain situations, some methods are more complicated to apply and create more challenges than others. We also recognize the MSA team's desire for a method that produces actuarially appropriate rate increases, while also acknowledging that such results could be perceived by some as inappropriate or unreasonable, creating challenges for regulators.

¹ The American Council of Life Insurers (ACLI) is the leading trade association driving public policy and advocacy on behalf of the life insurance industry. 90 million American families rely on the life insurance industry for financial protection and retirement security. ACLI's member companies are dedicated to protecting consumers' financial wellbeing through life insurance, annuities, retirement plans, long-term care insurance, disability income insurance, reinsurance, and dental, vision and other supplemental benefits. ACLI's 280 member companies represent 94 percent of industry assets in the United States.

² AHIP is the national association whose members provide health care coverage, services, and solutions to hundreds of millions of Americans every day. We are committed to market-based solutions and public-private partnerships that make health care better and to help create a space where coverage is more affordable and accessible for everyone.

Overall, we believe that reasonable adjustments can be applied to parts of the Blended/If-Knew (MN) method to address these challenges, while recognizing the regulatory desire for:

- a single approach for review,
- premium equity between states,
- an appropriate balance between policyholders and insurers, and
- preserving our state-based regulatory framework.

Potential Revisions to the Blended/If-Knew (MN) Method to Address Certain Challenges Regulators have indicated their desire for a single approach for the purpose of reviewing filings submitted through the MSRR process. In addition, this single approach should acknowledge, and address challenges associated with situations where a significant rate increase is proposed on policyholders at advanced ages and durations and who have already experienced a large cumulative increase.

While actuarial modeling will be necessary to avoid unintended consequences, a potential strategy to address this challenge is to consider revisions to certain aspects of the Blended/If-Knew (MN) methodology (e.g., rate increase implementation, cost sharing) that reflects some combination of attained age, duration, cumulative rate increase, and benefit level. To achieve rate equity among states, adjustments would not be applied to policyholders in states that have not approved past rate increases until the policyholder reaches the national target rate recommended by the MSA team.

We want to emphasize that, prior to the formal adoption of any method, it is important that the working group and industry work together to model any specific modifications under consideration. This step will help ensure that any unintended consequences can be avoided. We stand ready to assist you in any capacity needed.

Thank you again for the opportunity to comment. We look forward to discussing our comments with you.



Sincerely,
Jan Graeber, ACLI



Ray Nelson, Consultant for AHIP

Attachment



The comments below are applicable only to filings submitted through the Long-Term Care Insurance Multistate Rate Review (MSRR) Framework for the purpose of recommending a national premium rate schedule for long-term care policies, as described in the MSRR Framework adopted by the NAIC on April 8, 2022. The comments are not applicable to rate increase filings made with an individual state outside of the MSRR process. The points made below are not intended to be considered when solvency is a concern.

For rate-stabilized policies, all results are limited by the rate table that would be produced in accordance with Section 20.1(C) of the NAIC LTC Model Regulation.

Principle	PPV (TX)	Blended Make-up/If-knew (MN)	Revised Blended Make-up/If-knew (Proposal by Utah)
<p>1. The approach should result in premiums that are:</p> <ul style="list-style-type: none"> not inadequate, not unreasonable, and not excessive in relation to the benefits provided, and not unfairly discriminatory between individuals of the same actuarial risk class, or between risks of essentially the same degree of hazard. 	<ul style="list-style-type: none"> Produces actuarially sound results. From an MSA perspective, results are not inadequate, unreasonable, or excessive in relation to the benefits provided. <i>(Note: Application on an individual state basis, with a history of insufficient approvals, requires the use of the catch-up provision to avoid inadequate premiums).</i> Can become unstable for older blocks in later durations when the resulting increase percentage can be significant compared to the percentage increase in future claims, resulting in premiums that could be viewed by some as excessive. 	<ul style="list-style-type: none"> Generally, this method achieves a balance of the various features and creates a reasonable result in most durations when the cost-sharing provision is excluded. Cost-sharing factors can be viewed as arbitrary. The longer the company waits, the more weight is placed on the if-knew premium, potentially resulting in inadequate premiums. Produces significant increases for certain demographics, which could be mitigated by modifying the cost-sharing adjustment to reflect age and duration. 	<p>In addition to the comments to MN:</p> <ul style="list-style-type: none"> The proposed blending moves to If-Knew very quickly, which could be viewed as actuarially unsound by creating inadequate rates and result in potential solvency concerns. With a different blending, it is possible this could be alleviated. Method would not allow the future loss ratio for the make-up premium to fall under a specified target, preventing lifetime loss ratios from achieving levels closer to original pricing loss ratios, which could result in inadequate premiums.



Principle	PPV (TX)	Blended Make-up/If-knew (MN)	Revised Blended Make-up/If-knew (Proposal by Utah)
2. The approach should result in premiums charged to policyholders that do not allow remaining policyholders to be responsible for excess claims associated with past policyholders.	<ul style="list-style-type: none"> This approach ensures that remaining policyholders are not responsible for excess claims associated with past policyholders by considering only future projections, and only for those policyholders still paying premium. Does not account for situations where experience has been better than expected. More favorable experience should accrue and offset any rate increase for remaining policyholders. 	<ul style="list-style-type: none"> This approach uses a weighting of the if-knew and make-up premiums based on the percentage of policyholders remaining. As shown through prior testing of the MSRR methodologies, the weighting addresses this principle in a reasonable manner; however, the weights can be viewed as arbitrary. Any approach that considers past claims in the calculation of the rate increase, may be viewed as allowing remaining policyholders to be partially responsible for excess claims associated with past policyholders 	<ul style="list-style-type: none"> See MN comments
3. The approach should be designed to ensure the long-term financial stability of the insurance company by ensuring that any cost-sharing adjustment strikes an appropriate balance between the policyholders and the company.	<ul style="list-style-type: none"> Company assumes all past losses. Policyholders are responsible for paying the appropriate premium corresponding to their existing coverage moving forward. Method ensures financial stability when considering only future projections; however, an inappropriate balance between policyholders and the company could result if there have been past gains. 	<ul style="list-style-type: none"> May result in an inappropriate balance for products where the lifetime loss ratio after the increase exceeds 100%. Overall, cost sharing can be reasonable with this method; however, discretion may be needed to adjust blending/cost-sharing factors. 	<ul style="list-style-type: none"> This method does not have any explicit cost-sharing aspects but does implicitly apply cost-sharing to the weight applied to the If-knew premium. The new weighting using the present value of lives does not strike a balance and may result in potential solvency and long-term financial stability concerns for insurance companies.
4. The approach should be transparent and easily understood by actuaries	<ul style="list-style-type: none"> When there have been multiple assumption updates, this method 	<ul style="list-style-type: none"> Method can be calculated from traditional calendar year exhibits, 	<ul style="list-style-type: none"> Method can be calculated from traditional calendar year exhibits,



Principle	PPV (TX)	Blended Make-up/If-knew (MN)	Revised Blended Make-up/If-knew (Proposal by Utah)
experienced in pricing and reserving long-term care products.	becomes more complicated and relies on prior modeling, which makes it difficult for regulators to validate.	making it easier to work with in practice. <ul style="list-style-type: none"> Regulators have stated that legislators understand this method much better than the other methods under review. 	making it easier to work with in practice; however, the method has not been finalized and cannot be scored completely.
5. The approach should not require an unreasonable amount of time or unreasonable degree of effort.	<ul style="list-style-type: none"> Method is subject to more complications. For example, in order to correctly utilize the method, one needs a projection of current active lives under both current and prior filing assumptions, the latter of which can be prohibitively difficult for some carriers to do, especially when the needed calculations and projections rely on assumptions and modeling that are not as robust and detailed as current assumptions. Method requires maintaining old assumptions, which can be challenging due to changes in models, changes in pricing systems, etc. 	<ul style="list-style-type: none"> Method is straight-forward from a calculation perspective. 	<ul style="list-style-type: none"> Method is straight-forward from a calculation perspective.
6. The approach should not impose unnecessary complications that do not significantly change the resulting calculated rate increase.	<ul style="list-style-type: none"> When there have been multiple assumption updates, this method becomes more complicated and relies on prior modeling. 	<ul style="list-style-type: none"> The core calculation is straight-forward; however, some aspects outlined in the MSRR framework are complicated and need clarification (e.g., calculation and definition of the benchmark premium and sample policy verification). 	<ul style="list-style-type: none"> The core calculation is straight-forward.



Principle	PPV (TX)	Blended Make-up/If-knew (MN)	Revised Blended Make-up/If-knew (Proposal by Utah)
7. The approach should allow for predictable results when applied consistently.	<ul style="list-style-type: none"> Base method is straight-forward from an actuarial perspective. 	<ul style="list-style-type: none"> The core calculation is straight-forward; however, some aspects outlined in the MSRR framework may contribute to unpredictability of results and need clarification (e.g., calculation and definition of the benchmark premium and sample policy verification). 	<ul style="list-style-type: none"> See MN comments.
8. The approach should not apply subjective, arbitrary, or discretionary caps, factors, or limitations.	<ul style="list-style-type: none"> The calculation does not include any such factors. 	<ul style="list-style-type: none"> The weights applied to blending the make-up and if-knew premiums, along with the cost-sharing percentages can be viewed as arbitrary rather than actuarial. 	<ul style="list-style-type: none"> See MN comments.
9. The approach should allow for any variation in premiums or rate increases between classes of insureds that are based upon sound actuarial principles reasonably related to actual and anticipated loss experience.	<ul style="list-style-type: none"> The change in present value of future incurred claims can be run on as granular level as needed; however, this creates challenges if past rate increase filings were at less granular levels. Method does not correct for class subsidization if proposed increase request is on a more granular level than past rate increase requests. 	<ul style="list-style-type: none"> Method can be applied by cohort; however, the original lifetime loss ratio is often unavailable at the same level of granularity (especially if original pricing models are no longer usable or limited in functionality), and results in the aggregate original lifetime loss ratio being usable for this purpose. 	<ul style="list-style-type: none"> See MN comments.
10. The approach should allow for consideration of whether a product was priced with a margin for moderately adverse experience required under rate stability or whether the product was priced under pre-rate stability regulations.	<ul style="list-style-type: none"> Yes, separate formulas exist for pre-rate stabilized and rate stabilized blocks. 	<ul style="list-style-type: none"> Yes, calculations can be done with or without margins to address this principle. 	<ul style="list-style-type: none"> Yes, calculations can be done with or without margins to address this principle.



Principle	PPV (TX)	Blended Make-up/If-knew (MN)	Revised Blended Make-up/If-knew (Proposal by Utah)
11. A desired outcome of the approach is rate equity.	<ul style="list-style-type: none">• Yes	<ul style="list-style-type: none">• Yes	<ul style="list-style-type: none">• Yes

Draft: 7/3/23

Long-Term Care Actuarial (B) Working Group
Virtual Meeting
June 7, 2023

The Long-Term Care Actuarial (B) Working Group of the Health Actuarial (B) Task Force met June 7, 2023. The following Working Group members participated: Paul Lombardo, Co-Chair (CT); Fred Andersen, Co-Chair (MN); Ahmad Kamil (CA); Weston Trexler (ID); Nicole Boyd (KS); Marti Hooper (ME); William Leung (MO); Michael Muldoon (NE); Anna Krylova (NM); Bill Carmello (NY); Craig Kalman and Laura Miller (OH); Andrew Schallhorn (OK); Jim Laverty (PA); Andrew Dvorine (SC); Aaron Hodges (TX); and Tomasz Serbinowski (UT).

1. Discussed Comments Received on Exposures of Ideas for a Single LTCI Rate Increase Review Methodology

Andersen said the Working Group exposed a request for comments on ideas (Attachment One-B1) for a single, improved long-term care insurance (LTCI) rate review methodology approach for use in multistate actuarial (MSA) filing reviews. He said a methodology that the Utah Insurance Department (Attachment One-B2) proposed was also exposed for comment. He said comments were received from the American Council of Life Insurers (ACLI) and America's Health Insurance Plans (AHIP) (Attachment One-B3), as well as from the Virginia Bureau of Insurance (Attachment One-B4).

Serbinowski gave an overview of the Utah proposal. Andersen said the Utah proposal will need to be tested to compare its results to the currently used Minnesota and Texas approaches.

Jan Graeber (ACLI) gave an overview of the ACLI/AHIP comments. Serbinowski said that a metric will need to be established to evaluate whether an approach satisfies ACLI/AHIP's proposed guiding principle 1 and that it is difficult to say what is intended. Graeber said the intent is not to have specific criteria for evaluating this, but rather to determine what a given approach uses to judge the reasonableness of premiums in relation to benefits and use this as the evaluation standard. Miller said that if these principles are to be used to evaluate an approach, the criteria for principle 2 will need to be elaborated upon.

Miller said that there will need to be more detail as to what is considered an appropriate balance for principle 3. Andersen said that any difference between the makeup premium and the approved increased premium is a cost-sharing element in the Minnesota approach.

Andersen said the ACLI/AHIP guiding principles will not be exposed for comment, but may be used by the Working Group in developing a set of principles if it is decided it is needed.

Serbinowski said defining "classes of insured" as used in principle 9 could be difficult.

Referring to principle 10, Trexler and Boyd said it needs to be determined if rate increases should continue to be allowed to include a margin for moderately adverse experience.

Andersen said comments from the Virginia Bureau of Insurance will be addressed at the Working Group's next meeting. Serbinowski said he can address in writing questions asked about the Utah approach in the comments.

Andersen said he is hesitant for the Working Group to adopt a set of principles for evaluating LTCI rate review methodology approaches. He asked if the Working Group should further examine the proposed Utah approach, including comparing its results to the Minnesota and Texas approaches, and if it is helpful and necessary to produce a set of principles before it produces a single approach. Lombardo said the Working Group should focus on evaluating whether the Utah approach is one that could be adopted for use in MSA reviews. He said he does not think the Working Group necessarily needs to adopt a set of principles, but that it should ask questions similar to those that the ACLI/AHIP proposed when an approach is evaluated.

2. Exposed Three MSA Actuarial Approaches

Andersen said the Working Group will expose the Minnesota, Texas, and Utah approaches for a 30-day public comment period ending July 10. He said one option for the form of comments being sought is a scorecard assessing the approaches' success in meeting key principles. He said these principles can be from the list provided in the ACLI/AHIP comment letter or as developed or thought of by the commenter. He said the other option is assessment of the rate increase amounts resulting from the three approaches, including for various types of situations, such as older and newer business, or blocks with short or lengthy rate increase histories.

Having no further business, the Long-Term Care Actuarial (B) Working Group adjourned.

Meetings/Member Meetings/B CMTE/HATF/2023_Summer/06-07-23 LTCAWG/Minutes_LTCAWG_06-07-23.docx

Ideas for a single, improved MSA actuarial approach

As the Long Term Care Actuarial Working Group evaluates the two actuarial approaches embedded in the Multi-State Actuarial (MSA) Framework, there could be an opportunity to apply the evaluation to move towards a single, improved MSA actuarial approach.

Clarifying principles applied to develop the Texas and Minnesota approaches, key goals will continue to be:

1. The present value of lifetime premiums should not exceed the present value of lifetime benefits and related expenses for a class of policies.
 - a. This addresses the issue of “past losses” which can be a confusing concept related to a long-term insurance product.
 - b. This also addresses the shrinking block issue, ensuring a small number of remaining policyholders are not responsible for past excess claims associated with past policyholders.
 - c. The Minnesota and Texas approaches currently address these issues.
 - d. The Texas approach currently contains additional aspects regarding past losses.
2. Practical
 - a. The resulting rate increase should be reasonable.
 - b. The approach should be calculated in a reasonable amount of time with a reasonable amount of effort.
 - c. The approach should avoid unnecessary complications that don’t significantly change the resulting calculated rate increase.
3. Appropriate cost sharing
 - a. Recognition that in many cases, the lifetime loss ratio approach, an aspect of many states’ laws, leads to excessive rate increases that could be in conflict with other aspects of states’ laws.
 - b. Cost sharing should be balanced, considering consumer fairness and avoiding further company financial distress.
 - c. Any cost-sharing formula should allow for potential flexibility if concerns exist regarding an insurer’s financial solvency.

Note that the above-mentioned principles are in addition to the typical, professional approach applied by states, including review of insurer and industry experience; assessments of reasonability of assumptions; validation of projections; and professional judgment, where appropriate.

Here are aspects of the Minnesota approach where improvements may be considered:

- I. Is the “if-knew” the appropriate premium to blend with the makeup premium to achieve the results in item 1 above? If not, is it appropriate to achieve the practicality goals in item 2 above?
- II. Should the weighting towards the makeup premium continue to be the percentage of policyholders remaining to help achieve the goals of items 1 and 2 above?
- III. For simplicity, does it make sense to remove the investment component, perhaps adjusting the cost-sharing formula to calibrate the results to the current Minnesota approach?
- IV. Is the catchup approach of determining a rate increase from inception and removing past rate increase approvals effective?
- V. Is the aggregate application of the Minnesota approach working as intended, where the makeup premium is such that the resulting lifetime loss ratio does not exceed the pricing lifetime loss ratio?

Here are aspects of the Texas approach where improvements may be considered:

- I. What are features of the Texas approach not accounted for in the MN approach that could be part of a single, improved approach?
- II. How are transitional and catch-up provisions planned to be handled, including situations where the previous rate increase was applied prior to the implementation of the Texas approach or the company voluntarily reduces a past rate increase?
- III. Evaluation of the potential high sensitivity of mature blocks of business to later duration factors (and older assumptions) while placing less emphasis on past experience
- IV. Evaluation of the balance between fairness to consumers and avoiding further insurer financial distress.

Note that the stated goal of the MSA approach is rate equity. States and companies can still pursue a more equitable approach where the present value of premiums would be similar between states, i.e., recognize timing differences of past rate increase approvals.

Utah Proposal for an Alternative Approach to LTCI Rate Increase Reviews

Background

Over the last several years, the Multistate Actuarial LTCI Rate Review Team (MSA) team has used two methodologies to evaluate the appropriateness of LTCI rate increases:

- A blended if-knew and make up with cost sharing method (MN method); and
- A prospective present value method (TX method).

Each method has its strengths and weaknesses. Criticisms of the MN method included arbitrariness of the cost sharing formula. A criticism of the TX method, especially when applied to legacy blocks with prior rate increases, was that it may result in counterintuitive results.

I'd like to propose a method that could be considered a modification of the MN method that, in my opinion, is preferable to either of the two methods mentioned above.

The method still uses a blend of if-knew and make-up premium. However, there are some additional bounds on the make-up premiums. More importantly, the method puts more weight on the if-knew premium and foregoes cost-sharing adjustments.

Outline of the New Method

First, an if-knew increase and a make-up increase need to be calculated. At a high level, they represent the low and high of the range of "reasonable" rate increases.

An if-knew increase is an increase from the original rates that, if applied from inception (retrospectively), would result in a specified target loss ratio.

My initial proposal would be to use a target loss ratio of 60%, regardless of the actual initial pricing target, and to calculate all present values using the applicable valuation rate.

A make-up increase is an increase from the original rates, that if applied to the future premiums (prospectively), would result in a specified target lifetime loss ratio. The make-up increase could not result in a future loss ratio lower than the specified target loss ratio.

The last condition prevents the company that already has a high past loss ratio from using the make-up increase to result in a lower future loss ratio (recouping past losses).

My initial proposal would be to not allow the future loss ratio to drop below 60%.

Second, the two increases would be blended with the weight applied to the make-up premium being the fraction (on a present value basis) of the life-years remaining. This is a departure from the MN method. The MN method uses:

Percentage of lives remaining = policies in-force / all policies issued

My alternative proposal would use:

Percent of life-years remaining = PV of future life-years / PV of total life-years

Finally, the approvable rate increase (from current rates) would be such that it would result in a cumulative increase equal to the blended increase calculated above.

General Observations

Unlike the TX method, this method does not require much information with regard to the original pricing assumptions. This is also my reason for proposing a 60% target loss ratio rather than the company's actual target loss ratio at the time of the pricing. The actual pricing target loss ratio is often unavailable or poorly documented, and typically is calculated using assumed investment returns that are higher than the applicable valuation rates.

Most regulators would not allow an increase that results in a very low future loss ratio. This approach uses a make-up increase that would generally pass the requirement that both future and lifetime loss ratios exceed the statutory minimum.

The blending factor accounts for the stage of life of the block even if persistency is very high. To the extent that future life-years correlate with future premium, this approach limits the company's ability to increase rates when most premium was already collected and future premiums make up only a small percentage of lifetime premium.

Items That Would Need to be Specified

The minimum lifetime and future loss ratios used in the definitions of the if-knew and make-up increases.

The interest rates used to calculate present values. These could be valuation rates applicable to the block or rates based on available yields.



June 2, 2023

Paul Lombardo, Co-Chair, NAIC Long-Term Care Actuarial Working Group
Fred Andersen, Co-Chair, NAIC Long-Term Care Actuarial Working Group

Dear Paul and Fred,

The American Council of Life Insurers (ACLI)¹ and the America's Health Insurance Plans (AHIP)² appreciate the opportunity to comment on exposure relating to "Revised Ideas-Improved MSA Actuarial Approach."

The ACLI and AHIP continue to fully support a consistent national approach for reviewing current LTC rates that results in actuarially appropriate increases being granted by the states in a timely manner. Actuarially justified rates are fundamental to insurers' ability to fulfill future benefit promises made to their policyholders.

After reviewing the exposure, we believe that a productive first step would be to develop several overarching principles that can serve as the basis in the evaluation of any approach for determining an actuarially justified LTC rate increase, without reference to any specific method. The goal would be to come to a consensus on these overarching principles and then use them as guidance as we evaluate specific methods. Our attached comments on the exposure are based on this perspective.

We look forward to discussing our comments at the next call of the NAIC LTC Actuarial Working Group.

Sincerely,

A handwritten signature in blue ink, appearing to read 'Jan Graeber', is shown above a horizontal line.

Jan Graeber

A handwritten signature in blue ink, appearing to read 'Ray Nelson', is shown above a horizontal line.

Ray Nelson

¹ The American Council of Life Insurers (ACLI) is the leading trade association driving public policy and advocacy on behalf of the life insurance industry. 90 million American families rely on the life insurance industry for financial protection and retirement security. ACLI's member companies are dedicated to protecting consumers' financial wellbeing through life insurance, annuities, retirement plans, longterm care insurance, disability income insurance, reinsurance, and dental, vision and other supplemental benefits. ACLI's 280 member companies represent 94 percent of industry assets in the United States.

² AHIP is the national association whose members provide health care coverage, services, and solutions to hundreds of millions of Americans every day. We are committed to market-based solutions and public-private partnerships that make health care better and to help create a space where coverage is more affordable and accessible for everyone.



Guiding Principles for Actuarial Approaches for Evaluating Long-Term Care Rate Increases

The following principles are guidance and do not carry the weight of law or impose any legal liability. This guidance can serve to inform and establish actuarial approaches for evaluating longterm care premium increases.

1. The approach should result in premiums that are:
 - a. not inadequate, not unreasonable, and not excessive in relation to the benefits provided, and
 - b. not unfairly discriminatory between individuals of the same actuarial risk class, or between risks of essentially the same degree of hazard.
2. The approach should result in premiums charged to policyholders that do not allow remaining policyholders to be responsible for excess claims associated with past policyholders.
3. The approach should be designed to ensure the long-term financial stability of the insurance company by ensuring that any cost-sharing adjustment strikes an appropriate balance between the policyholders and the company
4. The approach should be transparent and easily understood by actuaries experienced in pricing and reserving long-term care products.
5. The approach should not require an unreasonable amount of time or unreasonable degree of effort.
6. The approach should not impose unnecessary complications that do not significantly change the resulting calculated rate increase.
7. The approach should allow for predictable results when applied consistently.
8. The approach should not apply subjective, arbitrary, or discretionary caps, factors, or limitations.
9. The approach should allow for any variation in premiums or rate increases between classes of insureds that are based upon sound actuarial principles reasonably related to actual or anticipated loss experience.

10. The approach should allow for consideration of whether a product was priced with a margin for moderately adverse experience required under rate stability or whether the product was priced under pre-rate stability regulations.
11. A desired outcome of the approach is rate equity. States and companies should pursue an approach where the present value of lifetime premiums, for a given level of benefits, would be similar between states and achieves premium equity over the lifetime of the policy.

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Good Afternoon Eric,

Virginia has the following questions and comments on the 2 attached documents.

Utah Proposal for an Alternative Approach to LTCI Rate Increase Reviews

Questions that we would want answered to more fully evaluate this method:

1. How are past rate increases taken into account in the UT method?
2. In some cases, a company has certified under rate stability at a previous rate increase that it will not seek further increases unless experience deteriorates. How would the UT method take this into consideration?
3. How do the allowable rate increases under this method compare to the TX and MN method for real-life examples?
4. What do you do in those circumstances where the data to calculate historical “life-years” is not available?

Ideas for a single, improved MSA actuarial approach

- Item 1: This excludes any type of disabled or active life reserves, correct?
- Item 2: What does “The resulting rate increase should be reasonable” mean?
- Integrated factoring for a company’s financial condition should either be omitted or broken out separately for optional consideration. This approach may enhance the reception of the MSA by those states who do not endorse approving additional amounts for financial condition.
- Items 2 & 3. Subjectivity on a state level remains a potentially divisive topic. Considerations such as average age, state enrollment, previous submissions, etc. can be difficult to ignore in the final decision. There are several terms in sections 2 and 3 that can be interpreted subjectively so any technical expansion on these terms may be helpful whether it be by offering a definition, calculation of a range of action, etc.
- VA is generally in favor of moving toward a single MSA actuarial approach and looks forward to future discussions to develop this concept further.

We look forward to the discussion next week.

Julie

Julie R. Fairbanks, CIE, FLMI, AIRC, MCM
Chief Insurance Market Examiner – Market Regulation
Life and Health Division
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Confidential

From: King, Eric <EKing@naic.org>
Sent: Thursday, May 11, 2023 2:31 PM
To: King, Eric <EKing@naic.org>
Subject: FW: Long-Term Care Actuarial (B) Working Group –xposure - Comments due June 2

Please see the attached proposal from Utah in response to the request for comments below.

From: King, Eric <EKing@naic.org>
Sent: Tuesday, May 2, 2023 9:20 AM
To: King, Eric <EKing@naic.org>
Subject: Long-Term Care Actuarial (B) Working Group –xposure - Comments due June 2

To: Long-Term Care Actuarial (B) Working Group Members, Interested Regulators, and Interested Parties

Please provide comments on the attached ideas for a single, improved MSA actuarial approach.

Comments should be submitted to [Eric King](#) by Friday, June 2.

Thanks,

Eric J. King, FSA, MAAA
Senior Health Actuary
Research & Actuarial Services



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Draft: 5/12/23

Long-Term Care Actuarial (B) Working Group
Virtual Meeting
May 1, 2023

The Long-Term Care Actuarial (B) Working Group of the Health Actuarial (B) Task Force met May 1, 2023. The following Working Group members participated: Paul Lombardo, Co-Chair (CT); Fred Andersen, Co-Chair (MN); Charles Hale (AL); Ahmad Kamil (CA); Lilyan Zhang (FL); Nicole Boyd (KS); Marti Hooper (ME); Kevin Dyke (MI); Michael Muldoon (NE); Anna Krylova (NM); Bill Carmello (NY); Craig Kalman and Laura Miller (OH); Andrew Schallhorn (OK); Jim Laverty (PA); Andrew Dvorine (SC); Aaron Hodges (TX); and Tomasz Serbinowski (UT). Also participating was: Eric UngeCO).

1. Discussed Comments Received on Proposals to Revise the Nationally Coordinated LTCI Rate Increase Review Checklist and Comments Received on an Exposure of the Minnesota and Texas LTCI Rate Increase Review Methodologies

Andersen said the Working Group exposed a request for comments on the Nationally Coordinated Long-Term Care Insurance (LTCI) Rate Increase Review Checklist and the Minnesota and Texas approaches as used in the Long-Term Care Insurance Multistate Rate Review Framework (LTCI MSA Framework). He said comments were received from the Colorado Division of Insurance (Attachment One-C1), the American Academy of Actuaries (Academy) (Attachment One-C2), and the American Council of Life Insurers (ACLI) and America's Health Insurance Plans (AHIP) (Attachment One-C3).

Unger gave an overview of Colorado's comments on the Checklist and the Minnesota and Texas approaches. He said a large discrepancy between the results of the Minnesota and Texas approaches has been observed in some multistate actuarial (MSA) filings, and he suggested considering using a single approach in the LTCI MSA Framework reviews. Lombardo asked Unger to elaborate on the suggestion for producing a less technical version or an additional section of the MSA Advisory Report. Unger said non-actuarial audiences within an insurance department may find it difficult to understand the MSA Advisory Report as it is currently structured. Andersen said the use of a single approach for LTCI MSA Framework reviews will be discussed later in the meeting.

Jamala Arland (Academy) gave an overview of the Academy's comments. Andersen said the Academy issue brief, *Long-Term Care Insurance: Considerations for Treatment of Past Losses in Rate Increase Requests*, mentions past persistency in excess of what was expected and past claims in excess of what was expected as potential sources of past losses. He said the Minnesota and Texas approaches treat past losses associated with excess persistency in significantly different ways. He said the Minnesota and Texas methods treat past losses associated with excess claims in a similar manner. He asked if past persistency in excess of what was expected should be considered to be a past loss for the purpose of LTCI MSA Framework reviews. Serbinowski said part of the problem with addressing past losses comes from framing them in terms of loss ratios. He said excess claims contribute to loss ratio calculations, but the calculation does not accurately reflect variances in persistency. He said the Texas approach provides no relief for higher-than-expected persistency. He said if variances from expected investment returns are to be included, the loss ratio formula needs to be adjusted to account for this. Lombardo said he believes it is very difficult to define past losses in a way that all actuaries will agree on.

Jan Graeber (ACLI) and Ray Nelson (AHIP) gave an overview of their organizations' comments. Miller referenced the ACLI/AHIP's comment on the Checklist, "... we recognize that an individual state might be interested in

information specific to their state, we suggest that the checklist clarify that state-specific information is not needed or used for purposes of an MSA review,” and she said Ohio has an interest in seeing its state-specific

cumulative increase and would also want to be able to compare it with that of other states. She said she agrees with that, and she would like to see a deeper analysis of the Minnesota and Texas approaches. Lombardo said Connecticut has seen insurers report implemented cumulative rate increases that are less than the rate increases approved in Connecticut. He said the MSA Advisory Reports attempt to identify such situations for each state, and he believes improvements in how the MSA Advisory Reports show and detail cumulative rate increases should be considered.

2. Exposed Ideas for a Single Improved MSA Actuarial Approach

Andersen said given the comments received on the Minnesota and Texas approaches, combining features of both to develop a single rate increase review approach for use in the LTCI MSA Framework may be warranted. He gave an overview of a draft principles document (Attachment One-C4) that outlines potential considerations and principles for evaluating proposals for a single approach. He said the prior evaluation performed on the Minnesota and Texas approaches can also be used in the consideration of a single approach.

Andersen said the Working Group will expose the draft principles document for a public comment period ending June 2.

Having no further business, the Long-Term Care Actuarial (B) Working Group adjourned.

Meetings/Member Meetings/B CMTE/HATF/2023_Summer/05-01-23 LTCAWG/Minutes_LTCAWG_05-01-23.docx

As of 4/20/2023 | Colorado Division of Insurance

Tab	Contents
New in MSA checklist	Items which Colorado thinks should be in data received from companies for rate increase request evaluation.
New for MSA report	Items which Colorado thinks should be added to the MSA report.

Item #	Description
1	How many policies were sold in each of [our state] and Nationwide
2	What was average issue and attained age in [our state] and Nationwide
3	What % of policies are on claim in [our state] and Nationwide
4	In what year was block opened and closed
5	Claims retrospective test showing how claims paid compares to initial DLR and IBNR set up.
6	Describe any reinsurance contract
7	In addition to A/E, need ratio of Actual / Projection for each of lapse, mortality, morbidity
8	State by State rate increase prior to this round, request in this round and approved in this round
9	On level premium projection
10	Investment income % received in each of historic years for assets backing the active life reserve
11	Show projections without margins
12	Show split out of incurred claims into paid, disabled life reserve and IBNR
13	Are special RBO options available for inflation policies (such as landing spot)?
14	Require this item from Supplemental Information for all filings: 3. RBOs a. Provide the history of RBOs offered and accepted for the block. b. Provide a reasonability analysis of the value of each significant type of offered RBO.
15	Inform the company they need to file all this information with each State. If information is only in objection response in MSA filing, company need to put in the body of information submitted in SERFF to States.

Item #	Description
1	Write MSA report for an non-actuarial audience with actuarial details in appendix.
2	Pick one methodology to review the filings; Large discrepancies between MN and TX methodologies reduces confidence in final conclusion
3	More thorough discussion of reasonability analysis done in evaluating RBO's. Was analysis qualitative or quantitative.



April 11, 2023

Fred Andersen, Co-Chair
Paul Lombardo, Co-Chair
Long-Term Care Actuarial (B) Working Group (LTCAWG)
Health Actuarial (B) Task Force
National Association of Insurance Commissioners (NAIC)

Re: Definition of “past losses” in the context of recouping past losses for long-term care (LTC)

Dear Co-Chairs Andersen and Lombardo,

On behalf of the Long-Term Care (LTC) Reform Subcommittee (“the subcommittee”) of the Health Practice Council of the American Academy of Actuaries (Academy),¹ we are reaching out to you to follow up on a concern you raised during the NAIC LTC Actuarial (B) Working Group Meeting on February 17, 2023, about the lack of a consistent definition of “past losses” in the context of recouping past losses for LTC.

We refer the LTCAWG to a specific Academy issue brief, [Long-Term Care Insurance: Considerations for Treatment of Past Losses in Rate Increase Requests](#) (October 2018), on considerations for treatment of past losses in rate increase requests for LTC insurance. That issue brief notes that there are many possible sources of past losses, including past persistency in excess of expected, past claims in excess of expected, delays in the request or approval of necessary premium rate increases, companies pricing different from industry standards, investment returns being lower than expected, and shortfalls in past premiums. As regulators review requested rate increases and consider how to and how much to adjust for past losses, there are a variety of approaches one might reasonably take depending on the source.

¹ The American Academy of Actuaries is a 19,500-member professional association whose mission is to serve the public and the U.S. actuarial profession. For more than 50 years, the Academy has assisted public policymakers on all levels by providing leadership, objective expertise, and actuarial advice on risk and financial security issues. The Academy also sets qualification, practice, and professionalism standards for actuaries in the United States.

We would welcome the opportunity to speak with you to provide more detail regarding past losses or on other issues. For example, the committee has offered comments to the Long-Term Care Insurance Multi-State Rate Review Framework.²

If you have any questions or would like to discuss further, please contact Matthew Williams, the Academy's senior health policy analyst, at williams@actuary.org.

Sincerely,

Jamala M. Arland, MAAA, FSA
Chairperson, LTC Reform Subcommittee
American Academy of Actuaries

Andrew H. Dalton, MAAA, FSA
Vice Chairperson, LTC Reform Subcommittee
American Academy of Actuaries

CC: Eric King, NAIC Support Staff

² https://www.actuary.org/sites/default/files/2021-10/Academy_Comment_Letter_NAIC_LTCL_MSA_Framework_10.2021.pdf



April 24, 2023

Paul Lombardo, Co-Chair, NAIC Long-Term Care Actuarial Working Group
Fred Andersen, Co-Chair, NAIC Long-Term Care Actuarial Working Group

Dear Paul and Fred,

The American Council of Life Insurers (ACLI)¹ and the America's Health Insurance Plans (AHIP)² appreciate the opportunity to comment on the following two exposures:

- Suggested improvements to the Health Actuarial Task Force-adopted Consolidated, Most Commonly Asked Questions – States' LTC Rate Increase Reviews checklist and MSA Supplemental information checklist.
- The Minnesota and Texas actuarial approaches as described in the NAIC Long-Term Care Insurance Multistate Rate Review Framework document.

The ACLI and AHIP continue to fully support a consistent national approach for reviewing current LTC rates that results in actuarially appropriate increases being granted by the states in a timely manner.

Our comments on each exposure are outlined in the following sections.

Suggested Improvements to Checklists

ACLI and AHIP members continue to support and encourage a general checklist that reduces the number of additional requests from states during the individual state review of the rate filing. While we understand that each state is responsible for the final review and approval of the filing in their state, additional information that is not included in the checklist may be warranted. We encourage the checklist to clarify that if a state believes that there are additional requests needed that are not included in the checklist, the state should provide the company with the reason that the additional item is needed.

Comments and suggested changes to specific sections of the checklists are outlined in Appendix A.

Comments to the Actuarial Approaches for Rate Increases

Our comments to the actuarial approaches for rate increases are more general in nature. It is our understanding that a detailed review of these methods, along with consideration of alternative methods, will occur after any modifications needed to the checklist are complete.

¹ The American Council of Life Insurers (ACLI) is the leading trade association driving public policy and advocacy on behalf of the life insurance industry. 90 million American families rely on the life insurance industry for financial protection and retirement security. ACLI's member companies are dedicated to protecting consumers' financial wellbeing through life insurance, annuities, retirement plans, long-term care insurance, disability income insurance, reinsurance, and dental, vision and other supplemental benefits. ACLI's 280 member companies represent 94 percent of industry assets in the United States.

² AHIP is the national association whose members provide health care coverage, services, and solutions to hundreds of millions of Americans every day. We are committed to market-based solutions and public-private partnerships that make health care better and to help create a space where coverage is more affordable and accessible for everyone.



Insurers best protect their policyholders when they can fulfill the obligations they made to these policyholders. This is accomplished when insurers have some level of predictability in their ability to effectively manage their current and future LTC business over time. At its core, this level of predictability can only be achieved through transparency and consistency with respect to the methodology used to calculate the increase recommended by the MSA Team. We firmly believe that companies need to understand how regulators are using the methodologies before submitting their rate filing to the MSRR, including why the MSA team would give more weight to one method over the other.

The Minnesota (Blended If-Knew/Make-Up) and Texas (Prospective Present Value) approaches, as described in the 2018 NAIC LTC Pricing Subgroup's paper – Long-term Care Insurance Approaches to Reviewing Premium Rate Increases ("NAIC Pricing Subgroup's Paper"), were the result of a deliberate and collaborative effort on the part of regulators and industry in 2018, during which each method was fully vetted. We believe that any change or clarification of the methods outlined in that document should occur only after the same robust discussion and review.

As was done in 2018, we encourage the NAIC LTC Actuarial Working Group to engage in another fulsome discussion of whether the current methodologies are still appropriate, along with the items used in each method so that regulators and companies are on the same page regarding how each component is used in the review process. This should include a discussion of all components of each method rather than the inclusion of only certain components of the methodologies. For example, under the Texas method, the catch-up and transitional provisions are not included in the framework. We believe these are valid and important adjustments that should be considered when applying the Texas method. The catch-up provision is intended to account for necessary additional premiums in a new rate increase related to assumptions provided to the department at the time of a previous rate increase request that were not approved in conjunction with the prior filing(s). Likewise, the transition provision, for pre-rate stability products and other products where the last rate increase request was voluntarily reduced by the company, provides the ability to make a single filing to provide the full amount of premium necessary to meet the actuarial certification.

Thank you for the opportunity to comment. We look forward to discussing our comments at the next call of the NAIC LTC Actuarial Working Group.

Sincerely,

A handwritten signature in blue ink, appearing to read 'Jan Graeber'.

Jan Graeber
Senior Actuary, ACLI

A handwritten signature in blue ink, appearing to read 'Ray Nelson'.

Ray Nelson
AHIP Consulting Actuary



Appendix A

Information Checklist	
Item Number	Comment/Suggestion
<p>Pages 18-19, Item 2b:</p> <p>2. New premium rate schedule, percentage increase for each rating scenario such as issue age, benefit period, elimination period, etc., from the existing and original rates.</p> <p>b. Provide the cumulative rate change since inception, after the requested rate increase, for each of the rating scenarios.</p>	<p>Comment: Due to differences in historical rate increase approvals by state, the "cumulative rate change since inception" will most likely vary by state.</p> <p>Suggestion: Remove this item from the checklist or clarify how the cumulative increase should be determined when historical rate increases have varied by state and clarify how the MSA team will use this information in its review.</p>
<p>Page 19, Item 3a and 3b</p> <p>3. Rate increase history that reflects the filed increase.</p> <p>a. Provide the month, year, and percentage amount of all previous rate revisions.</p> <p>b. Rate increase history that reflects the filed increase. Provide the SERFF MSA numbers associated with all previous rate revisions</p>	<p>Comment 3a: The date a rate revision is approved differs from the date the increase is implemented by the company.</p> <p>Suggestion: Clarify whether the date provided should be the approval date or the implementation date.</p> <p>Comment 3b: The MSA review process will assign a SERFF number to the MSA SERFF filing; however, this differs from the SERFF number assigned to the filing when it is submitted to the individual states. Therefore, the rate revision is actually associated with the state's SERFF number and not the MSA SERFF number. (i.e. clarify that this item refers only to prior MSA filings.)</p> <p>Suggestion: Add "if applicable" to clarify that this item refers to any prior MSA SERFF filing.</p>
<p>Page 19, Item 4.a.iv:</p> <p>4. Actuarial memorandum justifying the new rate schedule, which includes:</p> <p>a. Lifetime loss ratio projection, with earned premiums and incurred claims discounted at the maximum valuation interest rate.</p> <p>iv. Provide a comparison of state versus national mix of business. In addition, a state may request separate state and national data and</p>	<p>Comment: While we recognize that an individual state might be interested in information specific to their state, we suggest that the checklist clarify that state specific information is not needed or used for purposes of an MSA review.</p>



<p>projections. The insurer should accompany any state-specific information with commentary on credibility, materiality, and the impact on requested rate increase.</p>	
<p>Page 19, Item 5a: 5. Reasons for the rate increase, including which pricing assumptions were not realized and why. a. Attribution analysis - presents the portion of the rate increase allocated to and the impact on the lifetime loss ratio from each change in assumption</p>	<p>Comment: We believe this information is duplicative of the information requested in Item S2 of the Supplement checklist, which states: "Attribution of rate increase a. Provide the attribution of rate increase by factor: morbidity, mortality, lapse, investment, and other. b. For the morbidity factor, break down the attribution by incidence, claim length, benefit utilization, and other. c. Provide information on the assumptions that are especially sensitive to small changes in assumptions." Suggestion: Remove this item from the supplemental checklist.</p>
<p>Page 20, Item 10c: 10. Information from the Guidance Manual Question and Answer (Q&A): Morbidity, Lapse, Mortality, Interest. a. Provide actuarial assumptions from original pricing and most recent rate increase proposal and have the original actuarial memorandum available upon request.</p>	<p>Comment: Providing this information is challenging due to the fact that the most recent assumptions may vary by state. For example, timing differences between filings may vary by state. In addition, the original actuarial memorandum could vary by state as well. Suggestion: This item should be revisited after the review and discussions of the methodologies are complete in order to incorporate how the MSA will treat situations when the "most recent rate increase" assumptions vary by state.</p>
<p>Page 20, Item 11: 11. Provide the following calendar year projections, including totals, for current premium paying nationwide policyholders only, prior to the rate increase, all discounted at the maximum valuation interest rate: a. Present value of future benefits (PVFB) under current assumptions b. PVFB under prior assumptions (from prior rate increase filing, or if no prior increase, from original pricing). c. Present value of future premiums (PVFP) under current assumptions.</p>	<p>Comment: The data requested is only for base rate increase calculation. We believe the Texas method should utilize the catchup and transition provisions and therefore additional data should be requested in this checklist to accommodate those provisions. Suggestion: This item should be revisited after the review and discussions of the methodologies are complete to incorporate modifications made due to those discussions.</p>



<p>d. PVFP under prior assumptions (from prior rate increase filing, or if no prior increase, from original pricing).</p>	
<p>Page 20-21, Item 16: 16. Policyholder notification letter should be clear and accurate. a. Provide a description of options for policyholders in lieu of or to reduce the increase. b. If inflation protection is removed or reduced, is accumulated inflation protection vested? c. Explain the comparison of value between the rate increase and policyholder options. d. Are future rate increases expected if the rate increase is approved in full? If so, how is this communicated to policyholders?</p>	<p>Comment: We agree that the policyowner notification letter should be clear and accurate; however, different states have different definitions of what is clear and accurate. Suggestion: Remove this item from the MSA information checklist and leave it to the review of the individual state when the filing is made with that state.</p>
<p>Supplement Checklist</p>	
<p>Page 21, Items 3a and 3b 3. RBOs a. Provide the history of RBOs offered and accepted for the block. b. Provide a reasonability analysis of the value of each significant type of offered RBO.</p>	<p>Comment: Because historical rate increase approval amounts and timing could vary by state, the offer and acceptance data will vary by state as well. In addition, new/innovative approaches, like landing spots or cash buyouts are not approved by all states. Suggestion: Clarify how companies should provide this information when it varies by state.</p>
<p>Page 21, Item 5: 5. Expected loss ratio: a. With respect to the initial rate filing and each subsequent rate increase filing, provide the target loss ratio. b. Provide separate ratios for lifetime premium periods and non-lifetime premium periods and for inflation-protected and non-inflation-protected blocks.</p>	<p>Comment: This item does not take into account whether a company certified to rate stability. Will all companies be treated as if they did certify to rate stability even when they did not and even when the target loss ratio could not have been achieved because the state didn't approve the rate increase associated with that target loss ratio?</p>

Ideas for a single, improved MSA actuarial approach

As the Long Term Care Actuarial Working Group evaluates the two actuarial approaches embedded in the Multi-State Actuarial (MSA) Framework, there could be an opportunity to apply the evaluation to move towards a single, improved MSA actuarial approach.

Clarifying principles applied to develop the Texas and Minnesota approaches, key goals will continue to be:

1. The present value of lifetime premiums should not exceed the present value of lifetime benefits and related expenses for a class of policies.
 - a. This addresses the issue of “past losses” which can be a confusing concept related to a long-term insurance product.
 - b. This also addresses the shrinking block issue, ensuring a small number of remaining policyholders are not responsible for past excess claims associated with past policyholders.
 - c. The Minnesota and Texas approaches currently address these issues.
 - d. The Texas approach currently contains additional aspects regarding past losses.
2. Practical
 - a. The resulting rate increase should be reasonable.
 - b. The approach should be calculated in a reasonable amount of time with a reasonable amount of effort.
 - c. The approach should avoid unnecessary complications that don’t significantly change the resulting calculated rate increase.
3. Appropriate cost sharing
 - a. Recognition that in many cases, the lifetime loss ratio approach, an aspect of many states’ laws, leads to excessive rate increases that could be in conflict with other aspects of states’ laws.
 - b. Cost sharing should be balanced, considering consumer fairness and avoiding further company financial distress.
 - c. Any cost-sharing formula should allow for potential flexibility if concerns exist regarding an insurer’s financial solvency.

Note that the above-mentioned principles are in addition to the typical, professional approach applied by states, including review of insurer and industry experience; assessments of reasonability of assumptions; validation of projections; and professional judgment, where appropriate.

Here are aspects of the Minnesota approach where improvements may be considered:

- VI. Is the “if-knew” the appropriate premium to blend with the makeup premium to achieve the results in item 1 above? If not, is it appropriate to achieve the practicality goals in item 2 above?
- VII. Should the weighting towards the makeup premium continue to be the percentage of policyholders remaining to help achieve the goals of items 1 and 2 above?
- VIII. For simplicity, does it make sense to remove the investment component, perhaps adjusting the cost-sharing formula to calibrate the results to the current Minnesota approach?

- IX. Is the catchup approach of determining a rate increase from inception and removing past rate increase approvals effective?
- X. Is the aggregate application of the Minnesota approach working as intended, where the makeup premium is such that the resulting lifetime loss ratio does not exceed the pricing lifetime loss ratio?

Here are aspects of the Texas approach where improvements may be considered:

- V. What are features of the Texas approach not accounted for in the MN approach that could be part of a single, improved approach?
- VI. How are transitional and catch-up provisions planned to be handled, including situations where the previous rate increase was applied prior to the implementation of the Texas approach or the company voluntarily reduces a past rate increase?
- VII. Evaluation of the potential high sensitivity of mature blocks of business to later duration factors (and older assumptions) while placing less emphasis on past experience
- VIII. Evaluation of the balance between fairness to consumers and avoiding further insurer financial distress.

Note that the stated goal of the MSA approach is rate equity. States and companies can still pursue a more equitable approach where the present value of premiums would be similar between states, i.e., recognize timing differences of past rate increase approvals.

MEMORANDUM



TO: Commissioner Andrew N. Mais (CT), Chair of the Health Actuarial (B) Task Force and Fred Andersen (MN), Chair of the Long-Term Care Valuation (B) Subgroup

FROM: Steve Drutz (WA), Chair of the Health Risk-Based Capital (E) Working Group

DATE: Feb. 25, 2022

RE: AG 51 – Asset Adequacy Testing

The Health Risk-Based Capital (E) Working Group established the Health Test Ad Hoc Group in 2018 to review the health test language within the *Annual Statement Instructions* due to inconsistencies in reporting of health business across the different blanks, as well as a significant amount of health business reported on the life and fraternal blank. Currently, a company passes the health test if the following requirements are met:

- The values for the premium and reserve ratios in the Health Statement Test equal or exceed 95% for both the reporting and prior year.

AND

- The entity passing the Health Statement Test is licensed and actively issuing and/or renewing business in five states or less.

AND

- At least 75% of the entity's current year premiums are written in its domiciliary state.

OR

- The values for the premium and reserve ratios in the Health Statement Test equal 100% for both the reporting and prior year, regardless of the number of states in which the entity is licensed.

The intent of the Ad Hoc Group was to evaluate if changes were warranted to the health test because of industry changes since its original development. The Ad Hoc Group has drafted a phase 1 proposal that will delete the requirements for an entity being licensed and actively issuing and/or renewing business in five states or less and at least 75% of the entity's current year premiums being written in their domicile state. The Ad Hoc Group is continuing to evaluate the current 95% premium and reserve ratios.

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Kansas City 1100 Walnut Street, Suite 1500, Kansas City, MO 64106-2197

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New York One New York Plaza, Suite 4210, New York, NY 10004

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www.naic.org

Through the evaluation and discussion of the 95% reserve ratio, there was a question brought up as to whether an entity would still be required to perform asset adequacy testing of long-term care (LTC) business if the entity moved from the life blank to the health blank. It is the Ad Hoc Group's understanding that asset adequacy testing is required, regardless of the blank if the criteria for asset adequacy testing are met. The Working Group is asking the Health Actuarial (B) Task Force to consider adding a sentence to *Actuarial Guideline LI—The Application of Asset Adequacy Testing to Long-Term Care Insurance Reserves* (AG 51) that would indicate that regardless of the blank the entity files, asset adequacy testing is required by the entity if the criteria are met.

This clarification would help to make it abundantly clear that all companies with LTC exposure that are subject to asset adequacy testing would still be required to meet these requirements, regardless of the blank they are filing on.

If you have any questions regarding the suggested clarification, please contact Crystal Brown (cbrown@naic.org).

cc: Eric King, Crystal Brown



August 12, 2023



Long-Term Care Insurance Products

Note, the WA state effect in 2021 increased sales by **37%** for Hybrid products and standalone LTC by **118%**.

	Type	2021 Policies	2022 Policies	% increase	2022 Annualized Premium
New Business	Standalone LTC	90,752	36,872	-59.4%	137,799,414
	Hybrid Life w/Extension	40,411	25,940	-35.9%	270,571,855
	Hybrid LTC Acceleration	158,859	98,075	-38.3%	500,270,703
	CI Acceleration	291,681	290,590	-0.4%	2,164,297,602
	Total	581,733	451,477	-22.4%	
In Force	Standalone LTC	~ 6 million*			
	Hybrid	1,720,727			

Source: LIMRA 2022 US Individual Life Combination Product and Long-Term Care Insurance Product Sales and In Force Surveys. *NAIC Form 1 1



Long-Term Care Insurance Products

Observations from NAIC form 1:

- Were 120+ carriers “truly” writing LTC?
 - 5,981,777 total policies in force over 114 holding companies,
 - 35 have More than 10,000 policies with an average inforce of 167,380, and
 - 79 have Less than 10,000 policies with an average inforce of 1,563
 - Of the top 20 carriers:
 - Average inforce is 277,237 policies,
 - **14/20** continue selling long-term care solutions (Standalone LTC/Riders/etc.)

In addition, there are dozens more carriers placing worksite, Life/LTC riders, Life/Annuity riders, Chronic Illness riders, Short-Term Care, and supplemental health policies covering LTSS needs.

About 600 Medicare Advantage plans cover LTSS benefits including Adult Day Care, Transportation and Meals
(source: Forbes Feb 28, 2023 quote of ATI Advisory analysis of CMS PBP files, excludes EGHPs, PDPs, MMPs, Part B-only plans, and PACE)

2



Reaching the Middle-Income Market – “the Red Box”

Family Income	MN Population	General Idea of where “clients” are served for HCBS				
		Medicaid Programs	OAA Programs	EW Programs	Personal pay	Private pay
<\$10,000	44,763	X		X		
\$10,000-24,999	186,569	X	X	X		
\$25,000-49,999	233,175	X	X	X		
\$50,000-74,999	177,876		X		X	
\$75,000-99,999	102,906				X	
\$100,000-\$124,999	67,775				X	X
\$125,000-\$149,999	30,726				X	X
>=\$150,000	76,885					X
Total	920,675					

3

Minnesota DHS: Options to Increase Access to Long Term Care Financing, Services and Supports in Minnesota



Primary Objective and Goals of the Study :

- Improving access to LTSS for Minnesotans that typically do not qualify for Medicaid,
- Examining and evaluating integrated LTSS funding options, and
- Transforming the LTC funding system.

Provide **Stakeholder-led** comprehensive recommendations addressing the needs of individuals, families, caregivers, government programs, insurance programs, and many others.

An emphasis on options that; enable older adults to receive care in their homes, improve the caregiver supply, and develop a broad base of support for positive recommendations.

Encourage **simplicity**, system **integration**, **equity**, and **accessibility** of LTSS services.

Considers **revised roles** for private LTC insurance, for Minnesota's Medicaid program and for other funding sources including Medicare LTSS and Older Americans Act programs.

Explores new and innovative models of LTC financing and service delivery.

4

Building Upon What Works in MN: It's All About the Supports!



Minnesota's existing LTSS approaches:

Partners including the Area Agencies on Aging, Counties, Tribal Nations, and Managed Care Organizations

A "no wrong door" approach: Senior LinkAge Line, Office of Ombudsman for Long-Term Care, MN Adult Abuse Reporting Center, etc.

A provider capacity that taps all revenue streams, including private pay.

Reaching older adults and family caregivers further upstream from Medical Assistance (Medicaid).

Minnesota Medicaid - Managed Care for Seniors:

- PMAP: Over 35 years experience with managed care for Medicaid seniors.
- 65,000+ Medicaid seniors currently required to enroll statewide.
- PMAP for seniors changed to Minnesota Senior Care (MSC) and MSC+ statewide during 2005.
- Minnesota Senior Care Plus (MSC+): Adding Elderly Waiver and 180 days of nursing home services to managed care. Statewide phase in completed in 2009
- MSHO: 25+ years experience with integration of Medicare/ Medicaid and primary/acute/LTC service delivery

5



Public/Private Coordinated Plan Designs from the MN RFP

Range of Policy Options:

“Back End Catastrophic” Public Program Option

- Financial support for longer duration care situations (i.e. 3 or more years). It would require a waiting period (or deductible dollar amount) be met before people could begin accessing benefits. Enables integration with other potential funding sources to fill the initial waiting period gap.

Home and Community-Based Services

- A public program providing funding for care and services for middle income older Minnesotans similar with more modest benefit levels and caps on the benefit duration to keep the program costs down. Like Option 1, this program will have a waiting period or dollar deductible.

Early Intervention Benefit for Medicare Recipients Option.

- A public program providing modest, capped dollar, at-home benefits to Medicare recipients to delay or mitigate their need to spend out of pocket funds for paid care or spend down to be eligible for Medicaid. Provides care coordination and preventative support services before they first begin to evidence the need for LTSS.

Private Long-term Care Insurance Incentives Option

- Strengthen the appeal and encourage innovation within private long term care insurance to help address gaps in funding. Includes regulatory or legislative modifications that can make private long term care insurance more affordable and more accessible to middle income adults.

6

A Sampling of Potential Designs Under Consideration based on Minnesota Stakeholders:



Option 1: Early Intervention and Support

A state developed program to provide a care support structure that leverages existing services, provides strong awareness and education, and supports informal caregivers. This option would also provide modest, capped, at-home benefits with the goals of delaying or mitigating their need to spend down to be eligible for Medicaid. A Care Navigation service will also focus on obtaining access to community services offered by waiver and alternative care programs and be the platform to support residents and their caregivers. The aim is to maintain a safe home environment and preserve the safety net.

Option 2: Medicare MLTSS

A mandatory state sponsored LTSS program of 1 year of coverage, purchased by non-Medicaid eligible residents during Medicare enrollment or earlier. Participants receive care support and preventive services coordinated with their Medicare plans. The program will also offer additional options to buy-up for more than a year of coverage. Purchase/funding options prior to age 65 and with employer support may be offered. The approach is modelled after the comprehensive care coordination approaches of MLTSS plans.

Option 3: Catastrophic Coverage

A mandatory state insurance program to help pay for long-lasting, long-term care expenses that exceed 2 years, without Medicaid's income and asset restrictions. The program will be self-funded by a state specific payroll deduction for all workers 21 years of age and over. The deductions will go into a restricted fund for this program's use only.

7



THE Essential Criteria 2.0 – A MN Version

Quantitative:	
Access	Improves access to and usage of LTSS by Minnesota’s older adult population.
Costs and Efficiency	The system improves efficiency and generates savings for public programs, consumers and their families/caregivers.
Benefits	Total benefits are reasonable in relation to the total costs borne by the consumers across the system of public/private/ personal approaches.
Sustainable	The funding mechanism is sustainable and adjusts to changing economics, demographic eras, changes in family composition, and care support conditions. Sustainability applies across all stakeholder groups including consumers (out of pocket costs), public and private programs (solvency), and care providers (reasonable reimbursement).
Qualitative:	
Systemic Change	Provides fundamental positive changes to the way LTSS funding and service delivery is coordinated in Minnesota.
Feasibility	Implementation of the financing program is feasible and with limited obstacles and limited administrative costs to implement.
Integration	The care and supports, financing, and care coordination/management between private, public and other sources should be part of an integrated system.
Incentivization	The financing approach encourages support for care, prevention, and wellness initiatives. The approach aligns stakeholder needs. The system promotes consumer responsibility.
Supportive:	
Adaptable and Supportive	The system is flexible and adaptable related to market conditions, demographic shifts, and availability of care providers and resources. The system is responsive to cultural needs and embraces caregiving approaches of different cultures and family composition.
Understandable and Marketable	Eligibility for LTSS benefits, the financing approach, and the processes are simpler, clearer, and more understandable to consumers and their families/caregivers, providers, employers, and other stakeholders.
Equity of Access	Equity of access applies across urban and rural areas and across demographic and ethnic groups.

8

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SOCIETY OF ACTUARIES RESEARCH UPDATE TO HATF

August 12, 2023

Cindy MacDonald, FSA, MAAA
Senior Director, Experience Studies



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Experience Studies Pro

In 2021, LIMRA and the SOA Research Institute entered into a partnership to support the industry with a **comprehensive program of industry experience studies**.

This program will provide timely, consistent, and comprehensive releases of industry experience data — providing you with the necessary tools for addressing **product development, pricing, and regulatory** strategies.



SOA Experience Studies
Regulator Input on Prioritization

Benefits to the Industry



Credible, robust, benchmarking, and strong industry representation:
70% market participation is typical



Comprehensive and timely: updates of industry data on a regularly published schedule



Detailed and deeper analytics: to support product development, inforce management, reserving, and growth strategies



Together, We have Unmatched Breadth & Depth of Experience

Expertise

We are both associations dedicated to this industry, with a long history of conducting large data-intensive efforts

Trust

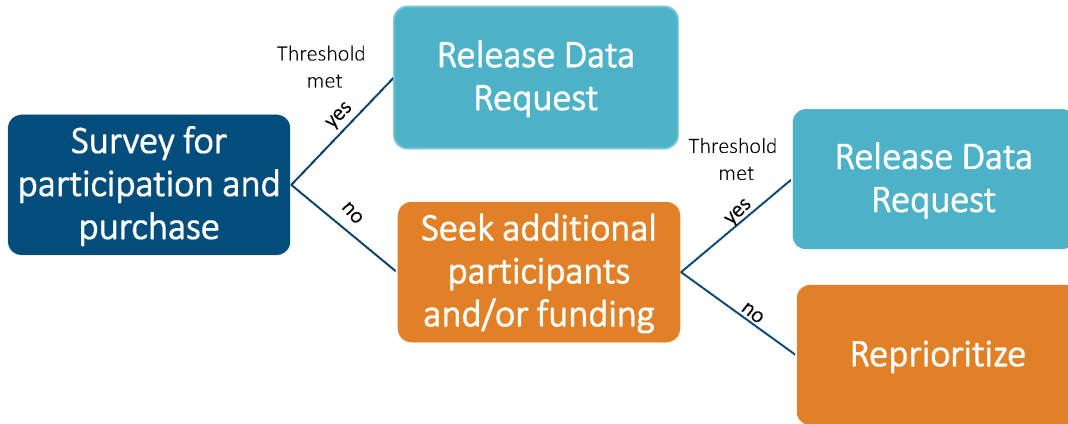
Strong reputation for unbiased research, analysis, and industry relationships

Value

Together we provide unparalleled value while delivering cost-effective insights



Feasibility Survey ... before a study starts



Studies at Risk for Participation and Funding

Product	Contingency Studied	Funding Concerns
Long-term care	claim incidence, claim termination, claim utilization, active life lapse and mortality	Blocks in run-off; complicated study/higher cost
Individual disability	claim incidence, claim termination	Few carriers; complicated study/higher cost
Group annuity	mortality	Few carriers; niche line of business
Structured settlements	mortality	Few carriers; niche line of business



HATF Interest Survey Results



Results Regulator Interest Survey - HATF

Experience Study	
Long-Term Care – claim incidence, termination, and utilization	★
Group Long-Term Disability – claim incidence	
Long-Term Care – lapse, mortality	★
Group Life Waiver of Premium – recovery, mortality	
Group Long-Term Disability – claim termination	
Individual Disability – claim incidence and termination	
Individual Life Waiver of Premium – claim incidence and termination	



Results Regulator Interest Survey - HATF

Tables/Projects	
Long-Term Care – claim incidence, termination, and utilization	
Group Long-Term Disability – claim termination	
Individual Disability – claim incidence and termination	
Long-Term Care – lapse, mortality	
Group Long-Term Disability – claim incidence	
Group Life Waiver of Premium – recovery, mortality	★
Individual Life Waiver of Premium – claim incidence and termination	



Comments

- HATF
 - Hospital indemnity, other indemnity, critical illness/specified disease



Individual Disability Income Experience

- Current valuation standard based on 1990 to 2007 data
- 2019 – SOA 2006-2014 claim incidence report
 - Incidence rates > 60% of the valuation standard table
 - ALR's may be 25-50% too high
- 2021 -- SOA 2006-2014 claim termination report
 - Termination rates > 50-65% of the valuation standard table
 - DLR's may be 25-50% too high



What can regulators do to help?

For studies, tables, project desired by regulators

- Help us clarify the prioritization
- Support/encourage voluntary participation in Experience Study Pro studies
- Support/encourage potential funding through NAIC, where funding through direct sales is not feasible



Discussion



Additional Health Research



Experience Studies, Practice Research & Data Driven In-house Research

Project Name	Objective	Expected Completion Date
Digital Health	A study focusing on telehealth and other digital communications.	https://www.soa.org/49e6b8f60ba/assets/files/resources/research-report/2023/digital-health-covid-19am.pdf
Emerging Impact of Long COVID on HealthCare Costs and Medical Conditions	Examine the impact of a COVID 19 diagnosis on patient claims and medical conditions.	https://www.soa.org/resources/research-reports/2023/hcc-covid-effects-longterm/
Group Life Waiver of Premium Valuation Tables	Develop valuation tables for claim mortality and recovery on Group Term Life policies with Waiver of Premium benefits.	https://www.soa.org/resources/experience-studies/2023/group-life-waiver/
Health and Health Care Inequalities: Research Challenges and Considerations	A summary of the challenges involved in conducting research that requires health or health care data and protected personal information. Includes considerations for future research.	https://www.soa.org/resources/research-reports/2023/health-and-healthcare-inequalities/
Risk Adjustment White Paper	Interview Risk Adjustment SMEs and create a white paper that will address recent concerns brought up by political leaders about the use of Risk Adj through an actuarial user's guide to its past and future applications.	https://www.soa.org/resources/research-reports/2023/risk-adjustment-may/
Social Physical and Cultural Determinants of Health	Qualitative SDOH research project.	https://www.soa.org/resources/research-reports/2023/soc-phy-cultural-doh/
State Based Public LTC Catastrophic Research	Studies the feasibility, possibilities and potential options for a state specific public product for Catastrophic LTC protection.	https://www.soa.org/resources/research-reports/2023/tc-catastrophic-insurance/ https://www.soa.org/4936e5f60ba/assets/files/resources/research-report/2023/tc-catastrophic-report.pdf https://www.soa.org/497a68f60ba/assets/files/resources/research-report/2023/covid-impact-on-state-based-cat-program.pdf
Wall Street Journal Health Forum Summary 2023	This project is a brief that summarizes the March 2023 Wall Street Journal Health Forum.	https://www.soa.org/resources/research-reports/2023/wall-street-journal-health/
Modeling the Impact of the COVID-19 Public Health Emergency (PHE) on State Medicaid Programs	Develop a model to help estimate the impact of the anticipated unwinding of the PHE on State Medicaid Programs. This includes an excel model, a users guide to the model, and a paper that illustrates how the model works and what it is trying to measure.	8/23/2023
2024 Getzen Model	This research examines is a model that does long term medical trend projects. In addition, there is a write-up which describes how each of the assumptions were chosen.	9/15/2023
HCCI Quick Hit - Specialty Pharmacy Trends	This research will examine some key specialty drugs to look at how increases in uptake in drugs worth between 10K and 200K are driving current pharmacy trend.	9/15/2023
Calculated Risk: Driving Decisions Using the 5/50 Research	Validate the 5/50 Premise through % of total costs and average allowed annual costs by percentile grouping. Analyze ability to predict the 5% based on prior claims and risk factors. Calculate Transition probabilities between different groups. Introduce the concept of Total Risk Analysis which looks at the likelihood of large financial losses in health insurance as well as what types of risk and variance contribute to the possibility of those losses.	9/30/2023



We've heard your feedback

FSA candidates encounter significant challenges along the pathway



- Lack of flexibility or customization
- Less relevant to global markets
- Little guidance on what to study
- Slow grading process
- No exam feedback
- Difficult source materials that lack focus



2



The Evolution of the FSA Pathway

NAIC presentations
Stuart Klugman, FSA, CERA, PhD
SOA Senior Staff Fellow

August 2023



Regulatory Material Shift

Current Challenge

- In-depth U.S. and Canadian regulatory material lacks relevance to global markets



SOA Shift

- Detailed local regulatory material moved outside of the current FSA requirements
- Fundamental regulatory principles and frameworks will still be covered in the FSA pathway
- FSA will qualify actuaries to sign General Statements of Actuarial Opinion

CERTIFICATES:



- Stand-alone, optional regulatory certificates will be offered. Certificates can be taken when needed.
- The SOA is collaborating with regulatory bodies to develop the certificates

4



Introducing a range of improvements for a better candidate experience



3





Flexible Pathway

Current Challenge

- Forced track structure lacks flexibility and customization
- Highly specialized tracks are less relevant for developing markets



SOA Shift

- Shifting from “tracks” to a flexible pathway
- Flexibility to focus on a single practice area or create a combination of courses relevant to you
- 5 courses required:
 - 4 Technical courses (one must build on another)
 - 1 Decision Making and Communications (DMAC) Course
 - + Fellowship Admissions Course (FAC)

5



Choose from About 20 Courses

Life/Annuities



Retirement Benefits



Health



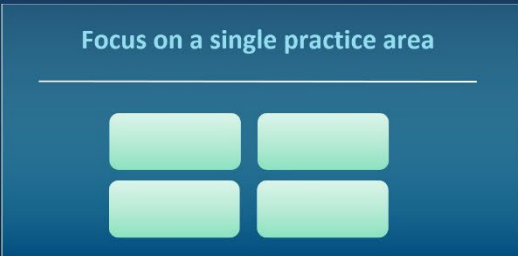
General Insurance



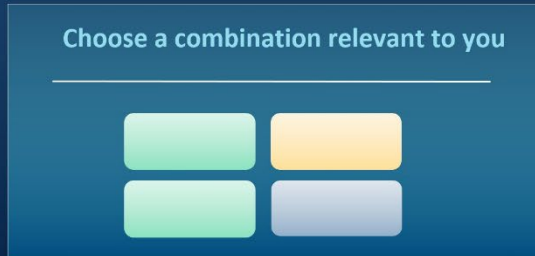
Finance/Investments/
ERM



Focus on a single practice area



Choose a combination relevant to you



6



Questions?

FSA2025@soa.org



American Academy of Actuaries Health Practice Council—Summer 2023 Updates

August 12, 2023—National Association of Insurance Commissioners (NAIC)
Health Actuarial (B) Task Force (HATF) Meeting

Matthew J. Williams, JD, MA
Senior Policy Analyst, Health
American Academy of Actuaries



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About the American Academy of Actuaries



The American Academy of Actuaries is a 19,500-member professional association whose mission is to serve the public and the U.S. actuarial profession. For more than 50 years, the Academy has assisted public policymakers on all levels by providing leadership, objective expertise, and actuarial advice on risk and financial security issues.

The Academy also sets qualification, practice, and professionalism standards for actuaries in the United States.

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Public Policy and the Academy

The Academy, through its public policy work, seeks to address pressing issues that require or would benefit from the application of sound actuarial principles. The Academy provides unbiased actuarial expertise and advice to public policy decision-makers and stakeholders at the state, federal, and international levels in all areas of actuarial practice.

Health Practice Council Updates & Priorities

Health Practice Council: Key Policy Priorities for 2023

- Health equity
- COVID-19 and other public health challenges
- Insurance coverage and benefit design
- Health care costs and quality
- Medicare sustainability
- Long-term services and supports (LTSS)
- Financial reporting and solvency
- Professionalism

Health Equity

- Presentations:
 - [Presentation to SEAC on Health Equity and the Upcoming Health Equity Symposium/Workshops](#) (June 2023)
 - [Academy Presents on Health Equity at SOA Meeting](#) (June 2023)
- Events:
 - Series of health equity workshops throughout summer/fall 2023, focused on the intersection of benefit design and health equity
 - Health Equity Symposium (scheduled for Nov. 15, 2023, in Washington, DC)

COVID-19 and Other Public Health Challenges

- Webinar: "[The Great Unwinding: What's Next for the Medicaid Population?](#)" (March 14, 2023)
 - Topic is included in our [Drivers of 2024 Health Insurance Premium Changes](#) issue brief

COVID-19 and Other Public Health Challenges: Climate Change and Health

[Climate Change Joint Committee](#)

- November 2021, the Climate Change Joint Committee was launched
- Members reflect the health, casualty, life, and pension practice areas and reports to the Risk Management and Financial Reporting Council (RMFRC)
- Activities to date
 - Comment letters to federal agencies and other stakeholders on climate-related disclosures and financial risks
 - [Climate Risks Pose Broad Impacts on Financial Security Systems](#) (June 2023) report
 - [Glossary](#) on climate-related terms (May 2023)

Health Insurance Coverage and Benefit Design

Issue Briefs:

- [Drivers of 2024 Health Insurance Premium Changes](#) (July 2023)
- [Considering Employee Benefits for Health Policy Development](#) (April 2023)

Comment Letter:

- Comments to CMS on [Medicaid Managed Care NPRM](#) (June 2023)

Presentation:

- Senior Health Fellow Cori Uccello, "[Considerations for Calculating Cost-Sharing Reduction Load Factors](#)" at the Society of Actuaries (SOA) Virtual Health Meeting (July 2023)

Webinars:

- "[Drivers of 2024 Health Insurance Premium Changes](#)" (July 2023)
- "[2024 Final Rules for Exchanges](#)" (May 2023)



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Health Care Costs and Quality

Issue Briefs:

- *Addressing High Insulin Spending: Moving Beyond Co-pay Caps* (forthcoming Q4 2023)
- *Gene Therapy Drug Costs* (forthcoming Q4 2023)



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Medicare Sustainability

Issue Brief:

- [Medicare's Financial Condition: Beyond Actuarial Balance](#) (April 2023)

Capitol Forum Webinar:

- [Medicare's Financing Challenges and Options to Address Them](#) (May 2023)

Long-Term Services and Supports (LTSS)

Issue Briefs:

- Refresh of [Impact of COVID-19 on Long-Term Care Insurance](#) issue brief (originally published January 2021—forthcoming)
- Refresh of [Essential Criteria for Long-Term Care Financing Reform Proposals](#) issue brief (originally published November 2016—forthcoming)
- *State of Long-term Care and How It Is Evolving* (forthcoming)

Financial Reporting and Solvency

Comment letters:

- [Comment letter](#) to NAIC Long-Term Care Actuarial (B) Working Group (LTCAWG) on LTC Past Losses (April 2023)
- [Comment Letter](#) to NAIC Blanks (E) Working Group on the exposure of the 2023 Blanks Proposal 2023-04BWG (with (April 2023)
 - Joint letter with the Academy's Committee on Property and Liability Financial Reporting (COPLFR) of the Casualty Practice Council (CPC)

NAIC Workstream Updates

Health Actuarial (B) Task Force (HATF)

Group Life Waiver Valuation Table Work Group

- Joint project of the Academy's HPC and the Society of Actuaries Research Institute (SOARI).
- Status: The revised AG 44 and associated tables have been adopted by the Executive & Plenary at the NAIC 2022 Fall National Meeting.
- [Final Materials](#) (June 2023):
 - [2023 Group Term Life Waiver Experience Table Report](#)
 - [2023 Group Term Life Waiver Experience Tables and Reserve Factor Calculator](#)
 - [The 2023 Waiver Reserve Table Webcast](#)

Health Risk-Based Capital (E) Working Group (HRBC)

Health Care Receivables Factors Work Group

- The Work Group is completing a review of the current health care receivables factors for the NAIC
- Update to the NAIC HRBC Working Group on July 25, 2023
- Task 1: Update the chart of health care (HC) receivables
 - HC Receivables now being reported on the Blue Blank as well as the Orange Blank
- Task 2: Evaluate 2018-2021 NAIC data

Long-Term Care Actuarial (B) Working Group (LTCAWG)

NAIC Long-Term Care Insurance Mortality and Lapse Study

- [Report](#) released November 2021 by the Academy's LTC Valuation Work Group and the Society of Actuaries Research Institute (SOARI)
- [Exposed](#) by the NAIC LTCAWG until Sept. 5, 2022

Status: LTCAWG to discuss drafting changes to VM-25, with the intention of adopting the tables within the 2021 report will adopt tables (Aug. 2023)

Other Updates

Academy 2023 Annual Meeting

[Envision Tomorrow—2023 Annual Meeting](#)

- November 13 and 14, 2023, in Washington, D.C.
- Health-specific breakout sessions:
 - Behavioral Health
 - Prescription Drugs
 - Regulating the Affordable Care Act: What's New for 2024?
 - Featuring Center for Consumer Information and Insurance Oversight (CCIIO) of CMS representatives

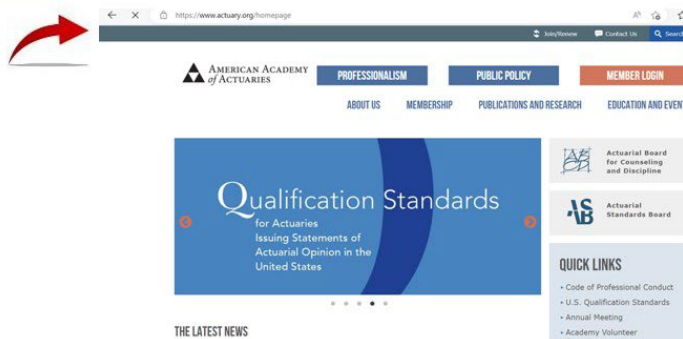


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Stay Up-to-Date

Under the [Public Policy tab](#),
access Academy:

- Comments and letters
- Issue briefs
- Policy papers
- Presentations
- Reports to the NAIC
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Questions?

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REGULATORY FRAMEWORK (B) TASK FORCE

Regulatory Framework (B) Task Force Aug. 13, 2023, Minutes	6-106
Accident and Sickness Insurance Minimum Standards (B) Subgroup Aug. 7, 2023, Minutes (Attachment One).....	6-108
Accident and Sickness Insurance Minimum Standards (B) Subgroup July 24, 2023, Minutes (Attachment Two)	6-110
Accident and Sickness Insurance Minimum Standards (B) Subgroup July 10, 2023, Minutes (Attachment Three).....	6-112
Accident and Sickness Insurance Minimum Standards (B) Subgroup June 29, 2023, Minutes (Attachment Four).....	6-114
Accident and Sickness Insurance Minimum Standards (B) Subgroup May 15, 2023, Minutes (Attachment Five).....	6-116
Accident and Sickness Insurance Minimum Standards (B) Subgroup April 24, 2023, Minutes (Attachment Six).....	6-118
Accident and Sickness Insurance Minimum Standards (B) Subgroup April 17, 2023, Minutes (Attachment Seven).....	6-120
Accident and Sickness Insurance Minimum Standards (B) Subgroup March 27, 2023, Minutes (Attachment Eight)	6-123
Employee Retirement Income Security Act (ERISA) Working Group Aug. 13, 2023, Minutes (Attachment Nine).....	6-125
Mental Health Parity and Addiction Equity Act (MHPAEA) (B) Working Group March 23, 2023, Minutes (Attachment Ten).....	6-128
Pharmacy Benefit Manager Regulatory Issues (B) Subgroup July 27, 2023, Minutes (Attachment Eleven).....	6-130
Pharmacy Benefit Manager Regulatory Issues (B) Subgroup April 17, 2023, Minutes (Attachment Eleven-A).....	6-133
Pharmacy Benefit Manager (PBM) White Paper Draft, April 16, 2023 (Attachment Eleven-A1) ..	6-134
PBM White Paper Adopted by the Subgroup (Attachment Eleven-B).....	6-170

Draft: 8/21/23

Regulatory Framework (B) Task Force
Seattle, Washington
August 13, 2023

The Regulatory Framework (B) Task Force met in Seattle, WA, Aug. 13, 2023. The following Task Force members participated: Sharon P. Clark, Chair (KY); Glen Mulready, Vice Chair, represented by Andy Schallhorn (OK); Michael Conway represented by Debra Judy and Jason Lapham (CO); Andrew N. Mais represented by Jared Kosky (CT); Karima M. Woods represented by Yohannes Negash (DC); Doug Ommen represented by Andria Seip (IA); Dean L. Cameron represented by Weston Trexler (ID); Amy L. Beard represented by Alex Peck (IN); Vicki Schmidt represented by Julie Holmes (KS); Gary D. Anderson represented by Kevin Beagan (MA); Timothy N. Schott represented by Marti Hooper and Robert Wake (ME); Grace Arnold represented by Peter Brickwedde (MN); Jon Godfread represented by Chrystal Bartuska (ND); Eric Dunning represented by Maggie Reinert, Michael Muldoon, and Margaret Garrison (NE); D.J. Bettencourt (NH); Justin Zimmerman (NJ); Judith L. French represented by Laura Miller (OH); Andrew R. Stolfi represented by TK Keen (OR); Michael Humphreys (PA); Larry D. Deiter represented by Jill Kruger (SD); Cassie Brown represented by Rachel Bowden (TX); Jon Pike represented by Tanji J. Northrup (UT); Scott A. White represented by Julie Blauvelt and Jackie Myers (VA); Mike Kreidler represented by Ned Gaines (WA); Nathan Houdek represented by Jennifer Stegall and Rebecca Rebholz (WI); and Allan L. McVey represented by Erin K. Hunter and Joylynn Fix (WV). Also participating were: Erica Weyhenmeyer (IL); and Jane Beyer (WA).

1. Adopted its Spring National Meeting Minutes

Keen made a motion, seconded by Seip, to adopt the Task Force's March 22 minutes (*see NAIC Proceedings – Spring 2023, Regulatory Framework (B) Task Force*). The motion passed unanimously.

2. Adopted its Subgroup and Working Group Reports

Before asking for a motion to adopt the Task Force's subgroup and working group reports, Commissioner Clark explained that in adopting the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup's report and minutes, the Task Force is not adopting the pharmacy benefit manager (PBM) white paper, which the Subgroup adopted during its July 27 meeting. The Task Force plans to meet following the Summer National Meeting to discuss its next steps for the white paper.

Gaines made a motion, seconded by Seip, to adopt the following reports: 1) the Accident and Sickness Insurance Minimum Standards (B) Subgroup, including its Aug. 7 (Attachment One), July 24 (Attachment Two), July 10 (Attachment Three), June 29 (Attachment Four), May 15 (Attachment Five), April 24 (Attachment Six), April 17 (Attachment Seven), and March 27 (Attachment Eight) minutes; 2) the Employee Retirement Income Security Act (ERISA) (B) Working Group, including its Aug. 13 (Attachment Nine) minutes; 3) the Mental Health Parity and Addiction Equity Act (MHPAEA) (B) Working Group, including its March 23 (Attachment Ten) minutes; and 4) the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup, including its July 27 (Attachment Eleven) minutes. The motion passed unanimously.

3. Heard a Panel Discussion on Prior Authorization

Lucy Culp (Leukemia & Lymphoma Society—LLS), Emily Carroll (American Medical Association—AMA) and Beyer discussed prior authorization. Culp discussed patient and consumer experiences with prior authorization and how the prior authorization process can create a barrier to care. She highlighted a 2023 Kaiser Family Foundation (KFF) survey of consumer experiences with health insurance, which showed that six in 10 insured adults reported problems with their health insurance in the past year. Culp also discussed the NAIC consumer representatives'

work group on prior authorizations, appeals, and denials, including its areas of focus. She also identified opportunities and key policy reforms the states can take to address patient and consumer needs to: 1) improve access to evidence-based care; 2) ensure continuity of care; 3) promote transparency and fairness; 4) improve timely access to care; and 5) reduce administrative barriers.

Carroll discussed how prior authorization can harm patients, be burdensome to physician practices, and waste overall health care resources. She also discussed opportunities and solutions for state insurance regulators to reform the prior authorization process and provided examples of how certain states, including Washington, are acting on those solutions to reform the prior authorization process. Carroll also discussed federal actions complementing state actions to reform the prior authorization process.

Beyer discussed prior authorization in Washington, including the prior authorization rules adopted in 2017 and legislation enacted in 2023. She explained that Washington's prior authorization requirements apply to all health services, including prescription drugs. Washington requires carriers to use evidence-based clinical review criteria that are updated at least annually and can accommodate evidence regarding appropriate care for people of color and gender differences. Beyer said Washington's prior authorization requirements also include timeliness standards. She noted that Washington considers a prior authorization denial to be an adverse benefit determination that the health care provider or consumer can appeal.

Beyer discussed Washington's requirements for carriers to have a secure online process for a health care provider or facility to use to: 1) determine whether prior authorization is required; 2) find applicable clinical criteria and required documentation; and 3) submit prior authorization request with any needed documentation. She said that Washington has added new requirements for the online process to allow a health care provider or facility to submit and obtain a response to prior authorization requests using an application programming interface (API) beginning in 2025 for health care services (or 2026 if the federal interoperability proposed rule is not finalized by Sept. 13, 2023) and beginning in 2027 for prescription drugs.

Beyer discussed Washington's findings on how carriers use prior authorization based on the data it receives in accordance with its data reporting law, which was effective in 2020. She said that based on the data received, the services most frequently subject to prior authorization are: 1) physical therapy; 2) colonoscopy/endoscopy; 3) continuous positive airway pressure (CPAP) device; 4) imaging, including computed tomography (CT) and magnetic resonance imaging (MRI); and 5) room and board for both medical and behavioral health. She discussed the findings from a review of 2021 data for services with an approval rate of 98% or more and at least 50 requests processed. She highlighted the average standard response times for prior authorization requests from this review for current procedural terminology (CPT)/Healthcare Common Procedure Coding System (HCPCS) codes with the most prior authorization requests for medical-surgical versus mental health/substance use disorder (MH/SUD). She said the data showed that carriers generally take longer to approve or deny prior authorization requests for mental health/substance use disorder services than for medical-surgical services. She said the states can use this type of data as an indicator, operationally, of what more may be needed for comparability between the provision of MH/SUD services and medical-surgical services.

Having no further business, the Regulatory Framework (B) Task Force adjourned.

SharePoint/NAIC Support Staff Hub/Member Meetings/B CMTE/RFTF/National Meetings/2023 Summer Meeting/RFTF 8-13-23
MtgMin.docx

Draft: 8/9/23

Accident and Sickness Insurance Minimum Standards (B) Subgroup
Virtual Meeting
August 7, 2023

The Accident and Sickness Insurance Minimum Standards (B) Subgroup of the Regulatory Framework (B) Task Force met Aug. 7, 2023. The following Subgroup members participated: Andy Schallhorn, Co-Chair (OK); Rachel Bowden, Co-Chair (TX); Tara Smith (CO); Chris Struk (FL); Robert Wake (ME); Maggie Reinert (NE); Shari Miles (SC); Heidi Clausen (UT); Mary Block and Jamie Gile (VT); and Lichiou Lee (WA).

1. Continued Discussion of Section 9A of Model #171

The Subgroup continued its discussion of the suggested revisions to the product statements in Section 9A—Required Disclosure Provisions of the *Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act* (#171). The Subgroup returned to its discussion of the NAIC consumer representatives' suggested revisions to Section 9A(12). The suggested revisions recommend deleting the first sentence, which states: "Except for riders or endorsements by which the insurer effectuates a request made in writing by the policyholder or exercises a specifically reserved right under the policy, all riders or endorsements added to a policy after date of issue or at reinstatement or renewal that reduce or eliminate benefits or coverage in the policy shall require signed acceptance by the policyholder." After discussion, the Subgroup decided to delete the clause beginning with "[e]xcept" and retain the remainder of the sentence. The Subgroup also accepted the non-substantive suggested revisions.

The Subgroup next returned to its discussion of the NAIC consumer representatives' suggested revisions to Section 9A(19) concerning the outline of coverages delivered to consumers for certain products regulated under Model #171 to include language on or attached to the first page of the outline of coverage stating that these products are not Medicare supplement policies. The Subgroup accepted the suggested revisions during its July 24 meeting. In continuing its discussion of this provision, the Subgroup discussed whether additional revisions were needed for consistency with the consumer disclosure language in Appendix C of the *Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act* (#651). The Subgroup also discussed whether there should be a distinction between the consumer disclosure notices received under Section 9A(12) for individuals eligible for Medicare by reason of age and individuals eligible for Medicare by reasons other than age. After discussion, the Subgroup decided to add a drafting note alerting the states that permit individuals under the age of 65 with Medicare coverage to purchase a Medicare Supplement (Medigap) policy to review how they should provide the notices required under Section 9A(12) to these individuals.

The Subgroup next discussed the NAIC consumer representatives' suggested revisions to Section 9A(20). The NAIC consumer representatives suggest deleting the exception for direct response insurers to provide a specified disease insurance buyer's guide to any person applying for a specified disease insurance policy. For consistency with its other suggested revision to this provision, the NAIC consumer representatives also suggest deleting the language requiring direct response insurers to provide the buyer's guide upon request, but not later than the time the policy or certificate is delivered. The Subgroup accepted the suggested revisions.

The Subgroup next moved to the NAIC consumer representatives' suggested revisions for Section 9A(21) to Section 9A(29). The Subgroup agreed that the suggested revisions for these provisions, which concern consumer disclosure language for the products in Model #171 that must be on the first page of a policy or certificate, is already addressed with the previous revisions the Subgroup discussed and accepted for Section 9A(2).

2. Discussed Section 9B of Model #171

The Subgroup next discussed the NAIC consumer representatives' suggested revisions to Section 9B establishing an outline of coverage requirements. Beginning with Section 9B(1), the Subgroup discussed the NAIC consumer representatives' clarifying revisions to this provision. The Subgroup accepted the suggested revisions.

The Subgroup next discussed the NAIC consumer representatives' suggested revisions to Section 9B(2). Section 9B(2) establishes requirements for providing a substitute outline of coverage when there is a change from when the outline of coverage was provided at the time of application or enrollment. The NAIC consumer representatives' suggested revisions would require insurers to provide a substitute outline of coverage to applicants and enrollees at the time of renewal. After discussion, the Subgroup did not accept the suggested revisions because it felt the suggested revisions would expand the scope and intent of the current language. The Subgroup accepted the NAIC consumer representatives' suggested revisions for the drafting note. However, the Subgroup decided to return to the drafting note during its next meeting on Aug. 21 to consider some additional clarifying language. The Subgroup discussed the NAIC consumer representatives' suggestion to add a clarifying sentence to Section 9B(3) to specifically state that a policy or certificate cannot be sold or renewed until the commissioner approves the alternate outline of coverage. No comments were received on Section 9B(4).

Having no further business, the Accident and Sickness Insurance Minimum Standards (B) Subgroup adjourned.

SharePoint/NAIC Support Staff Hub/Member Meetings/B CMTE/RFTF/Accident and Sickness Subgrp/Accident and Sickness Ins Min Stds Subgrp 8-7-23MtgMin.docx

Draft: 8/3/23

Accident and Sickness Insurance Minimum Standards (B) Subgroup
Virtual Meeting
July 24, 2023

The Accident and Sickness Insurance Minimum Standards (B) Subgroup of the Regulatory Framework (B) Task Force met July 24, 2023. The following Subgroup members participated: Andy Schallhorn, Co-Chair (OK); Rachel Bowden, Co-Chair (TX); Howard Liebers (DC); Chris Struk (FL); Robert Wake (ME); Camille Anderson-Weddle (MO); Martin Swanson (NE); Heidi Clausen (UT); Anna Van Fleet and Jamie Gile (VT); and Lichiou Lee (WA).

1. Continued Discussion of Section 9A of Model #171

The Subgroup continued its discussion of the suggested revisions to the product statements in Section 9A—Required Disclosure Provisions of the *Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act* (#171). Jolie H. Matthews (NAIC) said that prior to the meeting, she distributed a document reflecting the Subgroup’s discussions on Section 9A to date. She said the document also reflects Bowden’s suggested revisions to streamline language related to the readability and accessibility requirements for the product statement disclosures. Bowden pointed out a proposed new sentence in Section 9A(2) stating: “The disclosures required by this section may be modified only as approved by the commissioner and as needed to approve the accuracy and clarity of the disclosure.” The Subgroup discussed the document and confirmed that it accurately reflected the Subgroup’s discussions to date. The Subgroup also accepted Bowden’s suggested streamlining revisions and her suggested new sentence in Section 9A(2). The Subgroup also discussed whether the proposed federal rule on short-term, limited-duration (STLD) plan and hospital indemnity and other fixed indemnity plan consumer disclosures would affect the Subgroup’s proposed language for the product disclosures in Section 9A. After discussion, because the federal rule is not final and because of other issues related to the proposed federal rule, the Subgroup decided to add a drafting note to Section 9A(2) alerting states that they may have to review the language in Section 9A and consider any changes, as appropriate, for consistency with state and/or federal rules applicable to such coverage that may have changed after the Model #171 revisions are adopted.

The Subgroup discussed the NAIC consumer representatives’ suggested product statement disclosure language for limited-scope dental coverage and limited-scope vision coverage. The Subgroup accepted the suggested language. The Subgroup also asked NAIC staff to review the language for consistency with the other product statement disclosures.

The Subgroup discussed the NAIC consumer representatives’ suggested product statement disclosure language for STLD health insurance coverage. The Subgroup discussed whether it should consider the disclosure language in the proposed federal rules instead of the NAIC consumer representatives’ suggested language. After discussion, the Subgroup decided to use the proposed federal rule’s disclosure language.

The Subgroup next discussed the NAIC consumer representatives’ suggested revisions to Section 9A(12). The suggested revisions recommend deleting the first sentence, which states: “Except for riders or endorsements by which the insurer effectuates a request made in writing by the policyholder or exercises a specifically reserved right under the policy, all riders or endorsements added to a policy after date of issue or at reinstatement or renewal that reduce or eliminate benefits or coverage in the policy shall require signed acceptance by the policyholder.” The Subgroup discussed whether this sentence should be deleted and why the NAIC consumer representatives suggest its deletion. Anna Howard (American Cancer Society Cancer Action Network—ACS CAN) suggested the NAIC consumer representatives recommend deleting the language for consistency with other

proposed revisions. The Subgroup deferred deciding whether to accept the suggested revisions until it could review any other language in Model #171 on riders that could affect its decision.

The Subgroup discussed and agreed to accept the NAIC consumer representatives' suggested revisions to Section 9A(13) to add the language "and the combined total premium clearly identified as such." The Subgroup next discussed the NAIC consumer representatives' suggested revisions to Section 9A(16) adding language requiring certain notices to be prominently printed in a specified manner. The Subgroup discussed revising this language for consistency with other similar language used in Section 9A or reorganizing and placing this provision in Section 9A's general language. The Subgroup did not reach a decision. Similarly, the Subgroup discussed whether it should also reorganize and place Section 9A(17) in Section 9A's general language. It did not reach a decision. The Subgroup next discussed the NAIC consumer representatives' clarifying suggested revisions to Section 9A(18). The Subgroup accepted the suggested revisions. The Subgroup next discussed the NAIC consumer representatives' suggested revisions to Section 9A(19) concerning the outline of coverages delivered to consumers for certain products regulated under Model #171 to include language on or attached to the first page of the outline of coverage stating that these products are not Medicare supplement policies. The Subgroup accepted the suggested revisions. It also requested NAIC staff to revise the suggested language for consistency with similar language in Section 9A.

The Subgroup next discussed the NAIC consumer representatives' suggested revisions to Section 9A(20). The NAIC consumer representatives suggest deleting the exception for direct response insurers to provide a specified disease insurance buyer's guide to any person applying for a specified disease insurance policy. For consistency with its other suggested revision to this provision, the NAIC consumer representatives also suggest deleting the language requiring direct response insurers to provide the buyer's guide upon request, but not later than the time the policy or certificate is delivered. The Subgroup did not finish its discussion. The Subgroup plans to continue the discussion during its next meeting on Aug. 7.

Having no further business, the Accident and Sickness Insurance Minimum Standards (B) Subgroup adjourned.

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Draft: 7/17/23

Accident and Sickness Insurance Minimum Standards (B) Subgroup
Virtual Meeting
July 10, 2023

The Accident and Sickness Insurance Minimum Standards (B) Subgroup of the Regulatory Framework (B) Task Force met July 10, 2023. The following Subgroup members participated: Andy Schallhorn, Co-Chair (OK); Rachel Bowden, Co-Chair (TX); Stephen F. Flick (DC); Christina Jackson (FL); Robert Wake (ME); Camille Anderson-Weddle (MO); Shari Miles (SC); Heidi Clausen and Shelley Wiseman (UT); Anna Van Fleet and Jamie Gile (VT); and Lichiou Lee (WA).

1. Discussed Small Stakeholder Group Revisions to Section 9A of Model #171

Prior to continuing its discussion of the suggested revisions to the product statements in Section 9A—Required Disclosure Provisions of the *Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act* (#171), the Subgroup discussed the impact, if any, of the recently issued federal proposed rule on short-term, limited-duration (STLD) plans and hospital indemnity and other fixed indemnity plans. The Subgroup discussed if the rule would require the Subgroup to pause its work revising Model #171 and reopen Model #171's companion model act, the *Supplementary and Short-Term Health Insurance Minimum Standards Model Act* (#170). After discussion, the Subgroup decided to continue revising Model #171 but remain cognizant of the provisions in the federal proposed rule. The Subgroup also concluded that Model #170 most likely would need to be reviewed and possibly reopened after that review for additional revisions to reflect the provisions of the federal rule if it is finalized as proposed. However, this work would begin after the Subgroup finishes revising Model #171. The Subgroup reached these conclusions because, at this point, the federal rule is a proposed rule, which means that after a review of the comments received on it, the federal rule's final language could change. In addition, NAIC staff explained the Subgroup's approach to revising both Model #170 and Model #171 as being focused on state laws and regulations and tying both models' provisions to such laws and regulations, not federal laws and regulations.

Schallhorn said NAIC staff distributed prior to the meeting a revised document reflecting the Subgroup's June 29 discussion of the proposed language for the product statements. He asked for comments. The Subgroup agreed that the revised language accurately reflects the Subgroup's discussion.

Bonnie Burns (consultant to consumer groups) expressed concern with the language in some of the product statements stating that the product is "supplementary and not intended to replace major medical insurance." She said the language is confusing to consumers. After discussion, the Subgroup agreed to revise the language to state: "This [policy] [certificate] is not major medical insurance and does not replace it."

Schallhorn expressed concern with the use of the word "for" in the proposed statement language for hospital indemnity and other fixed indemnity coverage. He said using this word seems to imply that the coverage will pay the cost of the actual expenses for a covered hospitalization or for a covered event resulting from a sickness or injury, which is not how these coverages function. He suggested deleting "for" and replacing it with "as a result of." Burns noted the Subgroup's extensive discussion during its June 29 meeting on the issue and the potential for consumers to not understand what that phrase means. After additional discussion, the Subgroup decided to accept Schallhorn's suggested revision. To avoid duplicative language, the Subgroup also agreed to revise the statement language for hospital indemnity to delete the words "resulting from" and replace them with "due to."

The Subgroup agreed to defer discussion of the remaining suggested statement language for STLD plans and dental and vision coverage until its July 24 meeting.

Having no further business, the Accident and Sickness Insurance Minimum Standards (B) Subgroup adjourned.

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Draft: 7/13/23

Accident and Sickness Insurance Minimum Standards (B) Subgroup
Virtual Meeting
June 29, 2023

The Accident and Sickness Insurance Minimum Standards (B) Subgroup of the Regulatory Framework (B) Task Force met June 29, 2023. The following Subgroup members participated: Andy Schallhorn, Co-Chair (OK); Rachel Bowden, Co-Chair (TX); Shannon Doheny (FL); Robert Wake (ME); Camille Anderson-Weddle (MO); Martin Swanson and Maggie Reinert (NE); Shari Miles (SC); Heidi Clausen (UT); Anna Van Fleet and Jamie Gile (VT); and Shari Maier (WA).

1. Discussed Small Stakeholder Group Revisions to Section 9A of Model #171

The Subgroup discussed the small stakeholder group's suggested revisions to Section 9A—Required Disclosure Provisions of the *Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act* (#171) intended to reflect the Subgroup's discussion of the NAIC consumer representatives' suggested disclosure statement language during its May 15 meeting.

J.P. Wieske (Horizon Government Affairs) said following the Subgroup's May 15 meeting, a small group of stakeholders, including industry and consumer representatives, discussed potential revisions to the NAIC consumer representatives' suggested language for the disclosure statements required to be provided to consumers under Section 9A. This discussion aimed to address the Subgroup's concerns that the suggested language could be misleading to consumers about the type of benefit the product is providing. The Subgroup discussed the revised statement language for hospital indemnity and other fixed indemnity. After discussion, the Subgroup preliminarily agreed to the following revised statement language for hospital indemnity and other fixed indemnity:

Hospital Indemnity

"This [policy] [certificate] pays fixed dollar benefits for covered hospitalization resulting from a sickness or injury. The benefit amounts are not based on the cost of your medical expenses. These benefits are designed to be paid to the [policyholder] [certificate holder]. They are not intended to be paid directly to providers. This [policy] [certificate] is supplementary and not intended to replace major medical insurance. Read the description of benefits provided along with your [enrollment form /application] carefully."

Other Fixed Indemnity

"This [policy] [certificate] pays fixed dollar benefits for covered events resulting from a sickness or injury. The benefit amounts are not based on the cost of your medical expenses. These benefits are designed to be paid to the [policyholder] [certificate holder]. They are not intended to be paid directly to providers. This [policy] [certificate] is supplementary and not intended to replace major medical insurance. Read the description of benefits provided along with your [enrollment form /application] carefully."

The Subgroup also agreed to delete the word "review" in the last sentence of each of the revised statements and replace it with the word "read."

The Subgroup next discussed the disability income revised statement language. After discussion, the Subgroup agreed to revise the language to make it more consumer-friendly by deleting the words “set length of time” and substituting them with “specific period of time.” The Subgroup also agreed to delete the words “as a result of” and replace them with the word “from.”

The Subgroup next discussed the accident-only revised statement language. The Subgroup agreed to make the same revisions to the language it made to the disability income statement language.

The Subgroup discussed the revised statement language for specified disease coverage, specified accident coverage, and limited benefit coverage. After discussion, the Subgroup agreed to delete duplicative language in each.

The Subgroup asked NAIC staff to distribute prior to its next meeting on July 10 the revised statement language reflecting the Subgroup’s discussion for the Subgroup’s review during that meeting. The Subgroup also plans to continue its discussion of the NAIC consumer representatives’ comments on Section 9A during its July 10 meeting.

Having no further business, the Accident and Sickness Insurance Minimum Standards (B) Subgroup adjourned.

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Draft: 5/17/23

Accident and Sickness Insurance Minimum Standards (B) Subgroup
Virtual Meeting
May 15, 2023

The Accident and Sickness Insurance Minimum Standards (B) Subgroup of the Regulatory Framework (B) Task Force met May 15, 2023. The following Subgroup members participated: Andy Schallhorn, Co-Chair (OK); Rachel Bowden, Co-Chair (TX); Stephen F. Flick (DC); Chris Struk (FL); Camille Anderson-Weddle (MO); Martin Swanson (NE); Shari Miles (SC); Tanji J. Northrup and Heidi Clausen (UT); Anna Van Fleet and Jamie Gile (VT); and Lichiou Lee (WA).

1. Continued Discussion of Comments Received on Section 9 of Model #171

The Subgroup continued its discussion of the comments received on Section 9—Required Disclosure Provisions of the *Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act* (#171), beginning with the NAIC consumer representatives' comments for Section 9A(2)—Hospital Indemnity or Other Fixed Indemnity Coverage.

Jolie H. Matthews (NAIC) said that during its April 24 meeting, the Subgroup discussed, from a regulatory perspective, the appropriateness of including specific readability and accessibility requirements for consumer disclosures when such requirements are most likely already in other state laws and regulations, as well as other NAIC models. The Subgroup discussed this issue. After extensive discussion, the Subgroup decided not to accept the NAIC consumer representatives' suggested language on accessibility. The Subgroup decided to add a drafting note to Section 9A(2), alerting states to refer to their state laws and regulations and applicable NAIC models for provisions related to consumer disclosure readability and accessibility standards.

The Subgroup discussed the NAIC consumer representatives' suggested language for the statement in Section 9A(2) to be provided to consumers before submission of a completed application for coverage on hospital indemnity or other fixed indemnity coverage. The Subgroup raised a concern about the language because it seems to state that this type of coverage provides a benefit when it pays a fixed dollar amount triggered by a hospital stay or other covered health-related event regardless of the actual expense amount. The Subgroup discussed the issue, including other potential language to address it, but deferred deciding on what word to use until its May 22 meeting because of the NAIC consumer representatives' concerns that consumers would not understand the meaning of the word "trigger." The Subgroup did agree to bracket both "hospital stay" and "other covered health-related event."

The Subgroup next discussed the NAIC consumer representatives' suggested revisions to Section 9A(3). This provision outlines the statement to be provided to consumers on disability income protection coverage. The other suggested language on readability and accessibility requirements for the statement is identical to the suggested language for Section 9A(2). Based on the Subgroup's discussion on Section 9A(2), the Subgroup agreed to make the same changes to Section 9A(3). The Subgroup discussed the suggested language for the statement. The Subgroup did not have any initial concerns with the suggested statement language.

The Subgroup next discussed the NAIC consumer representatives' suggested revisions to Section 9A(4). This provision outlines the statement to be provided to consumers on accident-only coverage. The other suggested language on readability and accessibility requirements for the statement is identical to the suggested language for Section 9A(2). Based on the Subgroup's discussion on Section 9A(2), the Subgroup agreed to make the same

changes to Section 9A(4). The Subgroup discussed the suggested language for the statement. The Subgroup did not have any initial concerns with the suggested statement language.

The Subgroup next discussed the NAIC consumer representatives' suggested revisions to Section 9A(5). This provision outlines the statement to be provided to consumers on specified disease coverage. The other suggested language on readability and accessibility requirements for the statement is identical to the suggested language for Section 9A(2). Based on the Subgroup's discussion on Section 9A(2), the Subgroup agreed to make the same changes to Section 9A(5). The Subgroup discussed the suggested language for the statement. Like its discussion about the potential issues with the statement for hospital indemnity or other fixed indemnity coverage in Section 9A(2), the Subgroup discussed concerns that the statement could be misleading because it seems to imply the coverage to be provided under a specified disease policy is for diagnosing and treating a specified disease. The Subgroup agreed to revisit the issue during its May 22 meeting.

Having no further business, the Accident and Sickness Insurance Minimum Standards (B) Subgroup adjourned.

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Draft: 5/16/23

Accident and Sickness Insurance Minimum Standards (B) Subgroup
Virtual Meeting
April 24, 2023

The Accident and Sickness Insurance Minimum Standards (B) Subgroup of the Regulatory Framework (B) Task Force met April 24, 2023. The following Subgroup members participated: Andy Schallhorn, Co-Chair (OK); Rachel Bowden, Co-Chair (TX); Chris Struk and Shannon Doheny (FL); Robert Wake (ME); Camille Anderson-Weddle (MO); Martin Swanson and Maggie Reinert (NE); Shari Miles (SC); Shelley Wiseman and Heidi Clausen (UT); Anna Van Fleet and Jamie Gile (VT); and Ned Gaines (WA).

1. Discussed Comments Received on Section 9 of Model #171

The Subgroup discussed the comments received on Section 9—Required Disclosure Provisions of the *Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act* (#171), beginning with the NAIC consumer representatives' comments. Before discussing the comments, Lucy Culp (Leukemia & Lymphoma Society—LLS) asked if the Subgroup is planning to return to the short-term, limited-duration (STLD) plan provision considering the potential changes to the federal rules regulating those plans. Jolie H. Matthews (NAIC) said she did not believe this would be necessary because the proposed language for the STLD plan provision in Model #171 links the regulatory requirements for these plans with the state's regulatory requirements. Matthews also noted that the revisions to Model #171's companion model, the *Supplementary and Short-Term Health Insurance Minimum Standards Model Act* (#170) (formerly known as the *Accident and Sickness Insurance Minimum Standards Model Act*), took a similar approach. J.P. Wieske (Horizon Government Affairs), as an employee of the Wisconsin Department of Insurance (DOI) and chair of the NAIC group that revised Model #170, agreed with Matthews.

The Subgroup discussed the NAIC consumer representatives' comments on Section 9A—General Rules. Before explaining the comments, Culp asked if the Subgroup would consider the NAIC consumer representatives' request to have another NAIC group, such as the Consumer Information (B) Subgroup, review this section because of its subject matter expertise in this area of consumer disclosures. The Subgroup discussed Culp's suggestion. After discussion, the Subgroup decided to move forward with its review of the comments received on Section 9.

Culp explained that the NAIC consumer representatives' suggested revisions would provide a specific disclosure provision for each type of product regulated under Model #171. She explained that the rationale for this approach is that the disclosure statement for each type of product would vary depending on the product. As such, it makes sense to allow for that variability and for the Subgroup to discuss the language for each disclosure statement and why it would be different based on the type of product rather than discussing a universal disclosure statement.

Chris Petersen (Arbor Strategies LLC) expressed concern with the NAIC consumer representatives' suggested new language for Section 9A(1), which states: "Any disclosures, and the documents to which they refer, must be delivered in the same written medium as the application to consumers. These documents must be available no later than 24 hours before a completed application is submitted by the consumer to the issuer." He said the language is problematic because it seems to prohibit providing the application and other documents electronically, despite a consumer requesting only electronic communications. He said another problem is that the language appears to suggest the insurer is to gather information about the consumer and deliver a disclosure before the consumer submits an application, which raises potential privacy concerns. The Subgroup discussed the potential new language. After discussion, the Subgroup revised the language to read as follows: "Any disclosures,

and the documents to which they refer, must be delivered in the written medium requested by the consumer. These documents must be available before the consumer submits a completed application.”

The Subgroup next discussed the NAIC consumer representatives’ suggested disclosure language for Section 8B—Hospital Indemnity or Other Fixed Indemnity Coverage. Culp explained that the NAIC consumer representatives suggest revising Section 9A(2)(a) so that it only applies to hospital indemnity or other fixed indemnity coverage. She said other revisions suggest using a sans-serif font for the required statement and the proximity of the statement to the applicant’s signature block. Petersen asked why the NAIC consumer representatives suggest the sans-serif font. Culp said NAIC consumer representatives with expertise in consumer disclosures suggested that font type. Petersen also questioned if any of these provisions related to font type and font size would conflict with other state readability laws and regulations. He asked if the *Uniform Individual Accident and Sickness Policy Provision Law* (#180) would include such requirements and, if so, whether it would be appropriate to include the NAIC consumer representatives’ suggested language in Model #171 instead of relying on Model #180’s provisions. Another stakeholder suggested the Subgroup review the *Life and Health Insurance Policy Language Simplification Model Act* (#575). Culp said she would be concerned with separating these requirements from Model #171 and having to refer to provisions in another model. Wieske raised an issue from a regulatory perspective with the NAIC consumer representatives’ product-by-product approach if an insurer combines products. He said if separate disclosures are required for each product, then it could be confusing to consumers if the insurer combines one or more products.

The Subgroup discussed a possible way to streamline the NAIC consumer representatives’ suggested language. The Subgroup also discussed whether to include a drafting note acknowledging the existence of other state readability and accessibility requirements.

In discussing the NAIC consumer representatives’ proposed statement for hospital indemnity or other fixed indemnity coverage, the Subgroup did not have any concerns with the proposed language. Cindy Goff (American Council of Life Insurers—ACLI) said there could be an issue with the statement’s accuracy if hospital indemnity and other fixed indemnity are sold separately. The Subgroup discussed her concern. Bowden said she would not object to including brackets around both “hospital stays” and “other covered health-related event” to address the concern. She said she could also support adding a drafting note alerting insurers that, subject to the insurance commissioner’s approval, they may modify the statement, as needed, for accuracy for a specific product type. The Subgroup did not reach a decision on whether to accept these suggested revisions.

Having no further business, the Accident and Sickness Insurance Minimum Standards (B) Subgroup adjourned.

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Draft: 4/26/23

Accident and Sickness Insurance Minimum Standards (B) Subgroup
Virtual Meeting
April 17, 2023

The Accident and Sickness Insurance Minimum Standards (B) Subgroup of the Regulatory Framework (B) Task Force met April 17, 2023. The following Subgroup members participated: Andy Schallhorn, Co-Chair (OK); Rachel Bowden, Co-Chair (TX); Chris Struk (FL); Camille Anderson-Weddle (MO); Maggie Reinert (NE); Shari Miles (SC); and Tanji J. Northrup, Shelley Wiseman, and Heidi Clausen (UT).

1. Continued the Discussion of Section 7F of Model #171

The Subgroup continued its discussion of the comments received on Section 7F—Prohibited Policy Provisions of the *Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act* (#171) beginning with the Texas Department of Insurance’s (DOI’s) comments. Section 7F prohibits a policy from limiting or excluding coverage by type of illness, accident, treatment, or medical condition, except as provided in the subsection.

Bowden said her first comment on whether the exclusions in Section 7F are appropriate for short-term, limited-duration (STLD) plans was addressed during the Subgroup’s March 27 meeting. The Subgroup discussed Bowden’s next comment on Section 7F(4) concerning the exclusion of an illness, treatment, or medical condition arising out of war or an act of war (whether declared or undeclared). The Subgroup discussed how this provision would apply to acts of terrorism. After discussion, the Subgroup decided to leave the provision unchanged because of certain court rulings and other decisions related to acts of terrorism, finding that acts of terrorism are generally not considered acts of war. The Subgroup next discussed Bowden’s comments on Section 7F(8) concerning the exclusion for treatment provided in a government hospital. After discussion, the Subgroup agreed to delete the provision because it is no longer an issue for industry. Bowden said the Subgroup addressed her next comment related to the exclusion for dental care or treatment during its March 27 meeting.

The Subgroup next discussed Bowden’s comment on the territorial limitations exclusion. The Subgroup discussed what this provision means and whether the exclusion is related to territories outside the U.S. or a specific state in the U.S. The Subgroup discussed whether it should clarify the provision to note that it applies to territories outside the U.S. After discussion, which included a discussion of the impact of such a change with respect to the U.S. territories and possible confusion on whether the exclusion applies to U.S. territories, the Subgroup decided to leave the provision unchanged but add a drafting note explaining the intent of the provision.

The Subgroup next discussed the Health Benefit Institute’s (HBI’s) suggestion to add an exclusion to Section 7F for “genetic testing not ordered by a medical provider, and not used to diagnose or treat a disease.” The Subgroup discussed the comments. During the discussion, the Subgroup discussed whether medical necessity requirements would address the situation without adding the suggested language. The Subgroup noted that states generally do not apply their utilization review requirements to excepted benefit plans; as such, there would not be a medical necessity review. Cindy Goff (American Council of Life Insurers—ACLI) said she believes the purpose of adding the suggested language is to ensure that insurers can include a requirement in the contract that a health care provider must order the genetic testing to be covered. If a health care provider does not order it, then coverage is excluded. Goff said without this provision, a covered person could challenge the denial of coverage. After additional discussion, the Subgroup agreed to add the exclusion.

The Subgroup next discussed the NAIC consumer representatives' suggestion to delete Section 7G. Section 7G provides that Model #171 shall not impair or limit the use of waivers to exclude, limit, or reduce coverage or benefits for the specifically named or prescribed preexisting diseases, physical conditions, or extra hazardous activities. The Subgroup discussed the rationale for having such a provision and why it appears to benefit consumers. Goff said she believes this provision benefits consumers because it allows insurers to exclude certain pre-existing conditions without having to exclude coverage for the entire disease. She said this provision gives insurers more flexibility with respect to decisions related to the coverage of pre-existing conditions and other conditions not related to the pre-existing condition. The Subgroup discussed how this provision may or may not relate to Model #171's disclosure provisions. After additional discussion, the Subgroup deferred deciding on whether to accept the NAIC consumer representatives' suggestion to delete Section 7G until it completes its review of all the comments received on Model #171.

The Subgroup next turned to the NAIC consumer representatives' suggestions for adding new provisions to Section 7. The Subgroup deferred discussion of the suggested additional provisions until it completes its review of all the comments received on Model #171.

2. Discussed the Comments Received on Section 8H of Model #171

The Subgroup next discussed the comments received on the proposed Section 8H—Short-Term, Limited-Duration Health Insurance Coverage. The Subgroup only received comments from the NAIC consumer representatives. Anna Howard (American Cancer Society Cancer Action Network—ACS CAN) explained that the NAIC consumer representatives' suggestion to revise Section 8H(1) for consistency with similar language in Model #171's companion model, the *Supplementary and Short-Term Health Insurance Minimum Standards Model Act* (#170) (formerly known as the *Accident and Sickness Insurance Minimum Standards Model Act*). The Subgroup accepted the suggested revisions.

The Subgroup next discussed the NAIC consumer representatives' suggestion to revise the coinsurance percentage in Section 8H(2)(ii) to no more than "50%" of covered charges to no more than "20%" of covered charges. They also suggest striking "or" and substituting "and." Howard said the NAIC consumer representatives believe that a 50% coinsurance of covered charges in an STLD plan is too high of a percentage for consumers to potentially pay. After discussion, the Subgroup decided not to accept the suggested revision to the coinsurance percentage. The Subgroup accepted the suggested revision to strike "or" and substitute "and." The Subgroup next discussed the NAIC consumer representatives' suggestion to revise the provision's drafting note to delete the sentence suggesting that those states that have severely limited coverage time frames with limited renewals or extensions should apply smaller annual and lifetime limits and out-of-pocket maximums. The Subgroup did not accept the suggested revision, but because of impending changes to the federal rules regulating STLD plans, the Subgroup agreed to delete the last sentence in the drafting note suggesting that those states that allow coverage up to the federal maximum of three years might want to consider different limits.

No comments were received on Section 8H(3). The Subgroup discussed the NAIC consumer representatives' suggestion to delete Section 8H(4)(iii). This provision would require an insurer to include a statement in the STLD plan that the insurer retains the right, at the time of policy renewal, to make changes to the premium rate by class. After discussion, the Subgroup agreed to delete the provision, but it agreed to revisit the decision, if necessary.

No comments were received on Section 8H(5). The Subgroup discussed the NAIC consumer representatives' suggestion to add the word "intentionally" to Section 8H(6) to provide that a carrier may not rescind an STLD plan during the coverage period unless the insured "intentionally" fails to disclose a prior diagnosis of a health condition. After discussion, the Subgroup accepted the suggested revision.

No comments were received on Section 8H(7). The Subgroup discussed the NAIC consumer representatives' suggestion to revise the number of days an insurer must notify an insured of policy cancellation or rescission prior to the cancellation or rescission from 20 days to 30 days in Section 8H(8). After discussion, the Subgroup accepted the suggested revision.

Jolie H. Matthews (NAIC) pointed out a sentence in the drafting note for Section 8H(8) referencing the current federal rules for STLD plans, which limit coverage under such plans to less than 12 months and provide for a maximum duration of coverage of no longer than 36 months. The Subgroup decided to retain the sentence and revisit it after the release of the anticipated federal proposed rules on STLD plans.

The Subgroup next discussed the NAIC consumer representatives' suggestion to add a new provision to Section 8H prohibiting an insurer from issuing an STLD plan during the annual enrollment periods for individual health insurance and individual health insurance marketplace plans. The Subgroup discussed the pros and cons of adding such a provision. The Subgroup decided to defer the discussion until a later date.

Matthews pointed out for the Subgroup's future discussion a note to the Subgroup at the end of Section 8H suggesting that the Subgroup may want to consider adding language on pre-existing conditions to the subsection. The note to the Subgroup also alerts the Subgroup that it will have to craft a definition of "pre-existing condition" for STLD plans because the current definition of "pre-existing condition" in Section 6J applies to all coverages regulated under Model #171 except STLD plans.

Having no further business, the Accident and Sickness Insurance Minimum Standards (B) Subgroup adjourned.

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Draft: 4/25/23

Accident and Sickness Insurance Minimum Standards (B) Subgroup
Virtual Meeting
March 27, 2023

The Accident and Sickness Insurance Minimum Standards (B) Subgroup of the Regulatory Framework (B) Task Force met March 27, 2023. The following Subgroup members participated: Andy Schallhorn, Co-Chair (OK); Rachel Bowden, Co-Chair (TX); Debra Judy (CO); Howard Liebers (DC); Chris Struk (FL); Camille Anderson-Weddle (MO); Maggie Reinert (NE); Shari Miles (SC); Shelley Wiseman and Heidi Clausen (UT); Anna Van Fleet, Jamie Gile, and Mary Block (VT); and Ned Gaines (WA).

1. Continued Discussion of Section 7F of Model #171

The Subgroup continued its discussion of the comments received on Section 7F—Prohibited Policy Provisions of the *Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act* (#171) beginning with the NAIC consumer representatives' comments on this subsection. Section 7F prohibits a policy from limiting or excluding coverage by type of illness, accident, treatment, or medical condition, except as provided in the subsection.

The Subgroup discussed the NAIC consumer representatives' suggestion to delete Section 7F(2), which provides an exclusion for "mental or emotional disorders, alcoholism and drug addiction." Jackson Williams (Dialysis Patient Citizens—DPC) said the NAIC consumer representatives' suggestion to delete this exclusion relates to the issue of whether the products regulated under Model #171 should include a mental health parity component. He said he has identified someone to speak on this issue, and he requested that the Subgroup defer discussion of this issue until this individual could present during an upcoming Subgroup meeting. The Subgroup discussed the issue, noting that federal mental health parity requirements do not apply to excepted benefit plans. The Subgroup also discussed whether there should be a difference between what short-term, limited-duration (STLD) plans should be required to cover versus what excepted benefit plans should be required to cover. After discussion, the Subgroup decided not to accept the NAIC consumer representatives' suggestion to delete Section 7F(2). In addition, the Subgroup decided not to hold a broad discussion of the mental health parity coverage issue related to excepted benefit plans, noting that based on the discussion, few states would require excepted benefit plans to cover mental health benefits. The Subgroup agreed to add a drafting note to the subsection explaining that states should decide if any of the exclusions allowed in Section 7F should apply to STLD plans.

The Subgroup next discussed the NAIC consumer representatives' suggestion to delete Section 7F(4)(b) concerning an exclusion related to suicide and Section 7F(4)(e) concerning an exclusion for incarceration with respect to disability income protection policies. The Subgroup discussed the rationale for such exclusions. The Subgroup returned to its discussion about how Section 7F should apply to STLD plans and whether there should be a specific carve-out included in this provision for STLD plans. After additional discussion, the Subgroup decided not to accept the NAIC consumer representatives' suggestion to delete Section 7F(3)(b) and Section 7F(3)(e). The Subgroup also agreed to revise the drafting note it had agreed to add earlier concerning STLD plans to add a sentence that some of the exclusions listed in Section 7F may not be appropriate for STLD plans, and each state will have to determine which should apply, if any, to such plans. The Subgroup did not accept the NAIC consumer representatives' suggested drafting note for Section 7F(5) because it seems unnecessary. The Subgroup decided during its March 13 meeting to preliminarily accept the NAIC consumer representatives' suggestion to add the language "to improve the function of a malformed body part," subject to additional clarification on the meaning of "malformed."

The Subgroup accepted the NAIC consumer representatives' suggestion to clarify Section 7F(7) by adding the word "chiropractic."

The Subgroup accepted the NAIC consumer representatives' suggestion to add language to Section 7F(9) modifying the exclusion to have it not apply when the provision of dental services is medically necessary due to the underlying medical condition or clinical status of the covered person. The Subgroup did not accept the NAIC consumer representatives' suggested new drafting note for the provision.

The Subgroup next discussed the NAIC consumer representatives' suggestion to delete "routine physical examinations" in Section 7F(11). The Subgroup did not accept the suggestion.

The Subgroup next discussed the Vermont Department of Insurance's (DOI's) suggestion to add a drafting note to Section 7F(2), noting that the exclusion related to mental or emotional disorders, alcoholism, and drug addiction is optional, and states should review the desirability of its use for certain products regulated under the Model #171.

Having no further business, the Accident and Sickness Insurance Minimum Standards (B) Subgroup adjourned.

SharePoint/NAIC Support Staff Hub/Member Meetings/B CMTE/RFTF/Accident and Sickness Subgrp/Accident and Sickness Ins Min Stds Subgrp 3-27-23MtgMin.docx

Draft: 8/17/23

Employee Retirement Income Security Act (ERISA) Working Group
Seattle, Washington
August 13, 2023

The Employee Retirement Income Security Act (ERISA) (B) Working Group of the Regulatory Framework (B) Task Force met Aug. 13, 2023. The following Working Group members participated: Andria Seip, Chair (IA); Crystal Phelps (AR); Debra Judy (CO); Julie Holmes (KS); Robert Wake, (ME); Carrie Couch (MO); Michael Muldoon, Maggie Reinert, and Margaret Garrison (NE); Ted Hamby (NC); Laura Miller and Craig Kalman (OH); Andrew Schallhorn (OK); Jill Kruger (SD); Tanji J. Northrup (UT); Charles Malone (WA); and Jennifer Stegall (WI). Also participating were: D.J. Bettencourt (NH); and Erin K. Hunter (WV).

1. Heard an Update from the DOL

Amber Rivers (U.S. Department of Labor—DOL) and Beth Baum (DOL) gave an update on two tri-agency proposals from the DOL, the U.S. Department of Health and Human Services (HHS), and the Internal Revenue Service (IRS). Rivers explained that the short-term, limited-duration insurance (STLDI)/fixed indemnity notice of proposed rulemaking (NPRM) proposes rules to amend the definition of STLDI, which is excluded from the definition of individual health insurance coverage under the federal Public Health Service Act and sets forth proposed amendments to the requirements for hospital indemnity or other fixed indemnity insurance to be considered an excepted benefit in the group and individual health insurance markets. Rivers said the proposed rule also solicits comments on the specified disease excepted benefits coverage and level-funded arrangements. Rivers said lastly, there is a proposal from the U.S. Department of the Treasury (Treasury Department) and the IRS that would clarify the tax treatment of certain fixed amount benefit payments under employer-provided accident and health plans

Rivers explained that historically, STLDI coverage was designed to fill temporary gaps in coverage when an individual is transitioning from one plan to another. She said the proposal focuses on amending the definitions to better align with that original purpose by shortening some of the key terms. Rivers also pointed out that the proposal also clarifies responsibilities for sales through group trusts or associations, including that group market reforms apply when plans are marketed to employers as employer-sponsored coverage. She emphasized that the DOL would like help identifying additional strategies to make clear the difference between short term limited duration (STLD)/fixed indemnity plans and comprehensive health coverage.

Rivers explained that level-funded arrangements are an increasingly popular method of funding for group health plans, particularly with small employers. She said numbers from the Kaiser Family Foundation (KFF) reported that in 2020, 13% of small employers were using level-funded arrangements compared to 42% of small employers reporting in 2021. She said the plan purports to be self-funded. However, employers make set monthly payments to cover estimated claims and administrative costs, as well as the premiums for stop loss insurance for when claims surpass a maximum dollar amount. She said that, usually, if the number of claims paid during the year is lower than what the contributions are, the plan sponsor may receive a refund or carry it over to the next year.

Rivers said that while level-funded arrangements self-identify as self-funded, they have certain features that look like fully insured plans. She said there are concerns when these arrangements are used by small employers with particularly low attachment points. One of the concerns the DOL has heard is that a lot of benefits are being provided under the stop loss coverage, which is not required to comply with federal reforms or state laws that apply to health insurance coverage. Rivers explained that the DOL is concerned that level-funded plans may be

used to deny or limit individual claims in a way that would otherwise be prohibited. She said that small employers may not understand the type of arrangement they are in because that monthly payment looks like a premium, and they do not realize they are actually on the hook for outstanding charges. She said the DOL would like to better understand what is going on in the marketplace to determine whether additional guidance is needed. Comments on the STLD/fixed indemnity NPRM are due Sept. 11, and Rivers encouraged the NAIC and the individual states to submit comments.

Baum said that the DOL will be presenting Aug. 14 at the Mental Health Parity and Equity Addiction Act (MHPAEA) (B) Working Group meeting. She said that a package was released in July that includes: 1) proposed rules; 2) a technical release requesting comments; 3) the second MHPAEA comparative analysis report to the U.S. Congress (Congress); and 4) an enforcement fact sheet for cases closed in the fiscal year 2022. Baum said there are two components to the proposed rules package. The first component proposed changes to the existing regulations that are designed to strengthen protections and ensure that participants and beneficiaries have access to mental health and substance use disorder (MH/SUD) coverage. She said a lot of those changes are in the sections of the rules that apply to non-quantitative treatment limitations (NQTLs). The second component proposed changes to some of the defined terms in the existing regulations, as well as a new section of the regulations with more specific requirements for the comparative analysis required for NQTLs. Baum said the technical release is a kind of companion to the proposed rules and includes what would be a new requirement for plans and issuers to collect and evaluate relevant data on outcomes. The technical release requests comments on outcomes data that plans and issuers would be required to collect and evaluate. The comment deadline for this rule is Oct. 2.

2. Received an Update on Revisions to the NAIC MEWA/ MET Chart.

Jennifer Cook (NAIC) explained that she is in the process of surveying state insurance departments for the purpose of updating the NAIC chart on state laws addressing multiple employer welfare arrangements (MEWAs) and multiple employer trusts (METs). She said that Wake suggested that the chart could be a template for answering initial and follow-up questions, such as: 1) If a MEWA is not fully insured by an authorized insurer, does your state require some sort of MEWA-specific license or registration before the MEWA can lawfully provide coverage in your state? If so, what are the requirements?; 2) Can a MEWA based out-of-state lawfully provide coverage in your state? If so, what are the requirements?; 3) Can a domestic MEWA lawfully provide coverage in other states? If so, does your state have any specific regulatory requirements that apply?; and 4) What are your requirements for fully-insured MEWAs? Do they include standards requiring the maintenance of specified levels of reserves and specified levels of contributions, as authorized under ERISA § 514 (b)(6)(A)(i)? Cook said she would be following up after the meeting to solicit additional information for updating the chart. Seip said she would like to know how other states address MEWAs and that she supports the development of a comprehensive chart.

Wake said that it would be helpful to have a resource, as he is often the point person for state questions about MEWAs. He explained that there are several common questions about how to handle MEWAs that states should consider. One common question is how to handle MEWAs when there is no MEWA-specific state law, especially in cases where the MEWA is operating in more than one state. Wake said in interstate cases, it is important to coordinate, especially if a state is looking to defer to the domiciliary state or if the law requires it. He said another question that comes up is what the enforcement perspective is of a state when an arrangement starts doing business in a state and says it is not a MEWA, or if the arrangement does not really fit under the state's laws. Wake said that if the arrangement is not fully insured and not specifically authorized by the state, it is prohibited. Wake said states could also require some sort of license. Congress has left most of the regulation of MEWAs to the states for the past 40 years, and it is important for states to think about their options and how to interpret their own laws.

The ERISA (B) Working Group adjourned into regulator-to-regulator session, pursuant to paragraph 2 (pending investigations), paragraph 3 (specific companies, entities or individuals), and paragraph 8 (consideration of strategic planning issues relating to federal legislative and regulatory matters) of the NAIC Policy Statement on Open Meetings, to continue work on its goals.

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Draft: 4/10/23

Mental Health Parity and Addiction Equity Act (MHPAEA) (B) Working Group
Louisville, Kentucky
March 23, 2023

The MHPAEA (B) Working Group of the Regulatory Framework (B) Task Force met in Louisville, KY, March 23, 2023. The following Working Group members participated: Erica Weyhenmeyer, Chair (IL); Jane Beyer, Vice Chair (WA); Jimmy Harris (AR); Erin Klug (AZ); Kate Harris (CO); Kurt Swan (CT); Howard Liebers (DC); Andria Seip (IA); Julie Holmes (KS); Mary Kwei (MD); Peter Brickwedde (MN); Carrie Couch and Amy Hoyt (MO); Matthew Eberhardt (MT); Tracy Biehn (NC); Santana Edison (ND); Maureen Belanger (NH); Ralph Boeckman (NJ); Laura Miller (OH); Landon Hubbard and Ashley Scott (OK); David Buono (PA); Glynda Daniels (SC); Jill Kruger (SD); Rachel Bowden (TX); Tanji J. Northrup (UT); Julie Fairbanks (VA); Barbara Belling (WI); and Erin K. Hunter (WV).

1. Heard Presentations on *Wit v. United Behavioral Health*

Weyhenmeyer said speakers would inform the Working Group about the *Wit v. United Behavioral Health* case and its implications for mental health parity enforcement.

Brian Hufford (Zuckerman Spaeder) presented on the *Wit* case. He said the suit does not allege parity violations because the plaintiffs wanted to focus on the delivery of mental health services and not compare them to medical and surgical services. He said parity nonetheless had an impact on why the case was brought. He said plans used medical necessity guidelines to limit treatment even further than the quantitative limitations applied before the MHPAEA was passed. He said United Behavioral Health (UBH) limited its treatment to acute care and reduced the level of care after an acute episode. He said a trial court agreed that guidelines were overly restrictive in a 2019 decision. However, the Ninth Circuit appeals court overturned the decision and then later updated its decision to uphold in part the original ruling. He said four states require claims administrators to use specific guidelines.

Hufford said the newest decision included damaging findings related to the federal Employee Retirement Income Security Act (ERISA). He said plaintiffs had argued the company applied flawed guidelines. Therefore, the claims should be reprocessed. However, the Ninth Circuit ruled that reprocessing was not necessary. It also ruled that all class members had to have exhausted their administrative remedies such as internal and external appeals. He said plaintiffs are seeking further review of the decision, with support from 15 states; Washington, DC; and other organizations.

Hufford said UBH's guidelines were more restrictive than commonly accepted treatment standards. He provided examples, including applied behavioral analysis (ABA) and the treatment criteria established by the American Society for Addiction Medicine (ASAM). He said the court found that UBH lied to state insurance regulators regarding the guidelines they employed.

David Lloyd (The Kennedy Forum) provided comments on the importance of the *Wit* case. He said inappropriate medical necessity denials are a primary barrier to care. He said the Kennedy Forum has been pushing for inclusion of a definition of medical necessity in state and federal law. He said it has also advocated for making utilization review criteria consistent with generally accepted standards of care. He said some states have added a definition to their laws and that recently Georgia added it. Lloyd said professional medical societies have developed tools to show the level of care needed for patients, which provides a common standard for patients, providers, and payers. He said care decisions should be made using these tools and said some states have adopted rules to require them to be used. He said federal agencies have also made progress, including a federal Centers for Medicare & Medicaid

Services (CMS) requirement that Medicare Advantage plans made medical necessity determinations using appropriate guidelines. He said that regardless of the final decision in the Wit case, the issues will not go away.

Klug asked which state law definitions of medical necessity could serve as models for other states. Lloyd said laws in California, Georgia, Illinois, and Oregon are good models. Hufford said states should tie guidelines to generally accepted standards developed by medical societies, not those developed by private companies. He said that plans continue to limit treatment to only some parts of the ASAM guidelines. Klug asked whether the CMS definition of medical necessity used in Medicare is a good model. Lloyd said that it is pretty good.

Hoyt asked about exhaustion of administrative remedies. She said Missouri state law does not require internal review before a patient seeks external review. Hufford said prior decisions under federal law have required only a class representative to exhaust such remedies, but in the Wit case, the ruling requires all class members to do so. He said state laws would not be applicable to ERISA cases.

Having no further business, the MHPAEA (B) Working Group adjourned into regulator-to-regulator session, pursuant to paragraph 8 (consideration of strategic planning issues) of the NAIC Policy Statement on Open Meetings, to continue work on its goals.

SharePoint/NAIC Support Staff Hub/Member Meetings/B CMTE/RFTF/National Meetings/2023 Summer Meeting/MHPAEAWG Min 3.23.docx

Draft: 8/3/23

Pharmacy Benefit Manager Regulatory Issues (B) Subgroup
Virtual Meeting
July 27, 2023

The Pharmacy Benefit Manager Regulatory Issues (B) Subgroup of the Regulatory Framework (B) Task Force met July 27, 2023. The following Subgroup members participated: TK Keen, Chair (OR); Ashley Scott and Molly Clinkscales, Co-Vice Chairs (OK); Kayla Erickson and Sarah Bailey (AK); Steve Dozier (AL); Crystal Phelps (AR); Jared Kosky (CT); Howard Liebers (DC); Andria Seip (IA); Vicki Schmidt (KS); Sharon P. Clark and Daniel McIlwain (KY); Nina Hunter (LA); Chad Arnold and Karin Gyger (MI); Amy Hoyt, Cynthia Amann, and Camille Anderson-Weddle (MO); David Dachs (MT); Ted Hamby (NC); Cheryl Wolff (NE); Erin Porter (NJ); Paige Duhamel and Renee Blechner (NM); Eamon G. Rock (NY); Jodi Frantz (PA); Maggie Rosa (SC); Scott McAnally (TN); Ryan Jubber (UT); Don Beatty (VA); Jennifer Kreidler (WA); Jennifer Stegall (WI); and Jill Reinking and Tana Howard (WY).

1. Adopted its April 17 and Spring National Meeting Minutes

The Subgroup met April 17 to expose a draft of the pharmacy benefit manager (PBM) white paper for a 45-day public comment period ending June 1.

Scott made a motion, seconded by Arnold, to adopt the Subgroup's April 17 (Attachment Eleven-A) and March 22 (see *NAIC Proceedings – Spring 2023, Regulatory Framework (B) Task Force, Attachment Five*) minutes. The motion passed unanimously.

2. Adopted the PBM White Paper

Keen discussed the Subgroup's work to date on the PBM white paper. He noted the Subgroup's thoughtful discussions on extraordinarily complex issues and the collaborative process it followed throughout its work drafting the white paper. He said the current white paper draft the Subgroup is considering for adoption during this meeting includes revisions based on the comments received during the public comment period ending June 1. He asked for comments from Subgroup members.

Stegall expressed support for the white paper given the complexities of the issue. She said she believes it will be a great resource to state insurance regulators. Gyger also expressed support for the Subgroup's work, noting the Subgroup's collaborative process in drafting the white paper. She also noted the extensive stakeholder participation in the drafting process. She acknowledged that some stakeholders think additional edits should be made, but after almost two years of work, she believes the current white paper draft reflects the current state of play in the pharmaceutical drug supply chain and ecosystem and that it is time to move forward to the next step in the adoption process.

Kosky asked about the process moving forward assuming the Subgroup adopts the white paper during today's meeting. Keen said that if the Subgroup adopts the white paper during today's meeting, it will forward it to the Regulatory Framework (B) Task Force for its consideration and adoption. Following the Task Force's adoption, the Health Insurance and Managed Care (B) Committee would consider the white paper for adoption. Kosky said he wanted to make sure that this was the process moving forward because Connecticut still has concerns with the accuracy of some the information in the current white paper draft. He said that in addition, parts of the white paper lack citations for some of the statements. He said, generally, Connecticut is concerned with the overall lack of diversity and sources used for some of the information included in the white paper. He said Connecticut has concerns with the tone of some of the language as well. Kosky said that despite these concerns, Connecticut would

vote to support moving the white paper on to the next step in the process because it is important to move it along after more than two years of work. He said Connecticut will consider raising these concerns to the Regulatory Framework (B) Task Force as it considers the white paper.

Commissioner Clark echoed many of the comments already made about the Subgroup's work developing the white paper. Noting that its language will never be perfect to everyone, she expressed support for the white paper and moving it forward to the Regulatory Framework (B) Task Force for its consideration. Hoyt also expressed support for the white paper. She suggested, however, that because the white paper is intended to reflect a snapshot in time concerning the pharmaceutical drug supply chain and ecosystem, the Subgroup should consider including language in it clearly stating that intention. Keen expressed support for such language and the Regulatory Framework (B) Task Force adding it during its discussions on the white paper. He said there is an introduction section in the white paper that NAIC staff are using to track the white paper's development, which could be used to include the language she suggests. He also said that he considers the white paper to be the initial version, Version 1.0, because he believes that, as appropriate, other NAIC groups may want to revise it in the future to reflect changes, particularly with respect to any court decisions made after its adoption.

Keen asked for comments from interested parties. Carl Schmid (HIV+Hepatitis Policy Institute) noted the NAIC consumer representatives had suggested that the Subgroup develop the white paper. He also highlighted the Subgroup's work of approximately two years to complete the white paper and its inclusive process. He expressed support for moving the white paper forward despite the Subgroup not accepting many of the NAIC consumer representatives' suggested revisions.

Kris Hathaway (America's Health Insurance Plans—AHIP) also noted the Subgroup's deliberative and inclusive process in drafting the white paper. She said AHIP has three major concerns with the white paper as currently written. To address those concerns, AHIP believes the Subgroup should revise the white paper to: 1) fulfill the Subgroup's stated and agreed to charges because its focus is on PBMs and its failure to discuss the role of payors, wholesalers, pharmacy services administrative organizations (PSAOs), and other entities involved in the pharmaceutical supply chain; 2) remove non-objective, biased perspectives because there are sections of the white paper providing only one viewpoint; and 3) synthesize and streamline sections. Keen acknowledged AHIP's concerns. He said, however, that at this point in the process, he does not believe everyone agrees with AHIP's concerns about the white paper's biased language.

Peter Fjelstad (Pharmaceutical Care Management Association—PCMA) said the PCMA does not believe the current white paper version is a consensus document. He said the PCMA opposes its adoption. He suggested that because the PCMA does not consider it to be a consensus document, the Subgroup should include the comment letters it received on the white paper with their differing perspectives as an appendix to the paper. Keen acknowledged Fjelstad's comments. He explained that for him, the white paper is a consensus document because of the way the Subgroup members, given their different viewpoints, worked together and compromised on what the white paper should and should not include.

Joel Kurzman (National Community Pharmacists Association—NCPA) expressed appreciation for the Subgroup's work in developing the white paper. He said the NCPA has concerns about a few provisions in the white paper, particularly the language describing spread pricing. He said recent white paper revisions describing spread pricing as a risk mitigation pricing model legitimizes the practice. He said the real-life experience of NCPA members with spread pricing is vastly different. He also suggested that the white paper be carefully reviewed to ensure it does not include inaccurate and outdated views. Kurzman said that as other interested parties stated, the current white paper version does not reflect the NCPA's comments. He expressed hope that if the white paper is adopted, including its recommendation to consider developing model legislation, the NAIC would develop a robust model giving NAIC members the necessary tools to rigorously enforce PBM regulation. He said that assuming the

Subgroup adopts the white paper, he looks forward to working with the Regulatory Framework (B) Task Force to ensure that it incorporates moving forward some of the NCPA's previous suggestions, such as including language in the white paper recommending the creation of a standardized state-based system form for PBM complaints that will enable the NAIC and its Members to analyze and enforce regulation.

Will Dane (Healthcare Distribution Alliance—HDA) said the HDA submitted a comment letter suggesting the Subgroup revise a provision in the white paper concerning PSAOs for accuracy. Keen acknowledged the HDA's suggested revisions.

Sandra Guckian (National Association of Chain Drug Stores—NACDS) said that as other commenters have said, the NACDS' comments are not reflected in the current white paper draft. She said given this, as other comments have said, the NACDS may offer additional comments as the white paper moves forward to the Regulatory Framework (B) Task Force. She said like the NCPA, the NACDS would particularly like to add more language concerning the PBM complaint process.

Commissioner Clark made a motion, seconded by Scott, to adopt the PBM white paper (Attachment Eleven-B). The motion passed unanimously with the following Subgroup members present and voting: Alaska, Arkansas, California, Connecticut, District of Columbia, Iowa, Kansas, Kentucky, Michigan, Missouri, Montana, Nebraska, New Jersey, New Mexico, New York, North Carolina, Oklahoma, Pennsylvania, South Carolina, Tennessee, Utah, Virginia, Washington, Wisconsin, and Wyoming.

Having no further business, the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup adjourned.

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Draft: 4/18/23

Pharmacy Benefit Manager Regulatory Issues (B) Subgroup
Virtual Meeting
April 17, 2023

The Pharmacy Benefit Manager Regulatory Issues (B) Subgroup of the Regulatory Framework (B) Task Force met April 17, 2023. The following Subgroup members participated: TK Keen, Chair (OR); Ashley Scott and Molly Clinkscales, Vice Chair (OK); Anthony L. Williams (AL); Crystal Phelps (AR); Paul Lombardo and Michael Shanahan (CT); Brad Biren, Robert Koppin, and Brent Jambor (IA); Julie Holmes and Craig VanAalst (KS); Sharon P. Clark, Daniel McIlwain, Beth A. Taylor, and Jonathan Abbott (KY); Joshua Guillory (LA); Chad Arnold and Joe Stoddard (MI); Julia Dreier (MN); Amy Hoyt, Cynthia Amann, and Camille Anderson-Weddle (MO); Ted Hamby (NC); Cheryl Wolff (NE); Renee Blechner (NM); Eamon G. Rock (NY); Melissa Greiner (PA); Maggie Rosa (SC); Scott McAnally (TN); Tanji J. Northrup (UT); Don Beatty (VA); Ned Gaines (WA); Jennifer Stegall (WI); Michael Malone (WV); and Jill Reinking (WY).

1. Exposed a PBM White Paper for Public Comment

Keen said since the Subgroup's release of a working draft of the proposed pharmacy benefit manager (PBM) white paper during its meeting at the 2022 Fall National Meeting, the Subgroup has been working to refine and edit the working draft. He said the Subgroup met April 14 in regulator-to-regulator session to review a revised working draft and discuss issues related to the revised working draft. During this meeting, the Subgroup decided to expose the draft during today's meeting for a 45-day public comment period ending June 1. Keen said following the end of the public comment period, the Subgroup plans to hold meetings to review the comments received and update the draft based on those discussions. After the Subgroup completes its work, the Subgroup will forward the PBM white paper draft to the Regulatory Framework (B) Task Force for its consideration and adoption. Keen said following the Regulatory Framework (B) Task Force's adoption, the PBM white paper draft will be forwarded to the Health Insurance and Managed Care (B) Committee for its consideration and adoption.

Anna Howard (American Cancer Society Cancer Action Network—ACS CAN) asked about the type of comments stakeholders should submit and the Subgroup's process for reviewing the comments, such as a line-by-line review. Keen said the Subgroup is looking for comments on the language currently in the draft and additional language that should be added. He said for comments suggesting additional language, such comments should include the specific language to be added, not just a general comment. He said the Subgroup will determine its review process based on the type of comments received. He said he does not anticipate the Subgroup discussing the comments on a line-by-line basis, which is generally the review process for developing or revising NAIC models, but the Subgroup will determine its review process based on the type of comments received.

Without objection, the Subgroup exposed the PBM white paper draft (Attachment Eleven-A1) for a 45-day public comment period ending June 1.

Having no further business, the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup adjourned.

SharePoint/NAIC Support Staff Hub/Member Meetings/B CMTE/RFTF/PBM Regulatory Issues Subgrp/PBM Reg Issues MtgMin 4-17-23.docx

Draft: 4/16/23

Comments are being requested on this draft by June 1, 2023. Comments should be sent only by email to Jolie Matthews at jmatthews@naic.org.

GUIDE TO UNDERSTANDING PHARMACY BENEFIT MANAGER AND ASSOCIATED STAKEHOLDER REGULATION

NAIC White Paper Draft as of April 16, 2023

Drafted by the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup

TABLE OF CONTENTS

A. INTRODUCTION.....	3
B. KEY PLAYERS IN DRUG PRICING ECOSYSTEM.....	3
1. INSURERS.....	4
2. PRESCRIPTION DRUG MANUFACTURERS.....	4
3. PHARMACY BENEFIT MANAGERS.....	6
4. PHARMACIES.....	6
5. PHARMACISTS.....	7
6. PHARMACY SERVICES ADMINISTRATIVE ORGANIZATIONS.....	7
7. INTERRELATION OF PARTIES IN CHAIN AND TRANSACTION COSTS.....	8
C. ENFORCEMENT/FEDERAL PREEMPTION ISSUES.....	10
1. ERISA: SELF-INSURED AND FULLY INSURED.....	10
2. MEDICARE PART D.....	12
3. MEDICAID.....	13
D. FUNCTIONAL ISSUES.....	14
a. FORMULARY DESIGN.....	15
b. REBATES.....	15
c. PRICING AND CONTRACTING PRACTICES.....	17
d. VERTICAL INTEGRATION AND CONSOLIDATION.....	18
e. PHARMACY NETWORK ADEQUACY.....	19
f. LICENSING OF DIFFERENT ENTITIES INVOLVED IN THE DISTRIBUTION/SUPPLY CHAIN.....	20
E. STATE LAWS THAT OPERATE IN SUPPLY CHAIN.....	23
1. PHARMACY BENEFIT MANAGER REGULATION.....	23
a. STATE LAWS AND APPROACHES.....	23
b. DRUG PRICE TRANSPARENCY REGULATION.....	24
c. OTHER RELEVANT STATE LAWS AND PROPOSED LAWS.....	24
F. FEDERAL INTEREST AND POSSIBLE REGULATIONS.....	25
G. KEY JURISPRUDENCE.....	27
a. <i>PCMA v. RUTLEDGE</i>	27
b. <i>PCMA v. WEHBI</i>	29
c. <i>PCMA v. MULREADY</i>	30
H. RECOMMENDATIONS.....	31
Appendix 1: List of Subgroup meetings and topics.....	33

A. INTRODUCTION

The NAIC Regulatory Framework (B) Task Force established the NAIC Pharmacy Benefit Manager Regulatory Issues (B) Subgroup in 2018 to explore whether to develop a new NAIC model regulating pharmacy benefit managers (PBMs). In 2019, the Task Force adopted a charge for the Subgroup to, “[c]onsider developing a new NAIC model to establish a licensing or registration process for pharmacy benefit managers (PBMs). The Subgroup may consider including in the new NAIC model provisions on PBM prescription drug pricing and cost transparency.” The Subgroup developed a PBM model, which both the Regulatory Framework (B) Task Force and the NAIC Health Insurance and Managed Care (B) Committee adopted in 2021. However, at the NAIC 2021 Fall National Meeting, the proposed new PBM model failed to receive the necessary votes for adoption from the full NAIC membership. While it was discussing the proposed new PBM Model, in 2021, the Regulatory Framework (B) Task Force adopted a charge for the Subgroup to develop a white paper to: 1) analyze and assess the role pharmacy benefit managers (PBMs), Pharmacy Services Administrative Organizations (PSAOs), and other supply chain entities play in the provision of prescription drug benefits; 2) identify, examine and describe current and emerging state regulatory approaches to PBM business practices, such as price transparency and reporting requirements, rebating and spread pricing, including the implications of the *Rutledge vs. Pharmaceutical Care Management Association (PCMA)* decision on such business practices; and 3) discuss what challenges, if any, the states have encountered in implementing such laws and/or regulations.

After the proposed PBM model failed to receive sufficient votes for adoption, in early 2022, the Subgroup turned its focus on completing its charge to develop the white paper. Throughout 2022, the Subgroup held meetings to hear various stakeholders’, including consumers, PSAOs, insurers, and pharmacists, perspective on its charge to develop the PBM white paper. The Subgroup also heard presentations from various states that have enacted state laws regulating PBM business practices. The states discussed the process of enactment, their implementation process, and outstanding issues related to enforcement, including, in some cases, a discussion of enforcement challenges and lessons learned.

As the Subgroup was hearing the last few stakeholder presentations in a series of regulator-to-regulator meetings in July 2022 through September 2022, the Subgroup reviewed and approved an outline of the PBM white paper. Based on the outline, the Subgroup leadership solicited and obtained volunteers from the Subgroup members to draft initial language for the various provisions in the PBM white paper. The Subgroup reviewed an initial draft of the PBM white paper in October 2022. The Subgroup released a working draft of the PBM white paper during a meeting at the NAIC 2022 Fall National Meeting. Following the NAIC 2022 Fall National Meeting, the Subgroup met in early 2023 in a series of regulator-to-regulator meetings to discuss additional revisions to the working draft. On April 17, 2023, the Subgroup released a draft of the PBM white paper for a 45-day public comment period ending June 1, 2023.

[ADDITIONAL LANGUAGE WILL BE ADDED AS THE DRAFTING PROCESS MOVES FORWARD]

B. KEY PLAYERS IN PHARMACEUTICAL DRUG PRICING ECOSYSTEM

Inherent in the Subgroup’s review of the drug pricing ecosystem are the concerns of the consumer, the one key player who cannot see all of the levers before them but ultimately pays the price of the ecosystem that has been

put in place. Until very recently, pricing of pharmaceuticals has been opaque to many consumers.¹ However, increased costs of pharmaceutical drugs, several active campaigns by players in the ecosystem, increased federal and state attention on drug pricing, and drug price transparency programs have all operated to raise the consumer's knowledge of the cost levers of pharmaceutical drugs.

Pharmaceutical drugs are vital to both longevity and quality of life for many individuals. Not being able to afford lifesaving and life-improving prescriptions causes harm to patients and their families and contributes to additional burdens on our health care system. Some individuals can only afford prescriptions because they do so at the cost of other needs such as paying for housing and utility bills or addressing other medical issues. For these individuals there is a reduction in quality of life which can, and often does, affect overall health.² Affordability and access remain of high concern to consumers and lawmakers alike.

A 2021 poll by the Kaiser Family Foundation found that 60 percent of adults in the U.S. take at least one prescription drug and 25 percent take at least four per day. Of those prescribed medications, 29 percent of Americans reported not taking their medications as prescribed due to cost. They do this by not filling their medication, using an over-the-counter medication instead, or cutting the pills in half.³

It is the hope of the subgroup that by regulators gaining a greater understanding of the pharmaceutical drug ecosystem, research and price transparency programs, policymakers can better understand the levers that impact consumers. In so doing, consumers will see reduced costs for their pharmaceutical drugs.

Beyond the consumer, there are numerous players that make up the pharmaceutical drug ecosystem. Some of the key players in that ecosystem are described below.

1. INSURERS

Insurers contract with PBMs to manage the pharmacy benefit portion of their health care benefits provided to their insureds and enrollees.⁴ Insurers contract with PBMs because of the increasing complexity of prescription drug benefit management.⁵ In addition, in response to increasing prescription drug costs some insurers contract with PBMs for their services that help reduce costs, including utilization management, prescription drug rebates,

¹ See, e.g., the recent proliferation of drug price transparency programs across states, available as referenced by the National Academy for State Health Policy (NASHP): <https://nashp.org/prescription-drug-pricing-transparency-law-comparison-chart/>. At the time of this report, there are 13 states with drug price transparency programs.

² As indicated by Kaiser Family Foundation polls, Hamel, Liz et al. "Public Opinion on Prescription Drugs and Their Prices." Kaiser Family Foundation Polling, Oct. 20, 2022. <https://www.kff.org/health-costs/poll-finding/public-opinion-on-prescription-drugs-and-their-prices/>. Accessed Sept. 19, 2022. Discussed generally by Wisconsin's "Report of the Governor's Task Force on Reducing Prescription Drug Prices, p. 12, available at: <https://oci.wi.gov/Documents/AboutOCI/RxTaskForceFinalReport.pdf> and Oregon Drug Price Transparency reports 2019-2022 available at: <https://dfr.oregon.gov/drugtransparency/Pages/annual-reports.aspx>.

³ Hamel, Liz et al. "Public Opinion on Prescription Drugs and Their Prices." Kaiser Family Foundation Polling, Oct. 20, 2022. <https://www.kff.org/health-costs/poll-finding/public-opinion-on-prescription-drugs-and-their-prices/>. Accessed Sept. 19, 2022.

⁴ As discussed generally by Wisconsin's "Report of the Governor's Task Force on Reducing Prescription Drug Prices, p. 21, available at: <https://oci.wi.gov/Documents/AboutOCI/RxTaskForceFinalReport.pdf>.

⁵ *Id.*

and negotiation of pharmacy fees and prescription drug reimbursement, and access to pharmacy networks.⁶ Ultimately, the scope of the PBM's role in managing this benefit depends on the insurer.⁷

2. PRESCRIPTION DRUG MANUFACTURERS

Manufacturers

Pharmaceutical manufacturers research, develop, produce, market, and sell prescription drugs to treat medical conditions.⁸ The development of a new pharmaceutical product involves an investment of resources to create a product ready to be tested during clinical trials, where the safety and clinical efficacy of the drug are evaluated for a specific disease or condition.⁹ The U.S. Food and Drug Administration (FDA) reviews all applications for the sale of new drugs from manufacturers following clinical trials and decides whether the drug will be made available on the market to consumers.¹⁰ When a drug is approved, manufacturers then set the list price for medications and may change that price over time.¹¹

Brand manufacturers

Manufacturers who produce brand-name drugs may conduct the initial research and development of a new pharmaceutical product. Brand-name drugs receive patents and exclusivities from the FDA.¹² Manufacturers of these patent-protected brand-name products have market exclusivity to produce and sell their products during the life of the patent before therapeutically equivalent generic drugs can become available on the market.¹³

Generic manufacturers

Once a brand-name drug is no longer patent-protected, generic manufacturers may begin producing therapeutically equivalent generic drug products. Similar to brand-name drugs, the FDA must approve a generic drug application to ensure its equivalence to the branded drug before it can be produced.¹⁴ Generic drugs

⁶ *Id.*; Horvath Health Policy, *Innovations in Health Financing Policy* Presentation to the NAIC Pharmacy Benefit Manager Regulatory Issues (B) Subgroup, Aug. 15, 2019.

⁷ Report on Transparency Strategies for the Pharmaceutical Supply Chain – Pursuant to House Bill 4005 (2018), Oregon Joint Interim Task Force on the Fair Pricing of Prescription Drugs. November 2018.

[https://www.oregonlegislature.gov/committees/jfprx/Reports/House%20Bill%204005%20\(2018\)%20Report%20on%20Transparency%20Strategies.pdf](https://www.oregonlegislature.gov/committees/jfprx/Reports/House%20Bill%204005%20(2018)%20Report%20on%20Transparency%20Strategies.pdf).

⁸ As discussed generally by Wisconsin's "Report of the Governor's Task Force on Reducing Prescription Drug Prices, p. 18, available at: <https://oci.wi.gov/Documents/AboutOCI/RxTaskForceFinalReport.pdf>.

⁹ *Id.*

¹⁰ U.S. Food & Drug Administration. The FDA's Drug Review Process: Ensuring Drugs are Safe and Effective. < <https://www.fda.gov/drugs/information-consumers-and-patients-drugs/fdas-drug-review-process-ensuring-drugs-are-safe-and-effective>> Visited October 2022.

¹¹ As discussed generally at "A Tangled Web: An examination of the drug supply and payment chains", US Senate Committee on Finance, Minority Staff report, p. 4, available at: <https://www.finance.senate.gov/imo/media/doc/A%20Tangled%20Web.pdf>.

¹² U.S. Food & Drug Administration. Frequently Asked Questions on Patents and Exclusivity, available at: <https://www.fda.gov/drugs/development-approval-process-drugs/frequently-asked-questions-patents-and-exclusivity>.

¹³ *Id.*

¹⁴ U.S. Food & Drug Administration. Generic Drugs: Questions & Answers, available at: <https://www.fda.gov/drugs/frequently-asked-questions-popular-topics/generic-drugs-questions-answers..>

comprise the largest portion of the pharmaceutical market, approximately 90 percent of all drugs dispensed to consumers.¹⁵

Biologic manufacturers

Biologic manufacturers are distinct from traditional brand and generic manufacturers because they produce drug products made in living cells, such as monoclonal antibodies, antitoxins, and certain vaccines.¹⁶ Biologics are sometimes referred to as “large-molecule drugs.” Manufacturers of biologic drug products are also required to receive approval from the FDA to sell their products through a separate application process.¹⁷ Biologics approved by the FDA are granted 12 years of exclusivity, which is substantially longer than the five years typically granted to traditional small-molecule brand-name drugs.¹⁸ A biosimilar drug product may be produced following the expiration of the biologic’s patent and exclusivity period.¹⁹

Biosimilar manufacturers

Because of biologic drugs’ complexity, they are much more difficult to replicate than the chemically produced generics for other drugs. As a result, truly identical “generic” versions are currently virtually impossible to produce. However, once patents expire for the existing brand-name biologic drugs, “biosimilar” medicines can be produced, which is an occurrence that raises regulatory issues in the states. In recent years a cumulative total of at least 49 states have considered legislation establishing state standards for substitution of a “biosimilar” prescription product to replace an original biologic product.²⁰

Comparable to the relationship between brands and generics, biosimilars are required to be extremely similar to approved biologics by having no clinically meaningful differences – the same strength, dosage form, and route administration (such as injection).²¹ Many biologics and biosimilars are categorized as specialty drugs due to their complex structures using living organisms, the storage requirements needed, and the cost and complexity of administering the product to a consumer. According to the FDA, biologic and biosimilar drug products are the fastest growing class of therapeutic products in the U.S.²²

3. PHARMACY BENEFIT MANAGERS

¹⁵ U.S. Food & Drug Administration. Office of Generic Drugs 2021 Annual Report, available at: <https://www.fda.gov/drugs/generic-drugs/office-generic-drugs-2021-annual-report#:~:text=Currently%2090%20percent%E2%80%94%20out,they%20are%20on%20the%20market.>

¹⁶ Patient Protection and Affordable Care Act, 42 U.S.C. §262(i) (definition of “biological product”).

¹⁷ U.S. Food & Drug Administration. *Development & Approval Process (CBER)*, available at: <https://www.fda.gov/vaccines-blood-biologics/development-approval-process-cber>.

¹⁸ 42 U.S.C. §262(k)(7). Data exclusivity granted by the U.S. Food and Drug Administration to a drug manufacturer prevents other companies from relying on the same clinical data to obtain market approval.

¹⁹ 42 U.S.C. §262(k).

²⁰ National Conference of State Legislatures, *State Laws and Legislation Related to Biologic Medications and Substitution of Biosimilars*, May 3, 2019, available at: <https://www.ncsl.org/research/health/state-laws-and-legislation-related-to-biologic-medications-and-substitution-of-biosimilars.aspx>.

²¹ U.S. Food & Drug Administration. *Biosimilars: More Treatment Choices and Innovation*, available at: <https://www.fda.gov/consumers/consumer-updates/biosimilar-and-interchangeable-biologics-more-treatment-choices>.

²² U.S. Food & Drug Administration. *Biosimilar Product – Regulatory Review and Approval*, available at: <https://www.fda.gov/media/108621/download>.

PBMs negotiate and contract with all the various types of pharmacies, including independent pharmacies and pharmacy chains of all sizes, on reimbursement and pharmacy network related terms.²³ PBMs design, negotiate, implement, and manage formulary designs for prescription drugs, including negotiating rebates and drug coverage terms with pharmaceutical manufacturers.²⁴ PBMs are responsible for the design and implementation of preferred and non-preferred pharmacy networks, metric-based payment arrangements, and formulary design elements (drug coverage, out-of-pocket responsibilities for patients and utilization management protocols).²⁵ PBMs engage in the negotiation and financial transactions between pharmaceutical manufacturers, health plans, and pharmacies.²⁶

4. PHARMACIES

a. CHAIN

A pharmacy chain refers to a third party entity that engages in a retail business and that owns or operates multiple retail outlets at which an individual consumer may have a prescription drug order filled. The pharmacy retail outlet may also provide services that include providing immunizations, performing health screenings, testing at point-of-care, and providing medication counseling.²⁷

b. INDEPENDENT

Independent pharmacies refer to pharmacies that are privately and independently owned and operated by one or more pharmacists, and whose primary function is to provide direct pharmaceutical care to patients. These services include dispensing drugs, providing immunizations, performing health screenings, testing at point-of-care, and providing medication counseling in the community setting.²⁸

5. PHARMACISTS

The basic duty of a pharmacist is to check prescriptions from physicians and other authorized prescribers before dispensing the medication to the patients to ensure that the patients do not receive the wrong drugs or take an incorrect dose of medicine. Pharmacists also offer expertise in the safe use of prescriptions. They also may conduct health and wellness screenings, provide immunizations, oversee the medications given to patients, and provide advice on healthy lifestyles.

6. PHARMACY SERVICES ADMINISTRATIVE ORGANIZATIONS (PSAOs)

Pharmacy services administrative organizations (PSAOs) are organizations that provide administrative services to independent pharmacies to support the evaluation and execution of a contract with PBMs or wholesalers.²⁹ The PSAO overall administrative function is to assist with contract evaluation and execution, customer service,

²³ See, generally, “A Tangled Web” at p. 26-34.

²⁴ *Id.*

²⁵ *Id.*

²⁶ *Id.*

²⁷ Wisconsin’s “Report of the Governor’s Task Force on Reducing Prescription Drug Prices, p. 20; “A Tangled Web” generally at p. 39-40.

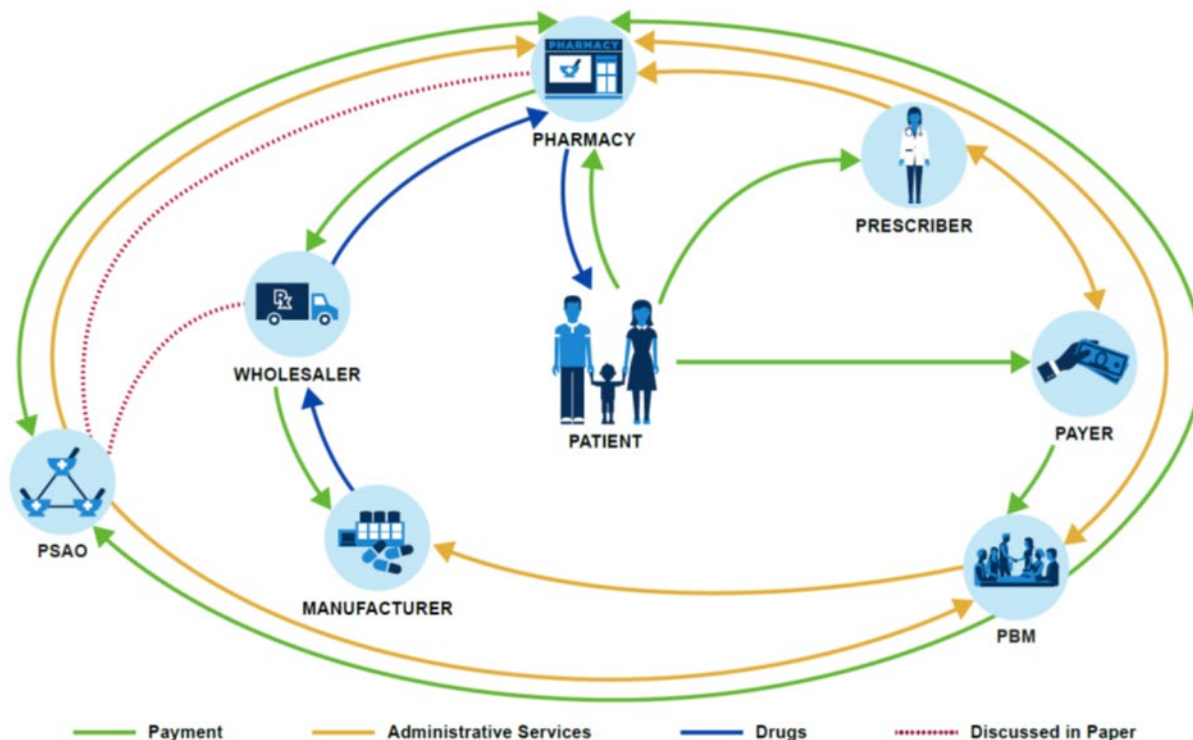
²⁸ *Id.*

²⁹ “A Tangled Web”, p. 34, 41.

central payment and reconciliation, and patient data evaluation.³⁰ In many instances a PSAO is owned by a wholesaler.³¹

7. INTERRELATION OF PARTIES IN THE CHAIN AND TRANSACTION COSTS

The diagram below provides a simplified illustration of the pharmaceutical distribution chain and the major entities involved that will be discussed in more detail in this section.³²



The following outlines the basic transactions that occur between the participants in the prescription drug supply chain system. For clarity, the transactions are organized into two categories: the physical distribution of a drug and the interactions on the pharmacy benefit side.

Physical Drug Distribution Chain

Pharmaceutical manufacturer and wholesaler

The pharmaceutical manufacturer provides prescription drugs to the wholesaler based on negotiated prices.³³ The average negotiated price is based on the wholesale acquisition cost (WAC) price set by the manufacturer.³⁴

Wholesaler and pharmacy

³⁰ *Id.*

³¹ Wisconsin's "Report of the Governor's Task Force on Reducing Prescription Drug Prices, p. 19.

³² Pharmaceutical Care Management Association (PCMA), "The Value of Pharmacy Benefit Management," Presentation to the NAIC Pharmacy Benefit Manager Regulatory Issues (B) Subgroup, Aug. 9, 2022

³³ Jane Horvath, Georgetown University, "Basics of the Pharmaceutical Market & PBMs," Presentation to the NAIC Pharmacy Benefit Manager Regulatory Issues (B) Subgroup, Aug. 19, 2019.

³⁴ *Id.*

The wholesaler sells their drugs to a pharmacy in an amount based on the WAC.³⁵ There are additional savings that can be achieved via volume rebates, functional rebates, bundle rebates, prompt pay discounts, free goods, marketing funds, and trade show discounts/rebates. The average wholesale price (AWP) is an estimate of the price wholesalers charge for drugs.³⁶ The National Average Drug Acquisition Cost (NADAC) is a federal Centers for Medicare and Medicaid Services (CMS)-calculated value that also attempts to capture the average price wholesalers charge to pharmacies.³⁷

Pharmacy and consumer

The pharmacy provides drugs directly to the consumer and collects certain cost sharing that may include co-pays or co-insurance.

Pharmacy Benefit Chain

Pharmaceutical manufacturer and PBM

The PBM negotiates rebates with the manufacturers, and rebates are typically based on volume. PBMs can offer manufacturers higher volume, and thus command higher rebates, by putting a manufacture's drug on the PBM's formulary and/or in a formulary's less expensive cost sharing tier.³⁸ Rebates create a market dynamic that may force up the "list" price of drugs by increasing the potential to generate "spread" profit.³⁹

Manufacturer and consumer

Pharmaceutical manufacturers can offer coupons or occasionally free samples of medications to consumers. The coupons can reduce a consumer's cost sharing below that which they would have paid had they used their pharmacy benefit plan.⁴⁰ If the coupon constitutes a third-party paying the consumer's cost share, some state laws require insurers to count this payment towards the consumer's deductible and pharmacy benefit maximum out of pocket amount.

PBM and PSAO

The PSAO assists the pharmacy in negotiating with the PBMs for reimbursement rates.⁴¹ Most reimbursement rates are set based on a percentage of AWP and are applicable to all drugs based on brand or specialty status, and are not negotiated on an individual drug basis.⁴²

Pharmacy and PBM

The pharmacy (mostly chains outside of PSAOs) negotiate with the PBM to determine a reimbursement rate for the drugs they dispense.⁴³ Like the PBM/PSAO relationship, negotiations are based on AWP less a percentage

³⁵ *Id.*; and generally, "A Tangled Web" at 21-25.

³⁶ *Id.*

³⁷ Jane Horvath, Georgetown University, "Basics of the Pharmaceutical Market & PBMs," Presentation to the NAIC Pharmacy Benefit Manager Regulatory Issues (B) Subgroup, Aug. 19, 2019.

³⁸ Wisconsin's "Report of the Governor's Task Force on Reducing Prescription Drug Prices, p. 21; "A Tangled Web" at 27.

³⁹ Dr. Neeraj Sood, "PBM Economics," Presentation to the NAIC Pharmacy Benefit Manager Regulatory Issues (B) Subgroup, Aug. 22, 2019.

⁴⁰ Wisconsin's "Report of the Governor's Task Force on Reducing Prescription Drug Prices, p. 50.

⁴¹ *Id.* at 19.

⁴² *Id.*

⁴³ Horvath; Wisconsin's "Report of the Governor's Task Force on Reducing Prescription Drug Prices, p. 21.

and apply to all drugs.⁴⁴ In addition, PBMs negotiate a dispensing fee with the pharmacies. Actual Acquisition Cost (AAC) is the final price a pharmacy pays after all discounts have been subtracted.⁴⁵

PBMs and Payors

A PBM negotiates rebates with the manufacturer, negotiates with pharmacies, and may develop the formulary on behalf of the payor, the plan sponsor or the insurer, or sell the payor a pre-determined formulary. PBMs also offer payors medical management/utilization review and disease management services.⁴⁶

PBMs are reimbursed by the payor on either a pass-through basis or a spread-pricing basis. Payors may have the ability to choose either option in its contract with the PBM. Payors may also have the options of retaining rebates or allowing their members or insureds to receive point of sale rebates.

Pass through – The payor will pay the actual amount owed to the pharmacy under the contract on a per prescription basis and will pay the PBM an administration fee.

Spread pricing – The payor will either not pay or pay a reduced administration fee and the PBM will retain certain risk related to the difference between the price paid by the customer and the price paid to the pharmacy (whether the spread is profitable will vary from drug to drug). This provides set price assurance to the payor.⁴⁷

Through these definitions and descriptions of the pharmaceutical drug ecosystem, legislatures have enacted various state laws to promote greater transparency of the actions taking place, and put in place specific requirements around the activities of those in the ecosystem.⁴⁸ State laws and enforcement mechanisms have from time to time butted up against federal pre-emption issues and those issues are further detailed in the sections that follow.

C. ENFORCEMENT AND FEDERAL PREEMPTION ISSUES

In general, states have wide leeway to regulate PBMs serving health benefit plans in the individual market, small group market, fully insured large group market, and Medicaid. Under recent U.S. Supreme Court precedent, states also have significant authority to regulate costs for PBMs serving self-insured federal Employee Retirement Income Security Act of 1974 (ERISA) plans, though the legal boundaries of this preemption continue to be tested. It remains unclear how much authority states may exercise over PBM pharmacy networks and other elements of PBM administration. State authority to regulate PBMs serving Medicare Part D plans is limited to areas where the federal government has not established related standards.

This section will discuss the scope of federal preemption of state laws regulating PBMs under ERISA, Medicare Part D, and Medicaid, including the implications of recent and ongoing litigation.

1. EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA): (SELF-INSURED AND FULLY INSURED)

⁴⁴ Horvath.

⁴⁵ Horvath.

⁴⁶ Horvath; Wisconsin’s “Report of the Governor’s Task Force on Reducing Prescription Drug Prices, p. 21.

⁴⁷ Horvath.

⁴⁸ See, e.g., the recent proliferation of drug price transparency programs across states, available as referenced by the National Academy for State Health Policy (NASHP): <https://nashp.org/prescription-drug-pricing-transparency-law-comparison-chart/>. At the time of this report, there are 13 states with drug price transparency programs.

The federal Employee Retirement Income Security Act of 1974 (ERISA) governs all health benefit plans established by private-sector employers and certain employee organizations, such as unions.⁴⁹ ERISA's preemption clause, section 514, preempts all state laws to the extent that they "relate to" employer-sponsored health plans.⁵⁰ However, states are still permitted to maintain regulation of "the business of insurance" including for ERISA plans.⁵¹ This generally allows the states to regulate insurance carriers operating traditional insurance business, including regulation of plan design, solvency, and capital requirements for insurance companies.

However, ERISA explicitly prohibits states from regulating self-insured health plans where an employer bears the primary risk of claims and an insurer acts solely in an administrative capacity without bearing any risk.⁵² Under current federal court precedent, this effectively divides the large-group market into "fully insured" plans that are generally subject to state insurance law, and "self-insured" plans that are generally exempt from state insurance regulation.

Over the last 30 years, the U.S. Supreme Court has issued a series of opinions that narrow the scope of ERISA's preemption language. The most recent case, *Rutledge v. Pharmaceutical Care Management Association (PCMA)*,⁵³ decided in 2020, held that an Arkansas law (Act 900) requiring PBMs to reimburse pharmacies at a price equal to or greater than a pharmacy's wholesale cost was not preempted by ERISA. This suggests that states can regulate the conduct of PBMs that serve both fully insured and self-insured employer plans, to at least the same extent as the Arkansas law.

In *Rutledge*, the U.S. Supreme Court affirmed a legal standard stated in a prior decision, *Gobeille v. Liberty Mutual Insurance Company*.⁵⁴ To determine whether a state law has an impermissible connection with an ERISA plan, the Court asks whether the law "governs a central matter of plan administration or interferes with nationally uniform plan administration." In particular, a state law that "merely affects costs" will not be preempted, even where a cost regulation creates a significant economic incentive for a plan administrator, so long as it does not "force" a plan to adopt a certain "scheme of substantive coverage."⁵⁵

Taken together, this suggests that a state law comparable to Arkansas's Act 900 will not be preempted by ERISA, even if it applies to self-insured plans. The features of Act 900 upheld by *Rutledge* are as follows:

- (1) Requires PBMs to reimburse a pharmacy at a price equal to or greater than what the pharmacy paid to buy the drug from a wholesaler;
- (2) Requires PBMs to timely update their Maximum Allowable Cost (MAC) lists when drug wholesale prices increase;

⁴⁹ Furrow, et al., "Health Law" Third Ed. (2014), p. 325-27.

⁵⁰ *Id.* at 328.

⁵¹ See, e.g., Furrow generally at 328-330.

⁵² *Id.* at 328.

⁵³ *Rutledge v. Pharmaceutical Care Management Association*, 141 S.Ct. 474 (2020).

⁵⁴ *Gobeille v. Liberty Mutual Insurance Company*, 577 US 312 (2016).

⁵⁵ *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 US 645 (1995). The Court found that a 13% surcharge that applied to all insurers other than Blue Cross / Blue Shield was not preempted by ERISA, despite creating a significant incentive for self-insured employers to choose Blue Cross / Blue Shield over other carriers. Since the law did not "force" plan administrators to make a particular choice, it was allowed by the court.

- (3) Requires PBMs to provide an administrative appeals procedure for pharmacies to challenge MAC reimbursement that is below a pharmacy's acquisition cost;
- (4) Requires PBMs to increase their reimbursement rate to cover a pharmacy's acquisition cost if that pharmacy is unable to acquire the drug at a lower price from a typical pharmaceutical wholesaler;
- (5) Requires PBMs to permit a pharmacy to "reverse and rebill" any reimbursement claim affected by the pharmacy's inability to acquire the drug at a price equal to or less than a PBM's MAC reimbursement price;
- (6) Permits a pharmacy to decline to sell a drug to covered beneficiary if the relevant PBM will reimburse the pharmacy for less than the pharmacy's acquisition cost.

The PCMA argued that the enforcement mechanisms of the Arkansas law impermissibly interfere with ERISA plan management. The U.S. Supreme Court rejected this argument, noting that if taken to the extreme, PCMA's proposed interpretation would preempt all state law mechanisms for resolving insurance payment disputes. However, beyond allowing Arkansas Act 900 to go into effect, the Court provided little guidance regarding what is or is not a matter "central to plan administration."

In a subsequent federal district court decision, *PCMA v. Mulready*⁵⁶, the lower court relied on *Rutledge* to conclude that Oklahoma's PBM law was not preempted by ERISA (the court's additional reasoning related to Medicare preemption is discussed below). The statute at issue in *Mulready* regulates both the network status of particular pharmacies as well as the conditions under which a PBM may reimburse for prescriptions, arguably going significantly beyond "mere cost regulation." However, the PCMA has appealed the *Mulready* decision, and it remains unclear whether the appeals court or other courts will follow its reasoning.

Another important aspect of the law at issue in *Rutledge* is that it is not applied exclusively to or even expressly to ERISA plans. Rather, it applies to PBMs whether or not they manage ERISA plans. Under prior U.S. Supreme Court precedent, a law may be preempted by ERISA if it "acts immediately and exclusively upon ERISA plans or where the existence of ERISA plans is essential to the law's operation."⁵⁷

Under the precedent of *Rutledge*, it seems clear that states have some leeway to regulate PBMs without concern for ERISA preemption. A law that distinguishes between ERISA and non-ERISA plans would be more likely to be preempted, particularly if it places a higher burden on ERISA plans than for other markets. A law that mandates particular pharmaceutical coverage, such as requiring reimbursement for a specific drug or diagnosis, would likewise be preempted as regulating plan design. On the other hand, a law that applies to PBMs regardless of market segment that merely regulates cost, similar to the Arkansas statute, would likely be upheld. Lesser regulations, such as transparency programs, are also unlikely to be preempted under ERISA.

2. MEDICARE PART D

Medicare Part D is an optional, federally supported prescription drug benefit available to Americans over the age of 65. The program's authorizing legislation incorporates the federal preemption language from the Medicare Part C, or "Medicare Advantage (MA)" program, which provides: "the standards established under this

⁵⁶ *Pharmaceutical Care Management Association v. Mulready*, 598 F.Supp.3d 1200 (2022).

⁵⁷ *Rutledge*, at 6.

part shall supersede any state law or regulation (other than state licensing laws or state laws relating to plan solvency) with respect to MA plans which are offered by MA organizations under this part.”⁵⁸

In general, courts have found that state laws are preempted under Medicare Part D where Congress or the CMS have established “standards” for the area regulated by said state laws. This means that the authority of states to regulate MA or Medicare Part D plans is significantly limited, though states explicitly retain the authority to regulate plan solvency. The Medicare Managed Care Manual indicates that state law should only be preempted where it would be impossible for a carrier to comply with both state and federal standards – a state standard that is stricter than the Medicare standard should not be preempted. However, courts have held that standards set by the CMS do not necessarily need to be in conflict with the provisions of state law for preemption to hold.

In *Mulready v. PCMA*, the federal district court ruled that many provisions of Oklahoma’s PBM statute were preempted with respect to Medicare Part D plans (the preceding section discussed the same court’s reasoning with respect to ERISA plans).⁵⁹

In its review of the statute at issue, the *Mulready* court found that several provisions of Oklahoma’s law were preempted by Medicare Part D. This included multiple elements of the law related to pharmacy reimbursement, including a ban on PBM service fees, a ban on PBMs reimbursing affiliated pharmacies at higher rates, and a ban on PBMs reducing pharmacy reimbursement after completion of a sale. Part D prohibits interference with negotiation between insurers and pharmacies, and Part D defines “negotiated price” by reference to said negotiations.⁶⁰ Accordingly, the district court agreed with the PCMA that these aspects of the state law were barred with respect to PBMs serving Medicare Part D plans as an impermissible interference in the price negotiations between PBMs, as the agents of Medicare Part D carriers, and pharmacies.⁶¹

The district court also ruled that Oklahoma’s retail-only pharmacy access standard was preempted because the CMS has established standards regulating convenient access to network pharmacies.

However, the district court held that the remaining provisions of the Oklahoma law challenged by the PCMA were not preempted by Medicare Part D.⁶² This includes the law’s requirements for preferred pharmacy networks, including the law’s any willing provider provision, affiliated pharmacy prohibition, and network provider restriction. The district court reasoned that while the CMS has promulgated a standard with respect to standard networks, there is no federal standard in place for preferred networks. Since all the relevant provisions of Oklahoma law apply only to preferred network status, the district court ruled there was no applicable standard in place that would preempt Oklahoma’s law.

Finally, the district court rejected the PCMA’s challenge to Oklahoma’s contract approval provisions.⁶³ Under the Oklahoma statute, insurers who utilize the services of PBMs are required to approve all contracts between the PBM and the PBMs retail pharmacy network. In this instance, the PCMA again pointed to Medicare Part D’s ban on interference in contract negotiations. However, the district court reasoned that Medicare Part D’s bar applies only to negotiations between plan sponsors and PBMs, while Oklahoma’s law regulates negotiations between

⁵⁸ 42 CFR § 422.402.

⁵⁹ *Pharmaceutical Care Management Association v. Mulready*, 598 F.Supp.3d 1200 (2022).

⁶⁰ *Id.*

⁶¹ *Id.*

⁶² *Id.*

⁶³ *Id.*

PBMs and pharmacies. Accordingly, the district court concluded that the contract approval provisions of Oklahoma’s law are not preempted by Medicare Part D.

The PCMA has appealed the district court’s decision. It is unknown whether the 10th Circuit or other courts will follow the same reasoning with respect to the scope of Medicare Part D preemption of state PBM laws.

3. MEDICAID

Medicaid is a federally funded program that provides health benefits to certain low-income Americans.⁶⁴ It is structured very differently from either Medicare Part D or ERISA. Both Medicare and ERISA were set up with the intent of establishing uniformity of implementation nationwide – making preemption of state laws that conflict with the federal plan an important element of the program’s structure. Medicaid, however, is structured as a federal-state partnership and its implementation varies significantly from state to state. This means that the states have broad leeway to regulate PBMs serving Medicaid carriers, as long as those regulations do not come into conflict with the state’s Medicaid structure.

Each state implements Medicaid pursuant to a Medicaid plan submitted by the state and approved by the CMS.⁶⁵ Any changes a state makes to Medicaid implementation must also be approved by the CMS via a plan amendment process.⁶⁶ In some cases, states may also receive a waiver from certain terms of the Medicaid provisions in the Medicare and Medicaid Act (herein referred to as the Medicaid Act) under Section 1115 of the Social Security Act. So long as the PBM regulation is consistent with the terms of the state’s current Medicaid plan, it should be safe from federal preemption.

However, state laws that conflict with the terms of the Medicaid Act can still be theoretically preempted under the supremacy clause of the U.S. Constitution. Unlike Medicare Part D and ERISA, the Medicaid Act does not include any preemption language that goes beyond common law interpretation of the supremacy clause. Under common law, a state law will generally be preempted only if it is impossible for a regulated entity to comply with both the state and the federal statute. However, jurisprudence specifically related to Medicaid preemption is extremely limited, making definitive analysis difficult.

In many states, the state Medicaid agency contracts with one or more managed care organizations (MCOs) to administer all or a part of the state’s Medicaid program, including the management of the pharmacy program through the MCO’s contracted PBM. Some states also contract with PBMs directly to administer the pharmacy benefit, either in conjunction with or separate from an MCO. In other cases, the state Medicaid agency manages the Medicaid pharmacy program on its own.

To address rising costs, Congress passed legislation enacting the Medicaid Drug Rebate Program in 1990. Under this program, pharmaceutical companies sign a master rebate agreement with the CMS, which administers the Medicaid program at the federal level. These rebates result in cost savings on prescription drugs that are paid for under the Medicaid program and are shared by both the state Medicaid agency and the CMS. State Medicaid programs are required to provide a pathway to coverage for any drug whose manufacturer has signed a rebate agreement with the CMS. Therefore, state Medicaid programs do not have the flexibility that insurers in the private market do to implement strict formularies to control prescription drug spending. Instead, state Medicaid programs are allowed to negotiate additional “supplemental rebates” with pharmaceutical manufacturers

⁶⁴ See, e.g., Furrow generally 460-462.

⁶⁵ Furrow at 490-492.

⁶⁶ *Id.*

individually, and to develop preferred drug lists in consultation with state Drug Utilization Review (DUR) Boards and Pharmacy and Therapeutics (P&T) Committees.

In summary, Medicaid preemption should not be a significant concern for states looking to regulate PBMs that serve Medicaid managed care or other Medicaid carriers. However, states should ensure that any changes to PBM regulation in the Medicaid space are consistent with the state's Medicaid plan or seek an appropriate plan amendment if they are not.

D. FUNCTIONAL ISSUES

As the national conversation has evolved, most of the direct regulation has involved the practices of PBMs. As such, the most robust bodies of law and descriptions of practices have focused on PBM activities. Several functional issues within this ecosystem have been identified by state regulators as key to the ultimate pricing consumers pay or as having other significant marketplace impacts. Those functional issues are discussed in the sections that follow.

1. FORMULARY DESIGN

PBMs implement formularies or lists of covered drugs⁶⁷. PBMs' customers – payors, such as insurers or self-funded employer plans, may request open formularies, develop their own formularies, or purchase formularies from PBMs. Even closed formularies typically require coverage for at least one drug per therapeutic class.

For PBM developed formularies, PBMs use panels of experts called Pharmacy and Therapeutics (P&T) Committees. These committees, made up of independent physicians, pharmacists, and other health care providers, evaluate clinical and medical literature to select the most appropriate medications for individual disease states and conditions.⁶⁸ The federal Affordable Care Act (ACA) introduced federal regulations on P&T Committees serving qualified health plans (QHPs).

P&T Committees typically reviews drugs to identify those that are required (preferred), unacceptable and acceptable based on medical standards. The category of those that are determined acceptable is where there is leeway on the PBM's part to determine formulary inclusion.⁶⁹

The PBM will look at acceptable drugs that have been determined "clinically equivalent" and negotiate for the highest rebate and include these drugs in the formulary. PBMs negotiate drug costs with pharmaceutical manufacturers across the board for all customers using their volume of scale and then work with individual customers to create formularies.

Formularies provide lists of pharmaceutical drugs covered by payors and can be differentiated between preferred or discouraged products by dividing into three to five "tiers," each with a separate level of cost sharing.⁷⁰ By placing a drug in a preferred tier, PBMs can drive volume to that drug's manufacturer. This is an effective way for PBMs to generate rebates for either multi-source brands or competing brands in a therapeutic

⁶⁷ Derek J. Oestreicher, Office of the Montana State Auditor, "A Prescription for the Drug Price Epidemic," Presentation to the NAIC Pharmacy Benefit Manager Regulatory Issues (B) Subgroup, Oct. 3, 2019.

⁶⁸ Horvath.

⁶⁹ *Id.*

⁷⁰ Oregon Drug Price Transparency Report of 2019 at 10-11, available at:

<https://dfr.oregon.gov/drugtransparency/Documents/Prescription-Drug-Price-Transparency-Annual-Report-2019.pdf>.

class. The PBM then keeps the rebates or shares all or a percentage of the rebate with the plan sponsor or patient, depending on the PBMs contract with the plan sponsor.⁷¹

Since formularies are essentially coverage decisions, a PBM's step-therapy protocol may be viewed as part of its formulary. Step-therapy requires a patient to try a particular drug before another drug is covered. PBMs may shift drugs between tiers or add or remove them from the formulary entirely during a plan year, a practice which is known as "non-medical switching."

2. REBATES

The negotiation between a pharmaceutical manufacturer and PBM may result in a rebate. The rebate flows back to the PBM from the manufacturer usually based on the volume of prescriptions generated by the manufacturer's drug's placement on the PBM's formulary. The PBM may pass the rebate on to the health benefit plan according to their shared contract, which may allow the PBM to keep a percentage of the rebate, but it is possible the PBM keeps the entire rebate with no direct benefit to the plan or the consumer.⁷²

Rebates are mostly used on branded and specialty drugs where there exist similar competing drugs from other manufacturers. From a manufacturer's perspective, the rebate is a tool to incentivize PBMs to place the manufacturer's drugs on formularies within preferred tiers.⁷³ PBMs negotiate based on their volume of scale to obtain highest rebate for selected drugs.⁷⁴ From the PBM's perspective, a large rebate results in a smaller amount spent by their customers and more income for the PBM from proportional pass-through contracts.⁷⁵

Rebates are negotiated separately with each plan sponsor and can take the form of a number of different options in how rebates get passed along:⁷⁶

- 100 percent pass-through – The PBM passes 100 percent of the rebate back to the plan sponsor. Most clients prefer this method.
- Proportional pass-through – The PBM keeps a percentage of the rebate and passes the remainder back to the plan sponsor.
- At Risk – The PBM keeps 100 percent of the rebate but guarantees a certain level of rebate to the customer. In this instance the PBM is "at risk" for the difference between the guarantee and actual rebates received. In exchange, this option provides cost predictability to the customer.

The existence of rebates alone is not a problem. However, the PBM's ability to retain a percentage of the rebate creates a concern as they are also commonly in charge of formulary design. These two factors give PBMs a financial incentive to prioritize drugs in the formulary based on the highest rebate instead of the lowest total cost to the plan sponsor or consumer.⁷⁷ This could result in health plans and consumers paying a higher cost for prescription drugs than is necessary, resulting in higher prescription drug coverage costs.

Approaches to curb the negative effects of rebates include:

⁷¹ Horvath.

⁷² *Id.*; Sood; Oestreicher.

⁷³ Sood; Oestreicher.

⁷⁴ *Id.*

⁷⁵ *Id.*

⁷⁶ *Id.*

⁷⁷ *Id.*

- Rebate retention prohibitions: Some states have enacted as part of their PBM laws a provision stating that a PBM must pass through 100 percent of a pharmaceutical manufacturer rebate to a plan sponsor.⁷⁸
- Rebates at point-of-sale (POS): Some believe that rebates should be provided directly to consumers at POS to reduce deductibles or co-insurance amounts owed when the drug is purchased. As a result, these funds would no longer be used to offset the plan sponsor costs and could result in higher premiums for all members. Additionally, members with low or no prescription drug usage might experience a disproportional impact as they would be paying higher premiums and would not have a financial benefit from the POS rebates. Some insurers have indicated that passing the rebates to the consumer at POS would have a dramatic enough effect on drug adherence that it would cover the potential benefit of using the rebates against premiums and result in no additional premium cost.⁷⁹
- Elimination of rebates: Some have recently called for the elimination of rebates to provide more price transparency within the system. While the elimination of rebates might serve to achieve this, it could also cause a major disruption in current market conditions. In the short term, eliminating rebates could lead to increasing the cost of drugs to PBMs, plan sponsors and ultimately consumers without corresponding legislation to lower pharmaceutical manufacturer prices. In the longer term, eliminating rebates could lead to increased transparency in price competition between manufacturers of similar drugs as price setting would no longer happen in a private contractual setting with a PBM.⁸⁰

3. PRICING AND CONTRACTING PRACTICES

PBMs negotiate with pharmaceutical manufacturers, health plans, and pharmacies. PBMs may also be affiliated with a health plan and a pharmacy. As discussed below, the unique market position and negotiating power of the three largest PBMs enables them to engage in contracting practices that may be detrimental to consumers and other market participants.⁸¹ The below terms and descriptors identify the most common pricing and contracting practices that have received scrutiny from regulators:

Gag clauses: The term “gag clause” refers to a stipulation in a pharmacy benefit contract that prohibits a pharmacy or pharmacist from informing consumers of an alternative option when purchasing a drug. For instance, a gag clause may prohibit a pharmacist from telling a consumer about a generic version of a prescription drug or if a prescription drug can be purchased at a lower price out-of-pocket rather than through their insurance plan.⁸²

Mandatory arbitration clause: Most PBMs require that disputes be submitted to binding arbitration by including a mandatory arbitration provision in their pharmacy contracts. Some believe mandatory arbitration limits legal recourse for individual pharmacies and results in pharmacies foregoing potentially successful audit challenges.⁸³

⁷⁸ Horvath; Sood. Oestreicher.

⁷⁹ *Id.*

⁸⁰ *Id.*

⁸¹ Sood.

⁸² “A Tangled Web,” p. 33, 44; National Conference of State Legislatures Glossary of PBM terms, available at: [State Policy Options and Pharmacy Benefit Managers \(ncsl.org\)](https://www.ncsl.org/state-policy/state-policy-options-and-pharmacy-benefit-managers).

⁸³ Oestreicher.

Copay clawbacks: Copay clawback is the PBM practice of taking back from a pharmacy the difference between a patient's copay and the actual cost of the medication when the patient's copay is larger than the cost of the drug.⁸⁴

MAC transparency: A maximum allowable cost (MAC) list is a list that includes the maximum amount that a plan will pay for certain drugs.⁸⁵ MAC lists are often generated by the PBM. There is no standardization in the industry as to the criteria for the inclusion of drugs on MAC lists or for the methodology as to how the maximum price is determined, changed or updated. PBMs may sometimes use multiple MAC lists and pocketing the spread between the two. For example, they might use a very low MAC list to reimburse pharmacies but a higher list when charging health plans.⁸⁶

Rebates: Rebates may provide incentive for a PBM to eliminate a less expensive, comparable medication from a formulary. Pharmaceutical manufacturers claim that these rebates are meant to be shared with plan sponsors or passed on to consumers in the form of lower drug prices. However, PBMs regularly keep a share of the rebates before passing the rest through to the plan sponsor.⁸⁷

Spread pricing: Spread pricing is the PBM practice of charging a plan sponsor a higher amount for a drug than they will reimburse the pharmacy and pocketing the difference. Pharmacy pricing is complex, and the process is not transparent. Plan sponsors are often unaware of the difference between the amount they are billed and the pharmacy reimbursement.⁸⁸

Pharmacy audit: PBMs routinely audit pharmacies to validate data entry, ensure compliance with regulatory and contractual requirements, and to help identify and mitigate fraud, waste, and abuse of a prescription drug benefit. However, many pharmacists have stated that the audits are unfair and may result in stiff penalties and fees.

Each of these practices have been regulated to a degree by regulation in some states; however, the degree and method of regulation has varied by those states. More details are provided in the state-specific sections below.

4. VERTICAL INTEGRATION AND CONSOLIDATION

In business and economics, vertical integration means a combination in one company of at least two stages of production normally performed by separate companies. For example, an entity that manufactures a product may also be affiliated with through common ownership a wholesale distributor and a retail store.⁸⁹ The entities at the various levels of the integrated enterprise may deal exclusively with the parent company's goods or services or may offer non-integrated products or services.⁹⁰

The three largest PBMs are each affiliated with a health plan and a pharmacy, so the parent company owns or controls up to three stages of the drug supply chain.⁹¹ Some PBMs are also affiliated with health care providers,

⁸⁴ *Id.*; "A Tangled Web," p. 33.

⁸⁵ National Conference of State Legislatures Glossary of PBM terms, available at: [State Policy Options and Pharmacy Benefit Managers \(ncsl.org\)](https://www.ncsl.org/state-policy/state-policy-options-and-pharmacy-benefit-managers).

⁸⁶ "A Tangled Web," p. 29-30.

⁸⁷ Horvath.

⁸⁸ Oestreicher.

⁸⁹ Sood.

⁹⁰ *Id.*

⁹¹ *Id.*

such as retail clinic services. Thus, one entity controls the diagnosis of a condition, the retail sale of a prescribed drug to the patient, the distribution of the drug from manufacturer to retail pharmacy, and the insurance payment to the pharmacy, including determination of the patient's cost-sharing amounts.

In theory, vertical integration allows a company to synergize operations between stages of production and pass the savings from smaller transaction costs to their customers. However, vertical integration can also be a contributing factor in the monopolization of markets due to market foreclosure, where the merger or acquisition of a stage of production denies competing businesses access to that firm's business.⁹²

Consolidation refers to the merger and acquisition of many smaller companies resulting in a few much larger companies. The benefit of consolidation is that a larger firm may be able to realize efficiencies of scale and pass the resulting cost savings to consumers. The downside of consolidation is that costs tend to rise when there are fewer existing firms around to compete on prices and the few remaining firms price their products to maximize profit.⁹³ Along with vertical integration, consolidation in the pharmacy benefit supply chain has led to current market conditions, which feature the three largest PBMs covering 79 percent of prescription drug claims.⁹⁴ Further, independent pharmacies are put at a competitive disadvantage compared to PBM-affiliated pharmacies when it comes to contracting.

The proliferation of PBM-health insurer affiliations has resulted in inefficiencies in the market.⁹⁵ From the health insurer's perspective, an affiliation with a PBM is incredibly valuable for two reasons: lower costs for pharmacy benefit services and exclusive or priority access to the PBM. From a market perspective, a PBM-health insurer relationship results in lower market competition, dealings within affiliated businesses and possible anti-competitive practices.⁹⁶ The three largest PBMs are all affiliated with health insurers, so other large health insurers not affiliated with a PBM are no longer able to find a PBM that operates on their scale that is not affiliated with a competitor.

A PBM-pharmacy affiliation creates several incentives for PBMs to act against the best interests of the consumer. PBMs have been found inserting language into pharmacy benefit contracts that requires enrollees to use PBM-owned mail pharmacy services for long-term (90 days or longer) "maintenance" medications.⁹⁷ This contractual requirement effectively eliminates any competition to fill these prescriptions, allowing the pharmacy to charge higher prices to the consumer. An affiliation with a pharmacy may also incentivize a PBM to do the following, which are all contrary to the best interests of consumers:

- Perform fewer generic substitutions;
- Switch patients to higher-cost therapeutic alternatives ("therapeutic interchange"); or,
- Repackage drugs in a manner that could lead to increased costs to plan sponsors, while maximizing revenue for the PBM ("package size pricing").

5. PHARMACY NETWORK ADEQUACY

⁹² *Id.*

⁹³ *Id.*

⁹⁴ [PBMs ranked by market share: CVS Caremark is No. 1](#); Becker's Hospital Review (website); March 8th, 2022.

⁹⁵ Sood.

⁹⁶ *Id.*

⁹⁷ "A Tangled Web," p. 42-43.

A pharmacy network is a list of pharmacies or pharmacists that a health plan or PBM has contracted with to provide prescription drug services to their members.⁹⁸ Pharmacy network adequacy is often defined as the distance between a patient's residence and where services can be physically accessed.

Pharmacy access is an integral component of the standards established under section 1860D-4(b)(1)(C) of the federal Medicare Modernization Act of 2003. The standards require in part that each sponsor secure the participation in their pharmacy networks of a sufficient number of pharmacies to dispense drugs directly to patients (other than by mail order) to ensure convenient access to covered drugs by plan enrollees. Several states have since followed suit, defining acceptable pharmacy network adequacy standards for network participation with respect to various regions of their states and across all health plan types. Pharmacy network adequacy provisions effectively prohibit a PBM from deciding to contract with a narrow pharmacy network, potentially limiting member access to prescription drugs.

Some states specify that mail order pharmacies cannot be used to determine compliance with pharmacy network adequacy standards, while others specify that a network must have a mix of both retail and mail order pharmacies. Standards can be established by time and distance standards relative to the state as a whole, or to counties, or zip codes. In determining whether a PBM complies with access requirements, states review and consider the relative availability of physical pharmacies in a geographic service area.⁹⁹ Common pharmacy network adequacy requirements include:

- Defining what is a reasonably adequate retail pharmacy network;
- Making clear that mail-order pharmacies cannot be used to meet access standards;
- Requiring pharmacy networks to consist of both retail and mail order pharmacies in a specific geographic service area;
- Requiring ongoing monitoring of a PBM's capacity to furnish services;
- Network accessibility reporting requirements;
- A current, accurate, and searchable directory of pharmacies; and
- Requiring a minimum of at least one pharmacy per county, zip code, or other specifically defined service area.

About 35 percent of the states have some type of legislation that addresses PBM's placing heightened accreditation requirements upon pharmacies seeking to join the PBM's networks.¹⁰⁰ When this is the case, common legislative elements include prohibiting PBMs from imposing provider accreditation standards or certification requirements inconsistent with, or more stringent than the requirements of the state board of pharmacy or other state/federal agencies. Typically, the PBM must apply standards without regard to PBM affiliation and may not change the standards more than once every 12 months. The last common element is requiring PBMs to provide written disclosures upon request.

Commonly, PBMs, or the health plans they contract with, require members to have their prescriptions filled *only* at pharmacies with which the PBM, or the health plan, is affiliated or has an ownership interest in. This is considered "steering," and is sometimes prohibited by state law.¹⁰¹ Sometimes PBMs will even mine members'

⁹⁸ Horvath; National Conference of State Legislatures Glossary of PBM terms, available at: [State Policy Options and Pharmacy Benefit Managers \(ncsl.org\)](https://www.ncsl.org/state-policy/state-policy-options-and-pharmacy-benefit-managers).

⁹⁹ National Conference of State Legislatures Glossary of PBM terms, available at: [State Policy Options and Pharmacy Benefit Managers \(ncsl.org\)](https://www.ncsl.org/state-policy/state-policy-options-and-pharmacy-benefit-managers).

¹⁰⁰ See generally, PBM Law Compilations, available at: https://content.naic.org/cmte_b_pharmacy_bmri_sg.htm.

¹⁰¹ Sood.

health data in an attempt to steer them to the PBM's affiliated pharmacies. This practice has become more popular as the number of health insurance companies that own PBMs has increased. Steering can limit a member's choice, increase costs, and lower quality of care to members.

Anti-steering state legislation typically prohibits PBMs from requiring drugs to be dispensed from specific contracted or affiliated pharmacies and prohibits PBMs from assessing additional fees when a prescription is filled by an in-network contracted pharmacy, but which is not specifically authorized by the PBM to fill certain types of prescriptions as a "specialty pharmacy." This occurs even when a pharmacy may otherwise have the credentials to do so, such as when it is a compounding pharmacy.

Such anti-steering legislation can have a major impact. It has been reported that even though less than 2 percent of the population uses specialty drugs, those prescriptions account for a staggering 51 percent of total pharmacy spending. This is a rapidly increasing trend. At a member level, plan sponsors see an average annual cost of \$38,000 to cover a specialty patient's drugs, compared to just \$492 for the coverage of a non-specialty patient's drugs. That is 75 times more to cover a specialty patient over the course of a year.¹⁰²

These types of practices can result in harm, including increasing drug prices, overcharging members, restricting a member's choice of pharmacies, underpaying community pharmacies and other dispensers, and fragmenting and creating barriers to care, particularly in rural areas, and for members battling life-threatening illnesses and chronic diseases.

6. LICENSING OF DIFFERENT ENTITIES INVOLVED IN THE DISTRIBUTION/SUPPLY CHAIN

Even though PBMs are engaged in interstate commerce and are not purely in the business of insurance, the trade practices described herein have largely eluded federal regulatory oversight. Many states have enacted licensing schemes to regulate PBMs in the absence of federal oversight. These licensing schemes usually put PBMs under the regulatory authority of a state's insurance department. Most states have gone about this in two ways: 1) regulating PBMs under a third party administrator (TPA) law; or 2) establishing a standalone license for PBMs. The various licensing laws address some of the issues herein through prohibition of certain behaviors, requiring transparency in business practices, or by requiring disclosures by the PBM.

Based on the conversations of the NAIC Pharmacy Benefit Manager Regulatory Issues (B) Subgroup, a standalone PBM license is generally preferred among regulators. Anything less than licensure, including a registration requirement, is considered to lack in significant enforcement mechanisms.

Other key players that are licensed in the distribution and supply chain are described below:

Health insurers

Commercial health insurers are subject to federal and state oversight. Insurers providing fully insured employer or group plans and individual market coverage are regulated by states.¹⁰³ Self-insured health plans sponsored by

¹⁰² See Evernorth Health Services, "What is Drug Trend and How to Manage It" last accessed February 27, 2023, available at: <https://www.evernorth.com/articles/specialty-drug-trends-and-utilization>.

¹⁰³ Furrow at 308, 314-316.

employers or unions are subject to federal oversight pursuant to the ERISA, although the *Rutledge v. PCMA* case does seemingly allow state regulation of certain PBM activities performed for ERISA plans.

Wholesalers

All 50 states and the District of Columbia require a wholesaler to be licensed. The structure of the statutes varies but attempt to incorporate federal regulation language. There are several federal regulations that establish the minimal licensing requirements for drug wholesalers in the states. Every wholesale distributor in a state must be licensed by the state licensing authority, and the state must require that personnel employed by distributors have the appropriate education and/or experience for the position that person is hired for.

Per 21 C.F.R. § 205.6, the following factors should be considered by the states before granting a wholesaler license:

- Any convictions of the applicant under any federal, state, or local laws relating to drug samples, wholesale or retail drug distribution, or distribution of controlled substances;
- Any felony convictions of the applicant under federal, state, or local laws;
- The applicant's past experience in the manufacture or distribution of prescription drugs, including controlled substances;
- The furnishing by the applicant of false or fraudulent material in any application made in connection with pharmaceutical manufacturing or distribution;
- Suspension or revocation by federal, state, or local government of any license currently or previously held by the applicant for the manufacture or distribution of any drugs, including controlled substances;
- Compliance with licensing requirements under previously granted licenses, if any;
- Compliance with requirements to maintain and/or make available to the state licensing authority or to federal, state, or local law enforcement officials those records required under this section; and
- Any other factors or qualifications the state licensing authority considers relevant to and consistent with the public health and safety.

Manufacturers

Pharmaceutical manufacturers are required to be registered with the FDA within five days of starting operations (see 21 C.F.R. § 207 et seq). Applicants are required to provide standard business information as well as the list of drugs they produce as part of the application process. In addition to registering pharmaceutical manufacturers, the FDA also reviews all human drugs, including biologics, for safety, effectiveness, and quality. Each new drug has an application process; there is a licensing application for biologics. The FDA also inspects manufacturing facilities for drugs, including biologics, before drug production begins and according to their Compliance Program Guidance Manual (CPGM).

While most states require pharmaceutical manufacturers that produce or distribute drugs within their state to be licensed, states exercise little total control over pharmaceutical manufacturers. The FDA is responsible for approving new drugs and allowing for a given drug's patent protection period, which gives manufacturers a period of exclusivity before generics of that drug are allowed to be produced. Because the federal government is responsible for this function, there is little states can do about some of the life cycle management practices manufacturers engage in to extend the market exclusivity of their drugs. Pharmaceutical manufacturers commonly seek to extend their patent protection period by providing a new formulation of a drug or changing the route of administration for a drug.

Pharmacies

All 50 states and the District of Columbia require pharmacists to be licensed to practice within the state. To obtain a pharmacist license, states commonly require the applicant to satisfy the following criteria:

- Complete an application and pay the required fee;
- Proof of completion of a college degree in pharmacy from an approved college or other institution
- Completion of an approved internship, typically requiring between 1,000 to 1,750 hours;
- The applicant has passed the Multistate Pharmacy Jurisprudence Examination (MPJE) and the North American Pharmacist Licensure Examination (NAPLEX); and
- A fingerprint background check of some nature, normally including a criminal record search and/or production of a birth certificate and/or other vital documents.

All 50 states and the District of Columbia also require pharmacies to be licensed. Typically, the information needed for a license includes:

- Business entity information;
- The type of pharmacy (retail, hospital, sterile compounding, nuclear, etc.);
- Pharmacist-in-charge information, including license number;
- Articles of incorporation/formation;
- A list of officers and owners of the business;
- Disciplinary and criminal history for owners and officers of the pharmacy;
- A list of other licensed personnel who will operate the pharmacy, such as pharmacy technicians and pharmacist interns;
- Pharmacy hours of operation; and
- Application and license fees.

Pharmaceutical sales representatives

In comparison to other entities in the pharmaceutical supply chain, few states require pharmaceutical sales representatives (PSRs) to be licensed. PSRs have a large potential impact on the use and overuse of pharmaceutical drugs based on their interactions with prescribing health care providers.

PSR licenses generally require a pharmaceutical manufacturer to supply a list of all PSRs to the regulating entity. For licensure, the PSRs are generally required to take a professional education course that may include training ethics, pharmacology, and pharmaceutical marketing laws and rules. A licensed PSR is required to submit an annual report to the regulating entity that includes information on which health care providers they have contacted, which drugs they sold, any samples or gifts that were provided, and if the providers were compensated for their time.

In the absence of a law, the Pharmaceutical Research and Manufacturers of America (PhRMA) has instituted a Code on Interactions with Health Care Professionals.¹⁰⁴

The licensing of entities involved in the distribution/supply chain is an evolving area. Many activities performed by some of these entities may be captured by state TPA laws, although some may not be. The Subgroup plans to continue to monitor developments in this area.

E. STATE LAWS THAT OPERATE IN THE SUPPLY CHAIN

¹⁰⁴See PhRMA Code on Interactions with Health Professionals, last accessed February 27, 2023, available at: [PhRMA-Code---Final.pdf](#)

In the last several years states have been working on legislation regarding the impact that Pharmacy Benefit Managers have on increasing prescription drug costs and what that means to consumers.

1. PBM REGULATION

The role of PBMs has changed from intermediaries for pharmacies, drugmakers, wholesalers and others within the prescription drug supply chain to facilitate transactions. Vertical integration of pharmacies, PBMs, and insurers, along with opaque contracting has created a disruption within the drug supply chain. The influence of PBMs has expanded from its original role, growing more complex and opaque, causing transparency concerns. This has prompted states to reevaluate regulations regarding licensure, reporting requirements, transparency, contract standards, health plan responsibility, spread pricing, network adequacy, and clawback issues. At least 20 states have begun the task of improving their regulations and laws¹⁰⁵ and 18 states have either amended or established new PBM licensure requirements within the last few years.¹⁰⁶

a. State Laws and Approaches

Several states on the Subgroup offered up summaries and key developments on their specific states. These summaries are meant to provide further detail to the updated list of laws offered by the Subgroup on the Subgroup's website.¹⁰⁷

i. Florida

Florida enacted the Florida Pharmacy Act to their Insurance Code, which gives the Florida Office of Insurance Regulation (OIR) the authority to enforce provisions, respond to potential violations, establish more protection for pharmacies in relation to audits, establish a \$10,000 penalty for PBMs that do not register with the OIR, and authorize pharmacies to appeal audit findings by PBMs and health plans. However, the responsibility of establishing rules for pharmacy provisions will be managed by the Board of Pharmacy.

ii. New Jersey

New Jersey has a bill that focuses on PBM transparency, licensing, and reporting requirements. Carriers would be required to maintain records of contracted PBMs including transaction records and compensation remittance. Carriers would also be required to have pharmacy and therapeutics committees with no conflict of interest. Additionally, they must use more than one formulary.¹⁰⁸

iii. Kentucky

Kentucky State Representative Steve Sheldon proposed HB 457 during the 2022 legislative session. Although the bill did not pass, it was drafted to address the ongoing abuses from PBMs in Kentucky. Some critics have stated this bill is one of the most comprehensive pieces of PBM regulation in the United States. The bill proposed to

¹⁰⁵ Shaikh, H., & Keller, B. A. (2022). PBM Regulatory Roundup (Spring 2022): The 8th Circuit Rules and More States Issue Regulations. *The National Law Review*, XII(88). Retrieved September 6, 2022, from <https://www.natlawreview.com/article/pbm-regulatory-roundup-spring-2022-8th-circuit-rules-and-more-states-issue>.

¹⁰⁶ Imber, S. L., Osborn, J. M., & Liby, J. T. (2022). Pharmacy Benefit Managers Licensing and Compliance Developments. *National Law Review*, XII(31). Retrieved September 6, 2022, from <https://www.natlawreview.com/article/pharmacy-benefit-managers-licensing-and-compliance-developments>.

¹⁰⁷ See generally, PBM Law Compilations, available at: https://content.naic.org/cmte_b_pharmacy_bmri_sg.htm.

¹⁰⁸ S.B. 220, 2022, 2022-2023 Reg. Sess. (NJ.2022). https://www.njleg.state.nj.us/bill-search/2022/S1616/bill-text?f=S2000&n=1616_11.

prohibit PBMs from the following: mandatory mail order pharmacy use, mandatory use of PBM affiliated pharmacies, limited preferred networks, patient incentives to use PBM affiliated pharmacies, spread pricing, and higher reimbursements to PBM affiliated pharmacies. The bill also contained provisions that addressed contract changes, offered 340B protections and applied to most commercial plans in Kentucky.

iv. Kansas

In 2022, Kansas enacted SB 28, which transformed the state's existing PBM registration requirements to a licensing scheme. As part of the license application, a PBM must submit a template contract to include a dispute resolution process, that ultimately involves an independent fact finder between the PBM and the health insurer or the PBM and the pharmacy or pharmacy's contracting agent; and a network adequacy report. The PBM Licensure Act also made updates to the MAC appeal law, gave the Commissioner some enforcement authority, but maintained an existing exemption for PBMs that hold a TPA registration in the state.

2. PBM DRUG PRICE TRANSPARENCY REGULATION

The push for implementation of laws that would require PBMs to disclose drug pricing, cost information regarding rebates, payments, and their fees collected from pharmaceutical manufacturers, insurers, and pharmacies has begun in many states.¹⁰⁹ The following states have proposed or implemented laws requiring transparency reporting: Delaware, Iowa, Michigan, Minnesota, New York, Oklahoma, Oregon, Texas, Washington, and West Virginia.

3. OTHER RELEVANT STATE LAWS AND PROPOSED LAWS

States have also implemented, or considered implementing other laws that touch upon the pharmaceutical drug ecosystem. A brief description of these approaches is contained below:

Affordability Review and Upper Payment Limits

Some states have proposed or implemented laws establishing prescription drug affordability review boards to set allowable rates for certain high-cost drugs, similar to the process states use to regulate utilities or insurance premiums. Under these laws, a state drug affordability review board would establish the maximum amount that certain payors would pay for individual drugs. The goal of these laws is to protect consumers and payors from over-priced drugs.

Unsupported Price Increases

Another approach to address high drug costs is enacting laws that would impose fines on pharmaceutical manufacturers whose drug price increases are unsupported by new clinical evidence. The state would use the revenue to provide cost assistance to consumers. Such laws impact the most frequently prescribed, high-cost drugs, and minimizes a state's administrative burden by using existing data sources.

¹⁰⁹ Colleen Becker, A. G. (2022, March 23). *State Policy Options and Pharmacy Benefit Managers (PBMs)*. State policy options and Pharmacy Benefit Managers (PBMs). Retrieved September 6, 2022, from <https://www.ncsl.org/research/health/state-policy-options-and-pharmacy-benefit-managers.aspx>

Anti-Price-Gouging

These laws prohibit pharmaceutical manufacturers from hiking prices for generic and off-patent drugs. Price increases that surpass a specific threshold identified in the law trigger action by a state's attorney general. Pharmaceutical manufacturers that price-gouge face fines and must stop charging the excessive price.

Importation

This legislative approach would create a state wholesale importation program to purchase lower-cost drugs from Canada and make them available to state residents through an existing supply chain that includes local pharmacies.

State Purchasing Pool Buy-in

These laws allow small businesses and individuals to buy into a state employee prescription drug benefit purchasing pool. They typically authorize non-state public employers, self-insured private employers, and insurance carriers who cover small groups or individuals to purchase drugs for their beneficiaries under the purchasing authority of the state. By adding more lives to a purchasing pool, purchasers can negotiate better prices for public employees and others who join the purchasing pool.

Licensing Pharmaceutical Representatives

This approach gives states the authority to license pharmaceutical sales representatives to increase transparency surrounding their activities and influence and to require training on ethical standards. For example, the laws would require representatives to disclose the wholesale acquisition cost of the drugs they market and to share the names of generic options in the same therapeutic class when available.

F. FEDERAL INTEREST AND POSSIBLE REGULATIONS

More and more state regulations have been brought before state legislators to help regulate PBMs. Many people think that mere state regulation is not enough, and that the federal government will need to step in to help. Given the overall expense of pharmaceutical drugs, some stakeholders have called for a federal overlay or federal preemption to create a uniform set of regulations for multistate PBMs. There are signs of increased interest from the federal government in PBM-related activities, as described below.

1. PHARMACY BENEFIT MANAGER TRANSPARENCY ACT OF 2022

Introduced on May 24, 2022, the Pharmacy Benefit Manager Transparency Act of 2022, is a bipartisan bill sponsored by Senators Maria Cantwell (D-WA) and Charles Grassley (R-IA). The act would enforce necessary disclosure requirements on PBMs and strive to prevent questionable PBM practices, such as three practices that could be deemed unfair or deceptive which are expressly outlawed by the proposed legislation. These include spread pricing, the practice of charging a health plan or payor a different amount for a prescription drug's ingredient cost or dispensing charge than the PBM reimburses a pharmacy for those costs, and keeping the difference as profit; reducing, canceling, or obtaining back any reimbursement payment made to a pharmacist or pharmacy for the price of a prescription drug's ingredients or dispensing charge arbitrarily, unfairly, or falsely; and deceptively reducing reimbursement to a pharmacy or arbitrarily raising fees to offset changes in reimbursement requirements would also be forbidden.

Beginning no later than one year after the proposed legislation's adoption, the act mandates that PBMs provide the following data to the FTC annually: 1) the difference between the sum that each health plan paid the PBM

for prescription medications and the sum that the PBM paid each pharmacy on behalf of the health plan; 2) the total of all fees, including those for the generic effective rate, compensation fees, or other price breaks offered to any pharmacy, and payments withheld from reimbursements to any pharmacy; 3) if the PBM shifted a prescription drug to a formulary tier with a higher cost, higher copayment, higher coinsurance, or higher deductible to a consumer or lower reimbursement to a pharmacy, an explanation for why the drug was moved to a different tier, including whether the move was requested by a prescription drug manufacturer or another entity; 4) information regarding any variations in reimbursement rates or practices, remuneration fees or other price concessions, and clawbacks between a pharmacy owned, controlled, or affiliated with the PBM and all other pharmacies, for any PBM that owns, controls, or is affiliated with a pharmacy.

The Senate Committee on Commerce, Science, and Transportation and the House Committee on Energy and Commerce would also need to receive two reports from the FTC-- one on general enforcement actions under the act and the other on PBM formulary design or placement practices. Under the proposed legislation, an annual report on enforcement activity would be filed. The report would include: 1) an anonymized summary of the annual reports that PBMs have submitted to the FTC; 2) the number of enforcement actions the FTC brought to enforce the act and the results of those actions; 3) the number of investigations and inquiries into potential violations of the act; 4) the number and nature of complaints the FTC received alleging violations of the act; and 5) recommendations for strengthening enforcement actions in response to violations of the act.

The agency's report to Congress on PBM formulary design or placement practices would be due within a year of the proposed law's passage. It would include information on whether PBMs use formulary design or placement to boost gross revenue without also enhancing patient access or lowering patient costs, as well as whether such PBM activities violate section 5(a) of the Federal Trade Commission Act (45 U.S.C. 45(a)). Employees in the healthcare sector who report violations of the act or take part in administrative, judicial, or investigative processes to enforce its provisions would not be fired, demoted, suspended, reprimanded, or subject to any other type of punishment under the proposed legislation. The proposed legislation also forbids companies from requiring employees to sign pre-dispute arbitration agreements in exchange for employment to make them give up their right to whistleblower protections under the act. The FTC and state attorneys general are given permission to carry out the proposed legislation's enforcement measures. Additionally, under the proposed law, offenders might face extra civil penalties of up to \$1 million in addition to the penalties provided under the Federal Trade Commission Act (15 U.S.C. 41 et seq.). The bill was adopted and forwarded to the full Senate by the Senate Committee on Commerce, Science, and Transportation on June 22, 2022.¹¹⁰

Additionally, the Act would incentivize fair and transparent PBM practices by providing exceptions to liability for PBMs that pass along 100 percent of rebates to health plans or payors and fully disclose prescription drug rebates, costs, prices, reimbursements, fees, and other information to healthcare plans, payors, pharmacies, and federal agencies.¹¹¹

¹¹⁰ Jang, T., & Shotlander, D. (2022, September 28). *Senate bill and FTC 6(b) study turn the heat on pharmacy benefit managers amid drug pricing concerns*. Food and Drug Law Institute (FDLI). Retrieved October 6, 2022, from <https://www.fdpi.org/2022/09/senate-bill-and-ftc-6b-study-turn-the-heat-on-pharmacy-benefit-managers-amid-drug-pricing-concerns/>.

¹¹¹ Dowell, M. A. (2022, August 16). *State PBM regulations protecting community pharmacies*. U.S. Pharmacist – The Leading Journal in Pharmacy. Retrieved September 6, 2022, from <https://www.uspharmacist.com/article/state-pbm-regulations-protecting-community-pharmacies>.

Democrats and Republicans have both turned their attention to PBMs in recent years as they try to control the soaring cost of prescription drugs. The PBM sector claims that their job is to reduce costs for health plans, but detractors claim that they raise list prices of prescription pharmaceuticals by requesting more rebates or discounts from pharmaceutical manufacturers, which in turn raises prices for consumers.¹¹²

2. THE FEDERAL TRADE COMMISSION

In June 2022, the FTC announced that it will launch an inquiry into the prescription drug middleman industry, requiring the six largest pharmacy benefit managers to provide information and records regarding their business practices. The agency's investigation will closely examine how vertically integrated pharmacy benefit managers affect the availability and cost of prescription medications. The FTC will issue mandatory orders to CVS Caremark, Express Scripts, Inc., OptumRx, Inc., Humana Inc., Prime Therapeutics LLC, and MedImpact Healthcare Systems, Inc. as part of this investigation.

Even though many individuals are unaware of them, pharmacy benefit managers exert a significant amount of influence on the nation's prescription drug system, according to Lina M. Khan, chair of the FTC. This investigation will shed insight on the procedures used by PBMs.¹¹³

G. KEY JURISPRUDENCE

As states continue to pass laws related to the pharmaceutical drug ecosystem, a body of jurisprudence has begun to develop that outlines the limits of state authority vis a vis federal authority. The key cases to date are described below.

1. ***RUTLEDGE v. PHARMACEUTICAL CARE MANAGEMENT ASSOCIATION*, 141 S.Ct. 474 (2020)**

In *Rutledge v. PCMA*, the U.S. Supreme Court held that ERISA did not preempt an Arkansas law, Act 900, which required PBMs¹¹⁴ to reimburse pharmacies at a price equal to or higher than what the pharmacy paid to buy the drug. Act 900 required PBMs to provide administrative appeal procedures for pharmacies to challenge reimbursement prices that are below the pharmacies' acquisition costs, and it also authorized pharmacies to decline to dispense drugs when a PBM would provide a below-cost reimbursement. Unlike the PBM laws in some states, Act 900 was not strictly structured as an insurance law. It applied to all transactions between PBMs and pharmacies, including transactions where the PBM was acting on behalf of a self-insured ERISA plan, so Arkansas could not rely on the saving clause as its defense against an ERISA preemption challenge.

In a suit brought by the PCMA, a national trade association representing 11 PBMs, the Eastern District of Arkansas ruled that Act 900 was preempted by ERISA, and the Eighth Circuit affirmed.¹¹⁵ Both courts relied on a recent Eighth Circuit decision striking down a similar Iowa law because it "made 'implicit reference' to ERISA by

¹¹² Manville, G., & Dross, D. (2022, July 7). *Congress takes aim at PBM Business Practices*. Mercer US. Retrieved October 10, 2022, from <https://www.mercer.us/our-thinking/healthcare/congress-takes-aim-at-pbm-business-practices.html#:~:text=Bipartisan%20legislation%20requiring%20pharmacy%20benefit,practices%20are%20advancing%20n%20Congress>.

¹¹³ *FTC launches inquiry into prescription drug middlemen industry*. Federal Trade Commission. (2022, June 7). Retrieved October 10, 2022, from <https://www.ftc.gov/news-events/news/press-releases/2022/06/ftc-launches-inquiry-prescription-drug-middlemen-industry>.

¹¹⁴ As the term is spelled in Act 900. Supreme Court style refers to "pharmacy benefit managers."

¹¹⁵ *PCMA v. Rutledge*, 891 F.3d 1109 (8th Cir. 2018).

regulating PBMs that administer benefits for ERISA plans”¹¹⁶ and “was impermissibly ‘connected with’ an ERISA plan because, by requiring an appeal process for pharmacies to challenge PBM reimbursement rates and restricting the sources from which PBMs could determine pricing, the law limited the plan administrator’s ability to control the calculation of drug benefits.”¹¹⁷

The U.S. Supreme Court, however, concluded that “[t]he logic of *Travelers* decides this case,”¹¹⁸ and ruled that Act 900 was not preempted by ERISA. The Court compared its decisions in *Gobeille*, where it held that a state law is preempted if it “governs a central matter of plan administration or interferes with nationally uniform plan administration,”¹¹⁹ and *Travelers*, where it held that ERISA does not preempt state price regulations that “merely increase costs or alter incentives for ERISA plans without forcing plans to adopt any particular scheme of substantive coverage,”¹²⁰ even if the law “affects an ERISA plan or causes some non-uniformity in plan administration.”¹²¹ The Court explained that ERISA is “primarily concerned with preempting laws that require ... structure[ing] benefit plans in particular ways, such as by requiring payment of specific benefits, or by binding plan administrators to specific rules for determining beneficiary status. A state law may also be subject to pre-emption if ‘acute, albeit indirect, economic effects of the state law force an ERISA plan to adopt a certain scheme of substantive coverage.’”¹²² The Court observed that Act 900 “does not require plans to provide any particular benefit to any particular beneficiary in any particular way,”¹²³ and determined that like the law at issue in *Travelers*, “Act 900 is merely a form of cost regulation.”¹²⁴

The Court reviewed the standards it has established for interpreting ERISA’s preemption clause, which preempts all state laws “insofar as they ... relate to any employee benefit plan”¹²⁵ unless some exception to preemption applies. The Court explained that a state law triggers the preemption clause when it “has a connection with or reference to” an ERISA plan.¹²⁶ The Court rejected the PCMA’s contention “that Act 900 has an impermissible connection with an ERISA plan because its enforcement mechanisms both directly affect central matters of plan administration and interfere with nationally uniform plan administration.”¹²⁷ The Court acknowledged that Act 900 required ERISA plan administrators to “comply with a particular process” and standards,¹²⁸ but explained that those enforcement mechanisms “do not require plan administrators to structure their benefit plans in any particular manner, nor do they lead to anything more than potential operational inefficiencies” for PBMs.¹²⁹ The Court held further that ERISA did not preempt Act 900’s decline-to-dispense provision, even though it “effectively denies plan beneficiaries their benefits” because any denial of benefits would be the consequence of the lawful state regulation of reimbursement rates and the PBM’s refusal to comply.¹³⁰

¹¹⁶ 141 S.Ct. at 479, quoting *PCMA v. Gerhart*, 852 F.3d 722, 729 (8th Cir. 2017).

¹¹⁷ *Id.* at 479, quoting *Gerhart*, 852 F.3d at 726, 731.

¹¹⁸ *Id.* at 481.

¹¹⁹ *Id.* at 480, quoting *Gobeille*, 577 U.S. at 320.

¹²⁰ *Id.* at 480, citing *Travelers*, 514 U.S. at 668.

¹²¹ *Id.*

¹²² *Id.*, quoting *Gobeille*, 577 U.S. at 320.

¹²³ *Id.* at 482.

¹²⁴ *Id.* at 481.

¹²⁵ 29 U.S.C. § 1144(a).

¹²⁶ 141 S.Ct. at 477.

¹²⁷ *Id.* at 481–482.

¹²⁸ *Id.* at 482, quoting PCMA brief at 24.

¹²⁹ *Id.*

¹³⁰ *Id.*

Finally, the Court rejected the PCMA’s claim that the law had an impermissible “reference to” ERISA. As the Court explained, Act 900 “applies to PBMs whether or not they manage an ERISA plan,” and Act 900 did not treat ERISA plans differently than non-ERISA plans.¹³¹ However, the Court only considered the provisions of the Arkansas PBM law as they stood at the time the PCMA filed its preemption challenge, not the amendments the legislature subsequently made while *Rutledge* was making its way through the appellate courts. Additionally, the Court did not address preemption under Medicare Part D.

2. PHARMACEUTICAL CARE MANAGEMENT ASSOCIATION v. WEHBI, 18 F.4th 956 (2021)

In 2021, the Eighth Circuit Court of Appeals issued its decision in *PCMA v. Wehbi*. This case was not appealed to the U.S. Supreme Court. At issue in the *Wehbi* case were two North Dakota laws prohibiting PBMs from engaging in deceptive and anti-competitive practices.

Ultimately, the court determined that none of the challenged provisions met the “connection-with” standard and all survived preemption by ERISA.¹³² The court concluded that some of the state law provisions “merely authorize pharmacies to do certain things,” such as:

- disclose certain information to plan sponsors;
- provide relevant information to patients;
- mail or deliver drugs to patients as an ancillary service; and
- charge shipping and handling fees to patients who request that their prescriptions be mailed or delivered.¹³³

The court also upheld provisions that “constitute, at most, regulation of a noncentral ‘matter of plan administration’ with de minimis economic effects.”¹³⁴ The court held that “whatever modest non-uniformity in plan administration [the sections] might cause does not warrant preemption.”¹³⁵ These provision include:

- limits on accreditation requirements a PBM may impose on pharmacies as a condition for participation in its network;
- requirements for PBMs to disclose basic information to pharmacies and plan sponsors upon request; and
- conditions on PBMs that have “an ownership interest in a patient assistance program and a mail order specialty pharmacy.”

In *Wehbi*, the court expands upon *Rutledge* in that the North Dakota statutes go beyond health care price/cost regulation and into disclosure requirements of PBMs, by prohibiting PBMs from preventing pharmacies from disclosing certain information (in compliance with HIPAA) to patients or plan sponsors. The court stops short of saying that PBM regulation cannot be preempted by ERISA. North Dakota’s laws, the court concluded, amount to regulation of a PBMs’ functions, rather than regulation of an ERISA plan itself so they are not preempted by ERISA.

¹³¹ *Id.* at 481.

¹³² 18 F.4th 956, 968.

¹³³ *Id.*

¹³⁴ *Id.*, quoting *Gobeille*, 577 U.S. 312, 320.

¹³⁵ *Id.*, citing *Rutledge*, 141 S. Ct. at 480.

For the Medicare Part D preemption, not all the North Dakota provisions were preempted by Medicare laws. The court held that preemption exists for some of the contested provisions because Medicare Part D directly governs some of the same matters that the state law attempts to regulate.

With respect to Medicare Part D, the court determines preemption by either of these questions:

1. Do the laws regulate the same subject matter as a federal Medicare Part D standard? If so, the state law is *expressly* preempted; or

2. Do the state laws otherwise frustrate the purpose of a federal Medicare Part D standard? If yes, then they are *impliedly* preempted.¹³⁶

3. PHARMACEUTICAL CARE MANAGEMENT ASSOCIATION v. MULREADY, 598 F.Supp.3d 1200 (2022)

In 2022, the U.S. District Court in the Western District of Oklahoma ruled in favor of the Oklahoma Insurance Commissioner Glen Mulready. The Patient’s Right to Pharmacy Choice Act (“Act”) passed in 2019 was challenged by PCMA as being preempted by ERISA, as well as Medicare Part D laws. The court held that the state law is not preempted by ERISA but agreed with PCMA that some of the law’s provisions are preempted by Medicare laws. PCMA has appealed the decision to the Tenth Circuit Court of Appeals.

The Oklahoma laws at issue protects Oklahoma consumers and their access to pharmacy providers and protects Oklahoma pharmacies from certain self-dealing and self-serving practices of PBMs that can harm consumers and put rural and independent pharmacies out of business. Relying on *Rutledge*, the court concluded that all of PCMA’s ERISA preemption claims fail as a matter of law. The court holds that “[the provisions] do not have a ‘connection with’ an ERISA plan” and that “[w]hile these provisions may alter the incentives and limit some of the options that an ERISA plan can use, none of the provisions forces ERISA plans to make any specific choices.” Finally, with regard to the Promotional Materials provision, the court holds that the law “does not regulate benefit design disclosures to beneficiaries but regulates how PBMs can advertise its providers” and that it “does not relate to a central matter of plan administration nor undermine the uniform regulation of ERISA plans.”

As it relates to PCMA’s ERISA preemption claim in totality, the court found that ERISA does not preempt enforcement of the following: “any willing provider” provisions; retail pharmacy network access standards; affiliated pharmacy prohibition; network provider choice restrictions; probation-based pharmacy limitations; cost sharing discounts; promotional material prohibitions; post-sale price reduction prohibitions; and affiliated pharmacy price match prohibitions on PBMs from reimbursing a pharmacy an amount less than the amount the PBM reimburses to a pharmacy it owns or is affiliated with.¹³⁷

With respect to preemption by Medicare Part D, the court found that about half of the PCMA’s preemption claims failed, while about half were meritorious. Specifically, the court ruled that Medicare Part D *does* preempt these provisions in the Act: retail pharmacy network access standards; promotional material prohibitions; cost sharing discounts; service fee prohibitions; post-sale price reduction prohibitions; and affiliated pharmacy price

¹³⁶ *Id.* at 972.

¹³⁷ 36 O.S. § 6961 (OSCN 2023) available at (last accessed February 27, 2023):

<https://www.oscn.net/applications/oscn/deliverdocument.asp?lookup=Previous&listorder=167560&dbCode=STOKST36&y ear=>

match prohibitions on PBMs from reimbursing a pharmacy an amount less than the amount the PBM reimburses to a pharmacy it owns or is affiliated with.¹³⁸

It is anticipated that additional cases will make their way to the U.S. Supreme Court and provide greater insights into the parameters of *Rutledge* and state regulation. The *Wehbi* and *Mulready* cases are instructive as to the parameters of *Rutledge*, but no doubt more decisions are to come.

H. RECOMMENDATIONS

The Subgroup acknowledges that issues in the pharmaceutical drug ecosystem are complex and often opaque; to the end consumer, many of these issues are difficult to understand. The most mature body of regulation has developed around PBM activities, but as noted throughout the paper, PBMs are not the only influential player in the ecosystem. Based on the information received by the subgroup over the last two years, the subgroup makes the following recommendations:

1. The NAIC should consider tasking the PBM subgroup or similar group with drafting a model guideline to address PBM regulation based on other state laws and recent jurisprudence;
2. The NAIC should consider expanding information sharing between the states through additional committees on the topic of pharmaceutical drug pricing and transparency;
3. The NAIC should consider any necessary updates to Model 22 out of the emergence of greater regulation in the prescription drug ecosystem;
4. The NAIC should consider impacts of this work on an ongoing basis on the federal 340B drug pricing program;
5. The NAIC should consider facilitating and maintaining a nationwide database of PBM contracting provisions. This would allow states to become familiar with common PBM contractual provisions and more easily identify issues that arise from them;
6. The NAIC should consider developing an open dialogue with Federal agencies that is broader than just PBM regulation. The discussion should consider regulation of all the stakeholders in the prescription drug ecosystem from a more holistic view and may be best achieved through a coordinated effort involving state and federal regulators; and
7. This subgroup, and successive subgroups, should continue to maintain a current listing of PBM laws and regulations and case law for reference by other states.

The Subgroup recognizes the critical role that the pharmaceutical drug ecosystem plays on consumer costs and the role states can play in understanding and best regulating the ecosystem. The body of knowledge gained by

¹³⁸ 36 O.S. § 6961 (OSCN 2023) available at (last accessed February 27, 2023): <https://www.oscn.net/applications/oscn/deliverdocument.asp?lookup=Previous&listorder=167560&dbCode=STOKST36&year=>

the subgroup over the last two years, and related resources provided to state regulators provides a solid foundation to continue to examine these key issues.

APPENDIX I.

Meeting #	Date	Presenter/Topic
Meeting #1	August 15, 2019	<ul style="list-style-type: none"> • Jane Horvath (Horvath Health Policy and Research Faculty, Georgetown University) presentation on “Basics of the Pharmaceutical Market & PBMs.” • Leanne Gassaway (America’s Health Insurance Plans—AHIP) presentation on “Pharmacy Benefit Managers Overview & Background.”
Meeting #2	August 22, 2019	<ul style="list-style-type: none"> • Dr. Neeraj Sood (Sol Price School of Public Policy, University of Southern California) presentation on “PBM Economics.” • Saiza Elayda (Pharmaceutical Research and Manufacturers of America—PhRMA) presentation on the pharmaceutical supply chain and how the pharmaceutical distribution and payment system shapes the prices of brand name medicines.
Meeting #3	August 29, 2019	<ul style="list-style-type: none"> • April Alexander (Pharmaceutical Care Management Association—PCMA) and J.P. Wieske (Horizon Government Affairs) presentation on the history, role, and services PBMs provide in managing prescription drug benefits. • Anne Cassity (National Community Pharmacists Association—NCPA) and Matthew Magner (NCPA) presentation on the community pharmacy industry’s perspective regarding PBMs and managing prescription drug benefits. • Claire McAndrew (Families USA) discussed the effect of PBMs and prescription drug costs on consumers. • Amy Killelea (National Alliance of State and Territorial AIDS Directors—NASTAD) discussed PBMs and their impact on consumer access and affordability of prescription drugs.
Meeting #4	October 3, 2019	<ul style="list-style-type: none"> • Kentucky discussed its PBM licensing process. • Arkansas discussed its PBM licensing law and other provisions related to PBM business practices. • Montana discussed the history, purpose, and provisions of S.B. 71 to address issues related to PBMs, which

Meeting #	Date	Presenter/Topic
		<p>passed in the legislature but was ultimately vetoed by the Governor.</p> <ul style="list-style-type: none"> • New Mexico discussed its PBM law focusing on its reimbursement provisions. • Oregon discussed its PBM law, including its PBM registration requirements, and Oregon’s Prescription Drug Price Transparency program.
Meeting #5	December 11, 2021	<ul style="list-style-type: none"> • North Dakota discussion on the <i>Pharmaceutical Care Management Association (PCMA) v. Wehbi</i> ruling. • Connecticut discussion on its PBM law and white paper. • Virginia discussion on its PBM law. • Oklahoma discussion on its PBM law and the <i>PCMA v. Mulready</i> case. • Wisconsin discussion on the work of the Governor’s Task Force on Reducing Prescription Drug Prices and its PBM law.
Meeting #6	March 16, 2022	<ul style="list-style-type: none"> • Montana discussion on its PBM law. • Employee Retirement Income Security Act (ERISA) (B) Working Group update on the U.S. Supreme Court’s ruling in <i>Rutledge v. PCMA</i> and the <i>ERISA Handbook</i> analysis and case summary.
Meeting #7	April 4, 2022	<ul style="list-style-type: none"> • Oklahoma update on its PBM law. • Oregon discussion on its PBM law and transparency in prescription drug pricing and Oregon Prescription Drug Affordability Board (PDAB) initiatives. • Discussion from a consumer perspective on the Subgroup’s charge to develop a white paper on PBMs and their business practices.
Meeting #8	April 25, 2022	<ul style="list-style-type: none"> • Dr. Neeraj Sood and Dr. Karen Van Nuys, University of Southern California (USC) Price School on Public Policy- presentation on “How Well Are PBM Markets Functioning?”
Meeting #9	June 15, 2022	<ul style="list-style-type: none"> • National Community Pharmacists Association (NCPA) presentation on the Subgroup’s charge to develop a

Meeting #	Date	Presenter/Topic
		white paper on PBMs and their business practices from an independent pharmacist perspective.
Meeting #10	July 29, 2022	<ul style="list-style-type: none"> • Healthcare Distribution Alliance (HDA) presentation on the Subgroup's charge to develop a white paper on PBMs and their business practices from a pharmaceutical distributor perspective. • Presentation on the Subgroup's charge to develop a white paper on PBMs and their business practices from a pharmacy services administrative organization (PSAO) perspective.
Meeting #11	August 9, 2022	<ul style="list-style-type: none"> • Presentation from the Pharmaceutical Care Management Association (PCMA) discussing the value of PBMs and the services PBMs provide with respect to pharmacy benefit management. • Presentation from the Pharmaceutical Research and Manufacturers of America (PhRMA) on the lack of transparency in PBM practices. • Oregon Primary Care Association (OPCA) presentation on the federal 340B prescription drug program.
Meeting #12	October 24, 2022	<ul style="list-style-type: none"> • America's Health Insurance Plans (AHIP) presentation on the Subgroup's charge to develop a white paper on PBMs and their business practices from an insurer perspective. • BlueCross and BlueShield Association (BCBSA) presentation on the Subgroup's charge to develop a white paper on PBMs and their business practices from an insurer perspective. • Civica presentation on its work with the BCBSA and several Blues plans to bring lower-priced generics to market.

SharePoint/NAIC Support Staff Hub/Member Meetings/B CMTE/RFTF/PBM Regulatory Issues Subgrp/PBM White Paper
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Adopted by the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup – 7/27/23

Draft: 7/21/23

A GUIDE TO UNDERSTANDING PHARMACY BENEFIT MANAGER AND ASSOCIATED STAKEHOLDER REGULATION

Table of Contents

I.	INTRODUCTION	5
II.	KEY PLAYERS IN PHARMACEUTICAL DRUG PRICING ECOSYSTEM	5
	A. PAYORS	6
	<u>1.</u> Insurers	6
	<u>2.</u> Employers/Unions/Taft Hartley Trusts	7
	<u>3.</u> Government Entities	7
	B. PRESCRIPTION DRUG MANUFACTURERS	7
	<u>1.</u> Manufacturers	7
	<u>2.</u> Brand-Name Drugs.....	8
	<u>3.</u> Generic Drugs.....	8
	<u>4.</u> Biologic Drugs	8
	<u>5.</u> Biosimilar Drugs	8
	C. PHARMACY BENEFIT MANAGERS (PBMs)	9
	D. PHARMACIES	9
	<u>1.</u> CHAIN	9
	<u>2.</u> INDEPENDENT	9
	E. PHARMACISTS	10
	F. PHARMACY SERVICES ADMINISTRATIVE ORGANIZATIONS (PSAOs)	10
	G. WHOLESALERS/DISTRIBUTORS.....	10
	H. INTERRELATION OF PARTIES IN THE CHAIN AND TRANSACTION COSTS.....	11
	<u>1.</u> Physical Drug Distribution Chain.....	11
	<u>2.</u> Pharmacy Benefit Management Chain	12
III.	ENFORCEMENT AND FEDERAL PREEMPTION ISSUES.....	13
	A. ERISA: (SELF-INSURED AND FULLY INSURED)	13
	B. MEDICARE PART D.....	15
	C. MEDICAID	17
IV.	FUNCTIONAL ISSUES.....	18
	A. FORMULARY DESIGN	18
	B. REBATES.....	19
	C. PRICING AND CONTRACTING PRACTICES	20
	D. VERTICAL INTEGRATION AND CONSOLIDATION	21

E.	PHARMACY NETWORK ADEQUACY	23
F.	LICENSING OF DIFFERENT ENTITIES INVOLVED IN THE DISTRIBUTION/SUPPLY CHAIN	24
	<u>1.</u> Health insurers.....	25
	<u>2.</u> Wholesalers	25
	<u>3.</u> Manufacturers	25
	<u>4.</u> Pharmacies.....	26
	<u>5.</u> Pharmaceutical sales representatives (PSRs)	26
V.	STATE LAWS IMPACTING THE DRUG SUPPLY CHAIN.....	27
	A. PBM REGULATION	27
	<u>1.</u> Florida	28
	<u>2.</u> New Jersey	28
	<u>3.</u> Kentucky.....	29
	<u>4.</u> Kansas	29
	<u>5.</u> Maine	29
	<u>6.</u> Oklahoma.....	29
	B. DRUG PRICE TRANSPARENCY REGULATION	30
	<u>1.</u> Insurer Transparency	30
	<u>2.</u> Drug Manufacturer Transparency	30
	<u>3.</u> PSAO Transparency.....	30
	C. OTHER RELEVANT PROPOSED OR IMPLEMENTED STATE LAW PROVISIONS	30
	<u>1.</u> Affordability Review and Upper Payment Limits.....	31
	<u>2.</u> Unsupported Price Increases	31
	<u>3.</u> Anti-Price-Gouging.....	31
	<u>4.</u> Importation.....	31
	<u>5.</u> State Purchasing Pool Buy-in	31
	<u>6.</u> Licensing Pharmaceutical Sales Representatives.....	31
VI.	FEDERAL INTEREST AND POSSIBLE REGULATIONS	31
	A. PHARMACY BENEFIT MANAGER TRANSPARENCY ACT OF 2022	31
	B. THE FEDERAL TRADE COMMISSION	33
VII.	KEY JURISPRUDENCE	33
	A. <i>RUTLEDGE v. PHARMACEUTICAL CARE MANAGEMENT ASSOCIATION, 141 S.Ct. 474 (2020)</i>	33
	B. <i>PHARMACEUTICAL CARE MANAGEMENT ASSOCIATION v. WEHBI, 18 F.4th 956 (2021)</i>	35
	C. <i>PHARMACEUTICAL CARE MANAGEMENT ASSOCIATION v. MULREADY, 598_F.Supp.3d_1200 (2022)</i>	36
VIII.	RECOMMENDATIONS.....	37

IX. APPENDIX I. LIST OF SUBGROUP MEETINGS AND TOPICS..... 39

I. INTRODUCTION

The NAIC Regulatory Framework (B) Task Force established the NAIC Pharmacy Benefit Manager Regulatory Issues (B) Subgroup in 2018 to explore whether to develop a new NAIC model regulating pharmacy benefit managers (PBMs). In 2019, the Task Force adopted a charge for the Subgroup to, “[c]onsider developing a new NAIC model to establish a licensing or registration process for pharmacy benefit managers (PBMs). The Subgroup may consider including in the new NAIC model provisions on PBM prescription drug pricing and cost transparency.” The Subgroup developed a PBM model, which both the Regulatory Framework (B) Task Force and the NAIC Health Insurance and Managed Care (B) Committee adopted in 2021. However, at the NAIC 2021 Fall National Meeting, the proposed new PBM model failed to receive the necessary votes for adoption from the full NAIC membership. While it was discussing the proposed new PBM Model, in 2021, the Regulatory Framework (B) Task Force adopted a charge for the Subgroup to develop a white paper to: 1) analyze and assess the role PBMs, Pharmacy Services Administrative Organizations (PSAOs), and other supply chain entities play in the provision of prescription drug benefits; 2) identify, examine and describe current and emerging state regulatory approaches to PBM business practices, such as price transparency and reporting requirements, rebating, and spread pricing, including the implications of the *Rutledge vs. Pharmaceutical Care Management Association (PCMA)* decision on such business practices; and 3) discuss what challenges, if any, the states have encountered in implementing such laws and/or regulations.

After the proposed PBM model failed to receive sufficient votes for adoption, in early 2022, the Subgroup turned its focus on completing its charge to develop the white paper. Throughout 2022, the Subgroup held meetings to hear various perspectives from stakeholders, including consumers, PBMs, PSAOs, insurers, and pharmacists. The Subgroup also heard presentations from various states that have enacted state laws regulating PBM business practices. The states discussed the process of enactment, their implementation process, and outstanding issues related to enforcement, including, in some cases, a discussion of enforcement challenges and lessons learned.

As the Subgroup was hearing the last few stakeholder presentations in a series of regulator-to-regulator meetings in July 2022 through September 2022, the Subgroup reviewed and approved an outline of the PBM white paper. Based on the outline, the Subgroup leadership solicited and obtained volunteers from the Subgroup members to draft initial language for the various provisions in the PBM white paper. The Subgroup reviewed an initial draft of the PBM white paper in October 2022. The Subgroup released a working draft of the white paper during a meeting at the NAIC 2022 Fall National Meeting. Following the NAIC 2022 Fall National Meeting, the Subgroup met in early 2023 in a series of regulator-to-regulator meetings to discuss additional revisions to the working draft. On April 17, 2023, the Subgroup released a draft of the white paper for a 45-day public comment period ending June 1, 2023.

[ADDITIONAL LANGUAGE WILL BE ADDED AS THE DRAFTING PROCESS MOVES FORWARD]

II. KEY PLAYERS IN PHARMACEUTICAL DRUG PRICING ECOSYSTEM

Inherent in the Subgroup’s review of the drug pricing ecosystem are the concerns of the consumer, the one key player who cannot see all the levers before them but pays the price of the ecosystem that has been put in place.

Until very recently, pricing of pharmaceuticals has been opaque to many consumers.¹ However, increased costs of pharmaceutical drugs, several active campaigns by players in the ecosystem, increased federal and state attention on drug pricing, and drug price transparency programs have all operated to raise the consumer's knowledge of the cost levers of pharmaceutical drugs.

Pharmaceutical drugs are vital to both longevity and quality of life for many individuals. Not being able to afford lifesaving and life-improving prescriptions causes harm to patients and their families and contributes to additional burdens on our health care system. Some individuals can only afford prescriptions because they do so at the cost of other needs such as paying for housing and utility bills or addressing other medical issues. For these individuals there is a reduction in quality of life which can, and often does, affect overall health.² Affordability and access remain of high concern to consumers and lawmakers alike.

A 2021 poll by the Kaiser Family Foundation found that 60 percent of adults in the U.S. take at least one prescription drug and 25 percent take at least four per day. Of those prescribed medications, 29 percent of Americans reported not taking their medications as prescribed due to cost. They do this by not filling their medication, using an over-the-counter medication instead, or cutting the pills in half.³

It is the hope of the subgroup that by regulators gaining a greater understanding of the pharmaceutical drug ecosystem, research and price transparency programs, policymakers can better understand the levers that impact consumers. In so doing, consumers will see reduced costs for their pharmaceutical drugs.

Beyond the consumer, there are numerous players that make up the pharmaceutical drug ecosystem. Some of the key players in that ecosystem are described below.

A. PAYORS

Payors of health care services include health insurance providers, large and small employers, and government entities, such as state employee plans and Medicaid agencies. The entity making decisions about benefits – including the use of PBMs and the design of the prescription drug benefit – may depend on the market (individual, small group, large group) and the arrangement that the payor chooses. In this paper, when PBM functions are referenced, payors may choose to do those tasks internally.

1. Insurers

¹ See, e.g., the recent proliferation of drug price transparency programs across states, available as referenced by the National Academy for State Health Policy (NASHP): <https://nashp.org/prescription-drug-pricing-transparency-law-comparison-chart/>. At the time of this report, there are 13 states with drug price transparency programs.

² As indicated by Kaiser Family Foundation polls, Hamel, Liz et al. "Public Opinion on Prescription Drugs and Their Prices." Kaiser Family Foundation Polling, Oct. 20, 2022. <https://www.kff.org/health-costs/poll-finding/public-opinion-on-prescription-drugs-and-their-prices/>. Accessed Sept. 19, 2022. Discussed generally by Wisconsin's "Report of the Governor's Task Force on Reducing Prescription Drug Prices, p. 12, available at: <https://oci.wi.gov/Documents/AboutOCI/RxTaskForceFinalReport.pdf> and Oregon Drug Price Transparency reports 2019-2022 available at: <https://dfr.oregon.gov/drugtransparency/Pages/annual-reports.aspx>.

³ Hamel, Liz et al. "Public Opinion on Prescription Drugs and Their Prices." Kaiser Family Foundation Polling, Oct. 20, 2022. <https://www.kff.org/health-costs/poll-finding/public-opinion-on-prescription-drugs-and-their-prices/>. Accessed Sept. 19, 2022.

Insurers contract with PBMs to manage the pharmacy benefit portion of their health care benefits provided to their insureds and enrollees.⁴ Insurers contract with PBMs because of the increasing complexity of prescription drug benefit management.⁵ In addition, in response to increasing prescription drug costs some insurers contract with PBMs for their services that help reduce costs, including utilization management, prescription drug rebates, and negotiation of pharmacy fees and prescription drug reimbursement, and access to pharmacy networks.⁶ Ultimately, the scope of the PBM's role in managing this benefit depends on the insurer.⁷

Some insurers are part of integrated health systems, in which a common entity owns an insurer, hospitals, and employs networks of providers and provides all health care services to their enrollees. Because these entities more closely coordinate all care under their roof, insurers in integrated systems may not utilize PBMs to the same extent as more traditional insurers.

2. Employers/Unions/Taft Hartley Trusts

Employers have a variety of options available when designing the health benefits that they offer to their employees. They may choose a self-insured model, where the employer holds the risk, but sometimes hires an insurance company, PBM, or other benefit manager to administer the benefits. Employers choose how much of the benefits they will allow a contracted insurance provider or PBM to design and may choose to “carve out” the pharmacy administration and have external entities perform different functions.

3. Government Entities

Like private employers, government entities may contract with health insurers or PBMs to administer and/or design the health benefits plan that they provide. This may include a state employee health plan, coverage provided by cities or counties, or other benefit plans that cover government employees. Within Medicaid, there are a number of state variations in coverage, but for states that contract with Medicaid managed care organizations, those organizations are often in charge of administering the benefit plan that the state designs.

B. PRESCRIPTION DRUG MANUFACTURERS

1. Manufacturers

Pharmaceutical manufacturers research, develop, produce, market, and sell prescription drugs to treat medical conditions.⁸ The development of a new pharmaceutical product involves an investment of resources to create a product ready to be tested during clinical trials, where the safety and clinical efficacy of the drug are evaluated for a specific disease or condition.⁹ Manufacturers may also partner with the federal government to develop drugs, or license drugs developed with federal research funding. Manufacturers may also purchase prescription drugs developed by other manufacturers to market as their own. The U.S. Food and Drug Administration (FDA)

⁴ As discussed generally by Wisconsin's “Report of the Governor's Task Force on Reducing Prescription Drug Prices, p. 21, available at: <https://oci.wi.gov/Documents/AboutOCI/RxTaskForceFinalReport.pdf>.

⁵ *Id.*

⁶ *Id.*; Horvath Health Policy, *Innovations in Health Financing Policy* Presentation to the NAIC Pharmacy Benefit Manager Regulatory Issues (B) Subgroup, Aug. 15, 2019.

⁷ Report on Transparency Strategies for the Pharmaceutical Supply Chain – Pursuant to House Bill 4005 (2018), Oregon Joint Interim Task Force on the Fair Pricing of Prescription Drugs. November 2018.

[https://www.oregonlegislature.gov/committees/jfprx/Reports/House%20Bill%204005%20\(2018\)%20Report%20on%20Transparency%20Strategies.pdf](https://www.oregonlegislature.gov/committees/jfprx/Reports/House%20Bill%204005%20(2018)%20Report%20on%20Transparency%20Strategies.pdf).

⁸ As discussed generally by Wisconsin's “Report of the Governor's Task Force on Reducing Prescription Drug Prices, p. 18, available at: <https://oci.wi.gov/Documents/AboutOCI/RxTaskForceFinalReport.pdf>.

⁹ *Id.*

reviews all applications for the sale of new drugs from manufacturers following clinical trials and decides whether the drug will be made available on the market to consumers.¹⁰ When a drug is approved, manufacturers then set the list price for medications and may change that price over time.¹¹

2. Brand-Name Drugs

Manufacturers who produce brand-name drugs may conduct the initial research and development of a new pharmaceutical product. Brand-name drugs receive patents and exclusivities from the FDA.¹² Manufacturers of these patent-protected brand-name products have market exclusivity to produce and sell their products during the life of the patent before therapeutically equivalent generic drugs can become available on the market.¹³

3. Generic Drugs

Once a brand-name drug is no longer patent-protected, generic manufacturers may begin producing therapeutically equivalent generic drug products. Similar to brand-name drugs, the FDA must approve a generic drug application to ensure its equivalence to the brand-name drug before it can be produced.¹⁴ Generic drugs comprise the largest portion of the pharmaceutical market, approximately 90 percent of all drugs dispensed to consumers.¹⁵

4. Biologic Drugs

Biologic drugs are distinct from traditional brand-name and generic drugs because they are made of living cells, such as monoclonal antibodies, antitoxins, and certain vaccines.¹⁶ Biologics are sometimes referred to as “large-molecule drugs.” Manufacturers of biologic drug products are also required to receive approval from the FDA to sell their products through a separate application process.¹⁷ Biologics approved by the FDA are granted 12 years of exclusivity, which is substantially longer than the five years typically granted to traditional small-molecule brand-name drugs.¹⁸ A biosimilar drug product may be produced following the expiration of the biologic’s patent and exclusivity period.¹⁹

5. Biosimilar Drugs

Because of biologic drugs’ complexity, they are much more difficult to replicate than the chemically produced generics for other drugs. As a result, truly identical “generic” versions are virtually impossible to produce

¹⁰ U.S. Food & Drug Administration. The FDA’s Drug Review Process: Ensuring Drugs are Safe and Effective. <https://www.fda.gov/drugs/information-consumers-and-patients-drugs/fdas-drug-review-process-ensuring-drugs-are-safe-and-effective> Visited October 2022.

¹¹ As discussed generally at “A Tangled Web: An examination of the drug supply and payment chains”, US Senate Committee on Finance, Minority Staff report, p. 4, available at: <https://www.finance.senate.gov/imo/media/doc/A%20Tangled%20Web.pdf>.

¹² U.S. Food & Drug Administration. Frequently Asked Questions on Patents and Exclusivity, available at: <https://www.fda.gov/drugs/development-approval-process-drugs/frequently-asked-questions-patents-and-exclusivity>.

¹³ *Id.*

¹⁴ U.S. Food & Drug Administration. Generic Drugs: Questions & Answers, available at: <https://www.fda.gov/drugs/frequently-asked-questions-popular-topics/generic-drugs-questions-answers..>

¹⁵ U.S. Food & Drug Administration. Office of Generic Drugs 2021 Annual Report, available at: <https://www.fda.gov/drugs/generic-drugs/office-generic-drugs-2021-annual-report#:~:text=Currently%2090%20percent%E2%80%94949%20out,they%20are%20on%20the%20market.>

¹⁶ Patient Protection and Affordable Care Act, 42 U.S.C. §262(i) (definition of “biological product”).

¹⁷ U.S. Food & Drug Administration. *Development & Approval Process (CBER)*, available at: <https://www.fda.gov/vaccines-blood-biologics/development-approval-process-cber>.

¹⁸ 42 U.S.C. §262(k)(7). Data exclusivity granted by the U.S. Food and Drug Administration to a drug manufacturer prevents other companies from relying on the same clinical data to obtain market approval.

¹⁹ 42 U.S.C. §262(k).

currently. However, once patents expire for the existing brand-name biologic drugs, “biosimilar” medicines can be produced, which is an occurrence that raises regulatory issues in the states. In recent years a cumulative total of at least 49 states have considered legislation establishing state standards for substitution of a “biosimilar” prescription product to replace an original biologic product.²⁰

Comparable to the relationship between brand-names and generics, biosimilars are required to be extremely similar to approved biologics by having no clinically meaningful differences – the same strength, dosage form, and route administration (such as injection).²¹ Biologics and biosimilars can be categorized as specialty drugs when their storage requirements and complexity of administering the product to a consumer are such that they cannot be filled routinely in traditional pharmacy settings. According to the FDA, biologic and biosimilar drug products are the fastest growing class of therapeutic products in the U.S.²² Some biosimilar drugs meet additional requirements set out by the FDA and may be substituted for the reference product at the pharmacy; these drugs are known as interchangeable biosimilars.

C. PHARMACY BENEFIT MANAGERS (PBMs)

PBMs negotiate and contract with all the various types of pharmacies, including independent pharmacies and pharmacy chains of all sizes, on reimbursement and pharmacy network related terms.²³ PBMs design, negotiate, implement, and manage formulary designs for prescription drugs, including negotiating rebates and drug coverage terms with pharmaceutical manufacturers.²⁴ PBMs are responsible for the design and implementation of preferred and non-preferred pharmacy networks, metric-based payment arrangements, and formulary design elements (drug coverage, out-of-pocket responsibilities for patients and utilization management protocols).²⁵ PBMs engage in the negotiation and financial transactions between pharmaceutical manufacturers, health plans, and pharmacies.²⁶

D. PHARMACIES

1. CHAIN

A pharmacy chain refers to a third-party entity that engages in a retail business and that owns or operates multiple retail outlets at which an individual consumer may have a prescription drug order filled. The pharmacy retail outlet may also provide services that include providing immunizations, performing health screenings, testing at point-of-care, and providing medication counseling.²⁷

2. INDEPENDENT

²⁰ National Conference of State Legislatures, *State Laws and Legislation Related to Biologic Medications and Substitution of Biosimilars*, May 3, 2019, available at: <https://www.ncsl.org/research/health/state-laws-and-legislation-related-to-biologic-medications-and-substitution-of-biosimilars.aspx>.

²¹ U.S. Food & Drug Administration. *Biosimilars: More Treatment Choices and Innovation*, available at: <https://www.fda.gov/consumers/consumer-updates/biosimilar-and-interchangeable-biologics-more-treatment-choices>.

²² U.S. Food & Drug Administration. *Biosimilar Product – Regulatory Review and Approval*, available at: <https://www.fda.gov/media/108621/download>.

²³ See, generally, “A Tangled Web” at p. 26-34.

²⁴ *Id.*

²⁵ *Id.*

²⁶ *Id.*

²⁷ Wisconsin’s “Report of the Governor’s Task Force on Reducing Prescription Drug Prices, p. 20; “A Tangled Web” generally at p. 39-40.

Independent pharmacies refer to pharmacies that are privately and independently owned and operated by one or more pharmacists, and whose primary function is to provide direct pharmaceutical care to patients. These services include dispensing drugs, providing immunizations, performing health screenings, testing at point-of-care, and providing medication counseling in the community setting.²⁸

E. PHARMACISTS

The basic duty of a community pharmacist is to assess the safety and efficacy of prescriptions from physicians and other authorized prescribers before dispensing the medication to the patients to ensure that the patients do not receive the wrong drugs or take an incorrect dose of medicine. Pharmacists also provide counseling on the use of prescriptions. In addition to the medication expertise pharmacists contribute during the dispensing process, pharmacists also provide numerous patient care services to their patients to optimize the safe and effective use of medications, increase access to acute and preventative care, and work collaboratively with other members of the healthcare team to assist patients in reaching their therapeutic goals.

F. PHARMACY SERVICES ADMINISTRATIVE ORGANIZATIONS (PSAOs)

Pharmacy Services Administrative Organizations (PSAOs) are organizations that provide administrative services to independent pharmacies to support the evaluation and execution of a contract with PBMs or wholesalers.²⁹ In the majority of cases, an independent pharmacy's contract is with the PSAO, rather than with the PBM directly. The PSAO overall administrative function is to assist with contract evaluation and execution, customer service, central payment and reconciliation, and patient data evaluation.³⁰ In many instances a PSAO is owned by a wholesaler.³¹

G. WHOLESALERS/DISTRIBUTORS

Wholesalers purchase drugs from manufacturers, store those drugs, and then sell and distribute them to pharmacies, hospitals, provider offices and mail-order pharmacies. About 92 percent of prescription drugs in the United States are distributed through wholesalers, with three companies accounting for more than 90 percent of wholesale drug distribution in the United States. Wholesalers own the largest PSAOs used by independent pharmacies.

²⁸ *Id.*

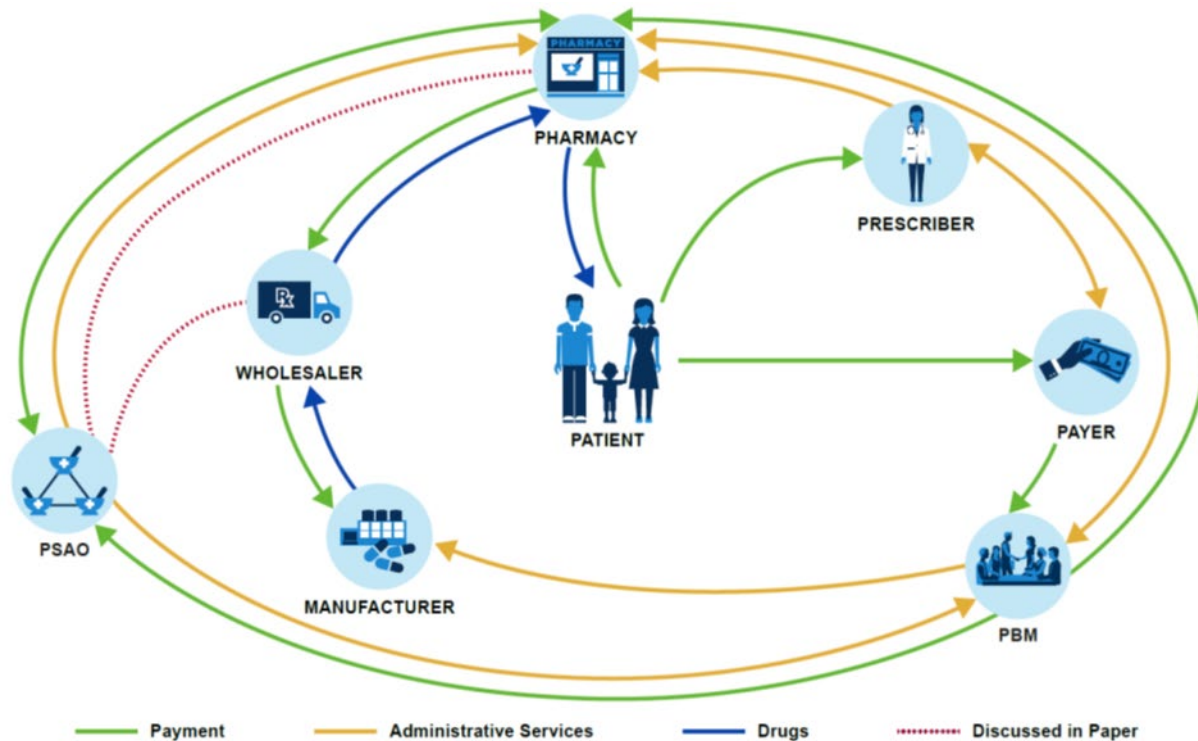
²⁹ "A Tangled Web", at p. 34, 41.

³⁰ *Id.*

³¹ Wisconsin's "Report of the Governor's Task Force on Reducing Prescription Drug Prices, p. 19.

H. INTERRELATION OF PARTIES IN THE CHAIN AND TRANSACTION COSTS

The diagram below provides a simplified illustration of the pharmaceutical distribution chain and the major entities involved that will be discussed in more detail in this section.³²



The following section outlines the basic transactions that occur between the participants in the prescription drug supply chain system. For clarity, the transactions are organized into two categories: the physical distribution of a drug and the interactions on the pharmacy benefit side.

1. Physical Drug Distribution Chain

This subsection explains interactions between participants in the physical distribution of prescription drugs.

Pharmaceutical manufacturer and wholesaler

The pharmaceutical manufacturer provides prescription drugs to the wholesaler based on negotiated prices.³³ The average negotiated price is based on the wholesale acquisition cost (WAC) price set by the manufacturer.³⁴

Wholesaler and pharmacy

The wholesaler sells their drugs to a pharmacy in an amount based on the WAC.³⁵ There are additional savings that can be achieved via volume rebates, functional rebates, bundle rebates, prompt pay discounts, free goods, marketing funds, and trade show discounts/rebates. The average wholesale price (AWP) is an estimate of the

³² Pharmaceutical Care Management Association (PCMA), “The Value of Pharmacy Benefit Management,” Presentation to the NAIC Pharmacy Benefit Manager Regulatory Issues (B) Subgroup, Aug. 9, 2022

³³ Jane Horvath, Georgetown University, “Basics of the Pharmaceutical Market & PBMs,” Presentation to the NAIC Pharmacy Benefit Manager Regulatory Issues (B) Subgroup, Aug. 19, 2019.

³⁴ *Id.*

³⁵ *Id.*; and generally, “A Tangled Web” at p. 21-25.

price wholesalers charge for drugs.³⁶ The National Average Drug Acquisition Cost (NADAC) is a federal Centers for Medicare and Medicaid Services (CMS)-calculated value that also attempts to capture the average price wholesalers charge to pharmacies.³⁷

Pharmacy and consumer

The pharmacy provides drugs directly to the consumer and collects certain cost sharing that may include co-pays or co-insurance.

2. Pharmacy Benefit Management Chain

This subsection explains interactions between participants in the administration of the pharmacy benefit plan.

Pharmaceutical manufacturer and PBM

The PBM negotiates rebates with the pharmaceutical manufacturers, and rebates are typically based on volume. PBMs can offer manufacturers higher volume, and thus command higher rebates, by putting a manufacturer's drug on the PBM's formulary and/or in a formulary's less expensive cost sharing tier.³⁸ Rebates create a market dynamic that may force up the "list" price of drugs by increasing the potential to generate "spread" profit.³⁹

Pharmaceutical Manufacturer and consumer

Pharmaceutical manufacturers can offer coupons or occasionally free samples of medications to consumers. The coupons can reduce a consumer's cost sharing below what they would have paid had they used their pharmacy benefit plan.⁴⁰

PBM and PSAO

The PSAO assists the pharmacy in negotiating with the PBMs for reimbursement rates.⁴¹ Most reimbursement rates are set based on a percentage of AWP and are applicable to all drugs based on brand or specialty status and are not negotiated on an individual drug basis.⁴²

Pharmacy and PBM

The pharmacy negotiates with the PBM to determine a reimbursement rate for the drugs they dispense.⁴³ Pharmacies typically negotiate as a chain in the case of chain pharmacies or through a PSAO. Like the PBM/PSAO relationship, negotiations are based on AWP less a percentage and apply to all drugs.⁴⁴ In addition, PBMs negotiate a dispensing fee with the pharmacies. Actual Acquisition Cost (AAC) is the final price a pharmacy pays after all discounts have been subtracted.⁴⁵

³⁶ *Id.*

³⁷ Jane Horvath, Georgetown University, "Basics of the Pharmaceutical Market & PBMs," Presentation to the NAIC Pharmacy Benefit Manager Regulatory Issues (B) Subgroup, Aug. 19, 2019.

³⁸ Wisconsin's "Report of the Governor's Task Force on Reducing Prescription Drug Prices, p. 21; "A Tangled Web" at 27.

³⁹ Dr. Neeraj Sood, "PBM Economics," Presentation to the NAIC Pharmacy Benefit Manager Regulatory Issues (B) Subgroup, Aug. 22, 2019.

⁴⁰ Wisconsin's "Report of the Governor's Task Force on Reducing Prescription Drug Prices, p. 50.

⁴¹ *Id.* at 19.

⁴² *Id.*

⁴³ Horvath; Wisconsin's "Report of the Governor's Task Force on Reducing Prescription Drug Prices, p. 21.

⁴⁴ Horvath.

⁴⁵ Horvath.

PBMs and Payors

A PBM may perform a number of services on behalf of its payor clients: negotiate rebates with the manufacturer, negotiate with pharmacies, and may develop the formulary on behalf of the payor, the plan sponsor or the insurer, or sell the payor a pre-determined formulary. PBMs also offer payors medical management/utilization review and disease management services.⁴⁶

PBMs are paid by the payor through an administrative fee or through a spread-pricing calculation, as specified in the contract. For payment on an administrative fee basis, the payor will pay the PBM an administrative fee, which can be in the form of a retainer, a per claim fee, or other similar arrangement. With spread pricing, also known as a risk mitigation pricing model, the payor will either not pay or pay a reduced administration fee and the PBM will retain certain risk related to the difference between the price paid by the customer and the price paid to the pharmacy. This arrangement provides the payor with the assurance of a set price.⁴⁷ Payors have the ability to choose either option in its contract with the PBM. Payors report the amount paid to PBMs for their services (including retained rebates and concessions) as administrative cost on their annual Medical Loss Ratio filings. The amount of rebates the payors receive is deducted from their claims paid.⁴⁸

With this complex pharmaceutical drug ecosystem as a backdrop, state legislatures around the country have enacted various state laws to promote greater transparency of the actions taking place and put in place specific requirements around the activities of those in the ecosystem. State laws and enforcement mechanisms have at times encountered federal pre-emption issues. Those issues are further detailed in the sections that follow.

III. ENFORCEMENT AND FEDERAL PREEMPTION ISSUES

In general, states have wide leeway to regulate PBMs serving health benefit plans in the individual market, small group market, fully insured large group market, and Medicaid. Under recent U.S. Supreme Court precedent, states also have significant authority to regulate costs for PBMs serving self-insured federal Employee Retirement Income Security Act of 1974 (ERISA) plans, though the legal boundaries of this preemption continue to be tested. It remains unclear how much authority states may exercise over PBM pharmacy networks and other elements of PBM administration. State authority to regulate PBMs serving Medicare Part D plans is limited to areas where the federal government has not established related standards.

This section will discuss the scope of federal preemption of state laws regulating PBMs under ERISA, Medicare Part D, and Medicaid, including the implications of recent and ongoing litigation.

A. ERISA: (SELF-INSURED AND FULLY INSURED)

⁴⁶ Horvath; Wisconsin's "Report of the Governor's Task Force on Reducing Prescription Drug Prices, p. 21.

⁴⁷ Horvath.

⁴⁸ 2 CMS Medical Loss Ratio (MLR) Annual Reporting Form Filing Instructions for the 2021 MLR Reporting Year. <https://www.cms.gov/files/document/2021-mlr-form-instructions.pdf>

ERISA governs all health benefit plans established by private-sector employers and certain employee organizations, such as unions.⁴⁹ ERISA's preemption clause, section 514, preempts all state laws to the extent that they "relate to" employer-sponsored health plans.⁵⁰ However, states are still permitted to maintain regulation of "the business of insurance" including for ERISA plans.⁵¹ This generally allows the states to regulate insurance carriers operating traditional insurance business, including regulation of plan design, solvency, and capital requirements for insurance companies.

However, ERISA explicitly prohibits states from regulating self-insured health plans where an employer bears the primary risk of claims and an insurer acts solely in an administrative capacity without bearing any risk.⁵² Under current federal court precedent, this effectively divides the large-group market into "fully insured" plans that are generally subject to state insurance law, and "self-insured" plans that are generally exempt from state insurance regulation.

Over the last 30 years, the U.S. Supreme Court has issued a series of opinions that narrow the scope of ERISA's preemption language. The most recent case, *Rutledge v. Pharmaceutical Care Management Association (PCMA)*,⁵³ decided in 2020, held that an Arkansas law (Act 900) requiring PBMs to reimburse pharmacies at a price equal to or greater than a pharmacy's wholesale cost was not preempted by ERISA. This suggests that states can regulate the conduct of PBMs that serve both fully insured and self-insured employer plans, to at least the same extent as the Arkansas law.

In *Rutledge*, the U.S. Supreme Court affirmed a legal standard stated in a prior decision, *Gobeille v. Liberty Mutual Insurance Company*.⁵⁴ To determine whether a state law has an impermissible connection with an ERISA plan, the Court asks whether the law "governs a central matter of plan administration or interferes with nationally uniform plan administration." In particular, a state law that "merely affects costs" will not be preempted, even where a cost regulation creates a significant economic incentive for a plan administrator, so long as it does not "force" a plan to adopt a certain "scheme of substantive coverage."⁵⁵

Taken together, this suggests that a state law comparable to Arkansas's Act 900 will not be preempted by ERISA, even if it applies to self-insured plans. The features of Act 900 upheld by *Rutledge* are as follows:

- (1) Requires PBMs to reimburse a pharmacy at a price equal to or greater than what the pharmacy paid to buy the drug from a wholesaler;
- (2) Requires PBMs to increase their reimbursement rate to cover a pharmacy's acquisition cost if that pharmacy is unable to acquire the drug at a lower price from a typical pharmaceutical wholesaler;

⁴⁹ Furrow, et al., "Health Law" Third Ed. (2014), p. 325-27.

⁵⁰ *Id.* at 328.

⁵¹ See, e.g., Furrow generally at p. 328-330.

⁵² *Id.* at 328.

⁵³ *Rutledge v. Pharmaceutical Care Management Association*, 141 S.Ct. 474 (2020).

⁵⁴ *Gobeille v. Liberty Mutual Insurance Company*, 577 US 312 (2016).

⁵⁵ *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 US 645 (1995). The Court found that a 13% surcharge that applied to all insurers other than Blue Cross / Blue Shield was not preempted by ERISA, despite creating a significant incentive for self-insured employers to choose Blue Cross / Blue Shield over other carriers. Since the law did not "force" plan administrators to make a particular choice, it was allowed by the court.

- (3) Requires PBMs to timely update their Maximum Allowable Cost (MAC) lists when drug wholesale prices increase;
- (4) Requires PBMs to provide an administrative appeals procedure for pharmacies to challenge MAC reimbursement that is below a pharmacy's acquisition cost;
- (5) Requires PBMs to permit a pharmacy to "reverse and rebill" any reimbursement claim affected by the pharmacy's inability to acquire the drug at a price equal to or less than a PBM's MAC reimbursement price;
- (6) Permits a pharmacy to decline to sell a drug to covered beneficiary if the relevant PBM will reimburse the pharmacy for less than the pharmacy's acquisition cost.

The PCMA argued that the enforcement mechanisms of the Arkansas law impermissibly interfere with ERISA plan management. The U.S. Supreme Court rejected this argument, noting that if taken to the extreme, the PCMA's proposed interpretation would preempt all state law mechanisms for resolving insurance payment disputes. However, beyond allowing Arkansas Act 900 to go into effect, the Court provided little guidance regarding what is or is not a matter "central to plan administration."

In a subsequent federal district court decision, *PCMA v. Mulready*⁵⁶, the lower court relied on *Rutledge* to conclude that Oklahoma's PBM law was not preempted by ERISA (the court's additional reasoning related to Medicare preemption is discussed below). The statute at issue in *Mulready* regulates both the network status of particular pharmacies as well as the conditions under which a PBM may reimburse for prescriptions, which the PCMA argued goes significantly beyond "mere cost regulation." However, the PCMA has appealed the *Mulready* decision, and it remains unclear whether the appeals court or other courts will follow its reasoning.

Another important aspect of the law at issue in *Rutledge* is that it is not applied exclusively to or even expressly to ERISA plans. Rather, it applies to PBMs whether or not they manage ERISA plans. Under prior U.S. Supreme Court precedent, a law may be preempted by ERISA if it "acts immediately and exclusively upon ERISA plans or where the existence of ERISA plans is essential to the law's operation."⁵⁷

Under the precedent of *Rutledge*, it seems clear that states have some leeway to regulate PBMs without concern for ERISA preemption. A law that distinguishes between ERISA and non-ERISA plans would be more likely to be preempted, particularly if it places a higher burden on ERISA plans than for other markets. A law that mandates particular pharmaceutical coverage, such as requiring reimbursement for a specific drug or diagnosis, would likewise be preempted as regulating plan design. In contrast, a law that applies to PBMs regardless of market segment that merely regulates cost, similar to the Arkansas statute, would likely be upheld. Lesser regulations, such as transparency programs, are also unlikely to be preempted under ERISA.

B. MEDICARE PART D

Medicare Part D is an optional, federally supported prescription drug benefit available to Americans over the age of 65. The program's authorizing legislation incorporates the federal preemption language from the

⁵⁶ *Pharmaceutical Care Management Association v. Mulready*, 598 F.Supp.3d 1200 (2022).

⁵⁷ *Rutledge*, at 6.

Medicare Part C, or “Medicare Advantage (MA)” program, which provides: “the standards established under this part shall supersede any state law or regulation (other than state licensing laws or state laws relating to plan solvency) with respect to MA plans which are offered by MA organizations under this part.”⁵⁸

In general, courts have found that state laws are preempted under Medicare Part D where Congress or the CMS have established “standards” for the area regulated by said state laws. This means that the authority of states to regulate MA or Medicare Part D plans is significantly limited, though states explicitly retain the authority to regulate plan solvency. The Medicare Managed Care Manual indicates that state law should only be preempted where it would be impossible for a carrier to comply with both state and federal standards – a state standard that is stricter than the Medicare standard should not be preempted. However, courts have held that standards set by the CMS do not necessarily need to conflict with the provisions of state law for preemption to hold.

In *Mulready v. PCMA*, the federal district court ruled that many provisions of Oklahoma’s PBM statute were preempted with respect to Medicare Part D plans (the preceding section discussed the same court’s reasoning with respect to ERISA plans).⁵⁹

In its review of the statute at issue, the *Mulready* court found that several provisions of Oklahoma’s law were preempted by Medicare Part D. This included multiple elements of the law related to pharmacy reimbursement, including a ban on PBM service fees, a ban on PBMs reimbursing affiliated pharmacies at higher rates, and a ban on PBMs reducing pharmacy reimbursement after completion of a sale. Part D prohibits interference with negotiation between insurers and pharmacies, and Part D defines “negotiated price” by reference to the negotiations.⁶⁰ Accordingly, the district court agreed with the PCMA that these aspects of the state law were barred with respect to PBMs serving Medicare Part D plans as an impermissible interference in the price negotiations between PBMs, as the agents of Medicare Part D carriers, and pharmacies.⁶¹

The district court also ruled that Oklahoma’s retail-only pharmacy access standard was preempted because the CMS has established standards regulating convenient access to network pharmacies.

However, the district court held that the remaining provisions of the Oklahoma law challenged by the PCMA were not preempted by Medicare Part D.⁶² This includes the law’s requirements for preferred pharmacy networks, including the law’s any willing provider provision, affiliated pharmacy prohibition, and network provider restriction. The district court reasoned that while the CMS has promulgated a standard with respect to standard networks, there is no federal standard in place for preferred networks. Since all the relevant provisions of Oklahoma law apply only to preferred network status, the district court ruled there was no applicable standard in place that would preempt Oklahoma’s law.

Finally, the district court rejected the PCMA’s challenge to Oklahoma’s contract approval provisions.⁶³ Under the Oklahoma statute, insurers who utilize the services of PBMs are required to approve all contracts between the PBM and the PBMs retail pharmacy network. In this instance, the PCMA again pointed to Medicare Part D’s ban on interference in contract negotiations. However, the district court reasoned that Medicare Part D’s bar applies only to negotiations between plan sponsors and PBMs, while Oklahoma’s law regulates negotiations between

⁵⁸ 42 CFR § 422.402.

⁵⁹ *Pharmaceutical Care Management Association v. Mulready*, 598 F.Supp.3d 1200 (2022).

⁶⁰ *Id.*

⁶¹ *Id.*

⁶² *Id.*

⁶³ *Id.*

PBMs and pharmacies. Accordingly, the district court concluded that the contract approval provisions of Oklahoma’s law are not preempted by Medicare Part D.

The PCMA has appealed the district court’s decision. It is unknown whether the 10th Circuit or other courts will follow the same reasoning with respect to the scope of Medicare Part D preemption of state PBM laws.

C. MEDICAID

Medicaid is a program that provides health benefits to certain low-income Americans and is jointly funded by the federal government and state governments.⁶⁴ It is structured very differently from either Medicare Part D or ERISA. Both Medicare and ERISA were set up with the intent of establishing uniformity of implementation nationwide – making preemption of state laws that conflict with the federal plan an important element of the program’s structure. Medicaid, however, is structured as a federal-state partnership and its implementation varies significantly from state to state. This means that the states have broad leeway to regulate PBMs serving Medicaid carriers, if those regulations do not come into conflict with the state’s Medicaid structure.

Each state implements Medicaid pursuant to a Medicaid plan submitted by the state and approved by the CMS.⁶⁵ Any changes a state makes to Medicaid implementation must also be approved by the CMS via a plan amendment process.⁶⁶ In some cases, states may also receive a waiver from certain terms of the Medicaid provisions in the Medicare and Medicaid Act (herein referred to as the Medicaid Act) under Section 1115 of the Social Security Act. So long as the PBM regulation is consistent with the terms of the state’s current Medicaid plan, it should be safe from federal preemption.

However, state laws that conflict with the terms of the Medicaid Act can still be theoretically preempted under the Supremacy Clause of the U.S. Constitution. Unlike Medicare Part D and ERISA, the Medicaid Act does not include any preemption language that goes beyond common law interpretation of the Supremacy Clause. Under common law, a state law will generally be preempted only if it is impossible for a regulated entity to comply with both the state and the federal statute. However, jurisprudence specifically related to Medicaid preemption is extremely limited, making definitive analysis difficult.

In many states, the state Medicaid agency contracts with one or more managed care organizations (MCOs) to administer all or a part of the state’s Medicaid program, including the management of the pharmacy program through the MCO’s contracted PBM. Some states also contract with PBMs directly to administer the pharmacy benefit, either in conjunction with or separate from an MCO. In other cases, the state Medicaid agency manages the Medicaid pharmacy program on its own.

To address rising costs, Congress passed legislation enacting the Medicaid Drug Rebate Program in 1990. Under this program, pharmaceutical manufacturers sign a master rebate agreement with the CMS, which administers the Medicaid program at the federal level. These rebates result in prescription drug cost savings that are paid for under the Medicaid program and are shared by both the state Medicaid agency and the CMS. State Medicaid programs are required to provide a pathway to coverage for any drug whose manufacturer has signed a rebate agreement with the CMS. Therefore, state Medicaid programs lack the flexibility that private insurers have to implement strict formularies to control prescription drug spending. Instead, state Medicaid programs are allowed to negotiate additional “supplemental rebates” with pharmaceutical manufacturers individually, and to

⁶⁴ See, e.g., Furrow generally at p. 460-462.

⁶⁵ Furrow at p. 490-492.

⁶⁶ *Id.*

develop preferred drug lists in consultation with state Drug Utilization Review (DUR) Boards and Pharmacy and Therapeutics (P&T) Committees.

In summary, Medicaid preemption should not be a significant concern for states looking to regulate PBMs that serve Medicaid MCOs or other Medicaid carriers. However, states should ensure that any changes to PBM regulation in the Medicaid space are consistent with the state's Medicaid plan or seek an appropriate plan amendment if they are not.

IV. FUNCTIONAL ISSUES

As the national conversation has evolved, most of the direct regulation has involved the practices of PBMs. As such, the most robust bodies of law and descriptions of practices have focused on PBM activities. Several functional issues within this ecosystem have been identified by state regulators as central to the ultimate pricing consumers pay or as having other significant marketplace impacts. Those functional issues are discussed in the sections that follow.

A. FORMULARY DESIGN

PBMs implement formularies or lists of covered drugs⁶⁷. PBMs' customers – payors, such as insurers or self-funded employer plans, may request open formularies, develop their own formularies, or purchase formularies from PBMs. Even closed formularies typically require coverage for at least one drug per therapeutic class.

For PBM developed formularies, PBMs employ panels of experts called Pharmacy and Therapeutics (P&T) Committees. These committees, made up of independent physicians, pharmacists, and other health care providers, evaluate clinical and medical literature to select the most appropriate medications for individual disease states and conditions.⁶⁸ The federal Affordable Care Act (ACA) introduced federal regulations on P&T Committees serving qualified health plans (QHPs).

P&T Committees typically reviews drugs to identify those that are required (preferred), unacceptable and acceptable based on medical standards. The category of those that are determined acceptable is where there is leeway on the PBM's part to determine formulary inclusion.⁶⁹

PBMs review acceptable drugs that have been determined "clinically equivalent" and negotiate for the highest rebate and include these drugs in the formulary. PBMs negotiate drug costs with pharmaceutical manufacturers across the board for all customers using their volume of scale and then work with individual customers to create formularies.

Formularies provide lists of pharmaceutical drugs covered by payors and can be differentiated between preferred or discouraged products by dividing into three to five "tiers," each with a separate level of cost sharing.⁷⁰ By placing a drug in a preferred tier, PBMs can drive volume to that drug's manufacturer. This is an

⁶⁷ Derek J. Oestreicher, Office of the Montana State Auditor, "A Prescription for the Drug Price Epidemic," Presentation to the NAIC Pharmacy Benefit Manager Regulatory Issues (B) Subgroup, Oct. 3, 2019.

⁶⁸ Horvath.

⁶⁹ *Id.*

⁷⁰ Oregon Drug Price Transparency Report of 2019 at 10-11, available at:

<https://dfr.oregon.gov/drugtransparency/Documents/Prescription-Drug-Price-Transparency-Annual-Report-2019.pdf>.

effective way for PBMs to generate rebates for either multi-source brands or competing brands in a therapeutic class.

Since formularies are essentially coverage decisions, a PBM's step-therapy protocol may be viewed as part of its formulary. Step-therapy, a utilization management tool, requires a patient to try a particular drug before another drug is covered. PBMs may shift drugs between tiers or add or remove them from the formulary entirely during a plan year, another utilization management practice which is known as "non-medical switching."⁷¹

B. REBATES

The negotiation between a pharmaceutical manufacturer and PBM may result in a rebate. The rebate flows back to the PBM from the manufacturer usually based on the volume of prescriptions generated by the placement of the manufacturer's drug on the PBM's formulary. The PBM may pass the rebate on to the plan sponsor according to their shared contract, which may allow the PBM to keep a percentage of the rebate; however, it is possible the PBM keeps the entire rebate with no direct benefit to the plan sponsor or the consumer.⁷²

Rebates are mostly used on brand-name and specialty drugs where similar competing drugs from other manufacturers exist. From a manufacturer's perspective, the rebate is a tool to incentivize PBMs to place the manufacturer's drugs on formularies within preferred tiers.⁷³ PBMs negotiate based on their volume of scale to obtain highest rebate for selected drugs.⁷⁴ From the PBM's perspective, a large rebate results in a smaller amount spent by their customers and more income for the PBM from proportional pass-through contracts.⁷⁵

Rebates are negotiated separately with each plan sponsor and can take different forms in how they are passed along:⁷⁶

- 100 percent pass-through – The PBM passes 100 percent of the rebate back to the plan sponsor. Most customers prefer this method.
- Proportional pass-through – The PBM keeps a percentage of the rebate and passes the remainder back to the plan sponsor.
- At Risk – The PBM keeps 100 percent of the rebate but guarantees a certain level of rebate to the customer. In this instance the PBM is "at risk" for the difference between the guarantee and actual rebates received. In exchange, this option provides cost predictability to the customer.

The existence of rebates alone is not a problem. However, the PBM's ability to retain a percentage of the rebate creates a concern as they are also commonly in charge of formulary design. These two factors give PBMs a financial incentive to prioritize drugs in the formulary based on the highest rebate instead of the lowest total

⁷¹ See, e.g., National Conference of State Legislatures Glossary at: <https://www.ncsl.org/health/state-policy-options-and-pharmacy-benefit-managers#anchor16752>.

⁷² Oregon Drug Price Transparency Report of 2019 at 10-11; Sood; Oestreicher.

⁷³ Sood; Oestreicher.

⁷⁴ *Id.*

⁷⁵ *Id.*

⁷⁶ *Id.*

cost to the plan sponsor or consumer.⁷⁷ This could result in plan sponsors and consumers paying a higher cost for prescription drugs than is necessary, resulting in higher prescription drug coverage costs.

Approaches to curb the negative effects of rebates include:

- **Rebate retention prohibitions:** As part of their PBM laws, some states have enacted a provision stating that a PBM must pass through 100 percent of a pharmaceutical manufacturer rebate to a plan sponsor.⁷⁸
- **Rebates at point-of-sale (POS):** Some believe that rebates should be provided directly to consumers at POS to reduce deductibles or co-insurance amounts owed when the drug is purchased. As a result, these funds would no longer be used to offset the plan sponsor costs and could result in higher premiums for all members. Additionally, members with low or no prescription drug usage might experience a disproportional impact as they would be paying higher premiums and would not have a financial benefit from the POS rebates. Some insurers have indicated that passing the rebates to the consumer at POS would have a dramatic enough effect on drug adherence that it would cover the potential benefit of using the rebates against premiums and result in no additional premium cost.⁷⁹
- **Elimination of rebates:** Some have recently called for the elimination of rebates to provide more price transparency within the system. While the elimination of rebates might serve to achieve this, it could also cause a major disruption in current market conditions. In the short term, eliminating rebates without corresponding legislation to lower pharmaceutical manufacturer prices could lead to increasing the cost of drugs to PBMs, plan sponsors and ultimately consumers. In the longer term, eliminating rebates could lead to increased transparency in price competition between manufacturers of similar drugs as price setting would no longer happen in a private contractual setting with a PBM.⁸⁰

C. PRICING AND CONTRACTING PRACTICES

PBMs negotiate with pharmaceutical manufacturers, health plans, and pharmacies. PBMs may also be affiliated with a health plan and a pharmacy. In particular, the unique market position and negotiating power of PBMs enables them to engage in contracting practices that may be detrimental to consumers and other market participants.⁸¹ A variety of pricing and contracting practices are used by PBMs and have received scrutiny from regulators. Several of these practices are described below:

- **Gag clauses:** The term “gag clause” refers to a stipulation in a pharmacy benefit contract that prohibits a pharmacy or pharmacist from informing consumers of an alternative option when purchasing a drug. For instance, a gag clause may prohibit a pharmacist from telling a consumer about a generic version of a prescription drug or if a prescription drug can be purchased at a lower price out-of-pocket rather than through their insurance plan.⁸²
- **Mandatory arbitration clause:** Most PBMs require that disputes be submitted to binding arbitration by including a mandatory arbitration provision in their pharmacy contracts. Some believe mandatory

⁷⁷ *Id.*

⁷⁸ Horvath; Sood. Oestreicher.

⁷⁹ *Id.*

⁸⁰ *Id.*

⁸¹ Sood.

⁸² “A Tangled Web,” p. 33, 44; National Conference of State Legislatures Glossary of PBM terms, available at: [State Policy Options and Pharmacy Benefit Managers \(ncsl.org\)](https://www.ncsl.org/state-policy/state-policy-options-and-pharmacy-benefit-managers).

arbitration limits legal recourse for individual pharmacies and results in pharmacies foregoing potentially successful audit challenges.⁸³

- Copay clawbacks: A copay clawback is the PBM practice of taking back from a pharmacy the difference between a patient's copay and the actual cost of the medication when the patient's copay is larger than the cost of the drug.⁸⁴
- MAC transparency: A maximum allowable cost (MAC) list is a list that includes the maximum amount that a plan will pay for certain drugs.⁸⁵ MAC lists are often generated by the PBM. There is no standardization in the industry as to the criteria for the inclusion of drugs on MAC lists or for the methodology as to how the maximum price is determined, changed or updated. PBMs may sometimes use multiple MAC lists and pocketing the spread between the two. For example, PBMs might use a very low MAC list to reimburse pharmacies but a higher list when charging plan sponsors.⁸⁶
- Rebates: Rebates may provide incentive for a PBM to eliminate a less expensive, comparable medication from a formulary. Pharmaceutical manufacturers claim that these rebates are meant to be shared with plan sponsors or passed on to consumers in the form of lower drug prices. However, PBMs regularly keep a share of the rebates before passing the rest through to the plan sponsor.⁸⁷
- Spread pricing: Spread pricing is the practice of a PBM charging a plan sponsor a higher amount for a drug than they will reimburse the pharmacy and pocketing the difference. Pharmacy pricing is complex, and the process is not transparent. Plan sponsors are often unaware of the difference between the amount they are billed and the pharmacy reimbursement.⁸⁸
- Pharmacy audit: PBMs routinely audit pharmacies to validate data entry, ensure compliance with regulatory and contractual requirements, and to help identify and mitigate fraud, waste, and abuse of a prescription drug benefit. However, many pharmacists have stated that the audits are unfair and may result in stiff penalties and fees.
- Retroactive fees: PBMs engage in retroactive claim reviews, meaning they review a claim after it has been adjudicated. A retroactive claim review may result in a denial of a claim or a reduction in reimbursement after payment for the claim has been authorized.

Each of these practices has been addressed by one or more state laws around the country; however, the scope and method of regulation has varied by those states. More details are provided in the state-specific sections below.

D. VERTICAL INTEGRATION AND CONSOLIDATION

In business and economics, vertical integration means the combination in one company of at least two stages of production normally performed by separate companies. For example, an entity that manufactures a product may also be affiliated with a wholesale distributor and a retail store through common ownership.⁸⁹ The entities

⁸³ Oestreicher.

⁸⁴ *Id.*; "A Tangled Web," p. 33.

⁸⁵ National Conference of State Legislatures Glossary of PBM terms, available at: [State Policy Options and Pharmacy Benefit Managers \(ncsl.org\)](https://www.ncsl.org/state-policy/state-policy-options-and-pharmacy-benefit-managers).

⁸⁶ "A Tangled Web," p. 29-30.

⁸⁷ Horvath.

⁸⁸ Oestreicher.

⁸⁹ Sood.

at the various levels of the integrated enterprise may deal exclusively with the parent company's goods or services or may offer non-integrated products or services.⁹⁰

The three largest PBMs are each affiliated with a health plan and a pharmacy, so the parent company owns or controls up to three stages of the drug supply chain.⁹¹ Some PBMs are also affiliated with health care providers, such as retail clinic services. Thus, one entity controls the diagnosis of a condition, the retail sale of a prescribed drug to the patient, the distribution of the drug from manufacturer to retail pharmacy, and the insurance payment to the pharmacy, including determination of the patient's cost-sharing amounts.

In theory, vertical integration allows a company to synergize operations between stages of production and pass the savings from smaller transaction costs to their customers. However, vertical integration can also be a contributing factor in the monopolization of markets due to market foreclosure, where the merger or acquisition of a stage of production denies competing businesses access to that firm's business.⁹²

Consolidation refers to the merger and acquisition of many smaller companies resulting in a few much larger companies. The benefit of consolidation is that a larger firm may be able to realize efficiencies of scale and pass the resulting cost savings to consumers. The downside of consolidation is that costs tend to rise when there are fewer existing firms around to compete on prices and the few remaining firms price their products to maximize profit.⁹³ Along with vertical integration, consolidation in the pharmacy benefit supply chain has led to current market conditions, which feature the three largest PBMs covering 79 percent of prescription drug claims.⁹⁴ Further, independent pharmacies are put at a competitive disadvantage compared to PBM-affiliated pharmacies when it comes to contracting.

The proliferation of PBM-health insurer affiliations has resulted in inefficiencies in the market.⁹⁵ From the health insurer's perspective, an affiliation with a PBM is incredibly valuable for two reasons: lower costs for pharmacy benefit services and exclusive or priority access to the PBM. From a market perspective, a PBM-health insurer relationship results in lower market competition, dealings within affiliated businesses and possible anti-competitive practices.⁹⁶ The three largest PBMs are all affiliated with health insurers, so other large health insurers not affiliated with a PBM are no longer able to find a PBM that operates on their scale that is not affiliated with a competitor.

A PBM-pharmacy affiliation creates several incentives for PBMs to act against the best interests of the consumer. PBMs have been found inserting language into pharmacy benefit contracts that requires enrollees to use PBM-owned mail pharmacy services for long-term (90 days or longer) "maintenance" medications.⁹⁷ This contractual requirement effectively eliminates any competition to fill these prescriptions, allowing the pharmacy to charge higher prices to the consumer. An affiliation with a pharmacy may also incentivize a PBM to do the following, which are all contrary to the best interests of consumers:

- Perform fewer generic substitutions;

⁹⁰ *Id.*

⁹¹ *Id.*

⁹² *Id.*

⁹³ *Id.*

⁹⁴ [PBMs ranked by market share: CVS Caremark is No. 1](#); Becker's Hospital Review (website); March 8th, 2022.

⁹⁵ Sood.

⁹⁶ *Id.*

⁹⁷ "A Tangled Web," p. 42-43.

- Switch patients to higher-cost therapeutic alternatives (“therapeutic interchange”); or,
- Repackage drugs in a manner that could lead to increased costs to plan sponsors, while maximizing revenue for the PBM (“package size pricing”).

E. PHARMACY NETWORK ADEQUACY

A pharmacy network is a list of pharmacies or pharmacists that a health plan or PBM has contracted with to provide prescription drug services to their members.⁹⁸ Pharmacy network adequacy is often defined as the distance between a patient’s residence and where services can be physically accessed.

Pharmacy access is an integral component of the standards established under section 1860D-4(b)(1)(C) of the federal Medicare Modernization Act of 2003. The standards require in part that each sponsor secure the participation in their pharmacy networks of a sufficient number of pharmacies to dispense drugs directly to patients (other than by mail order) to ensure convenient access to covered drugs by plan enrollees. Several states have since followed suit, defining acceptable pharmacy network adequacy standards for network participation with respect to various regions of their states and across all health plan types. Pharmacy network adequacy provisions effectively prohibit a PBM from deciding to contract with a narrow pharmacy network, potentially limiting member access to prescription drugs.

Some states specify that mail order pharmacies cannot be used to determine compliance with pharmacy network adequacy standards, while others specify that a network must have a mix of both retail and mail order pharmacies. Standards can be established by time and distance standards relative to the state as a whole, or to counties, or zip codes. In determining whether a PBM complies with access requirements, states review and consider the relative availability of physical pharmacies in a geographic service area.⁹⁹ Common pharmacy network adequacy requirements include:

- Defining what is a reasonably adequate retail pharmacy network;
- Making clear that mail-order pharmacies cannot be used to meet access standards;
- Requiring pharmacy networks to consist of both retail and mail order pharmacies in a specific geographic service area;
- Requiring ongoing monitoring of a PBM’s capacity to furnish services;
- Network accessibility reporting requirements;
- A current, accurate, and searchable directory of pharmacies; and
- Requiring a minimum of at least one pharmacy per county, zip code, or other specifically defined service area.

About 35 percent of the states have some type of legislation that addresses PBM’s placing heightened accreditation requirements upon pharmacies seeking to join the PBM’s networks.¹⁰⁰ When this is the case, common legislative elements include prohibiting PBMs from imposing provider accreditation standards or certification requirements inconsistent with, or more stringent than the requirements of the state board of pharmacy or other state/federal agencies. Typically, the PBM must apply standards without regard to PBM

⁹⁸ Horvath; National Conference of State Legislatures Glossary of PBM terms, available at: [State Policy Options and Pharmacy Benefit Managers \(ncsl.org\)](https://www.ncsl.org/state-policy/state-policy-options-and-pharmacy-benefit-managers).

⁹⁹ National Conference of State Legislatures Glossary of PBM terms, available at: [State Policy Options and Pharmacy Benefit Managers \(ncsl.org\)](https://www.ncsl.org/state-policy/state-policy-options-and-pharmacy-benefit-managers).

¹⁰⁰ See generally, PBM Law Compilations, available at: https://content.naic.org/cmte_b_pharmacy_bmri_sg.htm.

affiliation and may not change the standards more than once every 12 months. The last common element is requiring PBMs to provide written disclosures upon request.

Commonly, PBMs, or the health plans they contract with, require members to have their prescriptions filled *only* at pharmacies with which the PBM, or the health plan, is affiliated or has an ownership interest in. This is considered “steering,” and is sometimes prohibited by state law.¹⁰¹ Sometimes PBMs will even mine members’ health data in an attempt to steer them to the PBM’s affiliated pharmacies. This practice has become more popular as the number of health insurance companies that own PBMs has increased. Steering can limit a member’s choice, increase costs, and lower quality of care to members.

Anti-steering state legislation typically prohibits PBMs from requiring drugs to be dispensed from specific contracted or affiliated pharmacies and prohibits PBMs from assessing additional fees when a prescription is filled by an in-network contracted pharmacy, but which is not specifically authorized by the PBM to fill certain types of prescriptions as a “specialty pharmacy.” This occurs even when a pharmacy may otherwise have the credentials to do so, such as when it is a compounding pharmacy.

Such anti-steering legislation can have a major impact. It has been reported that even though less than 2 percent of the population uses specialty drugs, those prescriptions account for a staggering 51 percent of total pharmacy spending. This is a rapidly increasing trend. At a member level, plan sponsors see an average annual cost of \$38,000 to cover a specialty patient’s drugs, compared to just \$492 for the coverage of a non-specialty patient’s drugs. That is 75 times more to cover a specialty patient over the course of a year.¹⁰²

These types of practices can result in harm, including increasing drug prices, overcharging members, restricting a member’s choice of pharmacies, underpaying community pharmacies and other dispensers, and fragmenting and creating barriers to care, particularly in rural areas, and for members battling life-threatening illnesses and chronic diseases.

F. LICENSING OF DIFFERENT ENTITIES INVOLVED IN THE DISTRIBUTION/SUPPLY CHAIN

Even though PBMs are engaged in interstate commerce and are not purely in the business of insurance, the trade practices described herein have largely eluded federal regulatory oversight. Many states have enacted licensing schemes to regulate PBMs in the absence of federal oversight. These licensing schemes usually place PBMs under the regulatory authority of a state’s insurance department. Most states have gone about this in two ways: 1) regulating PBMs under a third-party administrator (TPA) law; or 2) establishing a standalone license for PBMs. The various licensing laws address some of the issues herein through prohibition of certain behaviors, requiring transparency in business practices, or by requiring disclosures by the PBM.

Based on the conversations of the NAIC Pharmacy Benefit Manager Regulatory Issues (B) Subgroup, a standalone PBM license is generally preferred among regulators. Anything less than licensure, including a registration requirement, is considered to lack significant enforcement mechanisms.

¹⁰¹ Sood.

¹⁰² See Evernorth Health Services, “What is Drug Trend and How to Manage It” last accessed February 27, 2023, available at: <https://www.evernorth.com/articles/specialty-drug-trends-and-utilization>.

Other key players that are licensed in the distribution and supply chain are described in this section. The level of regulation imposed on other players in the supply chain demonstrates the uniquely minimal level of oversight PBMs have experienced and continue to experience in many jurisdictions.

1. Health insurers

Commercial health insurers are subject to federal and state oversight. Insurers providing fully insured employer or group plans and individual market coverage are regulated by states.¹⁰³ Self-insured health plans sponsored by employers or unions are subject to federal oversight pursuant to ERISA, although the *Rutledge v. PCMA* case does seemingly allow state regulation of certain PBM activities performed for ERISA plans.

2. Wholesalers

All 50 states and the District of Columbia require a wholesaler to be licensed. The structure of the statutes vary but all of the statutes incorporate federal regulation language. There are several federal regulations that establish the minimal licensing requirements for drug wholesalers in the states. Every wholesale distributor in a state must be licensed by the state licensing authority, and the state must require that personnel employed by distributors have the appropriate education and/or experience for the position that person is hired for.

Per 21 C.F.R. § 205.6, the following factors should be considered by the states before granting a wholesaler license:

- Any convictions of the applicant under any federal, state, or local laws relating to drug samples, wholesale or retail drug distribution, or distribution of controlled substances;
- Any felony convictions of the applicant under federal, state, or local laws;
- The applicant's past experience in the manufacture or distribution of prescription drugs, including controlled substances;
- The furnishing by the applicant of false or fraudulent material in any application made in connection with pharmaceutical manufacturing or distribution;
- Suspension or revocation by federal, state, or local government of any license currently or previously held by the applicant for the manufacture or distribution of any drugs, including controlled substances;
- Compliance with licensing requirements under previously granted licenses, if any;
- Compliance with requirements to maintain and/or make available to the state licensing authority or to federal, state, or local law enforcement officials those records required under this section; and
- Any other factors or qualifications the state licensing authority considers relevant to and consistent with the public health and safety.

3. Manufacturers

Pharmaceutical manufacturers are required to be registered with the FDA within five days of starting operations (see 21 C.F.R. § 207 et seq). Applicants are required to provide standard business information as well as the list of drugs they produce as part of the application process. In addition to registering pharmaceutical manufacturers, the FDA also reviews all human drugs, including biologics, for safety, effectiveness, and quality. Each new drug has an application process; there is a licensing application for biologics. The FDA also inspects manufacturing facilities for drugs, including biologics, before drug production begins and according to their Compliance Program Guidance Manual (CPGM).

While most states require pharmaceutical manufacturers that produce or distribute drugs within their state to be licensed, states exercise little total control over pharmaceutical manufacturers. The FDA is responsible for approving new drugs and allowing for a given drug's patent protection period, which gives manufacturers a

¹⁰³ Furrow at p. 308, 314-316.

period of exclusivity before generics of that drug are allowed to be produced. Because the federal government is responsible for this function, there is little states can do about some of the life cycle management practices manufacturers engage in to extend the market exclusivity of their drugs. Pharmaceutical manufacturers commonly seek to extend their patent protection period by providing a new formulation of a drug or changing the route of administration for a drug.

4. Pharmacies

All 50 states and the District of Columbia require pharmacists to be licensed to practice within the state. To obtain a pharmacist license, states commonly require the applicant to satisfy the following criteria:

- Complete an application and pay the required fee;
- Proof of completion of a college degree in pharmacy from an approved college or other institution
- Completion of an approved internship, typically requiring between 1,000 and 1,750 hours;
- The applicant has passed the Multistate Pharmacy Jurisprudence Examination (MPJE) and the North American Pharmacist Licensure Examination (NAPLEX); and
- A fingerprint background check of some nature, normally including a criminal record search and/or production of a birth certificate and/or other vital documents.

All 50 states and the District of Columbia also require pharmacies to be licensed. Typically, the information needed for a license includes:

- Business entity information;
- The type of pharmacy (retail, hospital, sterile compounding, nuclear, etc.);
- Pharmacist-in-charge information, including license number;
- Articles of incorporation/formation;
- A list of officers and owners of the business;
- Disciplinary and criminal history for owners and officers of the pharmacy;
- A list of other licensed personnel who will operate the pharmacy, such as pharmacy technicians and pharmacist interns;
- Pharmacy hours of operation; and
- Application and license fees.

5. Pharmaceutical sales representatives (PSRs)

In comparison to other entities in the pharmaceutical supply chain, few states require pharmaceutical sales representatives (PSRs) to be licensed. PSRs have a large potential impact on the use and overuse of pharmaceutical drugs based on their interactions with prescribing health care providers.

PSR licenses generally require a pharmaceutical manufacturer to supply a list of all PSRs to the regulating entity. For licensure, the PSRs are generally required to take a professional education course that may include training ethics, pharmacology, and pharmaceutical marketing laws and rules. A licensed PSR is required to submit an annual report to the regulating entity that includes information on which health care providers they have contacted, which drugs they sold, any samples or gifts that were provided, and if the providers were compensated for their time.

In the absence of a law, the Pharmaceutical Research and Manufacturers of America (PhRMA) has instituted a Code on Interactions with Health Care Professionals.¹⁰⁴

The licensing of entities involved in the distribution/supply chain is an evolving area. Many activities performed by some of these entities may be captured by state TPA laws, although some may not be. The NAIC Pharmacy Benefit Manager Regulatory Issues (B) Subgroup continues to monitor developments in this area.

V. STATE LAWS IMPACTING THE DRUG SUPPLY CHAIN

In the last several years states have been working on legislative solutions to increase transparency and accountability for key players in the prescription drug supply chain and to increase affordability and accessibility of prescription drugs for consumers.

Over 40 states require PBMs to be licensed by or register with the state's Department of Insurance. In addition, a few states require PBMs to register as a TPA.¹⁰⁵ Based on NAIC member self-reporting, as of February 2023, states also have enacted legislation regulating certain PBM business practices. At least seven states give the state Department of Insurance (DOI) the authority to conduct PBM examinations. About eight states also have enacted legislation related to PBM pharmacy networks, including requirements related to network adequacy, prohibiting affiliate-only networks, and prohibiting PBMs from requiring consumers to use mail-order pharmacies. Numerous states have enacted laws prohibiting certain market conduct practices such as misleading advertising and solicitation. In addition, several states have enacted laws specifically prohibiting gag clauses, clawbacks, and spread pricing. Over 20 states have also enacted legislation regulating PBM pharmacy audit procedures. Rebating has also been a source of state legislation. Four states require PBMs to submit to the insurance commissioner annually or quarterly certain rebate information, including:

- 1) the aggregate amount of rebates the PBM received;
- 2) the aggregate amount distributed to the appropriate healthcare payor; and
- 3) the aggregate amount passed on the enrollees of each healthcare payor at the point of sale that reduced the enrollees' applicable deductible, copayment, coinsurance, or other cost-sharing amount.

States have also enacted legislation requiring transparency in pricing. The most common type of legislation in this area requires PBMs to make reimbursement lists, including MAC lists, or payment methodologies available to network pharmacies. About 20 states have enacted such legislation. Other types of transparency legislation include requiring PBMs to provide advance written notice of formulary changes and substitutions. In a recently enacted Florida law, prescription drug manufacturers are required to notify the Florida Department of Business and Professional Regulation of manufacturer prescription drug price increases.

A. PBM REGULATION

¹⁰⁴See PhRMA Code on Interactions with Health Professionals, last accessed February 27, 2023, available at: [PhRMA-Code---Final.pdf](#)

¹⁰⁵ <https://www.ncsl.org/health/state-policy-options-and-pharmacy-benefit-managers>.

As drug costs have risen, the influence of PBMs has expanded from its original role, growing more complex. This has prompted states to reevaluate regulations regarding licensure, reporting requirements, transparency, contract standards, health plan responsibility, spread pricing, network adequacy, and clawback issues.

Several states in the Subgroup provided summaries and key developments in their specific states. These summaries are meant to provide further detail to the updated list of laws offered by the Subgroup on the Subgroup's website.¹⁰⁶

1. Florida

Florida recently enacted new laws effective July 1, 2023, regulating prescription drug manufacturers and PBMs.¹⁰⁷ Under the new law, PBMs must obtain a certificate of authority from the Office of Insurance Regulation (OIR) by January 1, 2024. If a PBM fails to obtain a certificate of authority by that deadline but continues to operate, it will be subject to a \$10,000 fine per day.

Florida's law also regulates contracts between PBMs and pharmacy benefit plans requiring such to use a pass-through pricing model. In addition, the law prohibits PBMs from using "spread pricing" unless the difference is passed along to the pharmacy benefits plan. PBMs must also pass the entirety of all pharmaceutical manufacturer rebates received to the pharmacy benefits plan. In addition, Florida's law establishes requirements for pharmacy networks. PBMs must set up pharmacy networks that meet or exceed Medicare Part D standards for convenient access to network pharmacies. Other pharmacy network requirements prohibit PBMs from conditioning participation in one pharmacy network as a condition for participating in any other network and requiring participating pharmacies to meet accreditation standards that are more stringent than state pharmacy licensing requirements.

The Florida law also deals with contracts between PBMs and participating pharmacies, including prohibiting financial clawbacks, reconciliation offsets, and certain other types of recoupments. PBMs may no longer unilaterally change the terms of participation contracts with pharmacies. In addition, the Florida law includes gag clause provisions prohibiting PBMs from restricting pharmacists from disclosing to the consumer:

- 1) information about the nature of the treatment and possible side effects;
- 2) alternative forms of treatment;
- 3) information about any financial incentives used by the benefits program; and
- 4) information that may reduce the cost of pharmacist services.

2. New Jersey

New Jersey has a proposed bill that focuses on PBM transparency, licensing, and reporting requirements. Insurers would be required to maintain records of contracted PBMs including transaction records and

¹⁰⁶See generally, PBM Law Compilations, available at: https://content.naic.org/cmte_b_pharmacy_bmri_sg.htm.

¹⁰⁷<https://www.ausley.com/news-insights/florida-enacts-sweeping-new-legislation-regulating-pharmacy-benefit-managers>.

compensation remittance. Insurers would also be required to have P&T Committees with no conflict of interest. Additionally, they must use more than one formulary.¹⁰⁸

3. Kentucky

Kentucky State Representative Steve Sheldon proposed HB 457 during the 2022 legislative session. Although the bill did not pass, it was drafted to address the ongoing abuses from PBMs in Kentucky. Some critics have stated this bill is one of the most comprehensive pieces of PBM regulation in the U.S. The bill proposed to prohibit PBMs from the following: mandatory mail order pharmacy use, mandatory use of PBM affiliated pharmacies, limited preferred networks, patient incentives to use PBM affiliated pharmacies, spread pricing, and higher reimbursements to PBM affiliated pharmacies. The bill also contained provisions that addressed contract changes, offered 340B protections and applied to most commercial plans in Kentucky.

4. Kansas

In 2022, Kansas enacted SB 28, which transformed the state’s existing PBM registration requirements to a licensing scheme. As part of the license application, a PBM must submit a template contract, a network adequacy report, and a dispute resolution process that ultimately involves an independent fact finder between the PBM and the health insurer or the PBM and the pharmacy or pharmacy’s contracting agent. The PBM Licensure Act also made updates to the MAC appeal law, gave the Commissioner some enforcement authority, but maintained an existing exemption for PBMs that hold a TPA registration in the state.

5. Maine

In 2019, Maine enacted a comprehensive package of legislation impacting PBMs and other entities in the pharmaceutical drug supply chain.¹⁰⁹ The four laws included in this legislative package: 1) impose stricter requirements on PBMs; 2) update Maine’s drug transparency program to require more prescriptive data collection and enforcement mechanisms; 3) establish a drug affordability review board; and 4) express support for the state to pursue a wholesale drug importation program.

In looking at the requirements on PBMs, Maine’s law establishes a PBM licensure requirement. The law also includes provisions making the health insurance carrier responsible for monitoring all activities of the PBM if the carrier uses PBMs to manage their prescription drug benefits. The Maine law also stipulates that PBMs have a fiduciary duty to their insurance carriers when managing their prescription drug benefits and as such, carriers are empowered to hold PBMs accountable for their financial dealings. The Maine law requires health insurance carriers to use the prescription drug rebates that PBMs negotiate with pharmaceutical drug manufacturers to either lower health plan premiums or to reduce out-of-pocket costs for consumers when they purchase prescription drugs.

6. Oklahoma

In 2019, Oklahoma enacted HB2632, which created the Patient’s Right to Pharmacy Choice Act for the purpose of establishing uniform access to a pharmacy provider. As part of the regulatory framework, the Oklahoma Insurance Department must review retail pharmacy network access in addition to licensing PBMs and ensuring they are compliant with Oklahoma law. In addition to those provisions, the bill contains “any willing provider” language, prohibits PBMs from restricting individuals’ choice of in-network prescription drug providers and

¹⁰⁸ S.B. 220, 2022, 2022-2023 Reg. Sess. (NJ.2022). https://www.njleg.state.nj.us/bill-search/2022/S1616/bill-text?f=S2000&n=1616_11.

¹⁰⁹<https://nashp.org/maine-forges-new-ground-and-enacts-comprehensive-drug-package/#:~:text=Maine's%20new%20law%20regulating%20PBMs,carriers%20with%20whom%20PBMs%20contract>.

prohibits PBMs from taking certain actions, like incorporating “gag clauses” in their contracts with pharmacies. The bill established a fine amount of up to \$10,000 for any violation.

B. DRUG PRICE TRANSPARENCY REGULATION

The push for implementation of laws that would require PBMs to disclose drug pricing, cost information regarding rebates, payments, and their fees collected from pharmaceutical manufacturers, insurers, and pharmacies has begun in many states.¹¹⁰

1. Insurer Transparency

A number of states that require PBMs to disclose certain information about their costs also require health insurance providers to report similar prescription drug spending information to the state. Additionally, Section 204 of the transparency provisions of the Consolidated Appropriations Act of 2021 requires health plans to report information on premiums, plan medical costs, and prescription drug spending to the Secretaries of HHS, Labor, and Treasury, so that they may publish a report on prescription drug pricing trends and the contributions to health insurance premiums. The first filings under this law, known as the Prescription Drug Data Collection, or RxDC, were due in December 2022.¹¹¹

2. Drug Manufacturer Transparency

As drug costs have now become the largest expenditure of the premium dollar¹¹², states have moved to actively address by legislating transparency of drug prices. Multiple states have passed legislation requiring drug manufacturers to provide advance notice when the price of drugs being offered on the market will increase over a specific percentage or cost and to provide the reasoning behind those increases. For new drugs over a certain price threshold being placed on the market, drug manufacturers must provide advance notice and include reasoning on the price methodology. At least one state has limited their transparency laws to manufacturers that treat specific diseases. There has been a slight moderation of drug price increases which has paralleled the passage of these laws; however, the costs associated with new drugs have increased exponentially.¹¹³

3. PSAO Transparency

Some state laws have included PSAOs in their transparency laws, to understand the drugs with the highest reimbursement rates and/or year-to-year change in reimbursement rates, as well as the types of fees paid for the services provided by the PSAO.

C. OTHER RELEVANT PROPOSED OR IMPLEMENTED STATE LAW PROVISIONS

States have also implemented or considered implementing other laws that address the pharmaceutical drug ecosystem. A brief description of these approaches is contained below:

¹¹⁰ Colleen Becker, A. G. (2022, March 23). *State Policy Options and Pharmacy Benefit Managers (PBMs)*. State policy options and Pharmacy Benefit Managers (PBMs). Retrieved September 6, 2022, from <https://www.ncsl.org/research/health/state-policy-options-and-pharmacy-benefit-managers.aspx>.

¹¹¹ <https://www.cms.gov/ccio/programs-and-initiatives/other-insurance-protections/prescription-drug-data-collection>

¹¹² <https://www.ahip.org/resources/where-does-your-health-care-dollar-go>

¹¹³ Drug Price Transparency Laws Position States to Impact Drug Prices. NASHP. January 10, 2022. <https://nashp.org/drugprice-transparency-laws-position-states-to-impact-drug-prices/>

1. Affordability Review and Upper Payment Limits

Some states have proposed or implemented laws establishing prescription drug affordability review boards to set allowable rates for certain high-cost drugs, similar to the process states use to regulate utilities or insurance premiums. Under these laws, a state drug affordability review board would establish the maximum amount that certain payors would pay for individual drugs. The goal of these laws is to protect consumers and payors from over-priced drugs.

2. Unsupported Price Increases

Another approach to address high drug costs is enacting laws that would impose fines on pharmaceutical manufacturers whose drug price increases are unsupported by new clinical evidence. The state would use the revenue to provide cost assistance to consumers. Such laws impact the most frequently prescribed, high-cost drugs, and minimizes a state's administrative burden by using existing data sources.

3. Anti-Price-Gouging

These laws prohibit pharmaceutical manufacturers from sharply increasing prices for generic and off-patent drugs. Price increases that surpass a specific threshold identified in the law trigger action by a state's attorney general. Pharmaceutical manufacturers that price-gouge face fines and must stop charging the excessive price.

4. Importation

This legislative approach would create a state wholesale importation program to purchase lower-cost drugs from Canada and make them available to state residents through an existing supply chain that includes local pharmacies.

5. State Purchasing Pool Buy-in

These laws allow small businesses and individuals to buy into a state employee prescription drug benefit purchasing pool. They typically authorize non-state public employers, self-insured private employers, and insurance carriers who cover small groups or individuals to purchase drugs for their beneficiaries under the purchasing authority of the state. By adding more lives to a purchasing pool, purchasers can negotiate better prices for public employees and others who join the purchasing pool.

6. Licensing Pharmaceutical Sales Representatives

This approach gives states the authority to license pharmaceutical sales representatives to increase transparency surrounding their activities and influence and to require training on ethical standards. For example, the laws would require representatives to disclose the wholesale acquisition cost of the drugs they market and to share the names of generic options in the same therapeutic class when available.

VI. FEDERAL INTEREST AND POSSIBLE REGULATIONS

Increasing state regulations have been brought before state legislators to help regulate PBMs. Many believe that state regulation is not enough, and that the federal government will need to get involved. Given the overall expense of pharmaceutical drugs, some stakeholders have called for a federal overlay or federal preemption to create a uniform set of regulations for multistate PBMs. There are signs of increased interest from the federal government in PBM-related activities, as described below.

A. PHARMACY BENEFIT MANAGER TRANSPARENCY ACT OF 2022

Introduced on May 24, 2022, the Pharmacy Benefit Manager Transparency Act of 2022, was a bipartisan bill sponsored by Senators Maria Cantwell (D-WA) and Charles Grassley (R-IA). The act proposed disclosure requirements on PBMs and the prevention of questionable PBM practices, such as three practices that could be deemed unfair or deceptive which would have been expressly outlawed by the proposed legislation. These included spread pricing; reducing, canceling, or obtaining back any reimbursement payment made to a pharmacist or pharmacy for the price of a prescription drug's ingredients or dispensing charge arbitrarily, unfairly, or falsely; and deceptively reducing reimbursement to a pharmacy or arbitrarily raising fees to offset changes in reimbursement requirements.

Beginning no later than one year after the proposed legislation's adoption, the act would have mandated that PBMs provide the following data to the Federal Trade Commission (FTC) annually:

- 1) the difference between the sum that each health plan paid the PBM for prescription medications and the sum that the PBM paid each pharmacy on behalf of the health plan;
- 2) the total of all fees, including those for the generic effective rate, compensation fees, or other price breaks offered to any pharmacy, and payments withheld from reimbursements to any pharmacy;
- 3) if the PBM shifted a prescription drug to a formulary tier with a higher cost, higher copayment, higher coinsurance, or higher deductible to a consumer or lower reimbursement to a pharmacy, an explanation for why the drug was moved to a different tier, including whether the move was requested by a prescription drug manufacturer or another entity; and
- 4) information regarding any variations in reimbursement rates or practices, remuneration fees or other price concessions, and clawbacks between a pharmacy owned, controlled, or affiliated with the PBM and all other pharmacies, for any PBM that owns, controls, or is affiliated with a pharmacy.

The FTC would have been required to submit two reports to the Senate Committee on Commerce, Science, and Transportation and the House Committee on Energy and Commerce -- one on general enforcement actions under the act and the other on PBM formulary design or placement practices. Under the proposed legislation, an annual report on enforcement activity would be filed. The report would have included:

- 1) an anonymized summary of the annual reports that PBMs have submitted to the FTC;
- 2) the number of enforcement actions the FTC brought to enforce the act and the results of those actions;
- 3) the number of investigations and inquiries into potential violations of the act;
- 4) the number and nature of complaints the FTC received alleging violations of the act; and
- 5) recommendations for strengthening enforcement actions in response to violations of the act.

The agency's report to Congress on PBM formulary design or placement practices would have been due within a year of the proposed law's passage. It would have included information on whether PBMs use formulary design or placement to boost gross revenue without also enhancing patient access or lowering patient costs, as well as whether such PBM activities violated section 5(a) of the Federal Trade Commission Act (45 U.S.C. 45(a)). Employees in the healthcare sector who report violations of the act or take part in administrative, judicial, or investigative processes to enforce its provisions would not be fired, demoted, suspended, reprimanded, or subject to any other type of punishment under the proposed legislation. The proposed legislation would have

also forbade companies from requiring employees to sign pre-dispute arbitration agreements in exchange for employment to make them give up their right to whistleblower protections under the act. The FTC and state attorneys general would have been given permission to carry out the proposed legislation's enforcement measures. Additionally, under the proposed law, offenders would have been exposed to civil penalties of up to \$1 million in addition to the penalties provided under the Federal Trade Commission Act (15 U.S.C. 41 et seq.). The bill was adopted and forwarded to the full Senate by the Senate Committee on Commerce, Science, and Transportation on June 22, 2022.¹¹⁴ The bill was never voted out of committee.

Additionally, the act would have incentivized fair and transparent PBM practices by providing exceptions to liability for PBMs that pass along 100 percent of rebates to health plans or payors and fully disclose prescription drug rebates, costs, prices, reimbursements, fees, and other information to healthcare plans, payors, pharmacies, and federal agencies.¹¹⁵

B. THE FEDERAL TRADE COMMISSION

In June 2022, the FTC announced it will launch an inquiry into the PBM industry, requiring the six largest PBMs to provide information and records regarding their business practices. The agency's investigation will closely examine how vertically integrated PBMs affect the availability and cost of prescription medications. The FTC will issue mandatory orders to CVS Caremark, Express Scripts, Inc., OptumRx, Inc., Humana Inc., Prime Therapeutics LLC, and MedImpact Healthcare Systems, Inc. as part of this investigation.

VII. KEY JURISPRUDENCE

As states continue to pass laws related to the pharmaceutical drug ecosystem, a body of jurisprudence has begun to develop that outlines the limits of state authority vis a vis federal authority. The key cases to date are described below.

A. **RUTLEDGE v. PHARMACEUTICAL CARE MANAGEMENT ASSOCIATION, 141 S.Ct. 474 (2020)**

In *Rutledge v. PCMA*, the U.S. Supreme Court held that ERISA did not preempt an Arkansas law, Act 900, which required PBMs¹¹⁶ to reimburse pharmacies at a price equal to or higher than what the pharmacy paid to buy the drug. Act 900 required PBMs to provide administrative appeal procedures for pharmacies to challenge reimbursement prices that are below the pharmacies' acquisition costs, and it also authorized pharmacies to

¹¹⁴ Jang, T., & Shotlander, D. (2022, September 28). *Senate bill and FTC 6(b) study turn the heat on pharmacy benefit managers amid drug pricing concerns*. Food and Drug Law Institute (FDLI). Retrieved October 6, 2022, from <https://www.fdpi.org/2022/09/senate-bill-and-ftc-6b-study-turn-the-heat-on-pharmacy-benefit-managers-amid-drug-pricing-concerns/>.

¹¹⁵ Dowell, M. A. (2022, August 16). *State PBM regulations protecting community pharmacies*. U.S. Pharmacist – The Leading Journal in Pharmacy. Retrieved September 6, 2022, from <https://www.uspharmacist.com/article/state-pbm-regulations-protecting-community-pharmacies>.

¹¹⁶ As the term is spelled in Act 900. Supreme Court style refers to “pharmacy benefit managers.”

decline to dispense drugs when a PBM would provide a below-cost reimbursement. Unlike the PBM laws in some states, Act 900 was not strictly structured as an insurance law. It applied to all transactions between PBMs and pharmacies, including transactions where the PBM was acting on behalf of a self-insured ERISA plan, so Arkansas could not rely on the saving clause as its defense against an ERISA preemption challenge.

In a suit brought by the PCMA, a national trade association representing 11 PBMs, the Eastern District of Arkansas ruled that Act 900 was preempted by ERISA, and the 8th Circuit affirmed.¹¹⁷ Both courts relied on a recent 8th Circuit decision striking down a similar Iowa law because it “made ‘implicit reference’ to ERISA by regulating PBMs that administer benefits for ERISA plans”¹¹⁸ and “was impermissibly ‘connected with’ an ERISA plan because, by requiring an appeal process for pharmacies to challenge PBM reimbursement rates and restricting the sources from which PBMs could determine pricing, the law limited the plan administrator’s ability to control the calculation of drug benefits.”¹¹⁹

The U.S. Supreme Court, however, concluded that “[t]he logic of *Travelers* decides this case,”¹²⁰ and ruled that Act 900 was not preempted by ERISA. The Court compared its decisions in *Gobeille*, where it held that a state law is preempted if it “governs a central matter of plan administration or interferes with nationally uniform plan administration,”¹²¹ and *Travelers*, where it held that ERISA does not preempt state price regulations that “merely increase costs or alter incentives for ERISA plans without forcing plans to adopt any particular scheme of substantive coverage,”¹²² even if the law “affects an ERISA plan or causes some non-uniformity in plan administration.”¹²³ The Court explained that ERISA is “primarily concerned with preempting laws that require ... structure[ing] benefit plans in particular ways, such as by requiring payment of specific benefits, or by binding plan administrators to specific rules for determining beneficiary status. A state law may also be subject to preemption if ‘acute, albeit indirect, economic effects of the state law force an ERISA plan to adopt a certain scheme of substantive coverage.’”¹²⁴ The Court observed that Act 900 “does not require plans to provide any particular benefit to any particular beneficiary in any particular way,”¹²⁵ and determined that like the law at issue in *Travelers*, “Act 900 is merely a form of cost regulation.”¹²⁶

The Court reviewed the standards it has established for interpreting ERISA’s preemption clause, which preempts all state laws “insofar as they ... relate to any employee benefit plan”¹²⁷ unless some exception to preemption applies. The Court explained that a state law triggers the preemption clause when it “has a connection with or reference to” an ERISA plan.¹²⁸ The Court rejected the PCMA’s contention “that Act 900 has an impermissible connection with an ERISA plan because its enforcement mechanisms both directly affect central matters of plan administration and interfere with nationally uniform plan administration.”¹²⁹ The Court acknowledged that Act

¹¹⁷ *PCMA v. Rutledge*, 891 F.3d 1109 (8th Cir. 2018).

¹¹⁸ 141 S.Ct. at 479, quoting *PCMA v. Gerhart*, 852 F.3d 722, 729 (8th Cir. 2017).

¹¹⁹ *Id.* at 479, quoting *Gerhart*, 852 F.3d at 726, 731.

¹²⁰ *Id.* at 481.

¹²¹ *Id.* at 480, quoting *Gobeille*, 577 U.S. at 320.

¹²² *Id.* at 480, citing *Travelers*, 514 U.S. at 668.

¹²³ *Id.*

¹²⁴ *Id.*, quoting *Gobeille*, 577 U.S. at 320.

¹²⁵ *Id.* at 482.

¹²⁶ *Id.* at 481.

¹²⁷ 29 U.S.C. § 1144(a).

¹²⁸ 141 S.Ct. at 477.

¹²⁹ *Id.* at 481–482.

900 required ERISA plan administrators to “comply with a particular process” and standards,¹³⁰ but explained that those enforcement mechanisms “do not require plan administrators to structure their benefit plans in any particular manner, nor do they lead to anything more than potential operational inefficiencies” for PBMs.¹³¹ The Court held further that ERISA did not preempt Act 900’s decline-to-dispense provision, even though it “effectively denies plan beneficiaries their benefits” because any denial of benefits would be the consequence of the lawful state regulation of reimbursement rates and the PBM’s refusal to comply.¹³²

Finally, the Court rejected the PCMA’s claim that the law had an impermissible “reference to” ERISA. As the Court explained, Act 900 “applies to PBMs whether or not they manage an ERISA plan,” and Act 900 did not treat ERISA plans differently than non-ERISA plans.¹³³ However, the Court only considered the provisions of the Arkansas PBM law as they stood at the time the PCMA filed its preemption challenge, not the amendments the legislature subsequently made while *Rutledge* was making its way through the appellate courts, so it is important that *Rutledge* not be read as a finding that the Court analyzed Arkansas’ PBM law as it existed in 2020. Additionally, the Court did not address preemption under Medicare Part D.

B. PHARMACEUTICAL CARE MANAGEMENT ASSOCIATION v. WEHBI, 18 F.4th 956 (2021)

In 2021, the 8th Circuit Court of Appeals issued its decision in *PCMA v. Wehbi*. This case was not appealed to the U.S. Supreme Court. At issue in the *Wehbi* case were two North Dakota laws prohibiting PBMs from engaging in deceptive and anti-competitive practices.

Ultimately, the court determined that none of the challenged provisions met the “connection-with” standard and all survived preemption by ERISA.¹³⁴ The court concluded that some of the state law provisions “merely authorize pharmacies to do certain things,” such as:

- disclose certain information to plan sponsors;
- provide relevant information to patients;
- mail or deliver drugs to patients as an ancillary service; and
- charge shipping and handling fees to patients who request that their prescriptions be mailed or delivered.¹³⁵

The court also upheld provisions that “constitute, at most, regulation of a noncentral ‘matter of plan administration’ with de minimis economic effects.”¹³⁶ The court held that “whatever modest non-uniformity in plan administration [the sections] might cause does not warrant preemption.”¹³⁷ These provision include:

¹³⁰ *Id.* at 482, quoting PCMA brief at 24.

¹³¹ *Id.*

¹³² *Id.*

¹³³ *Id.* at 481.

¹³⁴ 18 F.4th 956, 968.

¹³⁵ *Id.*

¹³⁶ *Id.*, quoting *Gobeille*, 577 U.S. 312, 320.

¹³⁷ *Id.*, citing *Rutledge*, 141 S. Ct. at 480.

- limits on accreditation requirements a PBM may impose on pharmacies as a condition for participation in its network;
- requirements for PBMs to disclose basic information to pharmacies and plan sponsors upon request; and
- conditions on PBMs that have “an ownership interest in a patient assistance program and a mail order specialty pharmacy.”

In *Wehbi*, the court expands upon *Rutledge* in that the North Dakota statutes go beyond health care price/cost regulation and into disclosure requirements of PBMs, by prohibiting PBMs from preventing pharmacies from disclosing certain information (in compliance with the Health Insurance Portability and Accountability Act) to patients or plan sponsors. North Dakota’s laws, the court concluded, amount to regulation of a PBMs’ functions that have no or limited impact on plan administration, rather than regulation of an ERISA plan itself; therefore, they are not preempted by ERISA.

For the Medicare Part D preemption, not all the North Dakota provisions were preempted by Medicare laws. The court held that preemption exists for some of the contested provisions because Medicare Part D directly governs some of the same matters that the state law attempts to regulate.

With respect to Medicare Part D, the court determines preemption by either of these questions:

1. Do the laws regulate the same subject matter as a federal Medicare Part D standard? If so, the state law is *expressly* preempted; or
2. Do the state laws otherwise frustrate the purpose of a federal Medicare Part D standard? If yes, then they are *impliedly* preempted.¹³⁸

C. PHARMACEUTICAL CARE MANAGEMENT ASSOCIATION v. MULREADY, 598 F.Supp.3d 1200 (2022)

In 2022, the U.S. District Court in the Western District of Oklahoma ruled in favor of the Oklahoma Insurance Commissioner Glen Mulready. The Patient’s Right to Pharmacy Choice Act (“Act”) passed in 2019 was challenged by PCMA as being preempted by ERISA, as well as Medicare Part D laws. The court held that the state law is not preempted by ERISA but agreed with PCMA that some of the law’s provisions are preempted by Medicare laws. PCMA has appealed the decision to the 10th Circuit Court of Appeals.

The Oklahoma laws at issue protect Oklahoma consumers’ access to pharmacy providers through pharmacy network requirements, pharmacy reimbursement standards and prohibitions, and contract approval requirements. Relying on *Rutledge*, the court concluded that all of PCMA’s ERISA preemption claims fail as a matter of law. The court holds that “[the provisions] do not have a ‘connection with’ an ERISA plan” and that “[w]hile these provisions may alter the incentives and limit some of the options that an ERISA plan can use, none of the provisions forces ERISA plans to make any specific choices.” Finally, regarding the Promotional Materials provision, the court holds that the law “does not regulate benefit design disclosures to beneficiaries but regulates how PBMs can advertise its providers” and that it “does not relate to a central matter of plan administration nor undermine the uniform regulation of ERISA plans.”

¹³⁸ *Id.* at 972.

As it relates to PCMA’s ERISA preemption claim in totality, the court found that ERISA does not preempt enforcement of the following: “any willing provider” provisions; retail pharmacy network access standards; affiliated pharmacy prohibition; network provider choice restrictions; probation-based pharmacy limitations; cost sharing discounts; promotional material prohibitions; post-sale price reduction prohibitions; and affiliated pharmacy price match prohibitions on PBMs from reimbursing a pharmacy an amount less than the amount the PBM reimburses to a pharmacy it owns or is affiliated with.¹³⁹

With respect to preemption by Medicare Part D, the court found that about half of the PCMA’s preemption claims failed, while about half were meritorious. Specifically, the court ruled that Medicare Part D *does* preempt these provisions in the Act: retail pharmacy network access standards; promotional material prohibitions; cost sharing discounts; service fee prohibitions; post-sale price reduction prohibitions; and affiliated pharmacy price match prohibitions on PBMs from reimbursing a pharmacy an amount less than the amount the PBM reimburses to a pharmacy it owns or is affiliated with.¹⁴⁰

It is anticipated that additional cases will make their way to the U.S. Supreme Court and provide greater insights into the parameters of *Rutledge* and state regulation. The *Wehbi* and *Mulready* cases are instructive as to the parameters of *Rutledge*, but there is no doubt more decisions are forthcoming.

VIII. RECOMMENDATIONS

The Subgroup acknowledges that issues in the pharmaceutical drug ecosystem are complex and often opaque; to the end consumer, many of these issues are difficult to understand. The most mature body of regulation has developed around PBM activities, but as noted throughout the paper, PBMs are not the only influential player in the ecosystem. Based on the information received by the Subgroup over the last two years, the Subgroup makes the following recommendations:

1. The NAIC should consider tasking the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup or similar group with drafting a model guideline to address PBM regulation based on other state laws and recent jurisprudence;
2. The NAIC should consider expanding information sharing between the states through additional committees on the topic of pharmaceutical drug pricing and transparency;
3. The NAIC should consider any necessary updates to the *Health Carrier Prescription Drug Benefit Management Model Act* (#22) out of the emergence of greater regulation in the prescription drug ecosystem;
4. The NAIC should consider impacts of this work on an ongoing basis on the federal 340B Drug Pricing Program;

¹³⁹ 36 O.S. § 6961 (OSCN 2023) available at (last accessed February 27, 2023): <https://www.oscn.net/applications/oscn/deliverdocument.asp?lookup=Previous&listorder=167560&dbCode=STOKST36&year=>

¹⁴⁰ 36 O.S. § 6961 (OSCN 2023) available at (last accessed February 27, 2023): <https://www.oscn.net/applications/oscn/deliverdocument.asp?lookup=Previous&listorder=167560&dbCode=STOKST36&year=>

5. The NAIC should consider facilitating and maintaining a nationwide database of PBM contracting provisions. This would allow states to become familiar with common PBM contractual provisions and more easily identify issues that arise from them;
6. The NAIC should consider developing an open dialogue with Federal agencies that is broader than just PBM regulation. The discussion should consider regulation of all the stakeholders in the prescription drug ecosystem from a more holistic view and may be best achieved through a coordinated effort involving state and federal regulators; and
7. This Subgroup, and successive groups, should continue to maintain a current listing of PBM laws and regulations and case law for reference by other states.

The Subgroup recognizes the critical role the pharmaceutical drug ecosystem plays on consumer costs and the role states can play in understanding and best regulating the ecosystem. The body of knowledge gained by the Subgroup over the last two years, and related resources provided to state regulators provides a solid foundation to continue to examine these key issues.

APPENDIX I. LIST OF SUBGROUP MEETINGS AND TOPICS

Meeting #	Date	Presenter/Topic
Meeting #1	August 15, 2019	<ul style="list-style-type: none"> Jane Horvath (Horvath Health Policy and Research Faculty, Georgetown University) presentation on “Basics of the Pharmaceutical Market & PBMs.” Leanne Gassaway (America’s Health Insurance Plans—AHIP) presentation on “Pharmacy Benefit Managers Overview & Background.”
Meeting #2	August 22, 2019	<ul style="list-style-type: none"> Dr. Neeraj Sood (Sol Price School of Public Policy, University of Southern California) presentation on “PBM Economics.” Saiza Elayda (Pharmaceutical Research and Manufacturers of America—PhRMA) presentation on the pharmaceutical supply chain and how the pharmaceutical distribution and payment system shapes the prices of brand name medicines.
Meeting #3	August 29, 2019	<ul style="list-style-type: none"> April Alexander (Pharmaceutical Care Management Association—PCMA) and J.P. Wieske (Horizon Government Affairs) presentation on the history, role, and services PBMs provide in managing prescription drug benefits. Anne Cassity (National Community Pharmacists Association—NCPA) and Matthew Magner (NCPA) presentation on the community pharmacy industry’s perspective regarding PBMs and managing prescription drug benefits. Claire McAndrew (Families USA) discussed the effect of PBMs and prescription drug costs on consumers. Amy Killelea (National Alliance of State and Territorial AIDS Directors—NASTAD) discussed PBMs and their impact on consumer access and affordability of prescription drugs.
Meeting #4	October 3, 2019	<ul style="list-style-type: none"> Kentucky discussed its PBM licensing process. Arkansas discussed its PBM licensing law and other provisions related to PBM business practices.

Meeting #	Date	Presenter/Topic
		<ul style="list-style-type: none"> • Montana discussed the history, purpose, and provisions of S.B. 71 to address issues related to PBMs, which passed in the legislature but was ultimately vetoed by the Governor. • New Mexico discussed its PBM law focusing on its reimbursement provisions. • Oregon discussed its PBM law, including its PBM registration requirements, and Oregon’s Prescription Drug Price Transparency program.
Meeting #5	December 11, 2021	<ul style="list-style-type: none"> • North Dakota discussion on the <i>Pharmaceutical Care Management Association (PCMA) v. Wehbi</i> ruling. • Connecticut discussion on its PBM law and white paper. • Virginia discussion on its PBM law. • Oklahoma discussion on its PBM law and the <i>PCMA v. Mulready</i> case. • Wisconsin discussion on the work of the Governor’s Task Force on Reducing Prescription Drug Prices and its PBM law.
Meeting #6	March 16, 2022	<ul style="list-style-type: none"> • Montana discussion on its PBM law. • Employee Retirement Income Security Act (ERISA) (B) Working Group update on the U.S. Supreme Court’s ruling in <i>Rutledge v. PCMA</i> and the <i>ERISA Handbook</i> analysis and case summary.
Meeting #7	April 4, 2022	<ul style="list-style-type: none"> • Oklahoma update on its PBM law. • Oregon discussion on its PBM law and transparency in prescription drug pricing and Oregon Prescription Drug Affordability Board (PDAB) initiatives. • Discussion from a consumer perspective on the Subgroup’s charge to develop a white paper on PBMs and their business practices.
Meeting #8	April 25, 2022	<ul style="list-style-type: none"> • Dr. Neeraj Sood and Dr. Karen Van Nuys, University of Southern California (USC) Price School on Public Policy-presentation on “How Well Are PBM Markets Functioning?”

Meeting #	Date	Presenter/Topic
Meeting #9	June 15, 2022	<ul style="list-style-type: none"> National Community Pharmacists Association (NCPA) presentation on the Subgroup's charge to develop a white paper on PBMs and their business practices from an independent pharmacist perspective.
Meeting #10	July 29, 2022	<ul style="list-style-type: none"> Healthcare Distribution Alliance (HDA) presentation on the Subgroup's charge to develop a white paper on PBMs and their business practices from a pharmaceutical distributor perspective. Presentation on the Subgroup's charge to develop a white paper on PBMs and their business practices from a pharmacy services administrative organization (PSAO) perspective.
Meeting #11	August 9, 2022	<ul style="list-style-type: none"> Presentation from the Pharmaceutical Care Management Association (PCMA) discussing the value of PBMs and the services PBMs provide with respect to pharmacy benefit management. Presentation from the Pharmaceutical Research and Manufacturers of America (PhRMA) on the lack of transparency in PBM practices. Oregon Primary Care Association (OPCA) presentation on the federal 340B prescription drug program.
Meeting #12	October 24, 2022	<ul style="list-style-type: none"> America's Health Insurance Plans (AHIP) presentation on the Subgroup's charge to develop a white paper on PBMs and their business practices from an insurer perspective. BlueCross and BlueShield Association (BCBSA) presentation on the Subgroup's charge to develop a white paper on PBMs and their business practices from an insurer perspective. Civica presentation on its work with the BCBSA and several Blues plans to bring lower-priced generics to market.

SharePoint/NAIC Support Staff Hub/Member Meetings/B CMTE/RFTF/PBM Regulatory Issues Subgrp/PBM White Paper Draft Adopted PBM Subgroup 7-27-23.docx

SENIOR ISSUES (B) TASK FORCE

Senior Issues (B) Task Force Aug. 13, 2023, Minutes	6-212
Senior Issues (B) Task Force April 14, 2023, Minutes (Attachment One)	6-219
Letter to the U.S. Congress (Attachment One-A).....	6-220
Letter to the U.S. Department of Labor (DOL) (Attachment One-B).....	6-231

Draft: 8/24/23

Senior Issues (B) Task Force
Seattle, Washington
August 13, 2023

The Senior Issues (B) Task Force met in Seattle, WA, Aug. 13, 2023. The following Task Force members participated: Barbara D. Richardson, Chair (AZ); Larry D. Deiter, Vice Chair (SD); Lori K. Wing-Heier represented by Sarah Bailey (AK); Mark Fowler represented by Willard Smith (AL); Andrew N. Mais represented by Paul Lombardo (CT); Trinidad Navarro represented by Jeffrey Schott (DE); Doug Ommen represented by Andria Seip (IA); Dean L. Cameron represented by Shannon Hohl (ID); Amy L. Beard represented by Alex Peck (IN); Vicki Schmidt represented by Julie Holmes (KS); Sharon P. Clark represented by Angi Raley (KY); James J. Donelon represented by Ron Henderson (LA); Gary D. Anderson represented by Kevin Beagan (MA); Kathleen A. Birrane represented by Jamie Sexton (MD); Timothy N. Schott (ME); Anita G. Fox represented by Renee Campbell (MI); Grace Arnold represented by T.J. Patton (MN); Mike Causey represented by Ted Hamby (NC); Jon Godfread represented by Chrystal Bartuska (ND); Eric Dunning represented by Martin Swanson (NE); D.J. Bettencourt represented by Jennifer Li (NH); Justin Zimmerman (NJ); Scott Kipper represented by David Cassetty (NV); Judith L. French represented by Laura Miller (OH); Andrew R. Stolfi (OR); Michael Humphreys represented by Lindsay Swartz (PA); Carter Lawrence represented by Scott McAnally (TN); Cassie Brown represented by Rachel Bowden (TX); Jon Pike represented by Shelley Wiseman (UT); Scott A. White represented by Julie Blauvelt (VA); Kevin Gaffney represented by Anna Van Fleet (VT); Mike Kreidler represented by Todd Dixon (WA); Nathan Houdek represented by Rachel Cissne Carabell (WI); and Allan L. McVey represented by Erin K. Hunter (WV).

1. Adopted its April 14 and Spring National Meeting Minutes

Director Deiter made a motion, seconded by Henderson, to adopt the Task Force's April 14 (Attachment One) and March 22 (*see NAIC Proceedings – Spring 2023, Senior Issues (B) Task Force*) minutes. The motion passed unanimously.

2. Heard a Presentation Regarding New MA Marketing Rules and Regulations

Nyetta Patton (federal Centers for Medicare & Medicaid Services—CMS) and Ken Garnder (CMS) gave a review of CMS's Medicare Advantage (MA) marketing rules and regulations. Nyetta Patton said regarding communications, it is defined as activities and the use of materials created or administered by the plans or any downstream entity to provide information to current and prospective enrollees. She said activities and materials aimed at prospective and current enrollees, including their caregivers, are "communications" within the scope of the regulations. She said the definition of marketing is a subset of communications and must, unless otherwise noted, adhere to all communication requirements. She said to be considered marketing, communications materials must meet both intent and content standards. She said in evaluating the intent of an activity or material, the CMS will consider objective information, including, but not limited to, the audience, timing, other context of the activity or material, and other information communicated by the activity or material, and the organization's stated intent will be reviewed but not solely relied upon.

Nyetta Patton said the CMS issued an updated interpretation of marketing to include content that mentions any type of benefit (emphasis added) covered by the plan that is intended to draw a beneficiary's attention to a plan or plans, influence a beneficiary's decision-making process when selecting a plan, or influence a beneficiary's decision to stay enrolled in a plan—i.e., retention-based marketing—and thus subject to review. She said it is critical that state departments of insurance (DOIs) keep in contact with their CMS liaison offices and work together when problems arise.

Gardner said the CMS's plans for marketing and communications oversight improvements for 2024 include prohibiting marketing unless the names of MA organizations or marketing name(s) of entities offering the referenced products or plans, benefits, or costs are identified in the marketing material. He said MA organizations cannot use the Medicare name, logo, and card image in a misleading way, and the use of the Medicare card image is permitted only with authorization from the CMS. He said it also includes the prohibition of unsubstantiated statements without supporting data in the marketing piece, advertising benefits not available in the service area where the marketing appears, and marketing "savings" not realized; i.e., MA organizations cannot advertise about savings available that are based on a comparison of typical expenses for uninsured individuals, unpaid costs of dually eligible beneficiaries, or other unrealized costs of a person with Medicare.

Gardner said the improvements also include clarification of unsolicited door-to-door knocks, opt-out notices, and the prohibition of marketing events taking place within 12 hours of an education event. He said there will be a requirement that prior to an enrollment, the CMS' required questions and topics regarding the individual's needs in a health plan choice are fully discussed. He said a section is to be added to the pre-enrollment checklist (PECL) explaining the effect of enrolling in a new plan, and there will be a requirement that medical benefits be listed in specific order and at the top of a plan's Summary of Benefits.

Gardner said there is an update to the Third-Party Marketing Organization (TPMO) Disclaimer that State Health Insurance Assistance Programs (SHIPs) be added as an option for beneficiaries to get additional help, and it must include the number of organizations/plans represented. He said there is a limit to the requirement to record calls between TPMOs and people with Medicare to marketing/sales enrollment calls that TPMOs must list all MA organizations and Part D sponsors they represent on marketing materials, and MA organizations must establish and implement an oversight plan that monitors agent and broker activities, identifies non-compliance with CMS requirements, and reports non-compliance to the CMS.

Nyetta Patton said additional oversight plans for 2024 include television ads, online videos, radio ads, provider office material, sales presentations, and enrollment forms. She said it is important that any reporting issues to the CMS be done quickly, and she encouraged state insurance regulators to use the 1-800-Medicare number and utilize their CMS-DOI Liaison office. She said the slide presentation the CMS provided for the meeting includes the contacts for all 12 regions of CMS-DOI offices.

Director Richardson asked if there is any other role for state insurance regulators other than looking at the information of CMS-DOI liaisons or if there is a regulatory role the CMS has any expectations for states to perform Nyetta Patton said as different states have different regulations and the CMS regulates from a federal level, the CMS's goal is to partner with each state to address that state's specific concerns.

Swanson asked about better interactions between the states and the CMS in obtaining the necessary evidence when states engage in prosecutions for mis-marketing by those entities states have jurisdiction over. He said the process of obtaining the evidence requires layers and layers of procedures, and he asked if there is a way to streamline or cut down the time it takes to obtain the necessary evidence. Nyetta Patton said she will take that question back to the CMS to get an answer about how to expedite that process.

Swanson said there has been a utilization of both Social Security and Medicare. Although the CMS is toughening up the regulations and it is tied to the Social Security Act of 1935, the Office of Inspector General (OIG) has been unwilling to prosecute in the past. He asked if these new regulations will mean the OIG will take prosecutions or have the same position. Nyetta Patton said she cannot speak for the OIG, but the CMS coordinates with the OIG on these matters.

Henderson said many states are dealing with beneficiaries in crisis who have been switched into a plan they did not ask for or does not fit them, and they cannot utilize it because their doctor is not part of that new plan they

were switched into. He asked what the process is with dealing with third parties and the MA plans as far as educating them on what they are supposed and not supposed to do. He said he has a case in Louisiana where a beneficiary was switched on three different occasions in three months, and we scramble to help these folks with the CMS's help, but he asked how these issues can be addressed from the front end and not after the switch. Nyetta Patton said the most important advice is to keep working with the CMS regional offices and the CMS-DOI offices because we can then take care of the part of educating compliance.

McAnally asked about the narrowing of the scope on the requirement to record marketing calls and what kind of impact that has had as far as investigation and how useful that requirement is. Nyetta Patton said it is not really new but scaling back, for lack of a better term, and the CMS listens to those calls that it can help CMS staff better understand, as well as help the plans better understand what the beneficiary wanted.

3. Heard a Presentation Regarding Lead Generators

Charro Knight-Lilly (eHealth) and Gavin Galimi (eHealth) gave a presentation on lead generators. Galimi said eHealth is an online marketplace offering consumers a broad choice of insurance products from approximately 200 carriers that includes thousands of MA, Medicare Supplement (Medigap), and Medicare Part D plans, and it also offers individual and family health insurance, small business coverage, and ancillary health insurance products. He said eHealth cultivates long-term relationships with their customers, and that is the key to eHealth's success. He said retention is a constant focus, and if a customer cancels their plan or eHealth does not remain the broker of record, the commission revenue ceases. He said finding the right plan for each customer is essential.

Knight-Lilly discussed the marketing relationships with lead generators. She said the marketing relationships with lead generators may include affiliate organizations, online advertisers, content providers, and other marketing vendors. She said eHealth generally compensates lead generators for their referrals of potential customers. She said marketing partners, which include lead generation services, are a significant bridge for brokers and carriers to reach potential customers. She said partners are more effective in reaching potential customers who sign up to receive the partner's marketing materials and have invested in various ways of reaching customer segments, based on potential interests, such as suitability of product type and qualifying plan type.

Galimi said the success of the marketing partner relationship is dependent upon a series of factors, such as: 1) compliance of the marketing partner with applicable laws, regulations, and guidelines; 2) reputation and growth of the partner; 3) continued positive market presence; and 4) the ability to manage the partner. He said in recent years, the industry has experienced that some partners may be deceptive to consumers in their marketing message, and some partners may be deceptive to brokers and carriers about the sources of their referrals. He said when marketing partners fail to adhere to eHealth standards, they are subject to corrective action, up to and including termination of the relationship.

Knight-Lilly highlighted the characteristics of good marketing partners as the adherence with regulatory requirements, the referral of consumers interested in our products, and good long-term reputation and reliability. She said the indications of a concern with a marketing lead would be the failure to adhere to regulatory requirements, the referrals who are confused or not interested in our products, and a poor track record or short-term business focus. Galimi said insurance commissioners can help by distinguishing between high-quality, reputable referral sources and fly-by-night deceptive referral sources and continue to collaborate with eHealth on this topic.

Director Richardson asked whether a broker or agent referring a client or customer and choosing a different product or policy is considered a bad referral or something to learn from. She asked how one knows if it is a right

plan. Galimi said CMS provides the PCL and the checklist that has a list of questions that need to be gone through and a need assessment. He said on eHealth's platform, people are asked to put in necessary information to determine the right plan and the right value of the plan.

T.J. Patton said he reads a large percentage of insurance-related complaints that come into the Minnesota Department of Commerce, and one thing that is frustrating is hearing how Minnesota's elderly residents have challenges in getting the accurate and complete information they need to make the best choice for themselves when they become Medicare eligible. One of the subcategories of those complaints received relates to the online domains they have visited. T.J. Patton asked what eHealth's position is on the domains it operates, specifically Medicare.com. Galimi said there is a lot of information as eHealth transforms, not just with a new logo, but also the transformation underway with its marketing team and creating a differentiated brand message, but Medicare.com is not being rebranded nor making significant use of it, and it is in static mode. T.J. Patton said while he appreciates the commitment, it may be in eHealth's best interest to pull down that domain.

Lombardo asked in eHealth's selection process and process of matching an individual to the right plan use any type of artificial intelligence (AI) or machine learning (ML); if not, he asked if that is something being contemplated for the future. Galimi said eHealth does not use any generative AI for any health or customer-facing work. He said it may be used for ideation and the creation of ideas to start, but the chat platform is a live licensed agent, not an AI robot. He said ML algorithms are used as part of call matching, but there are no plans to launch any sort of AI customer interface. Lombardo asked if any AI currently used is in-house or from vendors. Galimi responded that it is in-house.

Henderson asked if eHealth is contracted with the MA plans that it provides information on. Galimi said they are contracted with their licensed agents and appointed with those carriers. Knight-Lilly said eHealth is a licensed agency. She said eHealth is aware that there are bad actors in the industry, and it is difficult to lump together TPMO statements and difficult for people to understand who is licensed and who is not, as well as what services are being performed by each entity.

Director Richardson said that is an important statement, as every state insurance regulator has at some point called up one of these organizations and asked for their license number to then be hung up on. Henderson said he gets calls, and when he makes inquiries, he gets cut off. Knight-Lilly said many of those are off-shore, and eHealth does not contract with off-shore entities.

Cissne Carabell asked about the slide that discusses failure to adhere to eHealth standards and whether eHealth has taken action against a company that has failed to adhere to those standards; if so, she asked how often that happens. Galimi replied that eHealth has done this. Knight-Lilly said she does not have an exact number; it does occur, but it is infrequent.

4. Heard a Presentation Regarding Concerns Related to Adverse Risk Selection in MA Plans

Dr. Barbara McAneny (New Mexico Oncology Hematology Consultants Ltd.—NMOHC) gave a presentation on her opinions and experience with MA. She emphasized that these are her own anecdotal experiences and do not reflect views from her past American Medical Association (AMA) presidency or her current position as Chief Executive Officer (CEO) of the NMOHC.

Dr. McAneny said she is a cancer doctor and has seen a significant deterioration of benefits for cancer patients and others with serious illnesses. She believes the NAIC, outside of the CMS, is the only organization that has any ability to provide oversight of MA plans. She said her hope is for regulations to be promulgated that allow patients to select a plan that is honestly marketed and lives up to expectations.

Dr. McAneny said her anecdotal experiences and opinions on MA plans related to cancer patients and others with serious illness are formed by: 1) discussions and interactions physicians have employed by managed care companies; 2) observations of delays in prior authorizations by MA companies; 3) attempts to participate in accountable care organizations (ACOs) or to be on the board; 4) discussions with other cancer practices; 5) discussions with physicians employed by hospitals that also have MA or other insurance plans; and 6) the report produced by the Governor of New Mexico’s Task Force on Drug Pricing on which she participated.

Dr. McAneny said she calls MA Medicare Dis-Advantage because of its poor treatment for those with serious illnesses. She said managers of the plans benefit from enrolling healthier seniors and finding hierarchical condition categories (HCCs) that increase the monthly payment from the CMS, such as gym memberships and dental care. She said primary care doctors she has tried to hire have told her that their job is more to find HCCs than to treat patients, and that step therapy is a deterrent to patients with serious illnesses. She said managers of the plans benefit from delaying care for enrolled seniors, especially near open enrollment when sicker patients can switch to fee-for-service (FFS) Medicare. She said managers of the plans benefit from higher drug prices as those increase the medical loss ratio (MLR), and they can get rebates from their pharmacy benefit managers (PBMs) utilizing copay accumulators and maximizers.

Dr. McAneny highlighted the chart from the Kaiser Family Foundation (KFF) in her presentation illustrating the massive margins MA makes per enrollee. She said the report’s findings are that in 2021, MA insurers reported gross margins averaging \$1,730 per enrollee, at least double the margins reported by insurers in the individual/non-group market (\$745), the fully insured group/employer market (\$689), and the Medicaid managed care market (\$768). She said the report found that for MA insurers, the gross margins per enrollee in 2021 were similar to the period before the COVID-19 pandemic, but the margins per enrollee for the individual and group markets in 2021 were below pre-pandemic levels, while the margins per enrollee for Medicaid managed care insurers are higher. She said these are the most profitable products the insurance companies market, and in her opinion, these companies are taking advantage of Medicare, taxpayers, and the people who are used to managed care when they are at work and they move to MA. She said it seems to her that these companies are trading free eyeglasses for the ability to treat cancer.

5. Heard an Update on Minnesota’s “Own Your Future” Initiative and Washington’s WA Cares Fund

Steve Schoonveld (FTI Consulting) gave a presentation on the progress of Minnesota’s “Own Your Future” initiative. He said the Minnesota Department of Human Services (DHS) sought options to increase access to long-term care (LTC) financing, services, and support for Minnesotans. He said the primary objective and goals are to improve access to long-term services and support (LTSS) for Minnesotans who typically do not qualify for Medicaid, examine and evaluate integrated LTSS funding options, and transform the LTC funding system. He said there is an emphasis on options to enable older adults to receive care in their homes; improve the caregiver supply; develop a broad base of support for positive recommendations; consider revised roles for private LTC insurance for Minnesota’s Medicaid program and other funding sources, including Medicare LTSS and Older Americans Act (OAA) programs; and explore new and innovative models of LTC financing and service delivery.

Schoonveld explained how Minnesota is building on what works. He said Minnesota’s existing LTSS approaches include partnering with a wide variety of agencies; tapping all revenue streams, including private pay; and reaching older adults and family caregivers further upstream from Medical Assistance; i.e., Medicaid. He highlighted what he called the “red box,” which is the middle-income market in Minnesota. He said that market consists of family incomes between \$25,000 and \$124,999. He said that population accounts for over 60% of the Minnesota population.

Schoonveld discussed the range of policy options: 1) “Back End Catastrophic” Public Program providing financial support for longer duration care situations—i.e., three or more years—and would require a waiting period or

deductible dollar amount to be met before people could begin accessing benefits; 2) Home and Community-Based Services, which would be a public program providing funding for care and services for middle income older Minnesotans with more modest benefit levels and caps on the benefit duration to keep the program costs down. He said, similar to option 1, this program will have a waiting period or dollar deductible; 3) Early Intervention Benefit for Medicare Recipients, which would be a public program providing modest, capped dollar, at-home benefits to Medicare recipients to delay or mitigate their need to spend out-of-pocket funds for paid care or spend down to be eligible for Medicaid; and 4) Private Long-Term Care Insurance Incentives, which would strengthen the appeal and encourage innovation within private long-term care insurance (LTCI) to help address gaps in funding and include regulatory or legislative modifications that can make private LTCI more affordable and more accessible to middle-income adults.

Schoonveld provided a sampling of potential designs under consideration. He said one option is early intervention and support, which is a state-developed program to provide a care support structure that leverages existing services, provides strong awareness and education, and supports informal caregivers. He said this option would also provide modest, capped, at-home benefits with the goals of delaying or mitigating their need to spend down to be eligible for Medicaid, and a Care Navigation service will also focus on obtaining access to community services offered by waiver and alternative care programs and be the platform to support residents and their caregivers. He said the aim is to maintain a safe home environment and preserve the safety net.

Schoonveld said the second option is a mandatory state-sponsored LTSS program of one year of coverage, purchased by non-Medicaid eligible residents during Medicare enrollment or earlier, and participants receive care support and preventive services coordinated with their Medicare plans. He said the program will also offer additional options to buy up for more than a year of coverage and purchase/funding options prior to age 65, and employer support may be offered. He said the approach is modeled after the comprehensive care coordination approaches of Managed Long-Term Services and Supports (MLTSS) plans. He said the third option is catastrophic coverage, which is a mandatory state insurance program to help pay for long-lasting, long-term care (LTC) expenses that exceed two years, without Medicaid's income and asset restrictions. He said the program will be self-funded by a state-specific payroll deduction for all workers 21 years of age and over, and the deductions will go into a restricted fund for this program's use only.

Ben Veghte (WA Cares Fund) said the Fund provides working Washingtonians a way to earn access to LTC benefits that will be available to eligible individuals when they need them. He said the Fund is an earned benefit, self-funded by worker contributions, and it works like an insurance program. He said people only contribute while they are working, everyone is covered at the same rate regardless of pre-existing conditions, there are no copays, there are no deductibles, and claims never have to be filed. He said the typical income is \$50,091, and the typical contribution is \$291 per year.

Veghte said the Fund is the product of a 2019 law, the LTSS Trust Act, which among other things created the LTSS Trust Commission. He said the Commission's report reached a set of recommendations on the structuring of a Supplemental Private Long-Term Care Insurance (SPLTCI) market, organized into six areas: 1) consumer protection; 2) a venue for filing policies; 3) a benefit trigger and elimination period; 4) transition issues for near retiree cohorts; 5) continuity of covered care settings and providers; and 6) coordination of benefits between the WA Cares Fund and SPLTCI policies.

Veghte highlighted three of the six areas. He said the goal of consumer protection is to ensure that consumers are aware of cost and benefit tradeoffs involved in choices around policy design features, particularly for a product that claims to supplement WA Cares Fund benefits. He said issues regarding filing venue could create barriers to market entry by private LTCI carriers, and the recommendation is that the state should endeavor to work through the logistical challenges for allowing "mix and match" to reach the agreed-upon goal of facilitating the development of a vibrant and competitive SPLTCI market.

Veghte said the challenges for a benefit trigger and elimination period are the potential gaps in coverage related to the benefit trigger and elimination period. He said the recommendations to tackle this challenge are that: 1) the SPLTCI deductible should be equal to the WA Cares Fund full maximum lifetime benefit, which starts at \$36,500 and should be automatically adjusted for inflation; the WA Cares Fund annual benefit inflation adjustment should be automatic, rather than an annual discretionary determination; and 3) carriers may not require that a client undergo a functional assessment or satisfy a benefit trigger in order to determine that a SPLTCI elimination period has begun or ended. He also highlighted that SPLTCI policies' elimination period may include, in addition to the monetary component—i.e., the deductible—a time component, such as three, six, nine, or 12 months, but not to exceed 12 months. He also said a new SPLTCI consumer guide, Statewide Health Insurance Benefits Advisors (SHIBA) counseling, and disclosures should support consumers in assessing tradeoffs between various elimination period options and price points and educate consumers about the importance of budgeting their WA Cares Fund benefits carefully to reduce the likelihood and size of a potential donut hole.

6. Discussed Other Matters

Bonnie Burns (California Health Advocates—CHA) raised the issue of the conflict between Medicare and the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) rules that has led to some confusion about which system and set of rules govern eligibility for coverage, as well as how the responsibility for the payment of health care benefits for eligible individuals is determined. She once again encouraged the Task Force to reconsider editing the *Coordination of Benefits Model Regulation* (#120).

Having no further business, the Senior Issues (B) Task Force adjourned.

Draft: 4/18/23

Senior Issues (B) Task Force
E-Vote
April 14, 2023

The Senior Issues (B) Task Force conducted an e-vote that concluded April 14, 2023. The following Task Force members participated: Larry D. Deiter, Vice Chair (SD); Lori K. Wing-Heier (AK); Mark Fowler (AL); Barbara D. Richardson (AZ); Andrew N. Mais (CT); Karima M. Woods (DC); Michael Yaworsky (FL); John F. King (GA); Doug Ommen (IA); Dean L. Cameron (ID); Amy L. Beard (IN); Vicki Schmidt (KS); Sharon P. Clark (KY); Gary D. Anderson (MA); Kathleen A. Birrane (MD); Anita G. Fox (MI); Chlora Lindley-Myers (MO); Mike Causey (NC); Jon Godfread (ND); Eric Dunning (NE); Glen Mulready (OK); Michael Humphreys (PA); Jon Pike (UT); Scott A. White (VA); Kevin Gaffney (VT); Mike Kreidler (WA); Nathan Houdek (WI); and Allan L. McVey (WV).

1. Adopted Letters Regarding the Conflict Between COBRA and Medicare

The Task Force conducted an e-vote to consider adoption of a letter to the U.S. Congress (Attachment One-A) and a letter to the U.S. Department of Labor (DOL) (Attachment One-B) regarding the conflict between Medicare and the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) rules that has led to some confusion about which system and set of rules govern eligibility for coverage, as well as how the responsibility for the payment of health care benefits for eligible individuals is determined.

Without objection, the Task Force adopted the comment letters by a vote of 26 to 2.

Having no further business, the Senior Issues (B) Task Force adjourned.



May 11, 2023

The Honorable Kevin McCarthy
Speaker
U.S. House of Representatives
Washington, D.C. 20515

The Honorable Hakeem Jeffries
Democratic Leader
U.S. House of Representatives
Washington, D.C. 20515

Dear Speaker McCarthy and Leader Jeffries,

On behalf of The National Association of Insurance Commissioners (NAIC), the standard setting organization representing the chief insurance regulators in the 50 states, the District of Columbia, and the United States territories, we write to you regarding the confusion and costly expenses some workers and retirees are facing with the transition to coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) accompanied by eligibility for Medicare.

As you are aware, COBRA grants temporary continuation of coverage to individuals enrolled in group health plans when coverage would otherwise end upon the occurrence of a qualifying event. For individuals who are eligible or enrolled in Medicare when COBRA coverage begins, Medicare is the primary payer and COBRA plans become secondary.

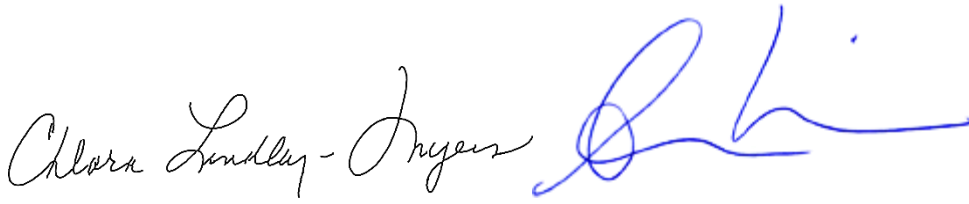
However, for individuals that qualify for COBRA and are eligible for Medicare but have not yet enrolled in either Medicare Part A or Medicare Part B, group health plans may recoup any paid claims and many workers and retirees are not aware of their Medicare eligibility or the need to enroll in the program, even if one is still employed. As a result, many workers and retirees find themselves facing out-of-pocket costs for claims paid under COBRA benefits due to their Medicare eligibility, as well as penalties for late enrollment in Medicare.

An example brought to our attention is of a gentleman who signed up for Medicare Part A at age 65 but did not sign up for Part B as he was still working. At age 76, he left employment and his employer provided eight months of COBRA as part of his separation agreement. The COBRA carrier paid benefits as the primary plan, but after six months the carrier discovered the gentleman was *eligible* for Medicare but was not *enrolled* for benefits. The gentleman had large medical expenses during this time and the carrier sought recovery for \$80,000 of benefits paid by COBRA.

Medicare enrollment and penalties, secondary payment rules, and COBRA are confusing, and we have heard some suggestions to help consumers better navigate these rules. One is better coordination between the Departments of Labor (DOL) and Health and Human Services (HHS). As you are aware, COBRA notices issued by DOL are not required under COBRA nor mentioned under Medicare. Another suggestion is for additional clarification in the law as to which coverage, Medicare or COBRA, is primary and which is secondary in these situations.

The NAIC requests you to examine this issue and we, as the state insurance regulators, are prepared to work with you to find solutions to aid and help our workers and retirees navigate this confusing interaction between COBRA and Medicare.

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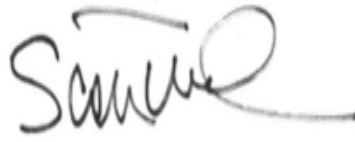


Lindley-Myers
NAIC President
Director
Missouri Department of Commerce
and Insurance

Andrew N. Mais (*He/Him/His*)
NAIC President-Elect
Commissioner
Connecticut Insurance Department



Jon Godfread
NAIC Vice President
Commissioner
North Dakota Insurance Department



Scott White
NAIC Secretary-Treasurer
Commissioner
Virginia Insurance Department



May 11, 2023

The Honorable Charles E. Schumer
Democratic Leader
United States Senate
Washington, D.C. 20510

The Honorable Mitch McConnell
Republican Leader
United States Senate
Washington, D.C. 20510

Dear Leader Schumer and Leader McConnell,

On behalf of The National Association of Insurance Commissioners (NAIC), the standard setting organization representing the chief insurance regulators in the 50 states, the District of Columbia, and the United States territories, we write to you regarding the confusion and costly expenses some workers and retirees are facing with the transition coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) accompanied by eligibility for Medicare. to

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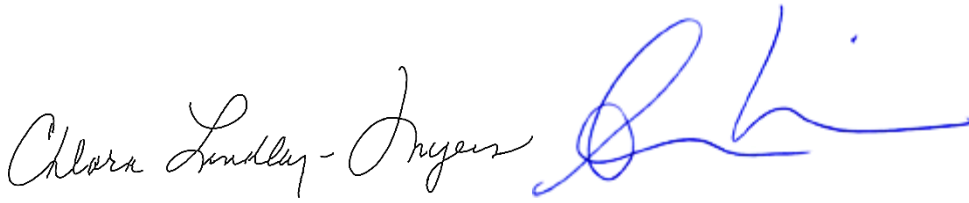
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An example brought to our attention is of a gentleman who signed up for Medicare Part A at age 65 but did not enroll for Part B as he was still working. At age 76, he left employment and his employer provided eight months of COBRA part of his separation agreement, The COBRA carrier paid benefits as the primary plan, but after six months the carrier discovered the gentleman was *eligible* for Medicare but was not *enrolled* for benefits. The gentleman had large expenses during this time and the carrier sought recovery for \$80,000 of benefits paid by COBRA.

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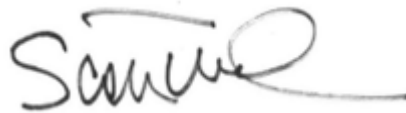


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Missouri Department of Commerce
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Connecticut Insurance Department



Jon Godfread
NAIC Vice President
Commissioner
North Dakota Insurance Department



Scott White
NAIC Secretary-Treasurer
Commissioner
Virginia Insurance Department



May 11, 2023

The Honorable Jason Smith
Chairman
Committee on Ways and Means
U.S. House of Representatives
Washington, D.C. 20515

The Honorable Richard Neal
Ranking Member
Committee on Ways and Means
U.S. House of Representatives
Washington, D.C. 20515

Dear Chairman Smith and Ranking Member Neal,

On behalf of The National Association of Insurance Commissioners (NAIC), the standard setting organization representing the chief insurance regulators in the 50 states, the District of Columbia, and the United States territories, we write to you regarding the confusion and costly expenses some workers and retirees are facing with the transition to coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) accompanied by eligibility for Medicare.

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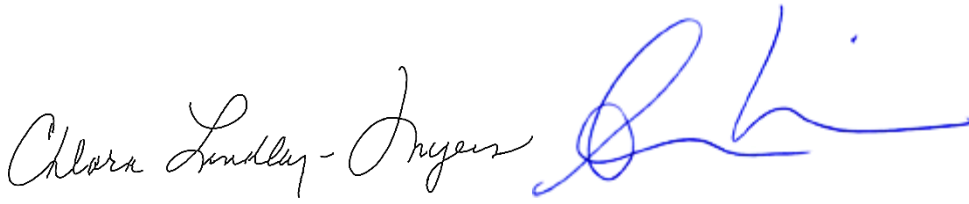
However, for individuals that qualify for COBRA and are eligible for Medicare but have not yet enrolled in either Medicare Part A or Medicare Part B, group health plans may recoup any paid claims and many workers and retirees are not aware of their Medicare eligibility or the need to enroll in the program, even if one is still employed. As a result, many workers and retirees find themselves facing out-of-pocket costs for claims paid under COBRA benefits due to their Medicare eligibility, as well as penalties for late enrollment in Medicare.

An example brought to our attention is of a gentleman who signed up for Medicare Part A at age 65 but did not sign up for Part B as he was still working. At age 76, he left employment and his employer provided eight months of COBRA as part of his separation agreement. The COBRA carrier paid benefits as the primary plan, but after six months the carrier discovered the gentleman was *eligible* for Medicare but was not *enrolled* for benefits. The gentleman had large medical expenses during this time and the carrier sought recovery for \$80,000 of benefits paid by COBRA.

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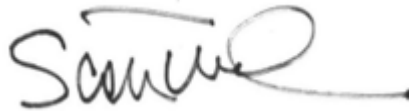


Lindley-Myers
NAIC President
Director
Missouri Department of Commerce
and Insurance

Andrew N. Mais (*He/Him/His*)
NAIC President-Elect
Commissioner
Connecticut Insurance Department



Jon Godfread
NAIC Vice President
Commissioner
North Dakota Insurance Department



Scott White
NAIC Secretary-Treasurer
Commissioner
Virginia Insurance Department



May 11, 2023

The Honorable Virginia Foxx
Chairwoman
Committee on Education and the Workforce
U.S. House of Representatives
Washington, D.C. 20515

The Honorable Robert C. Scott
Ranking Member
Committee on Education and the Workforce
U.S. House of Representatives
Washington, D.C. 20515

Dear Chairwoman Foxx and Ranking Member Scott,

On behalf of The National Association of Insurance Commissioners (NAIC), the standard setting organization representing the chief insurance regulators in the 50 states, the District of Columbia, and the United States territories, we write to you regarding the confusion and costly expenses some workers and retirees are facing with the transition to coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) accompanied by eligibility for Medicare.

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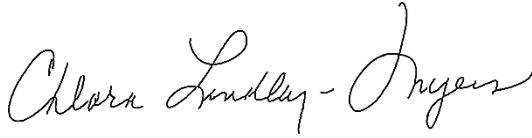
However, for individuals that qualify for COBRA and are eligible for Medicare but have not yet enrolled in either Medicare Part A or Medicare Part B, group health plans may recoup any paid claims and many workers and retirees are not aware of their Medicare eligibility or the need to enroll in the program, even if one is still employed. As a result, many workers and retirees find themselves facing out-of-pocket costs for claims paid under COBRA benefits due to their Medicare eligibility, as well as penalties for late enrollment in Medicare.

An example brought to our attention is of a gentleman who signed up for Medicare Part A at age 65 but did not sign up for Part B as he was still working. At age 76, he left employment and his employer provided eight months of COBRA as part of his separation agreement. The COBRA carrier paid benefits as the primary plan, but after six months the carrier discovered the gentleman was *eligible* for Medicare but was not *enrolled* for benefits. The gentleman had large medical expenses during this time and the carrier sought recovery for \$80,000 of benefits paid by COBRA.

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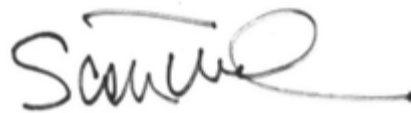


Lindley-Myers
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Connecticut Insurance Department



Jon Godfread
NAIC Vice President
Commissioner
North Dakota Insurance Department



Scott White
NAIC Secretary-Treasurer
Commissioner
Virginia Insurance Department



May 11, 2023

The Honorable Ron Wyden
Chairman
Committee on Finance
United States Senate
Washington, D.C. 20510

The Honorable Mike Crapo
Ranking Member
Committee on Finance
United States Senate
Washington, D.C. 20510

Dear Chairman Wyden and Senator Crapo,

On behalf of The National Association of Insurance Commissioners (NAIC), the standard setting organization representing the chief insurance regulators in the 50 states, the District of Columbia, and the United States territories, we write to you regarding the confusion and costly expenses some workers and retirees are facing with the transition to coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) accompanied by eligibility for Medicare.

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However, for individuals that qualify for COBRA and are eligible for Medicare but have not yet enrolled in either Medicare Part A or Medicare Part B, group health plans may recoup any paid claims and many workers and retirees are not aware of their Medicare eligibility or the need to enroll in the program, even if one is still employed. As a result, many workers and retirees find themselves facing out-of-pocket costs for claims paid under COBRA benefits due to their Medicare eligibility, as well as penalties for late enrollment in Medicare.

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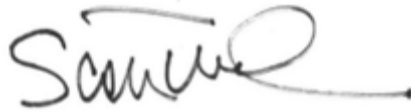
Chloria Lindley-Myers 

Lindley-Myers
NAIC President
Director
Missouri Department of Commerce
and Insurance

Andrew N. Mais (*He/Him/His*)
NAIC President-Elect
Commissioner
Connecticut Insurance Department

Handwritten signature of Jon Godfred in black ink.

Jon Godfred
NAIC Vice President
Commissioner
North Dakota Insurance Department

Handwritten signature of Scott White in black ink.

Scott White
NAIC Secretary-Treasurer
Commissioner
Virginia Insurance Department



May 11, 2023

The Honorable Julie A. Su
Acting Secretary
U.S. Department of Labor
200 Constitution Avenue NW
Washington D.C. 20210

Dear Acting Secretary Su:

On behalf of The National Association of Insurance Commissioners (NAIC), the standard setting organization representing the chief insurance regulators in the 50 states, the District of Columbia, and the United States territories, we write to you regarding the confusion and costly expenses some workers and retirees are facing with the transition to coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) accompanied by eligibility for Medicare.

We thank you for the members of your Department's Employee Benefits Security Administration who joined the October 17, 2022, open meeting of the NAIC's Senior Issues Task Force to discuss this topic. Their participation was helpful.

As you are aware, COBRA grants temporary continuation of coverage to individuals enrolled in group health plans when coverage would otherwise end upon the occurrence of a qualifying event. For individuals who are eligible for or enrolled in Medicare when COBRA coverage begins, Medicare is the primary payer and COBRA plans become secondary.

However, for individuals that qualify for COBRA and are eligible for Medicare but have not yet enrolled in either Medicare Part A or Medicare Part B, group health plans may recoup any paid claims. Many workers and retirees are not aware of their Medicare eligibility or the need to enroll in the program, even if one is still employed. As a result, many workers and retirees find themselves facing out-of-pocket costs for claims paid under COBRA benefits due to their Medicare eligibility, as well as penalties for late enrollment in Medicare.

One of the suggestions offered during the October 17 meeting is for more robust notification and communication about COBRA and Medicare to workers and retirees. We appreciate that Medicare enrollment and penalties, secondary payment rules, and COBRA are complicated issues. The NAIC requests you to examine this issue and we, as the state insurance regulators, are prepared to work with you to find solutions to aid and help our workers and retirees in this confusing interaction between COBRA and Medicare.

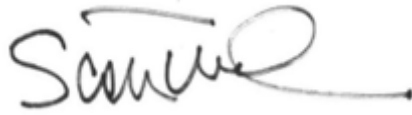
Sincerely,

Chlora Lindley-Myers
NAIC President
Director
Missouri Department of Commerce
and Insurance

Andrew N. Mais (*He/Him/His*)
NAIC President-Elect
Commissioner
Connecticut Insurance Department



Jon Godfread
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NAIC Secretary-Treasurer
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PROPERTY AND CASUALTY INSURANCE (C) COMMITTEE

Property and Casualty Insurance (C) Committee Aug. 15, 2023, Minutes.....	7-2
Title Insurance (C) Task Force Aug. 14, 2023, Minutes (Attachment One)	7-7
Workers’ Compensation (C) Task Force July 20, 2023, Minutes (Attachment Two)	7-11
Cannabis Insurance (C) Working Group July 18, 2023, Minutes (Attachment Three)	7-16
Cannabis Insurance (C) Working Group June 20, 2023, Minutes (Attachment Three-A)	7-23
Cannabis Insurance White Paper (Attachment Three-B)	7-27
Cannabis Insurance (C) Working Group April 11, 2023, Minutes (Attachment Three-C)	7-73
Catastrophe Insurance (C) Working Group Aug. 13, 2023, Minutes (Attachment Four)	7-77

Draft: 8/28/23

Property and Casualty Insurance (C) Committee
Seattle, Washington
August 15, 2023

The Property and Casualty Insurance (C) Committee met in Seattle, WA, Aug. 15, 2023. The following Committee members participated: Alan McClain, Chair (AR); Grace Arnold, Co-Vice Chair (MN); Larry D. Deiter, Co-Vice Chair (SD); Mark Fowler (AL); Ricardo Lara (CA); Andrew N. Mais and George Bradner (CT); Gordon I. Ito represented by Kathleen Nakasone (HI); Amy L. Beard represented by Patrick O'Connor (IN); James J. Donelon (LA); Mike Chaney and Andy Case (MS); D.J. Bettencourt (NH); Glen Mulready (OK); Kevin Gaffney (VT); and Allan L. McVey represented by Erin Hunter (WV). Also participating was: Peg Brown (CO).

1. Adopted its Spring National Meeting Minutes

Commissioner Arnold made a motion, seconded by Director Deiter, to adopt the Committee's March 24 minutes (see *NAIC Proceedings – Spring 2023, Property and Casualty Insurance (C) Committee*). The motion passed unanimously.

2. Adopted the Reports of its Task Forces and Working Groups

Commissioner Lara made a motion, seconded by Director Deiter, to adopt the following task force and working group reports: the Casualty Actuarial and Statistical (C) Task Force; the Surplus Lines (C) Task Force; the Title Insurance (C) Task Force (Attachment One); the Workers' Compensation (C) Task Force (Attachment Two); the Cannabis Insurance (C) Working Group (Attachment Three); the Catastrophe Insurance (C) Working Group (Attachment Four); the Terrorism Insurance Implementation (C) Working Group; and the Transparency and Readability of Consumer Information (C) Working Group. The motion passed unanimously.

3. Adopted the Regulatory Guide to Understanding the Market for Cannabis Insurance: 2023 Update

Commissioner Lara thanked Brown for her hard work in leading updates to the *Regulatory Guide to Understanding the Market for Cannabis Insurance*. Brown said the Cannabis Insurance (C) Working Group published the original white paper in 2019. At that time, the cannabis industry was in its infancy, and many insurance gaps for cannabis-related businesses existed. Since 2019, the cannabis industry has become more sophisticated. It has also continued to rapidly expand, driving new product development, infrastructure changes, and the need for businesses to provide ancillary services. The state of cannabis regulation, particularly at the state and local levels, has also evolved significantly since the last white paper. For these reasons, the original white paper needed to be updated to be of benefit to state insurance regulators.

Brown said the Working Group was officially tasked with providing an updated white paper in 2022. Since then, it has been exploring emerging issues, primarily in the commercial cannabis space, through presentations, panel discussions, and hearings held during open meetings. Information gained through these was leveraged to inform the content of the updated white paper.

Brown explained the Working Group designated a drafting group to develop the white paper after it reviewed and approved an outline during an open meeting. The drafting group held bi-weekly drafting sessions until completion. Drafting group member states included California, Colorado, Illinois, Oregon, Vermont, and Washington. The Insurance Services Office (ISO) and American Association of Insurance Services (AAIS) contributed educational materials and revisions to the sections of the white paper that discuss their products and services. The Working

Group was presented with periodic updates on the working drafts during open meetings so it could provide feedback.

Brown said the Working Group has not encountered any controversy related to the updated white paper. The white paper avoids advocacy-oriented discussion and focuses on issues affecting affordability and availability of insurance for cannabis-related risks in states that have legalized its use. The white paper finds that although capacity has improved since the first white paper's publishing, most of the commercial insurance for cannabis-related businesses is still found in the nonadmitted market. This affects smaller industry players most as the nonadmitted market does not offer the "off-the-shelf" insurance solutions typically available in the admitted market. Insurance gaps are most prevalent in the emerging areas of the cannabis industry, such as ancillary services, cannabis-infused products, and social consumption lounges. Among the potential structures being explored to facilitate cannabis-related business coverage are: the use of state-based commercial insurance programs, risk retention groups (RRGs), captives, and joint underwriting associations (JUAs).

Brown said the Working Group adopted the 2023 update to the *Regulatory Guide to Understanding the Market for Cannabis Insurance* white paper during an open meeting on July 18. The adoption followed an extensive public comment period.

Commissioner Lara made a motion, seconded by Commissioner Arnold, to adopt the *Regulatory Guide to Understanding the Market for Cannabis Insurance: 2023 Update* (Attachment Three). The motion passed unanimously.

4. Heard a Presentation on Telematics

Micheal DeLong (Consumer Federation of America—CFA) said consumer protections related to telematics programs are needed at the state level to protect consumers and make sure telematics programs improve pricing fairness and incentivize safe driving. He noted that telematics is an insurance program that captures consumers' driving data from cars, via devices, built-in technology, and mobile phones. Telematics programs use that data to assess consumers' driving behavior and driving patterns, as well as to calculate insurance premiums. He said savings and surcharges vary by company, and some companies say they do not surcharge people with bad driving behavior.

DeLong said safe drivers should, in theory, earn lower premiums, but there are concerns about the use of telematics related to transparency, data uses, consumer privacy, actuarial soundness, and fairness. He said telematics programs use hard braking, the time someone is driving, the distance or miles traveled, how quickly someone accelerates, their speed, cornering, and location. He said one company collects phone data even when a person is not driving. He said most drivers still do not have telematics-based auto insurance despite a lot of promotion and marketing from insurers. Consumers are wary of telematics for several reasons: concerns about privacy, worries about control over their information, and vulnerability to data hacks and breaches.

DeLong said the CFA believes that the NAIC should develop and provide guidance on telematics for departments of insurance (DOIs) and lawmakers. He said there are few state laws, regulations, or bulletins addressing telematics. He said better oversight, whether in the form of a model law or bulletin, or other guidance for state insurance regulators, would help protect consumers from harmful practices and their resulting consequences.

DeLong said there are several key objectives of telematics consumer protections: transparency clarity concerning all variables used in telematics programs along with consumer-facing explanations of the weight given to each variable; actuarial support for each variable included in the telematics algorithm and further demonstration that

variables used do not result in unfair discrimination on a protected class basis; strict limits on the data collected and used by auto insurers; strong privacy standards; and testing for unfair and unintentional bias.

DeLong said he believes insurers should provide their customers with a list of all variables used to calculate their premiums, in a format approved by the DOI. The list should be presented in an easily understandable manner for consumers and include an explanation of what each variable is assessing. The list should also disclose the relative weight given to each variable in the telematics algorithm, in a way that makes it clear how much impact each variable will have on consumer premiums. Insurance companies should disclose all the data they are collecting, but consumers need more detail, more explanations about how they are being evaluated, and why each item is needed to evaluate their insurance risk.

DeLong said companies should demonstrate to state insurance regulators why each of the factors is relevant and should be collected. There should be actuarial support for each variable. Regulators should only allow data that is both demonstrably related to the risk of loss and not unfairly discriminatory. He said insurers should provide actuarial justification and causative explanation for each data point used. He said insurers must also demonstrate that each component meets the standards for fair and unfair discrimination as understood in a civil rights context so a component cannot disproportionately harm consumers of a certain race or ethnicity or related to another protected class status. He said justification should be required whether an insurance company uses its own program or a third-party telematics program.

DeLong said the use of telematics should encourage driver safety and reduce insurance costs, and telematics should not be allowed to become a platform from which consumers are turned into products. He said there should be strict limits on the data collected and used by insurers. Insurers, and any third party managing a telematics system on an insurer's behalf, must only be allowed to collect data necessary to calculate a consumer's premium in accordance with the approved telematics program. He also noted that policyholders should have the right to access, review, contest, and use any data collected as part of a telematics program. He said he believes that, beyond its use for insurance rating, the only other appropriate uses of the data are driving safety communications, crash response, and claims handling. With respect to the use of data for handling claims, a condition for allowing insurers to use that data must be that the data is equally available to consumers for their use in the claims process.

DeLong said there should also be strong privacy standards for consumer data, and these standards should synchronize with the NAIC privacy model. Rules should be clear that data collected shall not be sold, loaned, rented, shared, monetized, or used in any way beyond the approved auto insurance purposes. Consumers should have access to all data collected and information about how and where the data is stored, and how long data will be maintained by the company. Insurers should meet standards for protections against hackers and should report any data breaches and other malicious activities to the appropriate authorities. He also noted that policyholders should have the right to opt out of a telematics program and to be rated without usage-based data in a manner that is not unfairly discriminatory.

DeLong said ensuring equity in the use of telematics requires testing for unfair discrimination and bias. He said charging higher premiums to consumers who drive at night or to those with varying time of day driving patterns could harm lower-income consumers who often work night shifts or jobs with inconsistent hours, with no control over their schedules. He said telematics programs should be subject to algorithmic bias testing. The focus should be on assessing the outcomes of the telematics algorithm, such as how much a customer is charged as a result of the telematics system and whether any data elements of the program are driving protected class discrimination.

Commissioner Mulready asked if there is an analysis of how states treat the usage of telematics. DeLong said most states do not have specific laws or regulations concerning telematics, although New York has some guidelines.

5. Heard Presentation on Underinsurance Issues

Ken Klein (California Western School of Law) said he has been conducting research into underinsurance. He said most homeowners in the U.S. believe they are fully insured, but they are significantly underinsured. He worked with the California DOI to obtain two years of fire claims. He said the data shows that after a catastrophe, about 95% of homeowners have less coverage than what it would take to rebuild. He said most homeowners are at least 57% underinsured. He said the explanation is not demand surge because many of the claims were not total losses, and they experienced 24% demand surge compared to underinsurance of 57%. He also said homeowners are not choosing to underinsure because many homeowners bought Extended Replacement Cost where they chose 100% of the estimate of reconstruction costs. He said these homeowners still have inadequate insurance, including the extended replacement coverage (ERC), at least 60% of the time. Klein said in the non-catastrophe losses, homeowners were underinsured 77% of the time by an average of 35.5%.

Klein said insurers use algorithms at point-of-sale (POS) to estimate reconstruction cost. He said the estimates are presented to customers as the insurer's estimated cost of reconstruction based on the information the insurer has about the house. He said the customer is given the right to select either more or less Coverage A than the estimate, but the customer typically is not given any information about error rates in the algorithm-generated estimates or any other reasons to doubt the accuracy of the estimates. Klein said the error rate of the algorithm-generated estimates apparently is significant and typically is significantly low. He noted the insurer's internal data makes error rates in algorithm-generated reconstruction estimates easily calculatable and knowable to insurers, but insurers cannot unilaterally adjust their pricing to correct for the error rates without causing competitive issues through high prices.

Klein said that although he reviewed 8,000 large loss claims, the data is not conclusive because data does not exist to compare claims that insurers internally identified as total losses to the amount of the POS estimated reconstruction cost for each claim.

Klein suggested that state insurance regulators should require insurers to report the following for each total loss claim: the insurer's POS estimated reconstruction cost and the estimation software used to determine that estimate; any updated estimated reconstruction cost and the software used for following years; the dwelling reconstruction coverages and the coverage limit of Coverage A; the incurred loss; and whether the loss occurred in a catastrophe.

Klein also said state insurance regulators should adopt the approach of California and Colorado in terms of disclosure rules by requiring insurers to: 1) make annual calculations of the error rates of their POS reconstruction cost algorithm; and 2) disclose to insureds their error rate within the algorithm so the insured can decide which coverage amount to choose. He said this would reduce the frequency of unintended underinsurance. Klein said this research would be published in January 2024.

6. Discussed Insurance Issues Related to Public Schools

Commissioner Mulready said he is hoping to learn from other states about how they are dealing with rising insurance rates for public schools. He said Oklahoma had two self-insurance pools for public schools, but one recently went out of business. He said 61 reinsurers participate in the pool with \$25 billion in property. The pool has seen a 262% loss ratio over the past six years. He said the program has a pilot program to conduct water and temperature monitoring in an attempt to keep claims down. Some schools are changing deductibles to improve rates. He noted that an Oklahoma company runs one of the three pools in the state of Texas. He said the Oklahoma legislature is looking into these insurance issues.

Commissioner McClain said Arkansas is seeing similar issues with rates. He said a recent tornado caused \$100 million in losses to schools. He said Arkansas has 24 reinsurers participating in its pool. Director Wing-Heier said two pools are merging in Alaska. She said members of the pool are responsible for losses. Commissioner Mulready said that is the case in Oklahoma as well and that when the prior pool went under, there were assessments to those school districts to pay for losses. Commissioner McClain said the Committee will look to have future discussions on this issue.

Peter Kochenburger (University of Connecticut School of Law) said this issue is national in scope. He said access to cyber insurance is difficult due to school vulnerabilities. He also said he has conducted work on the cost of insuring armed security.

7. Announced the Property Insurance Data Call Project

Commissioner McClain said state insurance regulators understand that increasing frequency and severity of weather events, rising reinsurance costs, and inflationary pressures are making property insurance availability and affordability more challenging for a growing number of regions across the country. These dynamics can vary significantly within a relatively small geographic area, so while a state's property insurance market may be generally healthy overall, there can be localized protection gaps that challenge certain communities.

Commissioner McClain said state DOIs have robust financial data to understand the impact of these forces on insurers' solvency and investments and can assess the strength and resilience of the industry, but many states lack granular data on how this translates to availability and affordability of coverage for consumers in some areas. He noted NAIC Members adopted a 2023 charge for the Property and Casualty Insurance (C) Committee to: "Assist state insurance regulators in better assessing their markets and insurer underwriting practices by developing property market data intelligence so regulators can better understand how markets are performing in their states, and identify potential new coverage gaps, including changes in deductibles and coverage types, and affordability and availability issues."

Commissioner McClain said interested regulators have begun preliminary scoping work to identify regulatory issues and considerations related to affordability and availability for which data is lacking, and then intend to refine a data template to respond to those specific needs of state insurance regulators. He said that although there is federal interest in this issue and proposals to gather data directly from insurers, NAIC Members believe the states have both the expertise and necessary regulatory authority to gather, analyze, and use data about their unique market conditions and meet the needs of policyholders, so they are best positioned to lead this work.

Commissioner McClain said that as the data template is developed over the coming weeks, state insurance regulators will work with interested parties in ensuring regulators receive accurate and meaningful data to meet regulatory needs.

Birny Birnbaum (Center for Economic Justice—CEJ) said in 1991, the Texas DOI tried to obtain data for a redlining study. He said they could not get the data from statistical agents, so the DOI developed a new data collection program for effective market monitoring through a single statistical agent. The new statistical plan was based on transactional-level reporting. He said this structure would work for state insurance regulators in conducting analyses to determine which insurers are writing in what areas and at what price. He said workers' compensation has a similar type of detailed transaction-level reporting. He said state insurance regulators should not try to become data collectors, but they should reform the statistical agent reporting system.

Having no further business, the Property and Casualty Insurance (C) Committee adjourned.

SharePoint/NAIC Support Staff Hub/Member Meetings/C CMTE/2023_Summer/National Meeting/C-08.doc

Draft: 8/18/23

Title Insurance (C) Task Force
Seattle, Washington
August 14, 2023

The Title Insurance (C) Task Force met in Seattle, WA, Aug. 14, 2023. The following Task Force members participated: Eric Dunning, Chair (NE); Kevin Gaffney, Vice Chair (VT); Mark Fowler represented by Erick Wright (AL); Karima M. Woods represented by Angela King (DC); Michael Yaworsky represented by Anoush Brangaccio, Jeffrey Joseph, and Bradley Trim (FL); Vicki Schmidt represented by Julie Holmes (KS); James J. Donelon represented by Chuck Myers (LA); Kathleen A. Birrane represented by Mary Kwei (MD); Grace Arnold represented by Paul Hanson (MN); Troy Downing (MT); Mike Causey represented by Tracy Biehn (NC); Judith L. French represented by Tom Botsko and Maureen Motter (OH); Glen Mulready represented by Erin Wainner and Diane Carter (OK); Michael Humphreys represented by Michael McKenney (PA); Elizabeth Kelleher Dwyer represented by Patrick Smock (RI); Michael Wise represented by Will Davis and Rachel Moore (SC); and Larry D. Deiter represented by Tony Dorschner (SD).

1. Adopted its Spring National Meeting Minutes

Commissioner Gaffney made a motion, seconded by Botsko, to adopt the Task Force's March 23 minutes (*see NAIC Proceedings – Summer 2023, Title Insurance (C) Task Force*). The motion passed unanimously.

2. Heard an Update on the Administration of the Survey of State Insurance Laws Regarding Title Data and Title Matters

Director Dunning stated that after investigating various survey administrative tools, NAIC staff have decided that using Microsoft Forms for the survey questions would make the most sense. The survey is anticipated to be administered to states shortly following the Summer National Meeting.

3. Heard an Update on the Compiling of Consumer Complaint Data Related to the Title Industry

Myers stated that the Task Force is charged this year with “obtaining information on consumer complaints submitted to states regarding title insurance to determine if updates are needed to insurance regulatory best practices or standards.” He leads the subsequently formed drafting group. Other drafting members include Montana; Nebraska; Ohio; Pennsylvania; Rhode Island; Washington, DC.

A draft survey of questions to send to states to collect title-related complaint information was drafted. The survey was not sent to states, as the drafting group became aware of the NAIC Complaints Database System (CDS) maintained by the NAIC's Market Regulation Department. NAIC staff were then directed to obtain the title-related complaint data from the CDS and compile it for analysis. Myers and NAIC staff then met with NAIC Market Regulation staff to better understand the submission process and how data is captured in the CDS. Additionally, Myers investigated how the Louisiana Department of Insurance (DOI) tracks and reports title-related complaints.

The drafting group met May 22 to review the draft survey of questions and four years of title complaint information compiled from the NAIC CDS. The drafting group found that more than 50% of complaint reasons were coded as “state-specific” for each year. Complaint dispositions can also be coded as “state-specific.” As this does not provide much information for analysis, NAIC staff were instructed to reach out to states reporting a significant number of complaint dispositions and reasons as “state-specific” for additional detail. Requests for additional information were sent to California, Florida, Missouri, and Texas.

California responded that all of its “state-specific” coded reasons for complaints were for escrow handling. Florida responded that more than half of its reasons for complaints came from agent handling, failure to disburse funds, and premium refunds. Texas reported that over half of its “state-specific” reasons were for closing, contract disputes, and earnest money. Texas also reported that over half of its “state-specific” dispositions were for contract language, information furnished, and questions of fact. Missouri declined to provide information citing the task as being too laborious.

The drafting group plans to meet again following the Summer National Meeting to discuss if additional detail is needed to identify trends. As part of its discussions, it will contemplate how reporting to the NAIC CDS could be enhanced to allow for more transparency on title-related complaints. Currently, title is captured under the CDS’s miscellaneous category, which does not offer the same coding options as those that have their own category.

4. Heard a Presentation on Issues with NTRAPS

Sylvia Smith-Turk (Stewart Title) stated that Non-Title Recorded Agreements for Personal Services (NTRAPS) are agreements that obligate the current owner to use the other party’s services in the future and further attempt to bind successor owners by purporting to create a real property interest. Failure to comply with these agreements may give rise to a lien against the property to secure liquidated damages. How these agreements are marketed to property owners and the terms, duration, and enforcement of these agreements are concerning. There are no regulatory disclosure requirements regarding these agreements. Consumers may not fully understand the implications of these agreements. The act of recording NTRAPS in property records can create a long-term barrier to the sale or refinancing of real estate or hamper estate administration. The practice of submitting NTRAPS for inclusion in property records characterized as liens, covenants, encumbrances, or security interests in exchange for money recently emerged throughout the country.

Smith-Turk stated that these agreements are harmful to consumers because they obligate current and future property owners to utilize the service providers for up to 40 years. Consumers do not have the expertise of real estate professionals or attorneys. They may not have the benefit of legal counsel and may not fully understand the agreement or the long-term implications of the ability to transfer or finance their property. Elderly homeowners or those in need of the financial incentives being offered are particularly at risk, and NTRAPS can result in a significant monetary loss when transferring or financing their home. Additionally, NTRAPS provisions allow the listing agreement to be assigned without notice to the property owner.

The American Land Title Association (ALTA) supports efforts to protect consumers by prohibiting the filing of unfair real estate fee agreements in property records, a practice that creates impediments and increases the cost and complexity of selling, refinancing, or transferring real estate. ALTA advocates for state laws and regulations preventing the enforcement of NTRAPS. ALTA’s model legislative bill: 1) makes agreements unenforceable; 2) prohibits the recording of these agreements in property records; 3) creates penalties for recording these agreements in property records; and 4) provides for the recovery of damages and the removal of agreements from property records. The proposed legislation protects consumers and provides state insurance regulators with the ability and authority to assist consumers in seeking damages caused by NTRAPS. There have been over 30 bills introduced in 21 states and 15 laws passed. Attorneys General from Florida, Massachusetts, New Jersey, North Carolina, Ohio, and Pennsylvania have filed complaints stating that NTRAPS being used in the marketplace are deceptive, unfair, and unconscionable business practices.

5. Heard a Presentation on Current Fraud Trends in the Title Space, Including Seller Impersonation Fraud

Thomas Cronkright (CertifID) stated that business email compromise (BEC) losses have increased four-fold over the past five years. BEC is a scam targeting businesses and individuals performing wire transfers of funds. Legitimate email accounts are compromised through social engineering and computer intrusion to conduct unauthorized wire transfers. Cryptocurrency has enabled accelerated funds movement, and compromises have evolved to include spoofed phone calls, videos, and websites. Open source of information, Multiple Listing Service (MLS) data syndication, and multiple transactional parties make real estate a top target. The pandemic led to rapid growth in digital closings without creating a safety net. Emerging technologies and expanded personal digital footprints create a growing divide between businesses that protect their customers and those that do not. Vulnerable businesses are reliant on the belief in trusted communications, focus on the manual detection of suspicious behavior, and believe they are too small to be a target. Protected businesses verify identities before sharing sensitive information, leverage technology to inspect every case thoroughly, and recognize that everyone is a target.

New technologies have led to advanced social engineering. SpoofCard is an application that offers users the ability to change what someone else sees on their caller ID display when they receive a phone call. A current practice in the industry to confirm identity has been to call someone and reach them live over the phone, which is known as the “call-back” procedure. Some errors and omissions insurance policies even require a call back before funds are initiated, or coverage may be denied if a loss occurs. The challenge is, you often cannot get a hold of someone in real-time, so they need to call you back. As an example, a hacker could spoof a title company and call the buyer when it is time to wire funds to close. Likewise, a fraudster could impersonate a seller and call the title company and provide them fraudulent wiring information for net proceeds to be transferred after closing.

Deepfakes—artificial intelligence (AI) voice replication—can impersonate real estate professionals to gain access to sensitive information about clients and defraud them. All it requires is a short voice sample of the human voice you want to replicate for the AI to learn it instantly. Fake AI-generated property tours online could deceive buyers and agents about property conditions. Influence Bots—open-source intelligence—use social media to influence users of social platforms. SIM swap—SS7 Network—is a type of account takeover fraud that generally targets a weakness in two-factor authentication and two-step verification, in which the second factor or step is a text message (SMS) or a call placed to a mobile telephone. AI-generated attack emails use ChatGPT AI text-generating interfaces to create malicious messages designed to spear phish, scam, harass, and spread fake news. These AI-based systems can also be used for BEC scams.

Seller impersonation fraud is a new type of scam hitting the real estate industry due to fewer opportunities for other fraud techniques from a decline in home sales. Fraudsters are impersonating an owner to sell unoccupied property, including vacant lots, they do not own. A fraudster will identify vacant lots using public records. Posing as the seller, the scammer contacts a real estate agent to list the property for below market value. The scammer quickly accepts the offer, with a preference for cash sales and then requests a remote notary signing and impersonates the notary. The funds are transferred to the scammer and not discovered until later. Florida and Texas have the highest percentage of vacant land sales as a percentage of total sales. The U.S. Secret Service and CertifID issued a joint bulletin recently advising of the rise in vacant land fraud.

Fraud attempts on mortgage payoffs increased by five times in the second quarter versus the prior three months. Payoff fraud is when fraudsters impersonate a lender or another title company to receive the funds from disbursement after the settlement process, either from refinancing or the sale of a property. Fraudsters use common tactics found in other wire fraud scams to send a falsified payoff statement with wiring instructions to the targeted settlement agent. Shifts in deposit relations stemming from the three high-profile bank failures opened the door for fraudsters.

The CertifID Fraud Recovery Services (FRS) team received an unprecedented number of reports of wire fraud in 2022. Cases increased by 145% year-over-year, with a \$158,000 average loss reported per case. Average wire fraud loss for businesses and consumer cases were \$295,000 and \$107,000, respectively. A layered protection process of education and engagement, technology, insurance coverage, and incidence response planning are needed to mitigate the impact.

Having no further business, the Title Insurance (C) Task Force adjourned.

SharePoint/NAIC Support Staff Hub/Member Meetings/C CMTE/2023/TITLE/08-TitleTF.docx

Draft: 8/2/23

Workers' Compensation (C) Task Force
Virtual meeting (*in lieu of meeting at the 2023 Summer National meeting*)
July 20, 2023

The Workers' Compensation (C) Task Force met July 20, 2023. The following Task Force members participated: Alan McClain, Chair, and Jimmy Harris (AR); John F. King, Vice Chair, and Steve Manders and Paula Shamburger (GA); Mark Fowler represented by Jimmy Gunn, Yada Horace, and Erick Wright (AL); Ricardo Lara represented by Yvonne Hauscarriague, Margaret Hosel, Giovanni Muzzarelli, Mitra Sanandajifar, and Sarah Ye (CA); Michael Yaworsky represented by Greg Jaynes (FL); Doug Ommen represented by Matthew Cunningham and Travis Grassel (IA); Dean L. Cameron represented by Maria Delvillar and Randy Pipal (ID); Vicki Schmidt represented by Chris Hollenbeck, Julie Holmes, and Sara Hurtado (KS); Sharon P. Clark and Sue Hicks (KY); James J. Donelon represented by Charles Hansberry (LA); Gary D. Anderson represented by Jackie Horigan and Matthew Mancini (MA); Timothy N. Schott represented by Brock Bubar, Sandra Darby, and Robert Wake (ME); Grace Arnold represented by Connor Meyer, and Phil Vigliaturo (MN); Chlora Lindley-Myers represented by Julie Lederer and Jo LeDuc (MO); Mike Causey represented by Sharon Thornton-Hall (NC); Scott Kipper represented by Anna Krylova and Gennady Stolyarov (NV); Glen Mulready represented by Cuc Nguyen (OK); Andrew R. Stolfi represented by TK Keen (OR); Michael Humphreys represented by Michael McKenney (PA); Elizabeth Kelleher Dwyer represented by Beth Vollucci (RI); Michael Wise represented by Will Davis and Melissa Manning (SC); Larry D. Deiter represented by Tony Dorschner (SD); and Kevin Gaffney, Rosemary Raszka, Zachary Rothammer, and Shane Silverman (VT). Also participating were: Tom Zuppan (AZ); Lucretia Prince (DE); Reid McClintock and Julie Rachford (IL); Linda Grant (IN); Paige Dickerson, and Tina Nacy, (MI); Christian Citarella (NH); Carl Sornson (NJ); Marianne Baker (TX); Rebecca Nichols, Lee Ann Robertson, and Zuhairah Tillinghast (VA); and David Haushalter (WI).

1. Adopted its Spring National Meeting Minutes

Commissioner King made a motion, seconded by Commissioner Clark, to adopt the Task Force's March 6 minutes (*see NAIC Proceedings – Spring 2023, Workers' Compensation (C) Task Force*). The motion passed unanimously.

2. Heard a Presentation from Lewis & Ellis on Workers' Compensation Rating

The Task Force heard a presentation from Katie Koch (Lewis & Ellis) on workers' compensation ratemaking. Workers' compensation laws, by design, protect workers by providing financial compensation. Workers' compensation payments include medical benefits for work-related injuries or illness, regardless of fault.

Workers' compensation insurance emerged in the early 20th century, and by mid-1900, most states had some form of legislation for workers' compensation. The National Council on Compensation Insurance (NCCI) and regional bureaus developed advisory rates that insurers widely adopted. The introduction of open competition in the workers' compensation market led to a reevaluation of pricing procedures.

The NCCI and other state rating bureaus typically provide loss costs instead of advisory rates today. Insurers must independently justify various components of the premium rate, including profit and contingency provisions, expense loads, investment income offsets, and other loss cost deviations. The loss cost variations include experience rating modifications and schedule rating, allowing insurers to deviate from bureau rates or loss costs.

Insurers consider the expense costs of participation in involuntary pools and special fund assessments. Additionally, insurers evaluate the cost implications of workers' compensation reforms enacted in state legislatures.

Pricing actuaries are often involved in determining rates that cover expected losses and expenses during the policy period while allowing the insurer to make a reasonable profit. Actuaries use two methods for determining rates. The first method is the loss ratio method, which quantifies needed revisions from current rates. The second method is the pure premium method, which quantifies the required rate per exposure unit and can be used in the deviation of rating factor relativities. Actuaries use the loss ratio methodology for an overall state rate indication and the pure premium methodology for classification ratemaking.

There are challenges when comparing workers' compensation rates across states. Experience rating, schedule rating, large deductible policies, and retrospective rating can significantly affect the final premium a policyholder pays under the existing overarching rating regime.

Experience rating involves identifying and collecting individual employers' payroll and loss information. It permits employer-specific deviations from manual rates with a foundation in a particular employer's historical loss experience.

Retrospective rating involves an endorsed insurance policy such that the final premium adjusts according to the losses experienced by the insured employer rather than according to industry-wide loss experience. This method takes actual losses during the policy period to modify the initial premium to one that more accurately reflects the loss experience of the individual employer.

Schedule rating refers to modifying manual rates either upward or downward to reflect the individual risk characteristics of the insured, generally done at the employer level.

The published loss costs of the state rating bureau (bureau), or NCCI, by industry code, are foundational to today's process. Typically, loss costs are reviewed and revised yearly. Insurers are permitted to use their own loss cost multipliers (LCMs), including a company-specific expense provision. Insurers may also use a loss cost modification factor (LCMF), which adjusts the rate level considering company-specific loss experience. There are often limitations on the degree to which an LCMF in a specific program is permitted to deviate.

Most states permit rating and schedule rating, which facilitates additional rate segmentation, but there may be some differences in specific rules. Some states are administrative pricing states, which may be the most restrictive in permitting insurers to deviate from a bureau filing. A workers' compensation model in a rate filing would likely not be allowed. Anyone can find state differences regarding laws and benefits by visiting the Workers Compensation Research Institute's (WCRI's) web page.

Workers' compensation rating laws can vary by state regarding the specific regulations and methodologies used to determine premium rates. Insurers use classification systems to establish the level of risk associated with each occupation. Classification systems influence premium rates. While many states have similar classification systems, some may have unique or more detailed classifications.

Many states permit insurers to use an experience modification factor, or an experience rating system, to adjust an employer's premium based on their historical claim experience. The experience modification factor compares an employer's actual claims history with the expected claims for companies in the same industry. A factor above 1.0 indicates higher-than-average claims, resulting in higher premiums. A factor below 1.0 indicates lower-than-average claims, leading to reduced premiums.

Some states have a competitive market where multiple insurers can provide workers' compensation insurance, allowing insurers to compete for business. Other states operate in a monopolistic system, where a state fund, or agency, is the sole provider of workers' compensation insurance.

Benefit levels provided under workers' compensation insurance, like medical coverage, disability payments, and vocational rehabilitation, can vary by state. Factors like average wage levels, cost of living, and specific state regulations may influence benefit levels.

Workers' compensation rating formulas consider factors such as industry classification, claims history, payroll, and other factors believed to be relevant. Although many states have similar risk classification plans, these formulas' specific components and weighting can differ.

IBM defines a predictive model as a statistical tool or algorithm that leverages patterns and relationships in historical data to make predictions or forecasts about future events. It involves training a model on a dataset and then using that model to make predictions about new, unseen data.

Insurers commonly use predictive models in personal lines products. The purpose of using the models is to promote more accurate risk segmentation, which correlates with expected costs. Predictive models must use a robust historical dataset. Using modeling approaches allows more formal control that eliminates some of the guesswork.

The use of workers' compensation models is lagging behind the use of personal lines models. The NCCI and rate bureau methods are sophisticated but not typically interpreted as applying a true "model" definition. Model usage is less prevalent in workers' compensation than in personal lines.

According to studies conducted by Robert Hartwig (University of South Carolina), there has been no statistically discernible relationship between workers' compensation underwriting performance and periods of recession over the past century. Workers' compensation rates have also been flat or decreased in recent years.

One hurdle to model rollouts in workers' compensation includes internal resource constraints and prioritization compared to other lines of insurance. Additionally, there may be pushback on regulatory or company management acceptance.

Workers' compensation has experience ratings and scheduled ratings built in. However, these components must be managed in a modeling process. The management of these components might increase the complexity of a model due to the extent there are differences by state.

There are some impacts of model usage on workers' compensation. One effect might be that if the regulatory framework permits models, insurers can conceivably use models to deviate from bureau loss cost plans and the current rating structure. Additionally, insurers could modify risk segmentation based on cost expectations. Due to state differences, there will likely be unique complexities in workers' compensation models that differ from personal lines pricing. However, workers' compensation models could offer risk management and pricing insights.

A good pricing model needs to comply with state laws and regulations. When used on a dataset not used in building the model, the model should predict the target variable, such as claim severity, claim frequency, pure premium, and loss ratio. A good model considers the dataset size; a more extensive dataset may permit a more complex model structure than a smaller dataset. Acknowledging that different data set sizes offer different credible insights is necessary. Finally, a good model uses appropriate input characteristics that meaningfully

contribute to a model's ability to predict the target variable. For example, the input variable can be demonstrated to have statistical significance or influence on the model results and improve the predictions of the target variable.

A good pricing model has appropriate control and offset variables to mitigate the risk of predictions without influencing a particular variable's model contributions (e.g., policy year and state). Sometimes an insurer will put a policy year in for a control variable when using multiple years of data because they do not want to distort their model results. Another control variable would be the state because each state likely has differences. The control variable is the variable that the modeler does not want to influence their target variable predictions.

Another factor that makes a good pricing model is integrating it into the model process. Insurers will have a current rating plan, but introducing a model into the rating plan requires an approach to control how the model gets integrated. For example, this will ensure there is no double counting.

When stakeholders, like regulatory communities, and consumers are concerned about the black box aspect of pricing models, it is important to ensure they:

- Understand the data underlying the model.
- Understand how the model validation works.
- Have some model memorandum or write-up.
- Get intuitive results.
- Have measured reliance (i.e., how the model improves a situation and why building a model is important).

Insurers may have concerns about protecting their proprietary information. Additionally, there are concerns regarding the time and speed-to-market, as well as compliance costs.

Commissioner McClain said everyone wants good data and analytics, and predictive modeling speaks to this. He said he has heard from stakeholders that they like the methods in place for years, as they have proved reliable. Commissioner McClain also heard that some insurers apply the models differently. He has heard from Arkansas' local industry concerns about the uniform applicability of models.

McKenney said he thought the presentation was helpful and liked how it touched on state insurance regulator concerns and state-by-state differences. He said Pennsylvania has had some workers' compensation insurers try to come in with predictive models, and Pennsylvania does not think their law allows it. McKenney said their workers' compact uses words like a uniform classification system, a uniform experience rating plan, and exclusive means. He said bringing in something that is essentially another way of classifying risk provides prospective pricing that deviates from what is supposed to be the exclusive means of providing prospective pricing in Pennsylvania's Act. McKenney said he understands that state-by-state laws vary. However, predictive models are not used as often in workers' compensation as in other lines of business.

Grassel said the workers' compensation industry has thrived for five to 10 years. He asked Koch if the workers' compensation market would deteriorate if she thought there might be more pressure on predictive modeling products. Grassel said workers' compensation insurance was a line of insurance needing improvement, say 25 years ago, and now it is the one that is performing the best.

Koch said she believes if the risk segmentation abilities deteriorate and the experience starts to deteriorate, there will be more efforts to use modeling. She said if insurers see ways predictive modeling could improve results, they would do so in jurisdictions that permit it.

Wake said he questions whether the improved performance in workers' compensation is due to improved performance. Instead, he wonders if the improved performance is a different inflation and investment environment in recent decades.

Wake asked if insurers need lower combined ratios to sustain the same level of performance. He said that combined ratios are not the only thing determining success or failure in workers' compensation because it is a long tail line; so much of the probability depends on investment return. Wake asked if the structure of investment return changes in low inflation and if a low nominal return economy needs more profitability from underwriting than investment. Koch said that if the investment returns are coming in lower than expected, that will put upward pressure on rates and pricing.

8. Discussed Other Matters

Commissioner McClain said the Task Force would meet in a couple of months to hear a presentation regarding the unintended consequences of the legalization of cannabis on workers' compensation.

Having no further business, the Workers' Compensation (C) Task Force adjourned.

SharePoint/NAIC Support Staff Hub/C CMTE/2023_Summer/WCTF/Minutes-WCTF-SNM.docx

Draft: 8/7/23

Cannabis Insurance (C) Working Group
Virtual Meeting (*in lieu of meeting at the 2023 Summer National Meeting*)
July 18, 2023

The Cannabis Insurance (C) Working Group of the Property and Casualty Insurance (C) Committee met July 18, 2023. The following Working Group members participated: Ricardo Lara, Chair, represented by Katey Piciucco (CA); Michael Conway, Vice Chair, represented by Peg Brown (CO); Jimmy Harris (AR); Angela King (DC); Randall Currier (NJ); Melissa Robertson (NM); Gennady Stolyarov (NV); Jan Vitus (OR); Sebastian Conforto (PA); Beth Vollucci (RI); Mary Block (VT); and Michael Walker (WA).

1. Adopted its June 20 Minutes

Currier made a motion, seconded by Vollucci, to adopt the Working Group's June 20 minutes (Attachment Three-A). The motion passed unanimously.

2. Discussed Exposure Comments Received on the Final Draft of the *Understanding the Market for Cannabis Insurance 2.0* White Paper

Brown stated that the *Understanding the Market for Cannabis Insurance 2.0* white paper was exposed during the Working Group's last meeting for a 45-day public comment period ending May 26. Notification of the exposure was redistributed on June 6 to include the Property and Casualty Insurance (C) Committee's distribution list, and the comment period was extended to July 7.

A comment letter was received from the Vermont Department of Insurance (DOI). The Vermont DOI suggested that claims adjusters be included in the Education section because they may need specialized training on cannabis-related claims. As such, the drafting group recommended the following red-lined revisions to the white paper:

D. Cannabis Education Landscape

Education could help address complications and gaps experienced in the cannabis and insurance industries caused by the recent and rapid rate of state regulation. Those needing to maintain currency include cannabis business owners, employees and licensees, regulators, and the insurance industry, such as insurers, claims adjusters, agents, and producers. Many involved in the cannabis industry and businesses would be better able to mitigate their risks with insurance through keeping current on applicable authorities and their requirements.

Regulators and other interested parties should enhance their knowledge through understanding industry trends, such as current and future state cannabis or insurance market conditions. For example, pre-license training for insurance producers does not touch on the topic of cannabis, but the insurance producers may be engaged in providing coverage to the cannabis industry. A producer of insurance should be well educated on the industry they provide coverage for, in order to ensure the procured policy is appropriate, adequate, and lawful. Additionally, claims adjusters may need specialized training on cannabis-related claims.

A comment was also received from the Insurance Services Office (ISO), which can be found in Attachment B of the meeting materials. It provided revisions to the sections of the white paper referencing the ISO and its products. Those revision suggestions reflect a preference for how things are worded rather than substantive changes. Since the changes do not affect the intent of the section and pertain to the ISO's organization and products, the drafting group recommended implementing them as requested by the ISO.

3. Adopted the *Understanding the Market for Cannabis Insurance 2.0* White Paper

Walker made a motion, seconded by Vitus, to adopt the *Understanding the Market for Cannabis Insurance 2.0* white paper (Attachment Three-B) as amended. The motion passed unanimously.

4. Heard a Panel Discussion on the Uncertainties in the Treatment of Hemp and Cannabis

Brown stated that the 2018 Farm Bill legalized hemp using broad language. She asked about the policy mindset and politics around this.

Courtney Moran (EARTH Law) stated that under the Controlled Substances Act (CSA), all parts of the cannabis plant were illegal, whether it was hemp or marijuana. The 2014 Farm Bill separated out industrial hemp, giving it a broad and simple definition of being from the plant *Cannabis sativa* L., whether growing or not, with a delta-9 tetrahydrocannabinol (THC) concentration of not more than 0.3% on a dry weight basis. The 2014 Farm Bill did not remove industrial hemp from the definition of marijuana. However, the U.S. Court of Appeals for the Ninth Circuit clarified that the U.S. Congress (Congress) had contemplated the interaction of the 2014 Farm Bill and the CSA. In 2016, the U.S. Department of Agriculture (USDA), in consultation with the U.S. Drug Enforcement Administration (DEA) and the U.S. Food and Drug Administration (FDA), developed a Statement of Principles on Industrial Hemp to inform the public of how federal law applies to activities associated with industrial hemp that is grown and cultivated in accordance with the 2014 Farm Bill. In doing this, the agencies attempted to modify the definition of industrial hemp to be below 0.3% THC and used exclusively for the industrial purposes of fiber and seed. Thus, the Statement of Principles on Industrial Hemp was in direct conflict with Congress's intent.

Congress submitted an amicus curiae brief in support of a legal challenge to the 2016 Administrative Rule issued by the DEA that established that all extracts from the plant *Cannabis sativa* L., including industrial hemp extracts, are illegal under federal law. The lawsuit, *Hemp Industries Association v. DEA*, was before the Ninth Circuit Court. The amicus supported the Hemp Industries Association's argument that the DEA's rule is contrary to and subverts the 2014 Farm Bill, which carved out certain legal exceptions for the growth, cultivation, and marketing of industrial hemp. The amicus argues that in passing the 2014 Farm Bill, Congress made it clear "that industrial hemp and any derivatives, extracts, and uses thereof would be exempted from the definition of 'marijuana' under the CSA." The amicus asked the court to find that the DEA's position that industrial hemp extracts "will continue to be treated as Schedule I controlled substances" was an abuse of the DEA's administrative procedure and rulemaking authority. The amicus noted that Congress recognizes the need within the 2014 Farm Bill for research and development to investigate the market potential of agriculture and the economic impact of hemp-derived avenues, such as cannabinoids.

It was U.S. Sen. Mitch McConnell (R-KY) and U.S. Sen. Ron Wyden (R-OR) who proposed the hemp amendment to the 2014 Farm Bill. While crafting the language for the 2018 Farm Bill, the reference to industrial hemp was removed to make it clear to federal agencies that the intent of the amendment was to authorize derivatives of cannabinoids coming from cannabis below 0.3% or less of THC. The same day the 2018 Farm Bill was signed into law, the FDA issued a notice stating that it views it as illegal to introduce into commerce any food or dietary supplement that contains cannabidiol (CBD). The USDA implemented the 2018 Farm Bill, utilizing the testing clause provided in another part of the bill and modifying any preharvest THC levels to a total THC standard, which

is different from the federal definition. In its interim rule in 2020, the DEA asserted that “a cannabis derivative, extract, or product that exceeds the 0.3% Delta-9 THC limit is a schedule I controlled substance, even if the plant from which it was derived contained 0.3% or less Delta-9 THC on a dry weight basis.” The DEA’s position created potential criminal risk for processors of hemp and hemp extracts if any substances created in processing or extraction even temporarily result in levels of THC over 0.3%. In doing so, the interim final rule creates additional criminal risks that were neither contemplated nor intended by Congress in passing the 2018 Farm Bill.

Beau Whitney (Whitney Economics) stated that prior to the 2018 Farm Bill, there was still interest in hemp, especially from the fiber and grain side. Driven by market value, production exploded in 2018, with most licensed acres being for cannabinoid production. Excess inventory resulted in a large influx of supply, driving prices down rapidly. Despite this, the total acres licensed between 2019 and 2020 did not change much because as some states pulled back on production, other states entered the marketplace. By 2021 and 2022, states began to legislate cannabinoids in the absence of federal actions. The resulting uncertainty led to a 62% drop in acres licensed in 2021 and a continued decrease in 2022. There was also a shift in interest towards fiber and grain because they have a more predictable market. Globally, the amount of fiber and grain used for construction materials, textiles, and automobile parts is significantly larger than that of adult and medical use. The intense legislative and regulatory activity around cannabis is forcing investors to pause investments in this space, leading to interstate commerce difficulties. The impact on the production of fiber and grains must be contemplated when setting policies for cannabinoids. State regulation of cannabinoids has had unintended consequences on the market.

Brown asked what developments, challenges, and implications are coming out of the 2018 Farm Bill and what the status is.

Gillian Schauer (Cannabis Regulators Association—CANNRA) stated that CANNRA members’ regulatory efforts are focused on protecting consumer safety, which has been challenging under the current landscape. The gaps in the 2018 Farm Bill are being used to produce products that can be high-risk for consumers. The 3% dry weight in a plant is not a lot, but in a beverage or chocolate bar, it can be a lot of milligrams of delta-9. Many CANNRA members see products in the hemp marketplace that have more milligrams of THC than they legally allow in their adult-use or medical-use marketplace. Additionally, the regulatory frameworks between marijuana and hemp are quite different. States and territories are putting in place rigorous regulatory frameworks that include packaging, labeling, and testing requirements for marijuana products to protect consumers. These are not in place federally or in certain states for hemp products. The 2018 Farm Bill definition of hemp focuses on delta-9. There are many sources online selling flower and concentrates that have high levels of THC. As soon as those buds or concentrates are heated, they convert into delta-9. These products are not regulated and could potentially be sold to anyone who indicates they are over 21 with a credit card. Also, the broad definition legalizing hemp allows for cannabinoids that have not been studied for safety to be produced and consumed. This leaves humans to be the test case for these cannabinoids. Consumer safety is an issue, as there are no required federal packaging and label standards, consumer disclosures, protections against child consumption, or testing standards. Regulated cannabis markets have a 96% compliance rate of not selling to minors. The FDA has openly said it needs Congress to tell them it can take the regulatory reins. Some of the challenges the FDA faces is the lack of a regulatory structure for combustion or aerosolized products outside of tobacco regulation, which is very different. There is no clear science to suggest what threshold is intoxicating and if this differs between synthetic and non-synthetic products. The lack of federal action has resulted in a patchwork of regulations across states. CANNRA was created, in part, to harmonize policy. Every member would like to see a robust food, fiber, feed, and grain marketplace. However, cannabinoid products need to have a more rigorous regulatory framework.

Moran clarified that the 2018 Farm Bill sought to solve the barriers to cultivation because the Ninth Circuit Court clarified that non-psychoactive hemp products were never scheduled under the CSA. It was the cultivation itself that required that registration. It was meant to greenlight the farming and commercial production of the crop

itself. The FDA wants to see a new regulatory framework for hemp-derived cannabinoid products. However, there is a regulatory framework at the farm level.

Schauer agreed that the regulatory framework stops at the farm. The U.S. Federal Food, Drug, and Cosmetics Act (FD&C Act) does not provide a regulatory framework because it does not contend with smoked or aerosolized products. These products remain the predominant way people consume cannabis.

Whitney stated that the inputs he has received from the hemp industry reflect that there is frustration even on the industry side on these issues. Commerce in this space is tremendous, with an estimated \$20–25 billion a year, making it on par with the legal regulatory sales of adult and medical-use cannabis. There is a desire to have labeling, testing, and ID checks implemented for consumer safety.

Michael Correia (Cannabis Consultant) stated that very few congresspeople understand the policy and science related to these issues. He stated that they are looking at this as an agricultural and industrial commodity.

Moran stated that Sen. McConnell signed on to the amicus brief and was supportive of CBD production and protecting it within the constructs of the 2014 and 2018 Farm Bills. He viewed it as an opportunity to help Kentucky farmers find a replacement crop for tobacco. However, he did not foresee intoxicating products coming about from it.

Whitney stated that hemp producers do not mind being regulated, but they do not want to be criminalized or treated like they are producing a scheduled drug.

Morgan Fox (National Organization for the Reform of Marijuana Laws—NORML) stated that legislative intent is important. The 2018 Farm Bill resulted in the widespread, unregulated use of intoxicating cannabinoids. The FDA holds a lot of blame for this because it chose to regulate in a way that allowed major distributors (such as Walmart) to sell these products. Producers were looking for additional markets for their large amounts of CBD isolate. Unscheduled intoxicating cannabinoids are most popular in states without legal-use markets. This loophole is being exploited to the potential detriment of consumers because research on the effects of various cannabinoids in amounts consumers are now putting in their bodies is limited. Production is a key part of the problem because producers are not regulated. They are essentially backyard scientists. Additionally, these hemp-derived intoxicating cannabinoids are less expensive than legal cannabis. The FDA essentially punted on the issue of regulating CBD. This leaves Congress to push down hard on intoxicating cannabinoids in the next Farm Bill. It is already occurring at the state level.

Schauer stated that it is important when talking about the regulatory framework for hemp to also talk about the regulatory framework for cannabis because they are the same plant. We have effectively legalized cannabis without consumer safety levels in effect. Hemp and cannabis products are overlapping, and the regulatory frameworks could not be more different.

Fox stated that marijuana markets have strict regulations in place, but none of this exists in other markets. In some state-legal markets, the regulations at the state and local level become onerous, and producers start to then pivot to unregulated markets so they can add additives to various products. People will continue to cut corners and bleed these two industries until there is a functional federal regulation framework.

Schauer stated that many have forgotten the lessons learned from the vaping lung injury outbreak because it happened right before the pandemic. The outbreak was largely due to additives and illicit market products.

There is a risk of a similar public health crisis on the hemp side without regulation. It is important that the upcoming Farm Bill address this, but there are rumors that this will not happen. If the threshold is raised to 1% and it does not include total THC, the regulated cannabis market will not likely survive.

Fox stated that he agrees that the regulated cannabis market would not likely survive a direct challenge from the hemp market with such a different regulatory framework. Despite states regulating a lot of these substances, science is constantly changing. This occurred with bath salts and other synthetic cannabinoids in that as soon as the FDA schedules a component, somebody changes the molecule to get around it. Rather than a complete ban, the solution is to develop a regulatory framework fluid enough to address all new cannabinoids.

Correia stated that he is also concerned about a public health outbreak from unregulated products. The National Cannabis Industry Association (NCIA) released a paper, *Adapting a Regulatory Framework for the Emerging Cannabis Industry* (<https://thecannabisindustry.org/reports/adapting-a-regulatory-framework-for-the-emerging-cannabis-industry/>), in 2019 on regulating the cannabis industry. The paper advocated for a regulatory structure that had regulatory agencies overseeing products based on the end-use of the product. The goal of legalization is to create a taxed and regulated market so products are known. Science will always be ahead of regulations and legislation. Regulations need to be designed so cannabinoids are under the same rule.

Schauer said the few markets that have implemented something similar have approved only a few manufacturers, if any, to go into this space. There continue to be issues with demonstrating that synthetic products can be safe for different modes of consumption. There needs to be a real separation between industrial hemp and cannabinoid products. This will help the industrial hemp industry to flourish and grow. There also needs to be a federal regulator with a public health and safety focus clearly named. This federal regulator should have a very rigorous timeline for putting regulations in place. The actual definition of the Farm Bill needs to be reconsidered, as it is currently broad enough to effectively legalize cannabis.

Fox stated that he has seen laboratory tests on delta-8 products that show they consist of 25% unknown substances. This is a serious consumer safety issue that will persist until there is a federal regulatory framework. A key hurdle is how this framework can be put in place while cannabis itself is still federally illegal. Lawmakers will need to consider that keeping cannabis as a Schedule 1 drug inhibits their own ability to regulate all these emerging products. It is likely that draconian measures will be added to the 2023 Farm Bill that could have long-lasting ramifications on both the cannabinoid and fiber side of the hemp industry.

Moran stated that she has been working on the Industrial Hemp Act of 2023 (H.R. 3755). This act would create a new sub-definition for industrial hemp and not allow for any flower harvesting. It would also set up a new regulatory framework for farmers electing to only grow grain and fiber. It would create a new enforcement provision with penalties for anyone attempting to deviate from industrial hemp production. This legislation is highly supported by green and fiber hemp producers. The CBD market has had a negative impact on the green and fiber farmers who tend to be traditional farmers adding hemp fiber into their crop rotations.

Fox asked if there is a chance the legislation will get added as an amendment to the 2023 Farm Bill or if it will have to go through on a stand-alone basis. He also asked what farmers do with the non-stock part of the plant and if regulations address this. Moran stated that it is a standalone bill, but it will hopefully become an amendment to the 2023 Farm Bill. Farmers are required to destroy the non-stock part of the plant before taking it off the field. The process for this will be specified in rulemaking.

Fox asked if there is potential for the bill to be amended to the point that farmers could donate the material to licensed operators in cannabinoid-producing areas. Moran stated that this was not likely, as the marijuana growers would object.

Whitney stated that there are over a million kilograms of excess biomass supply related to cannabinoids. This year, there are few growers in this space, which will have a significant impact on the supply of hemp-derived CBD, fiber, and grain in the market. Some fiber manufacturers are having to import from Canada to acquire their raw materials for plastic and textile production. Whitney Economics studied the cannabis and hemp policies of over 30 countries. In Europe, they are intertwined. Greater regulatory policies related to good agricultural products and manufacturing processes are needed.

Brown asked the panelists what they believe is next on the horizon.

Schauer stated that states and territories are looking to the 2023 Farm Bill to provide a federal regulatory framework and name a federal regulator. The FDA needs to be compelled to be involved to ensure public health and safety. Schauer expressed concern on what would happen if the 2023 Farm Bill does not aggressively name a regulator within a timeframe. This would leave states to continue creating a patchwork of regulations and potentially leave gaps in consumer safety, particularly for online sales. States do not have authority over the online marketplace.

Correia stated that the federal government ceded its authority to the states to regulate cannabis. Now there are 50 different regulatory models. The Secure and Fair Enforcement (SAFE) Banking Act was introduced 10 years ago, and it still has not been passed. This illustrates how hard it is for Congress to come together. The 2023 Farm Bill will likely clarify intoxicants, but the political issue of legalizing cannabis remains polarizing.

Moran stated that it is important to remember that the Farm Bill is about farming, and it is under USDA authority. It is not likely to resolve all these issues. A standalone bill may be more appropriate. Schauer asked if Moran would have concerns about another bill being passed through Congress. Moran stated that the FDA has given a clear directive to Congress on what it would like to see set up, and it is her hope that this, combined with the states' actions, will propel more than just economic interest parties to the negotiating table.

Whitney stated that it will come down to defining cannabinoids as an ingredient and then regulating it as such. Once the debate on legalization is resolved, policy will rest on the cannabinoid side. This is how it is occurring in the pharmaceutical industry in Europe with novel foods.

Brown said the NAIC has taken a position supporting the SAFE Banking Act and the Clarifying Law Around Insurance of Marijuana (CLAIM) Act. She asked what the panelists' thoughts were on these being passed by Congress.

Correia stated that if every Democrat in the Senate supported the SAFE Banking Act, it would take the support of 9–15 Republicans to get it passed. Politics is preventing this from happening. The U.S. Senate (Senate) Committee on Banking, Housing, and Urban Affairs chair is up for re-election. The main Republican sponsor in the Senate also oversees Republican retention in the Senate, and the dynamics of perceived political victories play into this. The U.S. House of Representatives (House) faces procedural challenges, but this may not prevent it from passing the SAFE Banking Act. However, the biggest issue with the SAFE Banking Act is that it does not end cannabis prohibition. It just provides more certainty for banks.

Whitney stated that the lack of progress on the SAFE Banking Act is affecting policies and operations globally. Jamaica is looking at the SAFE Banking Act as a condition for the legalization of cannabis in Jamaica. It wants to use the taxation money in support of reparations. The SAFE Banking Act reduces the cost of capital and borrowing costs, providing greater transparency with the ability to see the flow of money through the banking system. This would be beneficial to the insurance industry.

Brown stated that the white paper focuses on what policy issues are affecting the affordability and availability of insurance for cannabis-related risks and avoids advocacy-related discussion.

Vitus asked if there is a real possibility of a substantive vote on the SAFE Banking Act when Congress returns from summer recess. Correia stated that U.S. Sen. Chuck Schumer (D-NY) has said it is a priority for the summer, but it will more likely come up in September or October if there are enough votes.

Schauer stated that it is important for state insurance regulators to know and interact with the hemp and cannabis regulators in their states. She offered to make connections if needed.

5. Discussed Other Matters

Brown announced that she would be retiring in August.

Piciucco announced that she would be replacing Melerie Michael in representing California Insurance Commissioner Ricardo Lara as chair of the Working Group.

Having no other business, the Cannabis Insurance (C) Working Group adjourned.

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Draft: 7/5/23

Cannabis Insurance (C) Working Group
Virtual Meeting
June 20, 2023

The Cannabis Insurance (C) Working Group of the Property and Casualty Insurance (C) Committee met June 20, 2023. The following Working Group members participated: Ricardo Lara, Chair, represented by Ken Allen (CA); Michael Conway, Vice Chair, represented by Peg Brown (CO); Jimmy Harris (AR); Austin Childs (AK); Jeff Shot (DE); Angela King (DC); C.J. Metcalf (IL); Randall Currier (NJ); Melissa Robertson (NM); Gennady Stolyarov (NV); Michael Drummonds and Jan Vitus (OR); Sebastian Conforto (PA); Beth Vollucci (RI); Mary Block (VT); and Michael Walker (WA). Also participating were: Erick Wright (AL); Andy Case and Khapre Hollins (MI); and Lela Ladd (WY).

6. Adopted its April 11 Minutes

The Working Group met April 11. During this meeting, the Working Group took the following action: 1) adopted its Nov. 29, 2022, minutes; 2) discussed the final draft of the *Understanding the Market for Cannabis Insurance 2.0* white paper; 3) exposed the *Understanding the Market for Cannabis Insurance 2.0* white paper for a 45-day public comment period ending May 26; and discussed its work plan.

Currier made a motion, seconded by Robertson, to adopt the Working Group's April 11 minutes (Attachment Three-C). The motion passed unanimously.

7. Received an Update on the Exposed *Understanding the Market for Cannabis Insurance 2.0* White Paper

Brown stated that during its April 11 meeting, the Working Group exposed the *Understanding the Market for Cannabis Insurance 2.0* white paper for a 45-day public comment period ending May 26. Notification of the exposure was redistributed on June 6 to include the Working Group's interested regulators and the Property and Casualty Insurance (C) Committee's distribution list, and the comment period was extended to July 7.

The drafting group will meet July 11 to review comments and discuss how they should potentially be incorporated in the white paper draft. The Working Group will review the comments received and consider adoption of the white paper during its next meeting on July 18.

8. Heard a Presentation from NAMIC on the Impact of Cannabis in the Personal Lines

Tony Cotto (National Association of Mutual Insurance Companies—NAMIC) stated more research is needed across all personal and commercial lines. Cannabis-related issues in the private passenger auto insurance line include driving under the influence, challenges in measuring toxicology, and assessing driver risk analysis. Self-grow implications, goods/dwelling coverage, and risk of fire and theft are issues in the homeowner's line. Life and health insurance issues include prescription coverages and treatment of smoking.

Almost half of the U.S. lives in a state where recreational use of marijuana is legal under state law. As of June 2023, 23 states and the District of Columbia have laws legalizing recreational marijuana, 15 states have laws legalizing medical marijuana, 10 states have laws legalizing "limited" medical marijuana for specific designated medical conditions, and two states have no marijuana law. Driving while impaired is illegal in every state. However, marijuana-impaired driving laws vary widely in terms of the level of detail and

sophistication. They range from zero tolerance of any sort of impairment to specific quantity limits where they actually test for tetrahydrocannabinol (THC) and have different levels that are deemed acceptable. Specifically, 12 states have “zero tolerance” laws for THC driving: Arizona; Delaware; Georgia; Indiana; Iowa; Michigan; Oklahoma; Pennsylvania; Rhode Island; South Dakota (for drivers under the age of 21); Utah; and Wisconsin. Additionally, five states have specific per se limits for THC to establish “impairment” while driving: Illinois; Montana; Nevada (only for felony violations); Ohio; and Washington. Colorado has a unique “permissible inference law” that applies if THC is identified in the driver’s blood in quantities of 5 ng/ml or higher. The remaining 37 states and territories include marijuana under “driving under the influence of drug” (DUID) laws. As most of the applicable laws are found in traffic and criminal codes—not insurance codes—partnering beyond insurance is important.

The National Highway Traffic Safety Administration (NHTSA) traffic arrest and fatality data indicate cannabis is the illicit drug most frequently found in the blood of drivers involved in motor vehicle crashes. A 2017 National Academies of Science, Engineering, and Medicine (NASEM) study found marijuana combined with alcohol is the most frequent combination of drugs by drivers. Per the Centers for Disease Control and Prevention (CDC), marijuana slows reaction time and reduces the ability to make decisions, which is vital to driving. Crash risk associated with drug use in two European studies from 2012 and 2014 found an extremely increased crash risk for marijuana used in conjunction with alcohol. Surprisingly, when only marijuana is used, there is only a 6% increase in fatal crashes and a 1-3 relative risk increase.

A 2018 study by the Insurance Institute for Highway Safety (IIHS) compared claim frequencies in Colorado, Oregon, and Washington after recreational cannabis was legalized to four non-recreational use neighboring states. The IIHS found meaningful spikes in claim frequency after legalization of recreational marijuana. However, in Oregon, there appeared to be almost no effect on collision claims after legalization. An Insurance Information Institute (III) study in 2019 found crash risk increased 22% while under the influence of marijuana. However, the presence of THC does not necessarily equal impairment. Medical cannabis may contain either or both cannabidiol (CBD) and THC, and the cognition effects need much further study.

Enforcement and testing difficulties make research in this area challenging. There is a lot of effort going into developing roadside testing capacities, but it is still in its infancy. Unlike alcohol, there is no “breathalyzer” for THC. THC stays in the body for varying lengths of time depending on metabolism, product type, potency, quantity, and frequency of use. Biological screenings and field sobriety tests (saliva, urine, and blood testing) are time-consuming. If impairment beyond alcohol is suspected by a police officer, a drug recognition expert (DRE) is called to the scene. DREs go through Advanced Roadside Impaired Driving Enforcement (ARIDE) training to learn how to observe, identify, and articulate the signs of impairment related to drugs.

Funding for marijuana and road safety research has grown from \$30 million in 2000 to \$143 million in 2018. The federal Infrastructure Investment and Jobs Act directs the U.S. Department of Transportation (DOT) to produce a report about scientific research and associated research barriers on marijuana impairment while operating a vehicle. The federal Medical Marijuana and Cannabidiol Research Expansion Act removes some restrictions on research and allows for Food and Drug Administration (FDA) development and approval of CBD/THC. Emerging technology includes improved and faster oral fluid tests, ocular data systems to test eye movements, mobile fingerprinting devices for officers to use during stops, DRE tablet application to assist with drug influence evaluation, and computerized assessment and referral systems to reduce recidivism.

Public awareness surveys reveal a low level of perceived risks related to marijuana impairment. The American Auto Association (AAA) Traffic Culture Safety Index (2021) found 94% of drivers believe driving after drinking alcohol is dangerous, but only 65% believe driving within an hour of using marijuana is dangerous. Additionally, only 31% of drivers believe police will apprehend a driver for marijuana use. However, 79%

support making it illegal to drive with more than a certain amount of marijuana in your system. In 2022, the Virginia Cannabis Control Authority (CCA) found that 33% believe marijuana makes them a safer driver.

More research is needed on the specific influence of cannabis on frequency/severity of crashes, injuries versus fatalities, and the impact of different kinds of cars and roads. Road safety affects private passenger auto (PPA), commercial trucking, and workers' compensation. Additionally, the need for new contract language and claims, fraud, and litigation-related issues need to be evaluated.

Allen asked what four states the IIHS study compared California, Colorado, and Oregon against for auto claim frequencies related to impairment. Ladd stated she would also like the study. Brown stated the presentation materials and requested studies will be available on the Working Group's committee page. Cotto stated he would make the study available to NAIC staff for distribution. He provided the link to the NHTSA study (<https://www.nhtsa.gov/campaign/if-you-feel-different-you-drive-different>). He later provided additional links to studies done by the IIHS (<https://www.iihs.org/news/detail/crash-rates-jump-in-wake-of-marijuana-legalization-new-studies-show>) and other research studies (<https://www.iihs.org/topics/alcohol-and-drugs#marijuana>).

Erick Wright (AL) stated recent research findings in 2022 state users are three times less likely to drive at all within three hours of using cannabis. He asked why these more recent findings contradict those presented from 2017 research. He also asked if there was any concern about artificial intelligence (AI), police, and testing bias since policing can be biased by race, with African Americans being stopped and arrested three times more than any other race. Cotto stated the insurance industry is aware of the potential bias and is always looking for additional sources of unbiased data.

9. Heard a Presentation from Wilson Elser on the Unique Risks of Social Consumption Lounges

Ian Stewart (Wilson Elser) stated on-site social consumption facilities allow people to consume cannabis openly as opposed to the current model of consuming only in private homes. On-site consumption lounges (also called pot cafes or lounges) are licensed in 10 states: Alaska, California, Colorado, Illinois, Massachusetts, Michigan, New Jersey, New Mexico, Nevada, and New York. Illinois is unusual in that it is a bring-your-own cannabis model. Cannabis event licensing is much more robust in terms of what states are allowing in comparison to on-site consumption facilities. There are good insurance options for cannabis events, with a number of carriers offering coverages.

On-site licensing and permitting is highly varied by state and locality. However, there are certain license restrictions in all states. No one under the age of 21 is allowed in consumption lounges. Consumption areas must be properly ventilated. Cannabis consumption cannot be visible from the street. Alcohol and tobacco cannot be sold. Games that encourage consumption are prohibited. Facilities are subject to approval at the municipal level, which opt-in. Factors in assessing risk include: 1) if it is attached to the cannabis sales facility or a stand-alone facility; 2) if cannabis can be sold in the facility; 3) if there are serving limits; 4) if there is packaging; 5) if there are label and warning requirements; 6) if customers can leave with unused cannabis; 7) if customers can bring in their own cannabis; 8) if food is sold at the facility and if it is prepackaged; 9) if there are warnings or instructions given to patrons; and 10) if there are occupancy limits. Many jurisdictions are looking for ways to cap risk. This includes limiting sales, having customer identification cards that inform on impairment effects and require oral affirmation of understanding, preventing outside marijuana, and helping impaired consumers find transportation. Assisting impaired consumers find transportation through ride-sharing partnerships or no-tow policies can present a moral hazard issue if patrons abuse it.

Considerations around patrons taking unused cannabis off-site include ensuring possession limits and compliant packaging. Although it raises the question of potentially encouraging public intoxication, it also

potentially discourages over-consumption before leaving the facility. Considerations around how the facility is procuring cannabis include: 1) if the lounge is attached to a retail facility or stand-alone; 2) if the lounge can procure multi-serving items and resell individual pieces; 3) if Metrc modification is needed to allow the selling of fractional units; 4) if there are serving limitations; 5) if only prepackaged items are sold or if cannabis-infused food is allowed; 6) if there are good storage and disposal practices for cannabis waste; and 7) if there are constraints on last sales before the close of the business day. Nevada prohibits the sale of products two hours before the close of business. There is no uniform standard for service training related specifically to cannabis products. Cannabis needs a higher level of training due to the clinical effects on the body and difficulty identifying impairment compared to alcohol.

There are 35 states that currently have dram shop laws for alcohol that limit liability for those establishments that are serving alcohol to minors or visibly intoxicated adult patrons. (Some states only limit the liability for serving minors.) Some states, such as California, have their own standard for the obviously intoxicated minor. There are seven states that have no dram shop law. Nevada is one of the few states that have modified their dram shop laws to accommodate cannabis. In contrast, Michigan expressly allows for suits to be brought against establishments that service visibly intoxicated persons. Michigan also requires a minimum insurance coverage amount of \$50,000 through an admitted carrier.

The liability landscape is a critical consideration when determining the risk profile for any particular on-site cannabis consumption facility. The hypothetical scenario of a person killing someone while driving home intoxicated from a nightclub, after having also earlier consumed alcohol at a restaurant and bar and cannabis at an on-site consumption lounge, illustrates the difference between the treatment of alcohol and cannabis. In California, every establishment but the on-site consumption lounge is immune from prosecution or a civil suit. In most states, an establishment only needs to be a substantial cause of an occurrence, not the only or most significant cause. Complicating this issue is that data on the extent to which THC concentration is correlated to subjective impairment is lacking. Additionally, ventilation and filtration must meet standards. Underwriting risks for on-site social consumption lounges needs to account for the different liability laws. Policy exclusions and endorsements need to change and be adaptable to the risks specific to each state.

Currier asked how cannabis lounges make money and turn over tables if they cannot sell food or alcohol. Stewart said this issue is a big dispute driver in terms of some of the restrictions that drag on profits, such as stopping sales of cannabis products two hours before closing time. The consumer experience for consumption is different from a bar or restaurant because only prepackaged food products can be consumed versus a meal. Consumers tend not to stay for hours and spend a lot of money. The most profitable on-site consumption facilities are attached to a retail facility.

Brown stated she noted both presenters indicated more research was needed in this space. She stated the Working Group's drafting group noted the same need while working on the white paper. It is difficult to assess risk without the necessary data. She stated the Working Group would meet again July 18 to review exposure comments received and consider adoption of the white paper.

Having no further business, the Cannabis Insurance (C) Working Group adjourned.

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**NATIONAL ASSOCIATION OF
INSURANCE COMMISSIONERS**

*Adopted by the Cannabis Insurance (C) Working Group—July 18, 2023
Pending adoption by the Property and Casualty Insurance (C) Committee, Aug. 15, 2023
Pending adoption by the Executive (EX) Committee and Plenary, Aug. 16, 2023*

**REGULATORY GUIDE
UNDERSTANDING THE MARKET FOR CANNABIS INSURANCE:
2023 UPDATE**

NAIC White Paper

TBD

**Drafted by the
Cannabis Insurance (C) Working
Group of the
Property and Casualty Insurance (C) Committee**

TABLE OF CONTENTS

I. INTRODUCTION..... 3
II. UNDERSTANDING CANNABIS CONCEPTS AND TERMS.....4
III. THE EXPANSION OF STATES LEGALIZING CANNABIS.....7
IV. FEDERAL LEGISLATION ACTIVITY INTENSIFIES..... 10
V. CANNABIS BUSINESS REGULATORY, LICENSING AND EDUCATION LANDSCAPE..... 13
VI. CANNABIS OPERATING AND ORGANIZATIONAL STRUCTURES EVOLVE..... 24
VII. CANNABIS INSURANCE NEEDS AND COVERAGE AVAILABILITY..... 26
VIII. MARKET CONSIDERATIONS FOR COMMERCIAL CANNABIS INSURANCE33
IX. RESPONDING TO EMERGING TRENDS..... 39
X. CONCLUSIONS40
XI. APPENDIX43

I. INTRODUCTION

The cannabis industry continues to evolve and expand both in structure and in the number of states with legalized cannabis. The National Association of Insurance Commissioners (NAIC) Cannabis Insurance (C) Working Group's original white paper adopted in 2019, *Regulatory Guide Understanding the Market for Cannabis Insurance*, found there are substantial gaps in insurance coverage for the cannabis industry. While gaps remain, much has transpired since the writing of the original white paper. This white paper seeks to provide an update on activities and trends since the adoption of the previous white paper.

The original white paper focused on the cannabis industry's architecture, insurance needs and gaps, and insurance regulator best practices to encourage insurers to enter the market. The cannabis industry has become more sophisticated since the original white paper was published in 2019. It has also continued to rapidly expand. The maturation and expansion of the cannabis market are driving new product development, infrastructure changes, and the need for businesses to provide ancillary services. It is in these areas where insurance gaps most persist. As such, this white paper will include discussion on emerging insurance issues in these areas of the cannabis industry.

Additionally, the current state of cannabis regulation in the United States (U.S.) will be explored. States and U.S. jurisdictions continue to legalize cannabis, but it remains federally illegal under the Controlled Substances Act (CSA). This tension between federal and state law creates uncertainty about the insurability of cannabis and how policy language will be applied to coverages. Municipal bans on cannabis in states where cannabis has been legalized further complicate this issue. For these reasons, insurers remain reluctant to enter the cannabis space. Although capacity has improved since the first white paper's publishing, most of the commercial insurance for cannabis-related businesses is still found in the excess and surplus lines (also known as the non-admitted) market. Potential paths forward to these issues, including best regulatory practices and addressing the needs of states regulating insurance and cannabis operators under state law.

This white paper will outline the complexities of the cannabis industry, explaining the different designs of cannabis businesses, jurisdictional variations, current insurance types and offerings, potential future insurance products, differences presented by insuring hemp versus cannabis, and the importance of developing consistent regulatory practices for state cannabis insurance regulators. It will also cover cannabis history and terminology, cannabis policy trends at the state and national levels, current landscapes of cannabis regulation, licensing and education, cannabis business operating structures, and cannabis industry insurance market considerations. It will

conclude with a brief discussion on the future state of cannabis insurance, including possible next steps for all affected parties.

The need for accessible, affordable, and adequate insurance for the cannabis industry will only continue to increase. Therefore, it will be vitally important for state insurance regulators to fully comprehend and carefully consider the needs and risks of this industry. Regulators can play an important role in encouraging insurance participation in the new cannabis-related industry, which can help all affected parties achieve risk mitigation with proper financial management. This will lead to increases in consumer protections, as well as better functioning cannabis and insurance markets.

II. UNDERSTANDING CANNABIS CONCEPTS AND TERMS

Cannabis, also known as marijuana, is an annual herbaceous plant in the Cannabis genus under the Cannabaceae family.¹ Cannabis has been referred to as consisting of three species of plants: cannabis ruderalis, cannabis sativa, and cannabis indica. The properties of the plant depend on and are determined by the type of cannabis being produced. Each plant type differs in size, shape, and production yield. Many plants utilized in modern-day cannabis industries are hybrid species that have been selected for certain plant traits.²

Cannabis ruderalis has a naturally high composition of Cannabidiol (CBD), an anti-inflammatory non-psychoactive component, and low concentrations of delta-9 Tetrahydrocannabinol (THC) (the psychoactive substance associated with cannabis).³ This type of plant tends to be short and stalky and has the ability to begin the flowering cycle automatically at a certain point in the plant's lifespan, regardless of lighting.⁴ Cannabis ruderalis produces smaller yields when comparing it to the indica or sativa variants.⁵

¹ John M. McPartland, National Library of Medicine: National Center for Biotechnology Information – Cannabis Systematics at the Levels of Family, Genus, and Species (October 1, 2018) – <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6225593/>

² David Gloss, National Library of Medicine: National Center for Biotechnology Information – An Overview of Products and Bias in Research (July 23, 2015) – <https://pubmed.ncbi.nlm.nih.gov/26202343/>
<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4604179/#:~:text=Cannabis%20is%20often%20divided%20into,of%20the%20same%20parent%20species>

³ *Id.*

⁴ *Id.*

⁵ *Id.*

Cannabis sativa grows taller and more highly branched than the other two species.⁶ *Cannabis sativa* also grows narrow leaves and tends to produce higher yields than *cannabis ruderalis*.⁷ Additionally, it can produce high levels of THC composition.

Cannabis indica grows with short and dense branch structures.⁸ *Cannabis indica* generally has the shortest flowering period of the species.⁹ *Cannabis indica* also produces higher yields than *cannabis ruderalis* and can produce high levels of THC.¹⁰

Historically, the terms *indica* and *sativa* were introduced in the 18th Century to define different species of cannabis.¹¹ *Sativa* was used to describe cannabis hemp plants, which were cultivated for plant fibers and seeds.¹² *Indica* was used to describe intoxicating cannabis, which was harvested for seeds and hashish.¹³ The terms have been adapted to modern-day usage by allowing *sativa* to refer to cannabis with energizing properties and *indica* to be synonymous with cannabis that relaxes the consumer.

Recently, scientists have discovered that the effects of a cannabis plant on a consumer result from cannabinoids and terpenes. Cannabinoids are various naturally occurring, biologically active chemical constituents of cannabis, including some that possess psychoactive properties.¹⁴ Examples of cannabinoids include delta-9 THC, a chemical psychoactive component of cannabis, and CBD, a non-psychoactive and anti-inflammatory chemical component. THC is one of many chemical compounds found in the resin secreted by the glands of the cannabis plant. THC can stimulate cells in the brain to release dopamine, creating euphoria.¹⁵ CBD is non-impairing and non-euphoric, meaning it does not cause impairment or intoxication to the consumer.¹⁶

⁶ *Id.*

⁷ *Id.*

⁸ *Id.*

⁹ *Id.*

¹⁰ *Id.*

¹¹ Collective-Cannabis Education: Cannabis Strains: *Indica*, *Sativa*, & Hybrid (accessed June 27, 2022) –

[https://collective-cannabis.com/cannabis-strains-indica-sativa-hybrid/#:~:text=Cannabis%20Indica%20was%20used%20to.high%20THC%20\(tetrahydrocannabinol\)%20content](https://collective-cannabis.com/cannabis-strains-indica-sativa-hybrid/#:~:text=Cannabis%20Indica%20was%20used%20to.high%20THC%20(tetrahydrocannabinol)%20content)

¹² *Id.*

¹³ *Id.*

¹⁴ Merriam-Webster: Defined Term Cannabinoid (December 13, 2021) – <https://www.merriam-webster.com/dictionary/cannabinoid>

¹⁵ Alina Bradford, Live Science: What is THC? (May 18, 2017) – <https://www.livescience.com/24553-what-is-thc.html>

¹⁶ Kimberly Holland, Healthline: *Sativa* vs *Indica*: What to Expect Across Cannabis Types and Strains (March 22, 2021) – <https://www.healthline.com/health/sativa-vs-indica>

Cannabis also contains terpenes, which are aromatic chemical compounds produced and commonly found in plants. Each cannabis plant has a different terpene profile, and the profile of each plant can cause varied effects on the consumer.¹⁷

Usable cannabis and hemp are derived from the same species of plant. However, hemp is defined as cannabis that has a THC concentration of no greater than .3% total, as measured in dry weight.¹⁸ Hemp is cultivated for use in the production of a various assortment of products, including foods and beverages, personal care products, nutritional supplements, fabrics and textiles, paper, construction materials, and other manufactured and industrial goods.¹⁹

Cannabis is produced in several different forms: seeds, clones, plant tissue, plants, harvested materials (i.e., leaves, flowers, stalks, stems, pollen, and concentrates), and consumer products (consumable flowers, concentrates (i.e., hash, kief, waxes, oils, and vapor), topical goods, and infused consumables). The main categories of consumer cannabis products include flowers; concentrates; and infused goods.²⁰

- Cannabis Flower – THC in cannabis plants is produced by resinous glands that tend to concentrate in the plant’s flowers or buds.²¹ Cannabis farmers harvest the flower from the plant (removing bulky leaves and stems with less THC concentration) and dry the plant material of any moisture so it is prepared for consumption. Generally, cannabis flower is often smoked in pipes or hand-rolled cigarettes called joints, pre-rolled joints, or pre-rolls. Cannabis flowers can also be smoked in a cigar or combined with tobacco and smoked as a cigarette.²²
- Cannabis Concentrates – Cannabis can be harvested and processed through methods that produce cannabis concentrates. These products have been grown, harvested, and processed in a way to maximize cannabinoid, THC, and terpene content. Cannabis concentrates can take the form of hash, kief, waxes, or oils. The cannabis in these products has been concentrated through different scientific extraction and processing methods, including but not limited to: screens, sifts, bags, mechanical separation,

¹⁷ Leafly: Indica vs Sativa: understanding the differences between weed types (June 9, 2022) -

<https://www.leafly.com/news/cannabis-101/sativa-indica-and-hybrid-differences-between-cannabis-types#:~:text=The%20common%20understanding%20of%20indicas,social%20gatherings%2C%20and%20creative%20projects>

¹⁸ Amy Abernethy, MD, PhD, U.S. Food & Drug Administration: Hemp Production and the 2018 Farm Bill (July 25, 2019) – <https://www.fda.gov/news-events/congressional-testimony/hemp-production-and-2018-farm-bill-07252019>

¹⁹ Congressional Research Service: Defining Hemp: A Fact Sheet (March 22, 2019) – <https://sgp.fas.org/crs/misc/R44742.pdf>

²⁰ Weedmaps: A Guide to Cannabis Product Types (accessed June 27, 2022) – <https://weedmaps.com/learn/introduction/guide-cannabis-product-types>

²¹ *Id.*

²² *Id.*

chemical extractions, distillation, and pressurized heat applications. These methods employ different scientific strategies to extract, at highly concentrated ratios, THC from the cannabis plant. The final product of these extraction processes can result in a range of forms, from a dry and granular pollen powder similar to hash or kief to a sticky, resinous wax material, which can resemble plant sap, and is known as cannabis wax (i.e., budders, shatters, crumbles, sugars, distillates, or oils). These forms vary in properties, such as viscosity and density, and are named accordingly. For example, a cannabis concentrate wax marketed as a budder is likely to have the same consistency as household butter, being pliable and not too rigid. However, a cannabis concentrate wax marketed as shatter would have extremely rigid properties, and the wax could break into pieces or shatter if pulled or bent.²³

- Infused Goods – Cannabis can also be processed into topical products and infused consumables. Topical products are those that are placed directly on the consumer’s skin. Infused consumables include beverages, edibles, and suppository products that have been infused with cannabis, including cannabinoids such as THC or CBD. Topical products are not associated with impairment or intoxication to the consumer. However, infused consumable products will lead to intoxication or impairment of the consumer, as these products contain cannabis concentrates, including THC and CBD. Examples of infused consumable products include cannabis beverages and edibles.²⁴

III. THE EXPANSION OF STATES LEGALIZING CANNABIS

A. Medical-Use and Recreational-Use Legalization in States

California was the first state in the United States (U.S.) to legalize cannabis for medical use.²⁵ In 1996, California passed Proposition 215, allowing for the sale and medical use of cannabis for patients with AIDS, cancer, and other serious, painful diseases. Currently, as of February 3, 2022, 37 states, the District of Columbia (D.C), and three territories allow for the medical use of

²³ National Institute on Drug Abuse: Cannabis (Marijuana) Concentrates Drug Facts (accessed June 27, 2022) – <https://nida.nih.gov/publications/drugfacts/cannabis-marijuana-concentrates>

²⁴ Leafly: Cannabis Glossary – Topical (accessed June 27, 2022) – <https://www.leafly.com/learn/cannabis-glossary/topical>

²⁵ California Department of Cannabis Control: California’s Cannabis Laws (September 13, 2022) – [https://cannabis.ca.gov/cannabis-laws/laws-and-regulations/#:~:text=California%20became%20the%20first%20state,and%20adult%20\(recreational\)%20use](https://cannabis.ca.gov/cannabis-laws/laws-and-regulations/#:~:text=California%20became%20the%20first%20state,and%20adult%20(recreational)%20use)

cannabis.²⁶ In 2021, 25 years after California first authorized medical cannabis, the majority of states in the U.S. now allow the use of cannabis for medical purposes.

Colorado was the first state in the U.S. to legalize cannabis for recreational purposes in 2012.²⁷ Washington also passed marijuana reform legislation shortly after Colorado, in 2012, legalizing the recreational use of cannabis.²⁸ As of November 9, 2022, 21 states, two territories, and D.C. have enacted legislation to regulate cannabis for nonmedical or recreational use.²⁹ According to 2020 U.S. Census Bureau apportionment numbers, more than 145 million Americans now live in a state that has legalized cannabis.³⁰

The path toward legalization is not necessarily straight, nor is it quick. The following are examples of this experience.

Today, cannabis laws in Alaska allow adult use. The state first legalized medical marijuana in 1998, though for many years, there was no way for patients to legally purchase it.³¹ Alaska was the second state in the U.S. to decriminalize possession of up to one ounce and the third to legalize recreational marijuana.³² Residents over 21 years old with a valid state ID can legally grow up to six plants at home and purchase up to one ounce of marijuana or 7 grams of concentrates from regulated dispensaries.³³ Only cash is accepted.³⁴

²⁶ National Conference of State Legislators: State Cannabis Laws (September 12, 2022) – <https://www.ncsl.org/research/health/state-medical-marijuana-laws.aspx>

²⁷ Claire Hansen, Horus Alas, and Elliott Davis Jr., US News: Where is Marijuana Legal? A Guide to Marijuana Legalization (October 14, 2021) – <https://www.usnews.com/news/best-states/articles/where-is-marijuana-legal-a-guide-to-marijuana-legalization>

²⁸ The Marijuana Policy Project - Colorado and Washington: Life After Legalization and Regulation (2023) – <https://www.mpp.org/issues/legalization/colorado-and-washington-life-after-legalization-and-regulation/#:~:text=In%202012%2C%20Colorado%20and%20Washington,half%20of%20the%20U.S.%20population>

²⁹ National Organization for the Reform of Marijuana Laws (NORML): Legalization and State Laws Website (November 28, 2022) – [Legalization - NORML](https://www.norml.org/legalization); The Marijuana Policy Project: State Policy Website (November 28, 2022) – <https://www.mpp.org/states/>

³⁰ United States Census Bureau: 2020 Census Apportionment Results (September 12, 2022) – <https://www.census.gov/data/tables/2020/dec/2020-apportionment-data.html>

³¹ Alaska Medical Marijuana Act, Measure 8 (1998) (Accessed August 19, 2022) – [https://ballotpedia.org/Alaska_Medical_Marijuana_Act,_Measure_8_\(1998\)#:~:text=The%20Alaska%20Medical%20Marijuana%20Initiative,marijuana%20for%20certain%20medical%20purposes.%22](https://ballotpedia.org/Alaska_Medical_Marijuana_Act,_Measure_8_(1998)#:~:text=The%20Alaska%20Medical%20Marijuana%20Initiative,marijuana%20for%20certain%20medical%20purposes.%22)

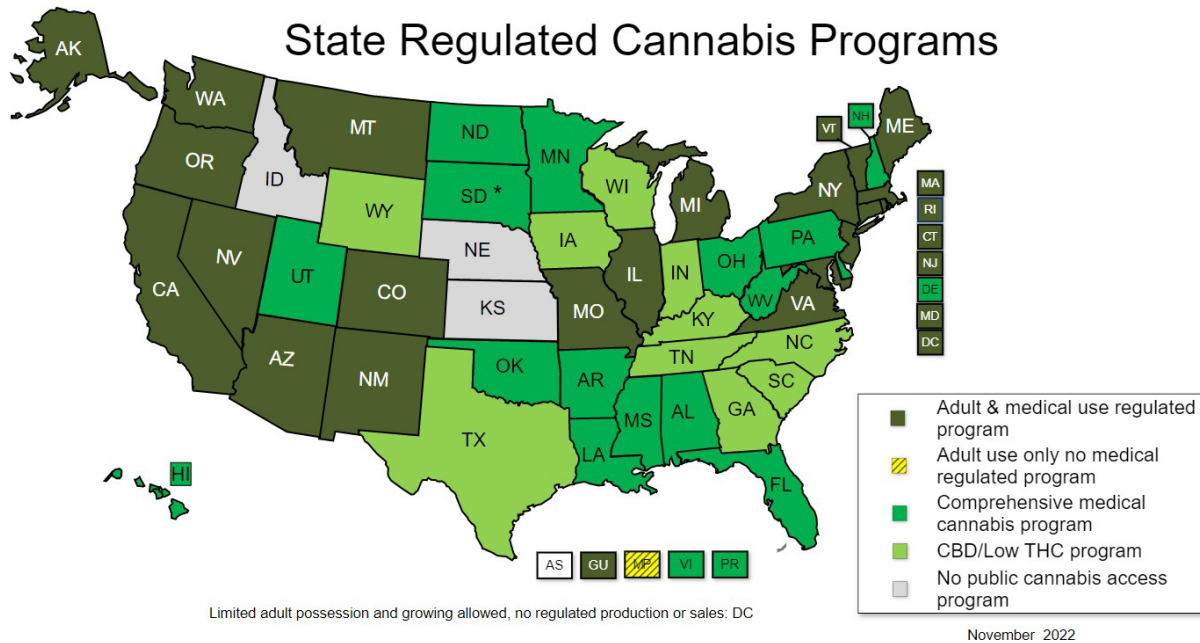
³² Alaska Marijuana Legalization, Ballot Measure 2 (2014) (Accessed August 19, 2022) – [https://ballotpedia.org/Alaska_Marijuana_Legalization,_Ballot_Measure_2_\(2014\)](https://ballotpedia.org/Alaska_Marijuana_Legalization,_Ballot_Measure_2_(2014)), and Michael Hartman, National Conference of State Legislatures, Cannabis Overview, Alaska Legalization (May 31, 2022) – <https://www.ncsl.org/research/civil-and-criminal-justice/marijuana-overview.aspx>

³³ Weedmaps: Alaska, Laws and Regulations (September 12, 2022) – <https://weedmaps.com/learn/laws-and-regulations/alaska>

³⁴ Laurel Andrews, Alaska Official Visitor's Guide, a Tourist's Guide to Legal Marijuana in Alaska (May 2, 2018) – <https://www.adn.com/alaska-visitors-guide/2018/05/02/a-tourists-guide-to-legal-marijuana-in-alaska/>

Some states did not see cannabis legalized overnight. For example, Oregon’s Measure 80 (Oregon Cannabis Tax Act Initiative) in 2012 did not receive enough “yes” votes.³⁵ Measure 80 would have permitted cannabis to be sold at state-licensed stores and would have permitted adults to purchase cannabis at such stores without a license. Oregon did not legalize such recreational cannabis use until July 2016.³⁶ This is a consistent experience among the states where there is a majority support for legalization, but it may take multiple attempts.

The nature of cannabis being regulated on a state-by-state basis permits state systems on cannabis regulation to differ quite drastically. The below map outlines the different states and their varied approaches to cannabis regulation:



* National Conference of State Legislatures: State Cannabis Laws – Map of State Regulated Cannabis Programs (November 2022 - <https://www.ncsl.org/research/health/state-medical-marijuana-laws.aspx>)

B. Public Opinion Supports Legality Expansion

As discussed in the previous white paper, the majority of Americans now support legalized cannabis.³⁷ In fact, public support for legalizing cannabis is increasingly favorable. Over 90% of

³⁵ Ballotpedia: Oregon Cannabis Tax Act Initiative, Measure 80 (2012) (July 15, 2022) – [https://ballotpedia.org/Oregon_Cannabis_Tax_Act_Initiative,_Measure_80_\(2012\)](https://ballotpedia.org/Oregon_Cannabis_Tax_Act_Initiative,_Measure_80_(2012))

³⁶ Travel Portland Website: Legal Cannabis in Portland and Oregon (March 4, 2022) – <https://www.travelportland.com/culture/legal-marijuana-portland-oregon/>

³⁷ NAIC: Regulatory Guide – Understanding the Market for Cannabis Insurance (May 24, 2019) – https://content.naic.org/sites/default/files/inline-files/cmte_c_cannabis_wg_exposure_understanding_cannabis_marketplace_0.pdf

U.S. adults in 2021 believe cannabis should be legal for either medical or recreational purposes.³⁸ Here, 60% support the legalization of cannabis for medical and recreational use, and 31% support the legalization of cannabis for medical use only.³⁹ Public opinion on cannabis and cannabis legalization have changed significantly since President Richard Nixon signed the Controlled Substances Act (CSA) of 1970 into law. Once associated with the war on drugs, cannabis now presents business opportunities, with the state-legal cannabis markets expected to reach over \$40 billion in the U.S. by 2026.⁴⁰

Public opinions and perspectives on cannabis are shifting to a level of lower scrutiny than experienced under the previous zero-tolerance approach adopted by the federal government and individual states. For example, U.S. Congress has considered replacing the statutory term of reference from marijuana or marihuana to cannabis.⁴¹ The changing of terms from marijuana to cannabis is being pursued in part because there are potentially negative connotations associated with the history and origin of the term marihuana.⁴² States have also sought similar legislation for the switching of statutory references from marijuana to cannabis.⁴³ The increasing legislative reformation of cannabis at the federal and state levels, as well as less scrutiny from the public, combine to show that cannabis is likely trending toward regulation versus outright prohibition.

IV. FEDERAL LEGISLATION ACTIVITY INTENSIFIES

Conflicting individual state and federal laws on cannabis have largely discouraged insurers from participating in coverage of the market. To illustrate this conundrum, cannabis is an illegal substance under the Classified Substances Act (CSA).⁴⁴ The CSA classifies cannabis as a Schedule I drug that has no currently accepted medical use in the U.S.⁴⁵ A 2018 Farm Bill provision removed hemp from the list of Schedule I controlled substances.⁴⁶ Therefore, the U.S. Drug Enforcement Administration (DEA) will not consider hemp-derived cannabinoids as a controlled substance that

³⁸ Ted Van Green, PEW Research Center: Americans overwhelmingly say marijuana should be legal for recreational or medical use (November 15, 2021) – <https://www.pewresearch.org/fact-tank/2022/11/22/americans-overwhelmingly-say-marijuana-should-be-legal-for-medical-or-recreational-use/>

³⁹ *Id.*

⁴⁰ Alex Malyshev and Sarah Ganley, Reuters: Reading the tea leaves: What might federal legalization of marijuana look like? (November 15, 2021) – <https://www.reuters.com/legal/litigation/reading-tea-leaves-what-might-federal-legalization-marijuana-look-like-2021-11-15/2021> – <https://www.pewresearch.org/fact-tank/2021/04/16/americans-overwhelmingly-say-marijuana-should-be-legal-for-recreational-or-medical-use/>

⁴¹ Congress.Gov: H.R. 3617 – MORE Act of 2021 – <https://www.congress.gov/bill/117th-congress/house-bill/3617>

⁴² Matt Thompson, NPR: The Mysterious History of ‘Marijuana’, (July 22, 20213) – <https://www.npr.org/sections/codeswitch/2013/07/14/201981025/the-mysterious-history-of-marijuana> ⁴³ Washington State: Chapter 16, Laws of 2022 (67th Legislature, 2022 Regular Session) – <https://lawfilesexxt.leg.wa.gov/biennium/2021-22/Pdf/Bills/Session%20Laws/House/1210-S2.SL.pdf>

⁴⁴ U.S. DEA Website, The Controlled Substances Act (Title 21 United States Code (USC) Controlled Substances Act) – <https://www.dea.gov/drug-information/csa>

⁴⁵ *Id.*

⁴⁶ U.S. Department of Agriculture Website, Farm Bill – <https://www.usda.gov/farmbill>

is subject to the CSA. However, cannabis and CBD (irrespective of being sourced from cannabis or hemp) are subject to Federal Drug Administration (FDA) approval under the federal Food, Drug, and Cosmetic Act (FD&C Act).⁴⁷ The FDA has not yet approved a cannabis drug for medical use or treatment. The FDA has approved CBD medicines for the treatment of epilepsy. Federal law currently prohibits CBD from being added to any food or drink product. On July 22, 2019, the FDA issued formal letters making the determination that certain CBD products were sold in violation of the FD&C Act.⁴⁸ Despite this prohibition, products containing CBD are generally widely available in the retail marketplace in formulations ranging from nutritional supplements to cosmetics and for both human and veterinary use.

Companies functioning within state-legal cannabis industries generally experience banking restrictions due to federal regulations.⁴⁹ This causes many cannabis businesses and cannabis-related businesses (CRBs) to function on a cash-only basis. Current estimates show that approximately 70% of CRBs operate solely as a cash-only business and have no formal relationship with a bank.⁵⁰ This causes CRBs to possess and process large amounts of money in cash form, which can create a higher risk of theft and additional liabilities.⁵¹ More on this and the federal authorities limiting the abilities of cannabis businesses to engage in financial transactions can be found in the NAIC's White Paper on *Understanding the Market for Cannabis Insurance (2019)*.

There is an ongoing concern about entities supporting cannabis businesses being charged with violation of the federal Racketeer Influenced and Corrupt Organizations (RICO) Act. In addition, the federal Internal Revenue Code 280E prevents cannabis businesses from taking advantage of tax deductions for actual economic expenses incurred in the ordinary course of business. This can prevent cannabis businesses from taking deductions related to insurance and premiums or costs, such as for workers' compensation and health insurance.

Recently, the federal government has been considering cannabis reform legislation at a record-setting pace. During the 117th Congress (in 2021 – 2022), at least five different pieces of national

⁴⁷ U.S. Food & Drug Administration Website (FD&C Act) – <https://www.fda.gov/regulatory-information/laws-enforced-fda/federal-food-drug-and-cosmetic-act-fdc-act>

⁴⁸ NAIC – CIPR Topics: Cannabis and Insurance (August 18, 2021) – https://content.naic.org/cipr_topics/topic_cannabis_and_insurance.htm

⁴⁹ NAIC: Regulatory Guide – Understanding the Market for Cannabis Insurance (May 24, 2019) – https://content.naic.org/sites/default/files/inline-files/cmte_c_cannabis_wg_exposure_understanding_cannabis_marketplace_0.pdf

⁵⁰ NAIC – CIPR Topics: Cannabis and Insurance (August 18, 2021) – https://content.naic.org/cipr_topics/topic_cannabis_and_insurance.htm ⁵¹

Id.

cannabis reform legislation were introduced.⁵² Each bill took a different approach to altering the federal government's position on cannabis. The bills include the federal Safe and Fair Enforcement (SAFE) Banking Act, the Clarifying Law Around Insurance of Marijuana (CLAIM) Act, the Marijuana Opportunity Reinvestment and Expungement (MORE) Act of 2021, the Cannabis Administration and Opportunity (CAOA) Act, and the States Reform Act of 2021.

The CLAIM Act would provide a safe harbor from penalties or other adverse agency action for insurance companies that provide services to cannabis-related legitimate businesses in jurisdictions where such activity is legal. The U.S. Government Accountability Office (GAO) must report on barriers to marketplace entry for minority-owned and women-owned cannabis-related businesses.⁵³

The NAIC submitted a letter in support of the CLAIM Act on June 17, 2021. The letter acknowledged the bill would provide a safe harbor from violations of federal law for those engaged in the business of insurance participating in cannabis industry activity that is permissible under state law. By removing barriers, the CLAIM Act would permit insurers to provide insurance coverage options for these commercial policyholders.⁵⁴

The SAFE Banking Act would remove constraints on depository institutions to provide banking services to a legitimate cannabis-related business. Under the SAFE Banking Act, proceeds would not be considered unlawful activity and not run afoul of anti-money laundering laws. Under this act, depository institutions would not be at risk of forfeiting financial assets for providing a loan or other financial services to a legitimate cannabis-related business. The NAIC also submitted a letter in support of the SAFE Banking Act on June 17, 2021.

The MORE Act would decriminalize cannabis. Specifically, it removes cannabis from the list of scheduled substances under the CSA and eliminates criminal penalties for an individual who manufactures, distributes, or possesses cannabis. The States Reform Act of 2021 would remove the legal obstacles preventing U.S. cannabis companies from accessing the financial system and allow for interstate commerce of cannabis. The bill also requests the release and expungement of people convicted of nonviolent cannabis-only crimes.⁵⁵

⁵² Julie Hyman, Yahoo! Finance: Weed is Likely to Remain Federally Illegal, but 'Cannabis Banking' Could Pass this Year (March 31, 2022) – <https://finance.yahoo.com/news/weed-is-likely-to-remain-federally-illegal-but-cannabis-banking-could-pass-this-year-132330251.html>

⁵³ Congress.Gov: H.R. 2068 – CLAIM Act – <https://www.congress.gov/bill/117th-congress/house-bill/2068>

⁵⁴ NAIC Support Letter – Claim Act 2021 (June 17, 2021) – <https://content.naic.org/sites/default/files/government-affairs-letter-support-claim-act-2021.pdf>

⁵⁵ Congress.Gov: H.R. 5977 – To amend the Controlled Substances Act regarding marihuana, and for other purposes. – <https://www.congress.gov/bill/117th-congress/house-bill/5977?s=1&r=5>

On July 21, 2022, Senate Majority Leader Chuck Schumer introduced the CAO Act.⁵⁶ The CAO Act attempts to accomplish significant reformation of federal cannabis policy, allowing states to lead on cannabis regulation and establishing a federal regulatory paradigm similar to that of alcohol and tobacco.⁵⁷ The CAO would expunge federal cannabis-related records and create funding for law enforcement departments to fight illegal cannabis cultivation.⁵⁸

On October 6, 2022, President Biden asked the Secretary of Health and Human Services and the Attorney General to review how marijuana is categorized under federal law.⁵⁹ President Biden also signed the Medical Marijuana and Cannabidiol Research Expansion Act (Statute at Large 136 Stat. 4178 - Public Law No. 117-215) in December 2022. This new law is anticipated to increase access to the scientific study of cannabis by streamlining the government issuance of permits to scientists who want to study the substance and expediting applications for cannabis producers (including universities) that grow the substance for research purposes.⁶⁰ None of these laws were passed in the previous Congress, but it is anticipated that discussion will continue on these issues.

V. CANNABIS BUSINESS REGULATORY, LICENSING, AND EDUCATION LANDSCAPE

A. States Legalize Cannabis Around the Cole Memorandum

Colorado and Washington were the first states to legalize cannabis for recreational use in 2012. At that time, 19 states had already legalized cannabis for medical use. To address the growing legalization of cannabis use by the states, the federal Department of Justice (DOJ) issued the Cole Memorandum in 2013. The Cole Memorandum provided states with the federal position on the enforcement of marijuana under the Classified Substances Act (CSA). Specifically, it provided that the federal government would not prioritize enforcement or interference with state implementation of regulated cannabis programs if states upheld the Department of Justice's (DOJ's) and federal government's priorities.⁶¹ These priorities included:

⁵⁶ Natalie Fertig, Politico: Schumer's Legal Weed Bill is Finally Here, (July 21, 2022) – <https://www.politico.com/news/2022/07/21/schumer-legal-weed-bill-00047058>

⁵⁷ John Schroyer and Jeff Smith, MJBizDaily: Schumer Marijuana Legalization Bill Finally Introduced in Senate, (July 22, 2022) – https://mjbizdaily.com/schumer-marijuana-legalization-bill-finally-introduced-in-senate/?utm_medium=email&utm_source=newsletter&utm_campaign=MJD_20220722_NEWS_Daily&nowprocket=1

⁵⁸ Natalie Fertig, Politico: Schumer's Legal Weed Bill is Finally Here, (July 21, 2022) – <https://www.politico.com/news/2022/07/21/schumer-legal-weed-bill-00047058>

⁵⁹ The White House: Briefing Room Website – Statement from President Biden on Marijuana Reform, (October 6, 2022) – <https://www.whitehouse.gov/briefing-room/statements-releases/2022/10/06/statement-from-president-biden-on-marijuana-reform/>

⁶⁰ Meredith Wadman, Science Insider: New U.S. Law Promises to Light Up Marijuana Research, (December 2, 2022) – <https://www.science.org/content/article/new-u-s-law-promises-light-marijuana-research>

⁶¹ *Id.*

- Preventing the distribution of marijuana to minors;
- Preventing revenue from the sale of marijuana from going to criminal enterprises, gangs, and cartels;
- Preventing the diversion of marijuana from states where it is legal under state law in some form to other states;
- Preventing state-authorized marijuana activity from being used as a cover or pretext for the trafficking of other illegal drugs or other illegal activity;
- Preventing violence and the use of firearms in the cultivation and distribution of marijuana;
- Preventing drugged driving and the exacerbation of other adverse public health consequences associated with marijuana use;
- Preventing the growing of marijuana on public lands and the attendant public safety and environmental dangers posed by marijuana production on public lands; and
- Preventing marijuana possession or use on federal property.

Many states that voted to legalize the sale and use of cannabis designed their regulated cannabis systems to carefully consider the DOJ and federal government priorities outlined in the Cole Memorandum. Each state took an individualized approach to implementing cannabis regulation. This has led to individual cannabis industries across the country that operate under separate and distinct authorities for their jurisdictions. The differences in state cannabis regulations are evident in the varied cannabis business licensing programs, regulation authorities, consumer experiences, and associated practices for CRBs. For example, Colorado has implemented a regulatory system where cannabis businesses can vertically integrate their businesses, including agriculture, retail sales, and manufacturing. Washington has implemented a prohibition on vertical integration, requiring licensed cannabis businesses to operate in their licensed business classification, such as a cannabis retailer, cannabis producer, or cannabis processor.

The Cole Memorandum was rescinded by the federal government in 2018.⁶² This created a gray area for states with legal cannabis operations. The United States Attorney General issued new guidance in 2018 under Attorney General Jefferson B. Sessions. The new guidance directed U.S. state attorneys to use their discretion, as well as well-established principles that govern all federal prosecutions, in cannabis enforcement.⁶³ The current administration has expressed views to return to a Cole-like environment but has not taken an official position.

⁶² Office of the Attorney General: Memorandum for All US Attorneys (January 4, 2018) – <https://www.justice.gov/opa/press-release/file/1022196/download>

⁶³ *Id.*

B. The Role of CANNRA

States have been striving to work toward best policies and practices in the cannabis and insurance industries by working through the Cannabis Regulators Association (CANNRA). CANNRA is a national not-for-profit organization of cannabis regulators that provides policymakers and regulatory agencies with the resources to make informed decisions when considering whether and how to legalize and regulate cannabis.⁶⁴ It is a support association for regulatory agencies, not a cannabis advocacy group. As such, it takes no formal position for or against cannabis legalization but rather seeks to provide government jurisdictions with unbiased information to help make informed decisions when considering whether or how to legalize or expand regulated cannabis.⁶⁵ Membership in CANNRA is limited to regulators and representatives from relevant government offices.⁶⁶ CANNRA is funded by member agencies and does not receive funding from industry or advocacy groups.⁶⁷

CANNRA strives to create and promote harmony and, where possible, standardization across jurisdictions that legalize and regulate cannabis.⁶⁸ CANNRA helps interested parties find objective data and evidence-based approaches to policymaking and implementation.⁶⁹ CANNRA also works to ensure federal officials benefit from the vast experiences of states across the nation so that any changes to federal law adequately address states' needs and priorities.⁷⁰

C. Cannabis Impairment and Insurance Considerations

Insurers rely on data to help them understand the risks they indemnify. However, there is still much to know about impairment and cannabis use. Cannabis shares the Schedule I classification along with some of the most serious drugs, including heroin, LSD, and meth. As such, cannabis used for studies must come from federally approved facilities. Historically, the University of Mississippi was recognized as the only institution federally approved to cultivate cannabis for research, with the license awarded in 1968.⁷¹ The cannabis that is produced in this facility does

⁶⁴ CANNRA: Home Website Page (accessed June 27, 2022) – <https://www.cann-ra.org/>

⁶⁵ *Id.*

⁶⁶ CANNRA: Membership Website Page (accessed June 27, 2022) – <https://www.cann-ra.org/leadership>

⁶⁷ CANNRA: News and Events Website Page (accessed June 27, 2022) – <https://www.cann-ra.org/news-events>

⁶⁸ *Id.*

⁶⁹ *Id.*

⁷⁰ *Id.*

⁷¹ Omar Sacirbey, MJ Biz Daily: DEA close to allowing companies to grow cannabis for scientific research (December 17, 2021) – <https://mjbizdaily.com/dea-preparing-to-ok-companies-to-grow-cannabis-for-scientific-research/#:~:text=Currently%2C%20the%20University%20of%20Mississippi,awarded%20its%20license%20in%201968.>

not resemble the cannabis in modern-day retailers. In fact, the cannabis produced in the federally approved facilities does not mimic the appearance nor potency of state-regulated cannabis.⁷²

Recently, the federal government, through the Drug Enforcement Administration (DEA), approved registrations for two other companies to produce cannabis for research purposes.⁷³ This is a historic development for the research of cannabis and allows the DEA to oversee the production of research-grade cannabis at a level not previously achieved by the University of Mississippi.⁷⁴ The two companies include Groff North America Hemplex and the Biopharmaceutical Research Company, which began harvesting their first crops by January 2022.⁷⁵

The limitations on human studies, with limited accessibility to cannabis that resembles that same substance in state-legal medical and retail markets, create substantial complications to the scientific research of cannabis, including long-term studies on the effects or dangers of impairment and usage. Thus, they provide limited information from which to develop policy or make informed decisions.

Testing for cannabis impairment is difficult due to the limits of drug testing technology, as well as the lack of a recognized limit to determine impairment. For example, the nationally recognized level of impairment for alcohol is set at .08 g/mL of blood alcohol concentration, which is well-founded in scientific research. However, there is no similar national standard set for driving under the influence of cannabis. Cannabis may not affect all people consistently. Cannabis may remain in a person's body for weeks after consumption, and may still appear in drug tests, even though it may no longer be causing impairment to the consumer. As a practical matter, because of these problems, drivers may be tested for high blood alcohol concentrations but may not be tested for other impairing substances.

The states of Illinois, Montana, Nevada, Ohio, and Washington have all adopted specific per se limits for THC present in a driver's body, with ranges between two nanograms and five nanograms per milliliter of blood.⁷⁶ These authorities provide that when a person has reached or

⁷² Christopher Ingraham and Tauhid Chappell, The Washington Post: Government marijuana looks nothing like the real stuff. See for yourself. (March 13, 2017) – <https://www.washingtonpost.com/news/wonk/wp/2017/03/13/government-marijuana-looks-nothing-like-the-real-stuff-see-for-yourself/>

⁷³ Kyle Jaeger, Marijuana Moment: Federal Marijuana Monopoly Finally Ends as Two Companies Harvest Cannabis Approved by DEA (January 4, 2022) – <https://www.marijuanamoment.net/dea-finally-breaks-federal-marijuana-grower-monopoly-with-two-new-companies-harvesting-cannabis-approved-by-agency/>

⁷⁴ *Id.*

⁷⁵ *Id.*

⁷⁶ National Conference of State Legislatures (NCSL): Drugged Driving | Marijuana-Impaired Driving (September 23, 2021) – <https://www.ncsl.org/research/transportation/drugged-driving-overview.aspx>

exceeded the legal threshold, that person is considered impaired under law. The state of Colorado has a reasonable inference law that outlines that in instances where THC is identified in a driver's blood, at quantities of 5ng/ml or more, it is assumed that the driver was under the influence.⁷⁷ The reasonable inference laws are different from the per se laws, as they allow drivers who are charged to raise an affirmative defense showing that despite having tested at or above the legal limit, they were not actually impaired. There are also 12 states that have zero- tolerance laws for THC, including Arizona, Delaware, Georgia, Indiana, Iowa, Michigan, Oklahoma, Pennsylvania, Rhode Island, South Dakota, Utah, and Wisconsin.⁷⁸

Complicating this issue is the lack of technologies, scientific methodologies, or accepted best practices in discovering or determining cannabis impairment. New technologies are being developed and generally involve biological screening or field sobriety tests. Here, examples of technologies used to detect cannabis impairment include saliva, urine, and blood testing machines. A few states, including Alabama and Michigan, have adopted active oral fluid roadside tests for drivers suspected to be impaired by cannabis use, among other drugs, which could negatively impact their driving.⁷⁹ Law enforcement officers in most states also generally possess discretion to determine whether an individual is impaired and presents a risk to themselves or others, whether using cannabis or other impairing substances in public, the workplace, or in driving situations. Many law enforcement agencies employ Drug Recognition Experts (DREs), who rely on professional experience and training to discover and determine whether an individual is impaired by cannabis usage. The use of new technology, scientific methodology, and best practices among law enforcement agencies will be critical in mitigating the risks of cannabis impairment in our workplaces and on our roadways.

1. Cannabis Driving Impairment – Cannabis DUI

Preventing cannabis users from driving while impaired was a top priority enumerated in the Cole Memorandum and an issue that each state with a regulated cannabis industry has considered. Cannabis is the second leading substance present in cases of driving under the influence, trailed only by alcohol.⁸⁰ Scientists and law enforcement are still seeking a reliable DUI test to identify impairment from cannabis use. While there are blood tests that can detect some of cannabis's components, such as THC, there is no scientifically accepted standardized method of testing or

⁷⁷ Colorado Department of Transportation: FAQs on Impaired Driving (September 13, 2022) – <https://www.codot.gov/safety/impaired-driving/druggeddriving/faqs>

⁷⁸ National Conference of State Legislatures (NCSL): Drugged Driving | Marijuana Impaired Driving (September 23, 2021) – <https://www.ncsl.org/research/transportation/drugged-driving-overview.aspx>

⁷⁹ *Id.*

⁸⁰ National Institute on Drug Abuse: Drugged Driving DrugFacts (September 13, 2022) – <https://nida.nih.gov/publications/drugfacts/drugged-driving>

determining the level of impairment from a cannabis user's blood or breath. Law enforcement officers may also have the discretion of completing a field sobriety test with any person they suspect is driving under the influence.

The National Association of Mutual Insurance Companies (NAMIC) analyzed this issue in 2021 with its research on the *Cannabis Conundrum: The Intersection of Property/Casualty Insurance and Cannabis-Impaired Driving*.⁸¹ NAMIC's research revealed that the states that have legalized cannabis for medical and recreational use will only continue to grow as ballot initiatives and legislation are codified. This places a focus on scientific research, funding, and technology development that will assist all parties in better understanding and ability to mitigate risks that cannabis-impaired driving may present. Educational campaigns to educate drivers of all ages and backgrounds on the potential risks associated with cannabis consumption will be needed.

Some studies, including studies associated with NAMIC and the American Property Casualty Insurance Association (APCIA), show a direct relation between cannabis regulation and increased auto accidents, as well as an associated increase in auto insurance premiums.^{82,83} Other studies focus on data that shows an increase in cannabis DUIs and related car accidents, whether related to recreational or medical cannabis legalization.^{84,85} Multiple insurance periodicals have recorded similar increases in car insurance claims and accident rates after states have regulated cannabis.^{86,87} Obviously, increased accident rates and claims have an effect on premiums; however, at this point, research is inconclusive on whether the relationship is a correlation or a direct causation.

Education for those outside of the cannabis industry can be conducted through public service announcements, government-sponsored education efforts, informative websites, and news media. For example, the U.S. Department of Transportation (DOT), the National Highway Traffic Safety Administration (NHTSA), and the Ad Council have recently started a campaign

⁸¹ Tony Cotto and Andrew Malin, NAMIC Advocacy: Cannabis Conundrum – The Intersection of Property/Casualty Insurance and Cannabis-Impaired Driving (May 10, 2021) – https://www.namic.org/pdf/publicpolicy/210510_cannibus_conundrum.pdf

⁸² Tony Cotto and Andrew Malin, NAMIC Advocacy: Cannabis Conundrum – The Intersection of Property/Casualty Insurance and Cannabis-Impaired Driving (May 10, 2021) – https://www.namic.org/pdf/publicpolicy/210510_cannibus_conundrum.pdf

⁸³ Stephanie Strategos Polis, American Property Casualty Insurance Association: Marijuana Legalization Reaffirms Auto Safety as Top Priority for Insurers (November 17, 2020) – <https://www.apci.org/media/news-releases/release/64148/>

⁸⁴ Angela Eichelberger, National Library of Medicine: Marijuana use and driving in Washington State: Risk perceptions and behaviors before and after implementation of retail sales (March 1, 2019) – <https://pubmed.ncbi.nlm.nih.gov/30822133/> ⁸⁵ The Highway Loss Data Institute: Recreational Marijuana and Collision Claim Frequency, Vol. 24, No. 14 (April 2017) – https://www.ihs.org/media/806f7c38-4594-4bbe-82ff-df4a749f5153/9fJfcw/HLDI%20Research/Bulletins/hldi_bulletin_34-14.pdf

⁸⁶ Insurance Journal: First States to Legalize Marijuana See Rise in Car Insurance Claims, Research Shows (January 7, 2019) – <https://www.insurancejournal.com/magazines/mag-features/2019/01/07/513762.htm>

⁸⁷ Jim Sams, Claims Journal: Insurance Group Says Data Suggests Cannabis is Increasing Accident Rates (March 14, 2019) – <https://www.claimsjournal.com/news/national/2019/03/14/289753.htm>

communicating the dangers of driving while under the influence of cannabis, called *Drug Impaired Driving: If You Feel Different, You Drive Different*.⁸⁸

2. Cannabis Workplace Impairment

Currently, two out of three Americans live in a state that has approved the sale and use of recreational cannabis.⁸⁹ Cannabis can appear in drug tests and remain in a consumer for 30 days or longer.⁹⁰ Therefore, cannabis users could lawfully consume the substance during their off-work hours but still be affected by cannabis or THC in their systems during work. Employers must assess if their staff present a risk of liability to themselves or others. Problems include issues with pre-employment drug testing, determining employee impairment, establishing reasonable accommodations, and maintaining medical privacy.

It should be noted that there is little data on the impact of legal market cannabis consumption on everyday life. There is a huge range of products available on the legal market that have never touched a research lab. Cannabis consists of a few primary cannabinoids and hundreds of minor cannabinoids and terpenes, and many are still being discovered. There is also a huge variation in potency across strains. Different products have different levels of major and minor cannabinoids, and each looks distinct. For these reasons, the study of cannabis is unlike the study of other drugs, where one is pretty much focused on a dose-dependent effect of a single pharmacological agent.⁹¹

Overlapping authorities and developments in case law on the topic have revealed that employers lack consistent and developed guidelines for cannabis drug testing in the workplace. Case law in several states, including California, Oregon, and Washington, has established that a private employer can terminate an employee for failing a company's drug test, even if that employee is authorized under state law to use cannabis as a medicine.⁹² Multiple states, including Arizona, Arkansas, Connecticut, Delaware, Maine, Minnesota, Oklahoma, Pennsylvania, Rhode Island, and

⁸⁸ U.S. Department of Transportation (NHTSA) (April 3, 2023) – <https://www.nhtsa.gov/campaign/if-you-feel-different-you-drive-different#:~:text=Several%20scientific%20studies%20show%20that,will%20be%20arrested%20for%20DUI>.

⁸⁹ Justin McCarthy, Gallup: Two in Three Americans Now Support Legalizing Marijuana (October 22, 2018) – <https://news.gallup.com/poll/243908/two-three-americans-support-legalizing-marijuana.aspx>

⁹⁰ Zawn Villines, Medical News Today: How long can you detect marijuana (cannabis) in the body (February 21, 2022) – <https://www.medicalnewstoday.com/articles/324315>

⁹¹ Cinnamon Bidwell, Presentation from the University of Colorado on Emerging Scientific Issues in the Cannabis Space (December 1, 2021)

⁹² Sachi Clements, Esq., NOLO Legal: State Laws on Off-Duty Marijuana Use (September 13, 2022) – <https://www.nolo.com/legal-encyclopedia/state-laws-on-off-duty-marijuana-use.html>

West Virginia, prohibit employers from refusing to employ an applicant or terminate an existing employee based only on a positive drug test for cannabis.⁹³

Recently, some employers in the private sector have been reducing the scrutiny placed on cannabis use and impairment in the workplace. In September 2021, Amazon made the corporate decision to no longer deny employment, or terminate employees, due to failed drug tests due to cannabis use.⁹⁴ Amazon even emphasized that the company would reinstate employment eligibility for previous applicants and staff who were terminated or deferred during random or pre-employment cannabis screenings.⁹⁵ However, this policy has exceptions, where employees involved in transportation may be required to prove they have not used and will not be impaired by cannabis.⁹⁶ The shift from a zero-tolerance policy on drug testing for cannabis use to one of acceptance is further evidenced by the developments in professional sports industries. Four of the biggest professional sports in America, including the NBA, NHL, MLB, and NFL, have all relaxed their drug testing policies as it pertains to cannabis.⁹⁷

3. Other Cannabis Impairment Considerations

Cannabis businesses are attempting to capitalize on the trend of increased usage by bringing ingenuity to their products and services.⁹⁸ While many consumers historically smoked the substance in private settings, there are now other innovative forms of cannabis in the regulated markets which allow consumers to eat or vaporize the substance discreetly in public environments.⁹⁹ These trends of increased exposure, additional usage, as well as ingenuity in the cannabis industry, combine to create complications with regulating and insuring the risks of cannabis impairment.

Prior to legalization, cannabis users would need to consume their cannabis products in private locations, out of view from the public and law enforcement. Cannabis users employed these strategies to secretly consume the illegal cannabis products for effect while also avoiding the risk of penalties from law enforcement. However, with the legalization of cannabis came the ability for consumers to use cannabis in different forms and settings. For example, a current medical

⁹³ *Id.*

⁹⁴ Janis I. Jeffreys, Cannabis Law PA: Why Amazon.com is no Longer Pre-employment Drug Testing for Marijuana (September 13, 2022) – <https://cannabislawpa.com/why-amazon-com-is-no-longer-pre-employment-drug-testing-for-marijuana/>

⁹⁵ *Id.*

⁹⁶ *Id.*

⁹⁷ Jeffrey Draluck, Athletes for Care: Which Major Sports Leagues Have Relaxed Their Cannabis Policies? (July 13, 2021) – <https://athletesforcare.org/news/573160/Which-Major-Sports-Leagues-Have-Relaxed-Their-Cannabis-Policies.htm>

⁹⁸ Heesun Wee, NBC News: Growing the Pot Industry: A Test of American Business Ingenuity (January 14, 2014) – <https://www.nbcnews.com/business/business-news/growing-pot-industry-test-american-business-ingenuity-flna2d11923844> ⁹⁹

Id.

cannabis patient in Las Vegas can lawfully use a cannabis vaporizer at a cannabis consumption lounge to administer their prescribed medications.¹⁰⁰

Cannabis legalization and ingenuity possess potential to increase the frequency, exposure, and risks of cannabis impairment. Cannabis is now offered in newer and varied mediums, such as beverages and edibles, and can be created with concentrated forms of cannabis that are much more potent. Cannabis consumers run the risk of being uninformed on if the product has been scientifically researched or studied for long-term side effects and what level of impairment it is likely to produce.

The risks posed by cannabis impairment must be carefully considered in the underwriting process to ensure adequate coverage and appropriate premiums. Risk selection and risk classification play important roles in insurance underwriting systems. The current state of cannabis research may not provide the insurance industry with a sufficient understanding of cannabis impairment and how it can impact underwriting. An incomplete understanding of the increased risks associated with cannabis impairment could lead to circumstances of underinsured policyholders or a lack of sustainable insurer solvency.

D. Cannabis Education Landscape

Education could help address complications and gaps experienced in the cannabis and insurance industries caused by the recent and rapid rate of state regulation. Those needing to maintain currency include cannabis business owners, employees and licensees, regulators, and the insurance industry, such as insurers, claims adjusters, agents, and producers. Many involved in the cannabis industry and businesses would be better able to mitigate their risks with insurance by keeping current on applicable authorities and their requirements.

Regulators and other interested parties should enhance their knowledge by understanding industry trends, such as current and future state cannabis or insurance market conditions. For example, pre-license training for insurance producers does not touch on the topic of cannabis, but the insurance producers may be engaged in providing coverage to the cannabis industry. A producer of insurance should be well educated about the industry they provide coverage for in order to ensure the procured policy is appropriate, adequate, and lawful. Additionally, claims adjusters may need specialized training on cannabis-related claims.

¹⁰⁰ Patrick Maravelias, MJBizDaily: Las Vegas Cannabis Industry Preps for Launch of Consumption Lounges (August 8, 2022) – <https://mjbizdaily.com/las-vegas-cannabis-industry-preps-for-launch-of-consumption-lounges/>

E. Vaping Regulations and Their Impact on Cannabis

As cannabis is legalized and regulated in different states across the country, ingenuity in cannabis products and technologies continues to create complications for regulators, insurers, businesses, and consumer populations alike. An example of this is the increased use of and access to cannabis vaping or vaporization products.

Vaping technology was developed to provide a noncombustible nicotine delivery system to help cigarette and tobacco smokers. Vaping devices heat liquid into an aerosol that can be inhaled. This method of vaporization has now been adapted for cannabis use and is the method often used to consume cannabis products. Studies have shown that cannabis users believe vaping the substance is less harmful to their health than the consumption alternative of combustible smoking methods.¹⁰¹ This theory is based on the reduction of ingesting harmful contaminants present in cannabis smoke, which are less present in cannabis vapors.¹⁰² The significant increase in vaping has raised concern about the health and safety of this practice. Of particular concern is the increase in vaping among teenagers.

A large illicit cannabis market continues to exist without concern for product safety and exacerbates issues of product liability coverage. Illicit products containing substances not allowed in a regulated market are part of the challenge. Current scientific research provides inadequate information to understand the effects of acute and long-term inhalation of aerosols emitted by vaping devices. A lack of studies on the substance itself or the consumption methodologies means the consequences of vaping cannabis are largely unknown. While many choose to vape, believing it is a safer method of consumption, studies are needed to determine whether vaporizing cannabis truly offers a safer experience for the consumer.

Millions of Americans have consumed cannabis from vaporization devices over the past decade, and the possibly dangerous effects are now being observed.¹⁰³ In 2019, the U.S. experienced an outbreak of e-cigarette, or vaping, product use-associated lung injuries (EVALI).¹⁰⁴ The Centers for Disease Control and Prevention (CDC) established a link between EVALI and cannabis users, where a substance called Vitamin E Acetate was added to cannabis vaporization products, which

¹⁰¹ Dustin C. Lee, Benjamin S. Crosier, Jacob T. Borodovsky, James D. Sargent, and Alan J. Budney, National Center for Biotechnology Information, U.S. National Library of Medicine: Online Survey Characterizing Vaporizer Use among Cannabis Users (December 30, 2015) – <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4745650/>

¹⁰² *Id.*

¹⁰³ Centers for Disease Control and Prevention: Outbreak of Lung Injury Associated with the Use of E-Cigarette, or Vaping, Products (December 6, 2021) – https://www.cdc.gov/tobacco/basic_information/e-cigarettes/severe-lung-disease.html#what-we-know

¹⁰⁴ *Id.*

can interfere with normal lung functioning.¹⁰⁵ Since this outbreak was the result of an additive, it does not speak to the impact of vaping itself but does speak to the need for regulation.

Governments in jurisdictions with regulated cannabis industries took alternative approaches to respond to the outbreak of EVALI cases in cannabis consumers. Washington and Oregon enacted emergency bans on cannabis vaping product additives, whereas Massachusetts temporarily stopped the sale of all vaping products.¹⁰⁶ While many jurisdictions were concerned about EVALI's association with consumers who vaporized cannabis, some states were confident in the safety of products being produced within their regulated systems. For example, Pennsylvania released a position in response to the EVALI outbreak, explaining that none of the EVALI cases experienced in the state were connected to the state's medical cannabis program.¹⁰⁷

F. Licensing Takes a Focus on Social and Economic Equality

The prohibition of cannabis in America has disproportionately and adversely impacted people of color.¹⁰⁸ Studies have shown that "... on average Black people are almost 4 times more likely to be arrested for pot than white people."¹⁰⁹ This racial disparity in law enforcement is present in all areas of the country, regardless of the demographics of the jurisdiction.¹¹⁰

State-legal cannabis industries are now estimated to be worth over \$18 billion and provide for hundreds of thousands of full-time jobs.¹¹¹ However, minority populations that were most adversely impacted by the war on drugs and the prohibition of cannabis are being excluded from

¹⁰⁵ Centers for Disease Control and Prevention: Severe Lung Disease FAQ (December 6, 2021) – https://www.cdc.gov/tobacco/basic_information/e-cigarettes/severe-lung-disease/faq/index.html

¹⁰⁶ Will Stone, NPR: Some States with Legal Weed Embrace Vaping Bans, Warn of Black Market Risks (October 26, 2019) – <https://www.npr.org/sections/health-shots/2019/10/26/770377080/some-states-with-legal-weed-embrace-vaping-bans-warn-of-black-market-risks>

¹⁰⁷ Tony Rhodin, Lehigh Valley Live The Express-Times: With 149 Illnesses in U.S. Linked to Vaping Pennsylvania Says its Medical Marijuana Vape Products are Safe (August 23, 2019) – <https://www.lehighvalleylive.com/news/2019/08/with-153-illnesses-in-us-linked-to-vaping-pennsylvania-says-its-medical-marijuana-vape-products-are-safe.html>

¹⁰⁸ Robert Hoban, Forbes: The Critical Importance of Social Equity in the Cannabis Industry (August 31, 2020) – <https://www.forbes.com/sites/roberthoban/2020/08/31/the-critical-importance-of-social-equity-in-the-cannabis-industry/?sh=41a7ba0d1a6d>

¹⁰⁹ Sagiv Galai, ACLU: Equity Must Be at the Heart of Marijuana Legalization (June 26, 2019) – <https://www.aclu.org/blog/criminal-law-reform/drug-law-reform/equity-must-be-heart-marijuana-legalization>

¹¹⁰ ACLU: Report: The War on Marijuana in Black and White (published June 2013) – <https://www.aclu.org/report/report-war-marijuana-black-and-white?redirect=criminal-law-reform/war-marijuana-black-and-white>

¹¹¹ Alex Malyshev and Sarah Ganley, Reuters: The Challenges of Getting Social Equity Right in the State-Legal Cannabis Industry (July 22, 2021) – <https://www.reuters.com/legal/litigation/challenges-getting-social-equity-right-state-legal-cannabis-industry-2021-07-22/>

the industry. In 2021, African Americans represented roughly 13% of the U.S. population, yet only 1.2% to 1.7% were business owners in the cannabis industry.¹¹²

States legalizing cannabis have recently taken efforts to resolve the racial disparity in cannabis business ownership by employing social and economic equity provisions into their laws. Social and economic equity in cannabis licensing can vary by jurisdiction, but includes reducing barriers, improving access, and assisting cannabis business license applicants who are from certain communities that have been adversely and disproportionately impacted by cannabis prohibition. These groups can include but are not limited to women-owned businesses, minority-owned businesses, distressed farmers, and service-disabled veterans. The intended goal of social and economic equity provisions in cannabis business authorities is to achieve participation in the legalized industry for those who were most negatively affected by the war on drugs.

States that have experienced cannabis reform legislation, either recreationally or medically, have taken different approaches to implementing social and economic equity provisions in their regulated cannabis markets. For example, Michigan, in processing recreational cannabis business licenses, will reduce licensing fees for prospective business owners living in cities where residents were disproportionately impacted by the war on drugs.¹¹³ California offers a statewide program for recreational cannabis to assist local governments with equity provisions in providing loans, grants, and technical assistance to cannabis entrepreneurs and employers.¹¹⁴ It is too early to know the effect on the insurance market for cannabis businesses of these regulatory policies. However, there are efforts to address social and economic equity concerns in insurance generally.

VI. CANNABIS OPERATING AND ORGANIZATIONAL STRUCTURES EVOLVE

The industry's growing legitimization has intensified merger and acquisition activity to gain market share. The year 2021 is generally acknowledged in both the financial and cannabis

¹¹² *Id.*

¹¹³ MJBizDaily: MI Marijuana rules changes include new licenses, lower fees, social equity (September 1, 2021) – <https://mjbizdaily.com/michigan-marijuana-rules-changes-include-new-licenses-lower-fees-social-equity/>

¹¹⁴ Alex Malyshev and Sarah Ganley, Reuters: The Challenges of Getting Social Equity Right in the State-Legal Cannabis Industry (July 22, 2021) – <https://www.reuters.com/legal/litigation/challenges-getting-social-equity-right-state-legal-cannabis-industry-2021-07-22/>

industry press as one of overall sales growth marked by rising incidence of consolidation.¹¹⁵ The significant amount of consolidation in the industry continues to produce frequent ownership changes and business structure modifications.¹¹⁶ There are varying aspects through which this cannabis market evolution can be viewed, and each has implications for insurance coverage availability. As noted in his article “The Year of Cannabis Industry Consolidation,”¹¹⁷ Robert Hoban writes: “There are loosely four common phases of an industry’s life cycle –introduction, growth, maturity, and decline. The cannabis industry is not yet mature across the board but is largely stuck in the growth phase. The step between the later stages of the growth phase and the beginning of maturity comes down to one word: *consolidation*. That is the mantra for 2021.”

There are some indications that more vertically integrated—or common ownership along the supply chain—is occurring. It is viewed that larger-scale cultivation operations permit greater consistency in raw material availability. Some of this can be demonstrated by the increasing prevalence of indoor or greenhouse cultivation, which permits a more controlled growing environment and avoids some of the risks associated with traditional outdoor grow operations (e.g., use of clones rather than seed; environmental controls for light, heat, water, pest control; multiple harvests per year in a smaller footprint; more accessible warehousing/storage for processing; etc.). Such physical consolidation is much more friendly to vertical integration of ownership. This integration also permits more risk management along with scale to support the acquisition of insurance coverage. Greater scale and integration of cannabis businesses also allow the purchase of more comprehensive coverage through the excess and surplus lines market. The downside is that there are indications that the reinsurance market to cover such risks continues to be constrained, resulting in policy limits that may not reflect the scale or potential risk of the business.

Larger, and more vertically integrated, cannabis businesses are able to seek out and negotiate more comprehensive insurance packages and can pay higher premiums for tailored coverage. In contrast, cottage industry players (e.g., independent retailers) tend to look for more “off-the-

¹¹⁵ Ellen Chang, US News and World Report: Upcoming Mergers in the Cannabis Industry to Watch (March 8, 2021) – [Upcoming Mergers in the Cannabis Industry to Watch \(usnews.com\)](https://www.usnews.com/story/news/health/2021/03/08/upcoming-mergers-in-the-cannabis-industry-to-watch); Robert Hoban, Forbes: The Year of Cannabis Industry Consolidation (March 22, 2021) – <https://www.forbes.com/sites/roberthoban/2021/03/22/the-year-of-cannabis-industry-consolidation/?sh=48d003db7715>; Michael Berger, Technical420.com: The Consolidation of the US Cannabis Market is About to Kick into High Gear (September 3, 2021) – [The Consolidation Of The U.S. Cannabis Market Is About To Kick Into High Gear - Technical420 | Technical420](https://www.technical420.com/news/the-consolidation-of-the-us-cannabis-market-is-about-to-kick-into-high-gear-technical420-technical420); and Tommy Wood, [Boulder, CO] Daily Camera: Robust sales, expanding legalization lead to increased mergers, acquisitions in Boulder County cannabis industry (Sept. 5, 2021) – <https://www.dailycamera.com/2021/09/05/robust-sales-expanding-legalization-lead-to-increased-mergers-acquisitions-in-boulder-county-cannabis-industry/>

¹¹⁶ Oregon Liquor Control Commission (OLCC): Update on Marijuana Licensing (August 30, 2018) –

www.oregon.gov/olcc/marijuana/Documents/Bulletins/Licensing_Delay_DirectorsMessage.pdf

¹¹⁷ Robert Hoban, Forbes: The Year of Cannabis Industry Consolidation (March 22, 2021) –

<https://www.forbes.com/sites/roberthoban/2021/03/22/the-year-of-cannabis-industry-consolidation/?sh=48d003db7715>

shelf” insurance solutions, as would typically be available in the admitted market (but appears to be not widely available). Some admitted insurance coverage is available for discrete types of insurance. A good example is workers’ compensation insurance, which is widely available for employers in the cannabis industry—but such niches are limited.

Another aspect of this consolidation is changes in the ownership and sophistication of the industry. In 2019, the Colorado legislature changed state law to allow people who live outside Colorado to own cannabis businesses in the state, and it permitted publicly traded companies and private capital funds to invest in Colorado cannabis businesses.¹¹⁸ This “opening” of the market for cannabis businesses was ostensibly premised on increased access to capital for cannabis businesses, but it also fueled merger and acquisitions (M&A) activity with concomitant insurance aspects. In particular, the availability of directors’ and officers’ liability coverage is often cited as a challenge for cannabis businesses.

VII. CANNABIS INSURANCE NEEDS AND COVERAGE AVAILABILITY

A. Admitted vs. Excess and Surplus Lines Market

While there are a few states with admitted carriers, most of the cannabis industry is purchasing insurance through the excess and surplus lines market. Some admitted carriers, mostly in specific lines, such as required workers’ compensation, will write coverage for cannabis businesses. However, for more comprehensive or package coverage, the substantial majority is written through excess and surplus carriers, which are generally exempt from state regulation, and in many to most cases, state laws. One result of this is that it is challenging, if not virtually impossible, for state regulators to assess the size and extent of insurance coverage, in both availability and affordability, along with coverage for cannabis businesses. Some admitted carriers do write coverage primarily in their domiciliary state or immediate region, or for a specific component of the marketplace (e.g., retail dispensaries) for general liability.

What state insurance regulators do know is that there is a burgeoning market for cannabis coverage in the excess and surplus lines and managing general agent/underwriter program arena. There are also a few other structures to provide coverages, such as captives and risk

¹¹⁸ Tommy Wood, [Boulder, CO] Daily Camera: Robust sales, expanding legalization lead to increased mergers, acquisitions in Boulder County cannabis industry (Sept. 5, 2021) – <https://www.dailycamera.com/2021/09/05/robust-sales-expanding-legalization-lead-to-increased-mergers-acquisitions-in-boulder-county-cannabis-industry/>

retention groups (RRGs) being explored.¹¹⁹ Estimates range from a handful to in excess of 30 insurers and managing general agents/underwriters are providing services in this area.¹²⁰ Nonetheless, a Google search of commercial insurance for cannabis business will yield several references to entities, primarily surplus lines brokers or managing general agents/underwriters, which “specialize” in writing coverage for cannabis businesses or have an insurance “program” for cannabis businesses. Review of some of these indicates the majority are surplus lines brokers who are providing excess and surplus lines coverage.

As more insurance companies feel comfortable writing insurance in this industry, it is anticipated the market will move from excess and surplus lines to the admitted market, similar to other products in the past.¹²¹ At one point, there were insurance companies that did not want anyone to know they were providing coverage for these exposures, and now they are openly providing this coverage.¹²² However, there is a chance that not all segments of the cannabis industry will move from the excess and surplus lines to the admitted market. We may see certain segments, like retail or dispensary, moving to the admitted market because the risks associated with those are less than with other segment areas.¹²³

B. Insurance Needs and Considerations from Seed-To-Market

Though most coverage is in the excess and surplus lines market, access to commercial insurance for cannabis businesses varies significantly by the market segment of the seed-to-sale continuum. For some market segments, there are an increasing number of options in areas such as general commercial liability or basic property coverage. In many cases, businesses in the cannabis space

¹¹⁹ According to IRMI.com an MGA is Managing General Agent (MGA) — a specialized type of insurance agent/broker that, unlike traditional agents/brokers, is vested with underwriting authority from an insurer. Accordingly, MGAs perform certain functions ordinarily handled only by insurers, such as binding coverage, underwriting and pricing, appointing retail agents within a particular area, and settling claims. Typically, MGAs are involved with unusual lines of coverage, such as professional liability and surplus lines of insurance, in which specialized expertise is required to underwrite the policies. However, MGAs also write some personal lines business, especially in geographically isolated Areas (e.g., western Oklahoma, North Dakota) where there are accessibility concerns. MGAs benefit insurers because the expertise they possess is not always available within the insurer's home or regional offices and would be more expensive to develop on an in-house basis. –

<https://www.irmi.com/term/insurance-definitions/managing-general-agent>

¹²⁰ Steve Hallo, National Underwriter Property and Casualty 360: Is cannabis the next insurance opportunity? (January 6, 2021) – <https://www.propertycasualty360.com/2021/01/06/is-cannabis-the-next-insurance-opportunity/>; and Alwyn Scott, Reuters: US cannabis insurers get ready to roll as federal legalization nears | Reuters; and New Dawn Risk, Broker at LLOYD: Understanding and opening up the US cannabis insurance market (accessed February 21, 2023) – https://www.newdawnrisk.com/wp-content/uploads/2020/05/Cannabis_report-FINAL.pdf

¹²¹ Alicja Grzadkowska, Insurance Business Canada (insurancebusinessmag.com): An insurance learning curve for all as cannabis legalization looms (March 2, 2018) – <https://www.insurancebusinessmag.com/ca/news/broker-perspective/an-insurance-learning-curve-for-all-as-cannabis-legalization-loom-93822.aspx>

¹²² Presentation Panel Discussion: Admitted and Nonadmitted Coverage Across the Cannabis Business Sectors (July 19, 2021) – [Webex Enterprise Site - Replay Recorded Meeting – https://naic.webex.com/webappng/sites/naic/recording/225c7bfecae91039aafd0050568f5657/playback](https://naic.webex.com/webappng/sites/naic/recording/225c7bfecae91039aafd0050568f5657/playback)

¹²³ *Id.*

are facing more expensive coverage than other similar businesses. While they can get some insurance, a common complaint is that the limits available are constrained, e.g., \$1 million per occurrence, \$2 million aggregate capped. A further challenge is the anticipated explosive business growth for established cannabis businesses year over year.¹²⁴

What follows is some discussion about the various cannabis business market segments, particular insurance needs and availability, and some of the particular risk considerations that make availability and affordability challenging.

1. Cultivation

Coverage for cannabis has several aspects. First, hemp was included as a “legal” crop in the 2018 Farm Bill.¹²⁵ As it currently stands, federal multi-peril crop insurance is available in certain states and communities with conditions. The cultivator must: 1) be licensed and meet all requirements of state, tribal, and federal authorities, 2) have at least one year of history producing the crop, and 3) have a contract for the purchase of the hemp crop at the policy inception.¹²⁶ Hemp has the additional risk of becoming “hot hemp” due to environmental causes (THC above the 0.3 compliance level). Additionally, hemp does not qualify for replant payments or prevented plant payments.¹²⁷

Second, for hemp that does not qualify and cannabis cultivation, the insurance coverage availability is much less clear. There appears to be a small market for private crop insurance, though reports are that it is prohibitively expensive until more data and experience is available to support underwriting. An option that is emerging is parametric coverage for outdoor cannabis crops with triggers including: recorded rainfall over a specified time, wind, early freeze, hail, and drought.¹²⁸

¹²⁴ Alexander T. Brown, see generally, Lathrop GPM: Five Insurance Considerations for Cannabis-Related Businesses (July 21, 2021) – [Five Insurance Considerations for Cannabis-Related Businesses: Lathrop GPM](https://www.lathropgpm.com/TheRoadToInsuranceRecovery/five-insurance-considerations-for-cannabis-related-businesses) – <https://www.lathropgpm.com/TheRoadToInsuranceRecovery/five-insurance-considerations-for-cannabis-related-businesses> ¹²⁵

Amy Abernethy, MD, PhD, U.S. Food & Drug Administration: Hemp Production and the 2018 Farm Bill (July 25, 2019) – <https://www.fda.gov/news-events/congressional-testimony/hemp-production-and-2018-farm-bill-07252019>

¹²⁶ USDA, Risk Management Agency, A Hemp Q&A with Andrew Kowalski (accessed February 21, 2023) – <https://www.rma.usda.gov/en/News-Room/Digital/RMA-Stories/Ask-the-Expert---A-Hemp-Questions-and-Answers-with-Andrew-Kowalski>

¹²⁷ USDA Farmers: Hemp and Farm Programs (accessed February 21, 2023) – <https://www.farmers.gov/your-business/row-crops/hemp>

¹²⁸ Evan Stait, Cannabis Industry Journal: Why You Should Consider Parametric Insurance to Protect Your Outdoor Cannabis Crop, (Sept. 22, 2020) – <https://cannabisindustryjournal.com/column/why-you-should-consider-parametric-insurance-to-protect-your-outdoor-cannabis-crop/>

More broadly, a primary differentiator amongst cannabis cultivators is whether the grow is outdoor or indoor (greenhouse). The two methods have significantly different risk profiles, leading to differing accessibility and affordability. Outdoor cultivation brings not only the traditional multi-peril concerns of crop insurance for destructive weather (hail, frost, damaging wind), disease, drought, fire, flooding, and insect damage.¹²⁹ The more controlled environment of an indoor grow protects from some of the environmental risks but presents its own array of challenges, including electrical, plumbing, security, and contaminants, including but not limited to mold, mildew, and pesticides. Anecdotally, coverage is more available for indoor cannabis cultivation, though it is undeterminable whether this is because the grow environment can be more easily managed, or whether the scale of a greenhouse grow permits several “crops” per year with increased proceeds.

2. Processing and Manufacturing

Cannabis products are available in a rising number of derivations. Cannabis is commercially available in flower (similar to loose tobacco), pre-rolled joints, vapes, dabable concentrates (highly concentrated extracts aka wax, shatter, or other appellations), edibles (including gummies, chocolates, taffy, beverages, and more), tinctures, topical applications, and more. Usage and the reasons for usage likewise can vary greatly by product format. According to IRI, a data analytics firm focused on consumer-packaged goods (CPGs), 43% of adults in fully legal states are cannabis consumers. Of those, 72% consume inhalable products, and 62% of those inhalable users are consuming cannabis at least once daily. Topical cannabis is more associated with pain relief, as the top reported relief communicated by consumers of those products. Better sleep is the top reported relief communicated for consumers of edibles. Users of CBD cite a myriad of health-related reasons for their use, the top four being pain relief, better sleep, and management of anxiety and stress.¹³⁰

As the number and variety of products/uses grows, so do the processing and manufacturing systems to produce a retail product. Traditional cannabis consumption relies on “flower” or “bud,” which is ground and then packed into a pipe or rolled. To achieve this basic formulation, the cannabis plant must be harvested, dried, sorted, trimmed to remove the flower from leaves and stalks, and then cured. Obviously, premises for drying, sorting, trimming, and curing are required, and some portions of these processes may be supported by mechanization. Under the Colorado cannabis regulatory structure, the premises used must be licensed as a “Regulated

¹²⁹ Insurance Information Institute (III): Understanding Crop Insurance (accessed February 21, 2023) – <https://www.iii.org/article/understanding-crop-insurance>

¹³⁰ Jessica Lukas, BDSA, and Larry Levin, IRI, Blog on BDSA and IRI: The Rise of Legal Cannabis as a Consumer Packaged Good, (September 30, 2021) – <https://www.iriworldwide.com/en-us/insights/blog/rise-of-cannabis-as-a-consumer-packaged-good>

Marijuana Business Operation,” which carries extensive rules about possession and access to the premises, security and lock standards, signage, floor plans, shared facilities (medical and adult use), waste disposal, inventory tracking, health and safety measures, audits, and prohibited chemicals and practices.¹³¹

Insurance for cannabis manufacturing premises is reportedly becoming more widely available, but pricing can be more expensive than for other sectors. The extensive regulation of the premises must be balanced against the enhanced risks, including potentially high-value raw materials, inventory in-process, risks of fire, theft, contamination, etc., and the potential of mishandling waste in violation of state law. Against this higher base level of premises, coverage can be increased risks from processing to make cannabis derivative products such as edibles, topicals, and dabs. For many of these derivative products, the raw material (including cannabis or the <.3% THC hemp) must be processed using solvents, pressure, heat, distillation/crystallization, or combinations thereof. Each adds an aspect of risk that should be considered and accounted for in the underwriting process.

3. Testing

State-mandated testing schemes are substantial and detailed to ascertain if the regulated cannabis (as either raw material or finished product) is: 1) contaminated or mislabeled, 2) is in violation of any product safety, health or sanitary statute, rule, or regulation, or 3) whether the results of a test raise questions requiring further investigation. The most significant area of liability will be professional liability if someone suffers legal injury due to a negligently erroneous test result. As an erroneous test could require the destruction of an entire crop or product run, the economic injury is obvious. From a consumer perspective, a test result indicating safety when a product is contaminated or varies from potency standards could lead to substantial recovery for personal injury. Consequently, professional liability or errors and omissions coverage is an important part of a testing facility’s portfolio.¹³²

4. Distribution

There are effectively two levels of distribution concern. One is raw material transport between cultivator and manufacturer/processor (and testing labs), and the other is consumer delivery. However, at the base, in Colorado, both levels rely on a comprehensive seed-to-sale tracking

¹³¹ Code of Colorado Regulations, Department of Revenue, Marijuana Enforcement Division, 1 CCR 212-3, Part 3 - Regulated Marijuana Business Operations

¹³² See subsequent section under Products Liability for further discussion of aspects of liability for a defective product.

system, which can be used to provide manifests documenting the transport of cannabis products throughout the state. In Colorado, this requirement is stated in statute as:

“To ensure that no marijuana grown or processed by a retail marijuana establishment is sold or otherwise transferred except by a retail marijuana store or as authorized by law, the state licensing authority shall develop and maintain a seed-to-sale tracking system that tracks retail marijuana from either seed or immature plant stage until the marijuana or retail marijuana product is sold to a customer at a retail marijuana store[.] . . .”¹³³

The seed-to-sale tracking system in Colorado is based on a Radio Frequency Identification (RFID) tag, which is affixed to a plant and, with aggregation of the information on it, follows the plant through cultivation, harvest, manufacturing, and distribution. For licensed operators who are transporting legal product, this permits explicit manifests that can be reconciled with the cargo between cultivator and manufacturer/processor. Both medical and retail cannabis in Colorado require a transporter’s license, which is obtained from the state’s regulatory authority, the Marijuana Enforcement Division of the Colorado Department of Revenue.

Insurance concerns of transporters include cargo coverage for an often high-value commodity that can be subject to theft/hijacking and spoilage. As described in a Reuters article, “Low coverage limits on cargo insurance, for example, can force companies to split shipments up, said Gene Brown, an insurance agent in Carmel, California, who specializes in cannabis coverage.”¹³⁴ Similarly, the cash-based current consumer economics of the industry has substantial security needs and a high risk of theft.

Recently, delivery to consumers through purchase on an app has been authorized in Colorado and has generated significant interest. This interest was likely accelerated by the expansion of other delivery services, such as Uber Eats, and similar services during the COVID-19 pandemic. This direct-to-consumer delivery has similar liability concerns as other delivery services (e.g., damage to third-party vehicles and parties, and the potential for theft, misdirection, or deception).

5. Retailers

When someone says, “legal cannabis,” the mental picture most people have is of a local dispensary in a state where it is legalized. Certainly, for most people a dispensary or store is how

¹³³ §44-12-202(1), Colo. Rev. Stat. - Powers and duties of state licensing authority - rules. § (1). Note: an almost identical provision is located in Colorado’s medical marijuana code.

¹³⁴ Alwyn Scott, Reuters: U.S. cannabis insurers get ready to roll as federal legalization nears (August 19, 2021) – <https://www.reuters.com/article/us-usa-insurance-cannabis-focus-idCAKBN2FK1AO>

they experience the industry. As storefronts, retailers have many of the same business insurance needs as other commercial establishments (e.g., premises/property and general liability coverage, inventory, employee benefits and employment practices liability insurance, business income/interruption, umbrella, commercial auto, and cybersecurity). Generally, insurance coverage is increasingly becoming available for these risks, albeit often at higher rates than for other types of retailers.

Primary among the risks is those of theft – both cash and product. In 2020, one of Colorado’s largest cannabis retailers, with 21 locations, reported 15 burglary attempts in 90 days.¹³⁵ Because most cannabis outlets deal almost exclusively in cash, there is ample opportunity for burglaries and robberies. Also, because the product for sale is high value itself, criminals do not go for just the cash. It is common for retailers to have substantially increased security, including around-the-clock guards, video screening, and extensive training and monitoring of their staff, to mitigate their enhanced risk.¹³⁶

In addition to the risk of damage to premises from break-ins for theft, personal injury to employees, customers, and bystanders is also a concern. As noted previously, workers’ compensation coverage is more available for cannabis retailers since it is a state-mandated coverage. However, questions of consistent occupational subclassification and experience rating may develop and have premium impacts.¹³⁷ In Colorado, complaints or concerns are not generally received about employee benefit coverages (primarily health). This is likely due to the federal Affordable Care Act (ACA) and the expansion of guaranteed availability to the individual health insurance market. On the employment practices liability aspect, there are anecdotal reports of challenges in finding coverage. At this time, additional information is needed to ascertain whether there is out-of-the-ordinary employment practices liability that is not mitigated by state regulatory schemes. This includes requiring criminal background checks and licensure of all persons employed in a business that possesses, cultivates, dispenses, transfers, transports, offers to sell, manufactures, or tests regulated cannabis.

6. Products Liability

One of the thorniest insurance issues for cannabis businesses is that of products liability coverage. As products liability claims may be made against any, and potentially all, entities in the supply chain from retailer or distributor, manufacturer, tester, or cultivator. The costs of defense

¹³⁵ Thomas Mitchell, Westword: Colorado’s Largest Dispensary Chain: Fifteen Burglary Attempts in Ninety Days Last Year (October 28, 2021) – <https://www.westword.com/marijuana/colorado-livwell-burglary-cash-cannabis-banking-12660338>

¹³⁶ *Id.*

¹³⁷ Insurance Information Institute: Spotlight on: marijuana and employment (November 24, 2020) For discussion of other aspects of marijuana in the broader employment context – <https://www.iii.org/article/spotlight-on-marijuana-and-employment>

in a products liability action alone make this coverage “in demand.” Moreover, the breadth of circumstances that can lead to a products liability claim raises legitimate concerns for all parts of the industry. By way of refresher, there are three basic theories of product liability: 1) design defect, which could include pesticide, mold, or biological contamination; 2) manufacturing defect, which can include contamination introduced during processing, or by faulty testing and results; and 3) warning/instruction defect, including product labeling violations or omissions, advertising misrepresentation, and packaging defects (i.e., child-resistant packages). It is easy to imagine the potential liability concerns of an industry involving an intoxicant that, until relatively recently, was comprehensively banned throughout the United States.

Reliance on a standard policy for products liability coverage for CRBs may not provide the full protection a business would anticipate. Most standard policies contain broad exclusions for Schedule 1 federally prohibited substances or criminal/fraudulent or dishonest acts or claims arising from violation of statute, code, rule, regulation, procedure, or guidance. Most standard policies do not include products completed, operations, and health hazard exclusions for cannabis businesses. Coverage for defense costs in a products liability action against a cannabis business is particularly key. The experience in the vaping crisis, referred to as “Vape-Gate,” is instructive. While it was ultimately found that most of the vaping injuries involved illicit or black market vape products, the potential for substantial and broad liability led to tighter risk management in the cannabis supply chain, including identification of unapproved or potentially dangerous additives resulting in adulterated products.¹³⁸ It is recommended that cannabis businesses specifically discuss with their insurer about coverage for products liability to ensure they understand the coverage provided and any limitations on it.

VIII. MARKET CONSIDERATIONS FOR COMMERCIAL CANNABIS INSURANCE

As noted above, the availability of insurance coverage for cannabis businesses is overwhelmingly found in the excess and surplus lines market at present. In part, this is due to the evolving nature of the commercial cannabis industry, and the lack of generally agreed upon data, measurement, and experience to support insurance underwriting. It is anticipated that just as the cannabis commercial industry evolves, so will the associated commercial insurance options in the admitted market. This evolution is anticipated and may be driven by how the cannabis business market

¹³⁸ Steve Hallo, National Underwriter Property and Casualty 360 Market Insights: Vape Gate and today’s cannabis product liability market (December 16, 2020) – <https://www.propertycasualty360.com/2020/12/16/vape-gate-and-todays-cannabis-product-liability-market/>

develops (e.g., vertical integration and consolidation versus continuation of niche commercial entities in the cannabis supply and distribution market).

A. Cannabis as a Client (and Consumer Beliefs)

As more states legalize cannabis for either recreational use or medical use, more insurance companies may enter the market to write cannabis businesses. The cannabis industry is a new aspect for insurance companies. Thus, they will need to understand the risks and exposures, as well as the needs of cannabis businesses as clients.¹³⁹

It is also important for producers to be educated on the cannabis market to serve this demographic. For example, it would be beneficial for a producer to be educated on the risks and exposures at each segment from seed to sale so that they can explain to their client what would be best suited for their needs. They may also help explain the differences between legal requirements and best practices. A cannabis business may not purchase coverage because it is not legally required; however, it may be a good business practice.

The cannabis business as a client has a similar learning curve. The cannabis business owner must have done their due diligence to obtain a license, be educated on cannabis products and processes, and know the applicable laws surrounding cannabis. However, a cannabis business as an insurance client may need some help with insurance terms and coverage options as they may not know what options are suitable for their needs.¹⁴⁰ Vocabulary from region to region or state to state also differs. This can be challenging for an insurance company when trying to explain coverage options to a cannabis business as a client.

Misconceptions also play a part when cannabis businesses seek insurance. When cannabis businesses first opened (around 1996 in California) there was fear that due to the federal illegality, they could be subject to criminal charges at any moment.¹⁴¹ There are concerns from the cannabis industry that the information provided to insurers can be accessed by the federal

¹³⁹ Jason Howard, CRC Group Wholesale & Specialty: Understanding the Issues Around Insuring Cannabis-Related Businesses (accessed February 21, 2023) – [Understanding the Issues Around Insuring Cannabis-Related Businesses - News - Tools & Intel | CRC Group](https://www.crcgroup.com/Tools-Intel/post/understanding-the-issues-around-insuring-cannabis-related-businesses) – <https://www.crcgroup.com/Tools-Intel/post/understanding-the-issues-around-insuring-cannabis-related-businesses>

¹⁴⁰ Don Jergler, Insurance Journal: Insuring Cannabis Summit: Talking to Clients About Risk Starts with Education (December 28, 2020) – [Insuring Cannabis Summit: Talking to Clients About Risk Starts with Education \(insurancejournal.com\)](https://www.insurancejournal.com/news/north-carolina/2020/12/28/10398fd70050568f0567/playback)

¹⁴¹ Brenda Wells, Ph.D., Presentation on Balancing Actual and Perceived Risks (East Carolina University). (July 27, 2021). See: [Webex Enterprise Site - Replay Recorded Meeting](https://naic.webex.com/webappng/sites/naic/recording/fe42d865d13210398fd70050568f0567/playback) – <https://naic.webex.com/webappng/sites/naic/recording/fe42d865d13210398fd70050568f0567/playback>

government.¹⁴² Some businesses in the industry may believe that insurance is not worth the cost or that coverage is not available.¹⁴³ Such misconceptions fuel belief that coverage is not available but, more recently, the concerns have been about the cost and limitations of coverage. Among the inherent limitations of excess and surplus lines are the higher costs of coverage and restrictions on the coverage beyond cannabis licensure requirements.

B. The Role of Data

Cannabis businesses are just like any other business; however, they continue to pay several times more than what other industries pay for insurance.¹⁴⁴ For example, a small mercantile general liability policy might run about \$1,000, but for a cannabis business, that policy could run about \$10,000 without products liability.¹⁴⁵ A directors and officers policy (D&O) for \$1 million in coverage could cost a cannabis business well into the six-figure range.¹⁴⁶ The difference in pricing may largely be due to the federal versus state treatment and the concomitant risks involved with cannabis businesses.¹⁴⁷ One major issue that persists for cannabis businesses and insurance is the lack of consistent and verifiable market data across market segments to inform of potential risks.¹⁴⁸ Insurers know very little about the losses and expenses associated with this industry, and therefore, it is difficult to price. An insurer can acquire information from their potential customer, but there is not a public source of comparative data that insurers can use to evaluate risks.¹⁴⁹

The lack of data relating to losses and expenses is a major issue, but data from similarly situated businesses can be used to assist in the underwriting process. When looking at dispensaries, an insurer can look at a pharmacy for medical use cannabis and liquor stores or vape shops for recreational use of cannabis to learn about underwriting a cannabis business. Similarly, cannabis processors and growers can look to processors from other similarly situated industries. Cannabis businesses need insurance at every point from seed to sell. Although data is lacking, there is

¹⁴² Jason Howard, CRC Group Wholesale & Specialty: Understanding the Issues Around Insuring Cannabis-Related Businesses (accessed February 21, 2023) – [Understanding the Issues Around Insuring Cannabis-Related Businesses - News - Tools & Intel | CRC Group](https://www.crcgroup.com/Tools-Intel/post/understanding-the-issues-around-insuring-cannabis-related-businesses/) – <https://www.crcgroup.com/Tools-Intel/post/understanding-the-issues-around-insuring-cannabis-related-businesses/>

¹⁴³ Brenda Wells, Ph.D., Presentation on Balancing Actual and Perceived Risks (East Carolina University). (July 27, 2021) – [Webex Enterprise Site - Replay Recorded Meeting](https://naic.webex.com/webappng/sites/naic/recording/fe42d865d13210398fd70050568f0567/playback) –

<https://naic.webex.com/webappng/sites/naic/recording/fe42d865d13210398fd70050568f0567/playback>

¹⁴⁴ Wendel Rosen, Wendel Rosen: Cannabis Insurance Presents Tough Choices. (March 28, 2017) –

<https://www.fennemorelaw.com/cannabis-insurance-presents-tough-choices/>

¹⁴⁵ Brenda Wells, Ph.D., Presentation on Balancing Actual and Perceived Risks. (East Carolina University). (July 27, 2021) –

[Webex Enterprise Site - Replay Recorded Meeting](https://naic.webex.com/webappng/sites/naic/recording/fe42d865d13210398fd70050568f0567/playback) –

<https://naic.webex.com/webappng/sites/naic/recording/fe42d865d13210398fd70050568f0567/playback>

¹⁴⁶ *Id.*

¹⁴⁷ *Id.*

¹⁴⁸ *Id.*

¹⁴⁹ *Id.*

information available to begin the underwriting process and to get a sense of what is needed by a cannabis-related business.

Insurers can also consider various factors during underwriting depending on the type of cannabis business. For processors, the results from a third-party inspection, the type of security system, and whether they are wired to outside monitoring stations, fire suppression systems, and the sufficiency of the electrical system with proper wattage and circuits all could be factors in the underwriting process. For retailers, the type of safe storing cash or product can also be considered when in the underwriting process, as there may be a regulatory requirement that a safe has to be so heavy as to not be easily moved, or the insurer may impose one. Overall, the insurer may want to know more about the owner/operator of the cannabis-related business. For instance, it may want to know if they are a member of a trade association or what education and training they have, and what they require of their staff. All this information can play a role in the risk involved with the cannabis-related business. What insurers would like to see is the risk be reduced. For example, the risk to insure someone who just decided to open a shop would be much higher than a person who took the time to get trained and educated in cannabis.

C. Developing Commercial Policy Forms

Most insurance policies, particularly those in the admitted market, are standardized. Advisory organizations help develop these forms that are used by property and casualty companies. The standardization of forms ensures: 1) the legal requirements from each state are taken into consideration; 2) premium rates are based on actuarial studies of insurable risks; and 3) case law is taken into consideration to prevent ambiguities in contract terms. Additionally, standardized forms using familiar terms and vocabulary may reduce the potential for disparate interpretations. Prior to legalization, insurance policies would typically exclude cannabis-related activities from a policy due to the illegality of the product as a federally listed Schedule 1 substance.¹⁵⁰ As states implement new cannabis laws, insurers will need to modify their contract forms to achieve compliance. Striving for consistent terminology and language is part of the normal work of advisory organizations.

¹⁵⁰ Heather Howell Wright, National Underwriter Property and Casualty 360: ISO Revises Policy Forms to Address Cannabis (November 1, 2019) – [ISO revises policy forms to address cannabis | PropertyCasualty360](https://www.propertycasualty360.com/2019/11/01/insurance-services-organization-revises-policy-forms-to-address-cannabis/) – <https://www.propertycasualty360.com/2019/11/01/insurance-services-organization-revises-policy-forms-to-address-cannabis/>

1. Insurance Services Office (ISO)

ISO is an insurance advisory organization that shares actuarial information with its customers, including insurance companies, actuaries, agents and brokers, and government entities.¹⁵¹ ISO gathers large amounts of loss data from various insurance companies to develop advisory prospective loss costs. Licensing carriers may use these loss costs to develop their ultimate insurance rates.¹⁵² ISO also creates insurance policy forms and endorsements often viewed by many as an industry standard.¹⁵³ ISO-created policy forms and endorsements often include policy language that has been tested in the courts, providing licensing carriers with potentially less volatility in interpretation than if an insurer creates its own form.¹⁵⁴

ISO insurance programs are available to provide insurance coverage to or exclude coverage with respect to cannabis-related businesses and exposures through policy endorsements.¹⁵⁵ An insurance endorsement can be used at policy inception or after a policy is issued to add, delete, exclude, or otherwise alter coverage.¹⁵⁶

Previously, neither the ISO Commercial General Liability (CGL), Commercial Property (Property), nor Commercial Auto (CA) forms expressly addressed cannabis. However, ISO developed several endorsements to specifically address the cannabis exposure in these and other insurance programs. The related endorsements can enhance an insurer's flexibility to tailor their product by expressly addressing coverage with respect to cannabis-related exposures.

If an insurance carrier prefers to avoid providing coverage with respect to cannabis-related exposures in any of the related insurance programs, ISO makes available several exclusionary endorsements to exclude coverage. However, if there is interest in providing coverage for a cannabis-related exposure, ISO has made available several endorsements for that purpose.

ISO's CGL and Property programs include options for the carrier to extend certain coverage with respect to the cannabis exposure. Carriers also have the option to extend limited coverage with respect to only the hemp exposure using a cannabis exclusion with an exception applying to

¹⁵¹ Marianne Bonner, The Balance: Insurance Services Office (ISO) (May 16, 2019) – [What Is the Insurance Services Office \(ISO\)? – thebalancesmb.com](https://thebalancesmb.com/iso-what-is-the-insurance-services-office/)

¹⁵² *Id.*

¹⁵³ *Id.*

¹⁵⁴ *Id.*

¹⁵⁵ Heather Howell Wright, National Underwriter Property and Casualty 360: ISO Revises Policy Forms to Address Cannabis (November 1, 2019) – [ISO revises policy forms to address cannabis | PropertyCasualty360 – https://www.propertycasualty360.com/2019/11/01/insurance-services-organization-revises-policy-forms-to-address-cannabis/](https://www.propertycasualty360.com/2019/11/01/insurance-services-organization-revises-policy-forms-to-address-cannabis/) ¹⁵⁶

Mila Araujo, The Balance: What Is an Insurance Endorsement (May 4, 2022) – [What Is an Insurance Endorsement? – thebalance.com](https://thebalance.com/insurance-endorsement/)

hemp. Additionally, the CGL program includes options for insurance carriers to exclude liability for specifically listed products.

Within the commercial general liability program, ISO developed liability coverage endorsements with an aggregate limit for cannabis, a cannabis exclusion with a hemp exception aggregate limit, and a cannabis liability exclusion with designated product or work exception subject to an aggregate limit.¹⁵⁷

Lastly, ISO developed the defense within limits endorsement specific to products liability coverage that allows the carrier to limit the cost of defense related to products covered by the coverage form. Similar options are available for ISO's Businessowners, Commercial Flood, and Commercial Inland Marine programs.

2. American Association of Insurance Services (AAIS)

AAIS, a not-for-profit advisory organization governed by its member insurance companies, provides insurance forms, rules, and loss costs to the property casualty insurance industry.¹⁵⁸ AAIS provides policy forms and manuals in commercial lines, inland marine, farm and agriculture business lines, as well as personal lines to more than 700 insurance carriers.¹⁵⁹ As a licensed statistical agent in 51 jurisdictions, AAIS collects data that helps members meet regulatory statistical reporting responsibilities, which also supports loss cost development and ratemaking activities.¹⁶⁰

AAIS' cannabis business owners' policy (CannaBOP) product was developed at the request of the California Department of Insurance (DOI) to strengthen carrier participation for coverage of commercial cannabis operations. The CannaBOP is a package policy that provides property and liability coverages for qualifying cannabis dispensaries, storage, distributors, processors, manufacturers, and private cannabis testing facilities and laboratories.¹⁶¹ Rather than providing coverage to legal cannabis businesses through an endorsement, AAIS advocates for cannabis-specific product development and cannabis-specific programs.¹⁶² The CannaBOP program also

¹⁵⁷ *Id.*

¹⁵⁸ AAIS: An Unwavering Commitment to our Members...and to the Success of the Insurance Industry (accessed February 21, 2023) – [Our Role in Insurance - AAIS Online](https://aaionline.com/our-role-in-insurance) – <https://aaionline.com/our-role-in-insurance>

¹⁵⁹ *Id.*

¹⁶⁰ *Id.*

¹⁶¹ AAIS Solutions Kit: CANNABOP: Cannabis - Businessowners (January 2020) – [30f1bcd6-6b5d-921f-ce64-654b16f08b88](https://aaionline.com) – aaionline.com

¹⁶² AAIS: Arizona Approves AAIS CannaBOP, Cannabis Business Owners Insurance Policy (March 9, 2021) – [Arizona Approves AAIS CannaBOP, Cannabis Business Owners Insurance Policy - AAIS Online](https://aaionline.com/press-arizona-approves-aa-is-cannabop-cannabis-businessowners-insurance-policy) – <https://aaionline.com/press-arizona-approves-aa-is-cannabop-cannabis-businessowners-insurance-policy>

includes the rules, loss costs, and a suite of optional endorsements to be used by an insurance company.¹⁶³ The program also offers technology support so that CannaBOP can be quickly distributed and AAIS dedicated personnel keeping a keen eye on the “legs & regs” to help carriers remain compliant within this space.¹⁶⁴

3. Filing Process and Adoption of ISO and AAIS Forms

AAIS and ISO are advisory organizations that submit advisory loss costs, rules, and forms to the respective regulating agency for review and approval. These advisory organizations have member or subscriber requirements to use their approved forms, rules, rates, or loss costs. Loss costs are the data on claims that have been paid out.

In some states, advisory organizations file on behalf of insurers that have given them authorization, and other states may have varying filing requirements, as in the case of California. In the absence of a filing made on behalf of an insurer, the insurance company submits a separate filing to adopt the product or endorsement before it can use what has been created by the advisory organization. For example, in California, insurer XYZ wanted to start writing a Cannabis Business Owners policy. As a member of an advisory organization, XYZ could use the advisory organization’s forms and data for what coverages to offer, forms to use, rules to apply, and rates (loss costs multiplied by a loss cost multiplier to account for the insurer expenses) to use. Insurer XYZ would submit a prior approval new program filing with the California DOI to adopt the portions of the advisory organization material they wanted to use. The filing would then be reviewed and approved before insurer XYZ could start writing cannabis business owners’ risks using the advisory organization’s filing as a foundation. So, two separate filing approvals are needed: first, the approval of the filing containing the advisory organization product; and then, after the advisory organization’s product is approved, the insurance company(s) filings requesting adoption of the already approved advisory organization’s product.

ISO’s Cannabis Endorsements were approved for use in a majority of the states in September 2019.¹⁶⁵ According to AAIS, CannaBOP was first filed and approved in California in 2018.¹⁶⁶

Since then, CannaBOP has been approved in Colorado, Nevada, Illinois, Michigan, and Washington.¹⁶⁷ In March 2021, CannaBOP was adopted by Golden Bear in Arizona.¹⁶⁸

¹⁶³ *Id.*

¹⁶⁴ AAIS: Introducing CannaBOP (accessed February 21, 2023) – [CannaBOP\(old\) - AAIS Online](https://aaisonline.com/cannabopold#:~:text=Introducing%20CannaBOP%20The%20AAIS%20CannaBOP%20program%20is%20a%20licensed%20cannabis%20dispensaries%2C%20distributors%20and%20testing%20labs.) – <https://aaisonline.com/cannabopold#:~:text=Introducing%20CannaBOP%20The%20AAIS%20CannaBOP%20program%20is%20a%20licensed%20cannabis%20dispensaries%2C%20distributors%20and%20testing%20labs.>

¹⁶⁵ Heather Howell Wright, National Underwriter Property and Casualty 360: ISO Revises Policy Forms to Address Cannabis (November 1, 2019) – [ISO revises policy forms to address cannabis | PropertyCasualty360](https://www.propertycasualty360.com/2019/11/01/insurance-services-organization-revises-policy-forms-to-address-cannabis/) – <https://www.propertycasualty360.com/2019/11/01/insurance-services-organization-revises-policy-forms-to-address-cannabis/> ¹⁶⁶

AAIS: Arizona Approves AAIS CannaBOP, Cannabis Business Owners Insurance Policy (March 9, 2021) – [Arizona Approves AAIS CannaBOP, Cannabis Business Owners Insurance Policy - AAIS Online](https://aaisonline.com/press-arizona-approves-aais-cannabop-cannabis-businessowners-insurance-policy) – <https://aaisonline.com/press-arizona-approves-aais-cannabop-cannabis-businessowners-insurance-policy>

¹⁶⁷ *Id.*

¹⁶⁸ *Id.*

IX. RESPONDING TO EMERGING TRENDS

Emerging trends in the cannabis industry provide opportunities for next steps in policy, regulation, and insurance. Cannabis product innovation is expanding past edibles to infuse cannabis into beverages, baking staples, crafts, and luxury products. New formulas and strengths are also being introduced with these new products. Innovation brings both new insurance needs and risks. For instance, states issued recalls in 2022 for cannabis edibles for mislabeling and contamination, resulting in litigation.¹⁶⁹

Growing demand for ancillary services and infrastructure in the cannabis space will also likely impact cannabis-related insurance. Ancillary services include those that complement the cannabis industry and are often non-plant touching. This includes marketing, transportation and delivery, financing, breathalyzers, product packaging, accountants, landlords, staffing firms, nutrient suppliers, and equipment companies.

Insurance regulators should also be informed of the emergence of on-site social consumption lounges. A few states have started issuing licenses for these establishments. On-site social cannabis lounge sites may operate similarly to bars, where consumers would gather to socially consume cannabis at a place of business. These businesses will face liability and insurance issues akin to businesses serving alcohol, like bars, breweries, and wineries.

X. CONCLUSIONS

A major aspect of obtaining insurance coverage for cannabis-related businesses is the complexity of limitations to interstate commerce hampering multi-state expansion. The current cannabis marketplaces are contained in individualized state jurisdictions without competition from other state marketplaces.¹⁷⁰ There have been state legislative authorizations in California (2022) and Oregon (2019) to create legal cannabis interstate commerce through trade pacts with other states. However, these laws require Congressional authorization or a memorandum from the DOJ allowing for interstate transfers of cannabis products. Federal legislation was introduced in 2021 with the States Reform Act (SRA). The SRA would decriminalize cannabis at the federal level while deferring to state powers over prohibition and commercial regulation.

¹⁶⁹ Jay Viridi, Cannabis Industry Journal: Challenges Abound for Cannabis Industry Growth in 2023 (November 30, 2022) – https://cannabisindustryjournal.com/feature_article/challenges-abound-for-cannabis-industry-growth-in-2023/

¹⁷⁰ Tommy Tobin and Andrew Kline, Yale Law & Policy Review: A sleeping Giant: How the Dormant Commerce Clause Looms Over the Cannabis Marketplace (January 3, 2022) – https://ylpr.yale.edu/inter_alia/sleeping-giant-how-dormant-commerce-clause-looms-over-cannabis-marketplace

Insurers are likely to continue to be cautious about entering the cannabis space in the absence of federal safe harbor provisions, legalization, decriminalization, or rescheduling. The federal prohibition has the effect of inhibiting access to vital ancillary services, such as banking with financial institutions and mitigating risk through insurance. States may look to add safe harbor laws into their authorities to ensure vital ancillary businesses can legally service the cannabis industry within state laws. The goal of safe harbor authorities is to seek and grant protections from liabilities or penalties, so long as certain conditions are met. For example, California recently passed a bill that states an individual or firm providing insurance or related services to a state legal cannabis business does not commit a crime under California law solely for providing that insurance or related service.¹⁷¹ The NAIC has supported federal legislation to provide a safe harbor for financial institutions and insurers serving cannabis-related businesses operating in states that have legalized cannabis.

Currently, most commercial insurance coverage for cannabis-related businesses is in the excess and surplus market. There is, however, growing interest among admitted carriers in entering this area. Among the potential structures to facilitate cannabis-related business coverage are: the use of state-based commercial insurance programs, risk retention groups (RRGs), captives, and joint underwriting associations (JUAs). States may want to look at their state laws to identify and remediate any restrictions in use of such programs for cannabis-related businesses.

Fair Access to Insurance Requirements (FAIR) plan programs afford opportunities for difficult risks to be underwritten by certain insurers when other insurance is not feasible. Sometimes known as insurers of last resort, the availability of these plans varies by jurisdiction. While commonly limited to personal lines, some states include commercial coverage. Generally, these programs help to provide insurance for those unable to acquire it from the admitted or excess and surplus insurance markets. FAIR plans are shared market plans, where several insurance companies provide coverage for the property, limiting the amount of risk that any one company assumes.

Risk retention groups and captive insurers also provide additional options for cannabis-related business insurance coverage. Governed by state law, there are many nuances that a state must consider. For example, Washington identified 17 businesses using captive insurance but not

¹⁷¹ Assembly Member Cooley, AB 2568 (Chapter 393, Statutes of 2022).

paying premium taxes to the state the captive was operating in. This was due to legal framework for captive registration and taxation had not yet been established.¹⁷²

Joint underwriting associations (JUAs) could be created to alleviate the lack of availability and affordability for state mandated cannabis-related commercial insurance coverage. A joint underwriting association is a nonprofit risk-pooling association established by a state legislature in response to availability crises in respect to certain kinds of insurance coverage. For example, a number of states have established JUAs to provide medical malpractice insurance for physicians who are unable to obtain affordably priced insurance coverage in the standard marketplace.

Addressing black-market cannabis operations could also help support capacity for cannabis-related commercial insurance. Black-market operations can take the form of illegal grows, unlicensed production and processing facilities, and criminal retailers. Black-market operations compete with the regulated markets and remove revenue that would be taxed and generated with the legal retailers. Black-market products are also not subject to any regulations for advertising, marketing, retail sales, or consumer safety. This creates risk than can spill over into the state-legal cannabis market. For example, during Vape Gate, insurers increased pricing and added product liability exclusions for unapproved additives. Many of the vape issues were found to be due to black market products. However, insurers' apprehension on writing vape-related risks lingered for a few years following the event.¹⁷³

Some states are already taking steps to address black market operations. For example, Oregon and Washington each involve their law enforcement agencies in a collaborative effort with their cannabis regulatory bodies to seek and enforce against illegal cannabis operations. Oregon even coordinates its enforcement efforts in collaboration with California agencies in these efforts. Colorado coordinates between law enforcement and the cannabis regulatory agencies. In Washington, state tax revenue generated at regulated cannabis retailers is also distributed to local law enforcement agencies, which can help fund their enforcement efforts against black-market operations. The cannabis and insurance industries, as well as consumers, benefit from these enforcement activities, as well as the removal of the unregulated black-market.

As the number of states legalizing cannabis continues to grow, so will the need for cannabis-related commercial insurance. Insurance regulators must stay current with the rapidly changing landscape. There has been a rapid introduction of new cannabis products whose product liability

¹⁷² Joel S. Chansky, FCAS, MAAA Craig R. Brophy, FCAS, MAAA David R. Kennerud, FCAS, MAAA Joseph T. Holahan, JD, Milliman Report: Captive Insurance Study (January 18, 2021) –

<https://www.insurance.wa.gov/sites/default/files/documents/captive-insurance-study.pdf>

¹⁷³ Steve Hallo, Market Insights: Vape Gate and today's cannabis product liability market (December 16, 2020) –

<https://www.propertycasualty360.com/2020/12/16/vape-gate-and-todays-cannabis-product-liability-market/>

needs and risks are still unknown. The insurance needs of ancillary businesses will also need to be understood. Finally, insurance regulators will need to access the capacity for new business models, such as on-site consumption lounges, to find insurance coverage and address associated educational needs.

XI. APPENDIX:

ADDITIONAL CANNABIS INFORMATIONAL RESOURCES

- **Americans for Safe Access:** <https://www.safeaccessnow.org/>
- **Cannabis Business Times:** <https://www.cannabisbusinesstimes.com/>
- **Cannabis Now:** <https://cannabisnow.com/>
- **Cannabis Regulators Association:** <https://www.cann-ra.org/>
- **Drug Policy Alliance:** <http://www.drugpolicy.org/>
- **Global Commission on Drug Policy:** <http://www.globalcommissionondrugs.org/>
- **Insurance Journal: Attaining Compliance in the Cannabis Universe:**
<https://www.insurancejournal.com/research/research/attaining-compliance-in-the-cannabis-universe/>
- **Law Enforcement Action Partnership:** <https://lawenforcementactionpartnership.org/>
- **Marijuana Policy Project (MPP):** <https://www.mpp.org/>
- **MJ Business Daily:** <https://mjbizdaily.com/>
- **NAIC - Cannabis Insurance Hearings:**
 - Hearing 1:
<https://naic.webex.com/webappng/sites/naic/recording/225c7bfecae91039aafd0050568f5657/playback>

- Hearing 2:
<https://naic.webex.com/webappng/sites/naic/recording/fe42d865d13210398fd70050568f0567/playback>
- **NAIC: Regulatory Guide – Understanding the Market for Cannabis Insurance:** https://content.naic.org/sites/default/files/inline-files/cnte_c_cannabis_wg_exposure_understanding_cannabis_marketplace_0.pdf
- **National Cannabis Industry Association:** <https://thecannabisindustry.org/>
- **National Conference of State Legislatures:** <https://www.ncsl.org/research/civil-and-criminal-justice/marijuana-overview.aspx>
- **National Highway Traffic Safety Administration:** <https://www.nhtsa.gov/drug-impaired-driving/understanding-how-marijuana-affects-driving#:~:text=Though%2033%20states%20have%20changed,the%20wheel%20of%20a%20vehicle>
- **National Organization for the Reform of Marijuana Laws:** <https://norml.org/>
- **Patients out of Time:** <https://www.medicalcannabis.com/>
- **Smart Approaches to Marijuana:** <https://learnaboutsam.org/>
- **Students for Sensible Drug Policy:** <https://ssdp.org/>
- **Transform Drug Policy Foundation:** <https://transformdrugs.org/>
- **United States Department of Agriculture – Hemp:** <https://www.ams.usda.gov/rules-regulations/hemp>
- **United States Drug Enforcement Administration – Marijuana:** <https://www.dea.gov/factsheets/marijuana>
- **Veterans for Cannabis:** <https://www.vetscp.org/>
- **White House, Office of National Drug Control Policy:** <https://www.whitehouse.gov/ondcp>

- **National Cannabis Industry Association:** <https://thecannabisindustry.org/>
- **National Conference of State Legislatures:** <https://www.ncsl.org/research/civil-and-criminal-justice/marijuana-overview.aspx>
- **National Highway Traffic Safety Administration:** <https://www.nhtsa.gov/drug-impaired-driving/understanding-how-marijuana-affects-driving#:~:text=Though%2033%20states%20have%20changed,the%20wheel%20of%20a%20vehicle>
- **National Organization for the Reform of Marijuana Laws:** <https://norml.org/>
- **Patients out of Time:** <https://www.medicalcannabis.com/>
- **Smart Approaches to Marijuana:** <https://learnaboutsam.org/>
- **Students for Sensible Drug Policy:** <https://ssdp.org/>
- **Transform Drug Policy Foundation:** <https://transformdrugs.org/>
- **United States Department of Agriculture – Hemp:** <https://www.ams.usda.gov/rules-regulations/hemp>
- **United States Drug Enforcement Administration – Marijuana:** <https://www.dea.gov/factsheets/marijuana>
- **Veterans for Cannabis:** <https://www.vetscp.org/>
- **White House, Office of National Drug Control Policy:** <https://www.whitehouse.gov/ondcp>

Draft: 4/13/23

Cannabis Insurance (C) Working Group
Virtual Meeting
April 11, 2023

The Cannabis Insurance (C) Working Group of the Property and Casualty Insurance (C) Committee met April 11, 2023. The following Working Group members participated: Ricardo Lara, Chair, represented by Melerie Michael (CA); Michael Conway, Vice Chair, represented by Peg Brown and Bobbie Baca (CO); Jimmy Harris (AR); Christina Miller (DE); Ryan Blakeney (MS); Randall Currier (NJ); Melissa Robertson (NM); Erin Summers (NV); Michael Drummonds (OR); Sebastian Conforto (PA); Beth Vollucci (RI); Karla Nuissl (VT); and Michael Walker (WA).

10. Adopted its Nov. 29, 2022, Minutes

Currier made a motion, seconded by Brown, to adopt the Working Group's Nov. 29, 2022, minutes (see *NAIC Proceedings – Fall 2022, Property and Casualty Insurance (C) Committee, Attachment One*). The motion passed unanimously.

11. Discussed the Final Draft of the *Understanding the Market for Cannabis Insurance 2.0* White Paper

Michael stated that the drafting group has been meeting several times a month since mid-2021. The white paper content was heavily informed by the many presentations and panels received and the two-day hearing held by the Working Group over the last two years. The introduction explains that the updated white paper was needed, as the cannabis industry rapidly evolves and expands in structure and geography. The maturation of the cannabis market since the adoption of the previous white paper is driving new product development, infrastructure changes, and the need for businesses to provide ancillary services. It is in these areas where insurance gaps most persist now. As such, the updated white paper includes a discussion on emerging insurance issues in these areas of the cannabis industry. Additionally, the white paper outlines the different operating structures and designs of cannabis businesses, jurisdictional variations, current insurance types and offerings, and differences presented by insuring hemp versus cannabis. It also covers cannabis policy trends, current landscapes of cannabis regulation, and licensing and education. It concludes with a brief discussion on the future state of cannabis insurance, including possible next steps for all affected parties.

Walker stated that there is a vast array of lingo, concepts, and scientific terms when discussing cannabis. Overlaying this with all the insurance lingo adds to the complexity. Knowing how these intersect is important to interpreting related regulations, legislation, products, and research. As such, the second section is dedicated to providing this information. The third section delves into the expansion of states legalizing cannabis. It covers the varied approaches to cannabis regulation across the states and U.S. jurisdictions and the role of growing public opinion support. Some states have joined the list of those that have legalized cannabis, while others have chosen not to.

Drummonds stated that the fourth section discusses the impact of conflicting state and federal laws on insurers' willingness to provide coverage for cannabis businesses. It also discusses recent federal legislative efforts, including the Secure and Fair Enforcement (SAFE) Banking Act, the Clarifying Law Around Insurance of Marijuana (CLAIM) Act, the Marijuana Opportunity Reinvestment and Expungement (MORE) Act of 2021, the Cannabis

Administration and Opportunity Act (CAOA), and the States Reform Act of 2021. The SAFE Banking Act would remove constraints on depository institutions to provide banking services to legitimate, cannabis-related businesses. The CLAIM Act would provide a safe harbor from penalties or other adverse agency action for insurance companies that provide services to cannabis-related, legitimate businesses in jurisdictions where such activity is legal. The MORE Act would decriminalize cannabis by removing it from the list of scheduled substances under the Controlled Substances Act (CSA). The COA would allow states to lead on cannabis regulation and establish a federal regulatory paradigm similar to that of alcohol and tobacco. The States Reform Act of 2021 would remove the legal obstacles preventing U.S. cannabis companies from accessing the financial system and allow for the interstate commerce of cannabis. Additionally, there is a discussion on President Joe Biden's request that the Secretary of the U.S. Department of Health and Human Services (HHS) and the Attorney General review how marijuana is categorized under federal law. The section concludes by noting that President Biden signed the Medical Marijuana and Cannabidiol Research Expansion Act in December 2022 to increase access to the scientific study of cannabis.

The fifth section of the paper provides an overview of the cannabis business regulatory, licensing, and education landscape. It begins by explaining that many states that legalized cannabis designed their regulated cannabis systems to carefully consider the priorities of the U.S. Department of Justice (DOJ) and federal government outlined in the Cole Memorandum. It then discusses how the Cannabis Regulators Association (CANNRA) provides policymakers and regulatory agencies with the resources to make informed decisions when considering whether and how to legalize and regulate cannabis. It then takes a deeper dive into insurance considerations around cannabis impairment, including research limitations, driving impairment testing, workplace considerations, and potency variances in newer products. It also discusses the need for education and the impact of vaping regulations on cannabis. It concludes with a discussion on social and economic equality provisions and licensing. The sixth section looks at the implications of evolving cannabis operating and organizational structures. Consolidation and sales growth were the dominant trends of 2021. This section discusses how this consolidation results in ownership changes and business structure modifications that lead to a more sophisticated industry.

Brown stated that the seventh section examines cannabis insurance needs and coverage availability. This section discusses the difficulty state insurance regulators have in assessing availability and affordability, given that the majority of cannabis business coverage is written through excess and surplus carriers. There are some admitted forms, such as through the Insurance Services Office (ISO) and the American Association of Insurance Services (AAIS). However, in most states, admitted carriers are not widely using these avenues to provide coverage. This section also examines how access to commercial insurance for cannabis businesses significantly varies by the market segment of the seed-to-sale continuum. In many cases, coverage for cannabis businesses is more expensive than for other sectors, and limits can be constrained. The eighth section explores market considerations for commercial cannabis insurance. It points out that a cannabis business as an insurance client may need some help with insurance terms and coverage options, as the client may not know what options are suitable for their needs. It also discusses leveraging data on similarly situated businesses to overcome difficulties evaluating risks given the lack of data specific to cannabis businesses. Additionally, cannabis business coverage forms offered by the ISO and the AAIS are discussed. The discussion includes the process the advisory organizations go through to adopt and file the forms.

Nuissl stated that in the ninth section, the paper provides an overview of emerging trends in the cannabis industry. Product innovations are moving past edibles to infuse cannabis into beverages, baking staples, crafts, and luxury products. Additionally, demand is growing for ancillary services and infrastructure. A few states have started issuing on-site social consumption lounges. All of these emerging trends create new insurance needs and risks to be addressed in policy and regulation.

Michael stated that the white paper's conclusion emphasizes the importance of federal safe harbor provisions. It notes growing interest among admitted carriers in entering the cannabis space. It also discusses the use of state-based commercial insurance programs, risk retention groups (RRGs), captives, and joint underwriting associations (JUAs) as potential structures to facilitate cannabis-related business coverage. Additionally, it notes the need for states to address black market operations.

12. Exposed the *Understanding the Market for Cannabis Insurance 2.0* White Paper

Brown made a motion, seconded by Nuisl, to expose the *Understanding the Market for Cannabis Insurance 2.0* white paper to NAIC staff for a 45-day public comment period ending May 26. The motion passed unanimously.

13. Discussed the Working Group's Work Plan

Michael stated that the work plan essentials include items specifically identified in the Working Group's charges and presentations or panel discussions needed to inform those items. This includes exposing and adopting the *Understanding the Market for Cannabis Insurance 2.0* white paper by the Summer National Meeting. Once that is accomplished, the Working Group can begin drafting its outline for the addendum to the white paper that will cover emerging issues. Drafting on the addendum can be done as information is gained through presentations to the Working Group throughout the year. Presentations on emerging areas will include cannabis-infused food and beverages and its oversight by the U.S. Food and Drug Administration (FDA), cannabis intoxication, delivery and social equity, and social consumption lounges. There is also a presentation anticipated from the National Underwriter Company on its launch of the first certification on cannabis insurance coverage for insurance agents and brokers, risk managers, and other professionals who advise cannabis-related businesses. The final essential work plan item is to continue receiving reports on cannabis-related legislative activities from the NAIC Government Relations (EX) Leadership Council staff and other legal experts.

Feedback is needed on items the Working Group could potentially include in its work plan. Cannabis regulations are state specific. Additionally, there are emerging areas like social consumption lounges that some states are already involved in, and others may want to know about for the future. For these reasons, feedback is needed regarding whether members want to hold an educational roundtable where states could share and learn from each other. Additionally, it has been hard to get something beyond anecdotal or second-hand information on what issues insureds are having in obtaining insurance coverage for cannabis-related exposures. It could also be helpful to understand what experiences insurers or prospective insurers are having as they approach state insurance regulators about writing cannabis-related coverages in the admitted market. For these reasons, feedback is needed on whether it would be beneficial to host hearings or panels to hear from insurers and prospective insurers and/or insureds. In a similar vein, feedback is needed on whether the Working Group should host a hearing or a series of panels on the unique structures being created to address cannabis insurance needs. This would include things such as RRGs, captives, and surplus lines-specialty programs. It would also include things like hearing from the Specialty Agriculture Risk and Financial Association (SARFA), a member-driven association designed to meet the insurance regulatory requirements of Michigan. Another idea is to compile a list of those writing cannabis coverage by surveying managing general agents (MGAs) and/or inquiring with the Surplus Lines Association about surveying their members for this information. If the Working Group surveys MGAs, it would need to find a list of MGAs and their contact information. Finally, the drafting group could leverage the research it compiled and wrote while drafting the white paper to develop issue papers that would be used for background information and not officially adopted.

Brown stated that the intersection of insurance and the cannabis industry is very complex. The commercial cannabis market is not available in all states. It is extensively regulated in states where it is available, but those state regulations differ, which creates a somewhat unique situation. It is important for state-based insurance

regulators to work closely with the state marijuana or cannabis regulatory entities in each member's respective state. Doing so ensures that state-based insurance regulators understand that not every state is alike and collaboration is needed on interstate issues of insurance coverage.

Walker stated that he also supports the potential work plan idea of holding educational roundtables with states sharing how cannabis is regulated in their jurisdictions and any related issues. For instance, some states have prohibited vertical integration, and others allow it. Additionally, variances between jurisdictions could become more complex as new concepts, such as social consumption lounges, launch.

Nuissl stated that she also supports the potential work plan idea of holding educational roundtables. It is important to examine issues with different sizes of companies in different segments. For instance, a very small grower might have very different issues from a larger one.

Michael requested that any additional feedback on the work plan be sent to NAIC staff.

Having no further business, the Cannabis Insurance (C) Working Group adjourned.

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Draft: 8/22/23

Catastrophe Insurance (C) Working Group
and the NAIC/Federal Emergency Management Agency (FEMA) (C) Advisory Group
Seattle, Washington
August 13, 2023

The Catastrophe Insurance (C) Working Group of the Property and Casualty Insurance (C) Committee met in Seattle, WA, Aug. 13, 2023, in joint session with the NAIC/FEMA (C) Advisory Group of the Catastrophe Insurance (C) Working Group of the Property and Casualty Insurance (C) Committee. The following Working Group members participated: Chlora Lindley-Myers, Chair, represented by Cynthia Amann, Brad Gerling, and Jo LeDuc (MO); Mike Causey, Vice Chair, represented by Jackie Obusek, Vice Chair (NC); Sian Ng-Ashcraft (AK); Mark Fowler and Brian Powell (AL); Alan McClain (AR); Ken Allen, Elsa Carre, Lucy Jabourian, and Lynne Wehmueller (CA); George Bradner (CT); Virginia Christy and Michelle Brewer (FL); Jerry Bump, Randy Jacobson, and Kathleen Nakasone (HI); Travis Grassel (IA); Craig VanAalst (KS); James D. Donelon (LA); Jackie Horigan and Matthew Mancini (MA); Joy Hatchette (MD); Ryan Dakeney (MS); Anna Krylova (NM); Landon Hubbard (OK); Tom Botsko and Maureen Motter (OH); Brian Downs (OK); Raven Collins (OR); David Buono and Michael McKenney (PA); Glorimar Santiago (PR); Beth Vollucci (RI); Will Davis (SC); Stephanie Cope (TN); Marianne Baker, J'ne Byckovski, Nicole Elliott, and Mark Worman (TX); Matt Stoutenburg (WA); Jeannie Tincher and Juanita Wimmer (WV); and. Also participating were Patrik O'Connor (IN); Paige Dickerson and Kevin Dyke (MI); Peter Brickwedde (MN); Dede Bennisan (NV); Tony Dorschner (SD); Tracy Klausmeier (UT); Marly Santoro (VA); Isabelle Turpin Keiser and Beth Sides (VT); and Bryan Stevens (WY).

The following Advisory Group members participated: Glen Mulready, represented by Brian Downs and Landon Hubbard (OK), Chair; Carter Lawrence, represented by Stephanie Cope, Vice Chair (TN); Mark Fowler and Brian Powell (AL); Sian Ng-Ashcraft (AK); Ken Allen, Elsa Carre, Lucy Jabourian, and Lynne Wehmueller (CA); George Bradner (CT); Virginia Christy and Michelle Brewer (FL); Travis Grassel (IA); Patrick O'Connor (IN); Craig VanAalst (KS); James D. Donelon (LA); Joy Hatchette (MD); Ryan Dakeney (MS); Cynthia Amann, Brad Gerling, and Jo LeDuc (MO); Anna Krylova (NM); Raven Collins (OR); Beth Vollucci (RI); Tony Dorschner (SD); Marly Santoro (VA); Matt Stoutenburg (WA) and Raven Collins (OR).

9. Adopted its Spring National Meeting Minutes

Botsko made a motion, seconded by Commissioner McClain, to adopt the Working Group's March 21 minutes (see *NAIC Proceedings – Spring 2023, Joint Meeting of the Catastrophe Insurance (C) Working Group and the NAIC/FEMA (C) Advisory Group, Attachment Five-A*). The motion passed unanimously.

10. Heard an Update on the Catastrophe Modeling Primer

Sara Robben (NAIC) provided an update on the progress of the drafting group in drafting the Catastrophe Modeling Primer. The drafting group met July 28 and plans to meet again during the last week of August.

Several primer sections have been drafted, and the drafting group continues to work diligently on this task. The drafting group now has access to a SharePoint site, allowing the state insurance regulators in the drafting group to view and edit the document at any time.

The drafting group hopes to complete the drafting and be able to expose the document by the Fall National Meeting.

11. Heard from Alabama, Louisiana, and Minnesota About Their Mitigation Programs

Commissioner Fowler talked to the Working Group about the wind mitigation program in place in Alabama. The name of the program in Alabama is Strengthen Alabama Homes. Alabama makes grants of up to \$10,000 dollars available to Alabama residents to fortify their homes to the Insurance Institute for Business and Home Safety (IBHS) Bronze Fortified standards. Commissioner Fowler said many qualifications go into the Bronze Fortified standards, and Alabama has built numerous strong partnerships with industry, academia, and nonprofit organizations. These partnerships include: Smart Home America; Habitat for Humanity; the Center for Risk and Resilience at the University of Alabama, Birmingham; and Protective Life. Working with these entities, about 100 homes have been fortified in five historic and mostly underserved neighborhoods around downtown Birmingham's new protective stadium.

Commissioner Fowler said the Alabama legislature passed a bill creating the Strengthen Alabama Homes (SAH) program in 2012. Funding comes from the insurance industry through fees paid to the Alabama Department of Insurance (DOI). The first grant was made in 2016, and since then, the DOI has distributed \$59.2 million to fortify more than 6,000 homes in Alabama. By the end of this fiscal year, the Alabama DOI will have granted \$62.5 million and fortified more than 6,300 homes.

Commissioner Fowler said the application and approval process occurs online through the SAH's website. The site is opened quarterly for grants for new applications at midnight on a designated day. The DOI only had 300 available grants left for this fiscal year, and more than 200,000 people were logged on to get one of those 300 available grants on the designated day. Brian Powell (SAH) is frequently called on by other states to consult with them on forming their own version of SAH.

Commissioner Fowler said that currently, 11 states are looking at establishing a program like SAH, some of which have already passed legislation. Powell often works with the IBHS and others to promote state mitigation programs. Alabama Gov. Kay Ivey strongly supports the SAH program and signed an executive order establishing the Alabama Resilience Council (ARC). The ARC is a broad-based collaborative effort where risk and vulnerabilities can be assessed, and resilience efforts can be aligned through council partners. The most beneficial strategies and actions can be identified, and the ARC's ongoing work is not limited to a single event. Commissioner Fowler serves as the ARC's co-chair, along with cabinet member Jeff Smitherman (Alabama Emergency Management Agency).

Commissioner Fowler said the ARC's consistent coordination with the numerous public agencies and private partners who comprise the members and stakeholders will continually generate rewards by setting priorities, leveraging resources, communicating effectively, and delivering measurable results for the people of Alabama before and after events.

Commissioner Fowler said that when adverse circumstances occur, reimagining the approach to resiliency through the work of the ARC will empower Alabamians in the community to build stronger, live safer, and recover quicker.

Commissioner Donelon said Alabama is the reason Louisiana is where it is today. Louisiana has copied Alabama's legislation as closely as it could. The Louisiana Fortify Homes Program (LFHP) addresses the increasing cost of wind and hail coverage from homeowners by encouraging people to retrofit and upgrade their homes to the Fortified roof standard.

Commissioner Donelon said Louisiana had back-to-back hurricane seasons that generated 800,000 claims being filed, resulting in \$20.3 billion in payments to homeowners and commercial property owners in 2020 and 2021. Through these events, the Fortified roof standard in construction has proven to offer greater resilience in the face of high wind, hail, and hurricanes. Fortified roofs are more readily insurable at lower rates than homes not built or retrofitted to that standard.

Commissioner Donelon said the two hurricanes making landfall in 2020 and 2021 had winds of 150 mph. In both cases, homes built to the Fortified standards were undamaged. These homes were located on the coast and barrier islands. The Louisiana legislature enacted the LFHP in 2022 but appropriated no money until 2023. In 2023, the legislature appropriated \$20 million from the general fund and another amount not to exceed \$10 million from excess revenue collected by the DOI. The current 2023/2024 fiscal year funding will permit 3,000 grants at \$10,000 per grant to be awarded. Since the creation of the LFHP, the Louisiana DOI has prepared for the receipt of funding by working closely with the SAH and Smart Home America to develop its grant administration system. The program will operate on a first-come, first-served basis, offering grants not to exceed \$10,000 to retrofit existing homes to the Fortified standard. This amount was chosen based on the experience of the SAH. Applicants must own a residential property with a homestead exemption, and the residential property cannot be a condominium or mobile home. The property must also have wind insurance coverage, and if the property is in a Special Flood Hazard Area (SFHA), there must be flood coverage. The grant process is managed through Louisiana's online system, from verification of eligibility to authorization of the grant payment upon receipt of the Fortified group certificate. Grant payments are made directly to participating contractors. In the 2023 legislative session, property insurers, like Alabama, were mandated to file rate discounts for properties with Fortified designation.

Commissioner Donelon said a separate program that is funded is the incentive program for insurers to write coverage in Louisiana, primarily focusing on taking the 120,000 homes that must get their insurance from Louisiana's state-sponsored market of last resort priced at the highest level of any private property insurance company offering coverage in each of Louisiana's parishes plus 10%.

Commissioner Donelon required the first \$15 million to go to those homes insured by Citizens when awarding grants during the October/November time period this year. If any of the \$15 million happens to be left over from that offering, it will be put into the second \$15 million offering, which will go out to the public. Louisiana hopes to get 3,000 homes insured with these grants.

Commissioner Donelon said that the Louisiana Insurance Department was one of several recipients of a two-year Robert Wood Johnson Foundation (RWJF) grant. This grant encourages resilient construction in studying the public health effects of resilient construction in underserved and at-risk communities.

Horigan asked if there is a time frame in which the mitigation must be done to a home. Commissioner Donelon said the contractor is paid directly to certified Fortified contractors. Louisiana has approximately 100 certified contractors. Inspectors also have to meet a certification standard. He said a homeowner has no motive to stall or delay the mitigation, but Louisiana does not have a deadline. Commissioner Fowler said he believes there is a 90-day limit. However, the mitigation is generally completed 55 days from the grant award. Alabama does not make the grants available to the individual and pays the contractor directly.

Brickwedde said Minnesota also used many elements of Alabama's program. Michael Newman (IBHS) and Fred Malik (IBHS) went to St. Paul, MN, in February to testify to the legislature about the work done under the Fortified program, which helped get Minnesota's program through legislation this year. Minnesota received \$1 million from the legislature this year for planning and implementation work over the next two years. Brickwedde said the money will be used to hire staff and build some of the relationships needed to get the work done. Currently, three homes in Minnesota have a Fortified roof, so Minnesota has to start at the level of creating a workforce to do the work and then raise awareness among Minnesotans.

Brickwedde said the Minnesota DOI believes there are tremendous health and safety benefits to a mitigation program, as well as cost savings to the consumer. He said the DOI had good discussions with the insurance industry as they put together the legislation to determine how that would be done. They are now working through the first-rate filing received from the insurers they had conversations with. Brickwedde said Minnesota is the first cold-weather state to have a mitigation program. This program will have compounding effects in conjunction with

other existing state programs. The DOI has Minnesota's energy offices in its department. The Fortify project will sit next to the weatherization program in the organization chart. In severe weather, this type of program can be helpful.

Amann said other states have mitigation programs in legislation currently or that have been recently enacted. She encouraged the Working Group members and interested state insurance regulators to share what worked and did not work in the process, as there is value in states learning from each other.

Birny Birnbaum (Center for Economic Justice—CEJ) asked how the level of funding relates to the need. He asked how many years it would take to retrofit all the properties needing to be retrofitted. Commissioner Donelon said it is a long process that will take many years to retrofit all the properties needing this done. He said it would be greatly beneficial to fortify the homes of the 120,000 consumers in the residual market, as most consumers using the residual market are in underserved communities.

Commissioner Donelon said the number of consumers in the residual market had depopulated following Hurricane Katrina. However, the residual market has grown again. He said the legislature funded \$55 million to give to insurers to write business in Louisiana amid this crisis. Commissioner Donelon said he had to engage the governor and the legislative leadership to call a special session to get the program in place one month before the regulator session. This was done before the regular session because 10,000 people are hit with up to 70% rate increases each month, causing thousands of people to lose their homes.

Commissioner Fowler said it needs to get to a point where the market reacts and responds to insurance rates, making it easier to provide access and availability. He said the DOI talked to several reinsurers to see what it would take before the market reacts. They determined that once 20% of homeowners in the coastal counties are fortified, they may see some market reaction, and Alabama is close to 20% now. There are 35 counties now that are in the program. Alabama credits former Commissioner Jim Ridling for getting the program started. This is a long-term program.

Birnbaum asked how the funds could be increased to retrofit more consumers' homes. Commissioner Donelon said that following Hurricanes Katrina and Rita, the governor called a special session and did some things, including implementing an incentive program and a statewide building code for the first time. He said that the governor approved upgrading building codes to the latest codes every three years. The building code upgrade was paused during the COVID-19 pandemic for one three-year period. As of Jan. 1, the paused and scheduled upgrades were done. This upgrade requires 95% of fortified or retrofitted construction in new buildings.

Commissioner Donelon said that getting to the last 5% will cost money because fortifying is above and beyond the building code. He said Louisiana is doing both at the same time, and it would be foolish to put an expensive Fortified roof, which is more expensive than a building code roof, on brother-in-law construction, which there was a lot of along the coast when roofs were unregulated or loosely regulated for building codes. These are the properties most affected by 135 mph to 150 mph winds. Louisiana is doing everything in its power not to fortify those homes and to strengthen their markets and make them more attractive and, in the process, help the property owners in the state, primarily residential property owners. Commissioner Fowler echoed these comments.

Commissioner Fowler said he believes many other opportunities are coming through at the federal level, like the federal "green bank" opportunities. He said there are also possible state-based "green bank" opportunities. No state will be able to invest the kind of resources it would take to mitigate every single home. The grant program can create an environment where consumers see that some roofs are not damaged following a storm, which makes them question what they can do so their room is not damaged following a storm.

12. Heard a Presentation from FLASH on Resources Available to States for Mitigation Grant Programs

Leslie Chapman-Henderson (Federal Alliance for Safe Homes—FLASH), said FLASH has been around for 25 years and is very diverse. FLASH’s central theme, which has not changed in 25 years, is to strengthen homes and safeguard families from disasters. FLASH is behind many projects, including “Turn Around Don’t Drown.” FLASH focuses on finding trusted voices for audiences that need to know about disaster safety and resilience. Once FLASH finds the audience, it works to provide consumers with information using information outreach and other types of campaigns or training that meets the need of its audiences.

FLASH works with meteorologists, the weather center, and the broadcast community to shape messages that drive solutions.

FLASH’s most recent initiative is its “Disaster Smart” initiative, which began five years ago. Chapman-Henderson said it is an exciting time in resilience because there is much momentum. One of the things FLASH has recognized is that there is increased interest due to disruption in the marketplace. The disruption has likely caused an increased interest in the public about solutions for building better.

FLASH recently completed a research project this year that focused on how to take all the information that Alabama, Louisiana, and Minnesota just talked about and make the information accessible. Building code leadership is an important way to encourage retrofitting.

States like Alabama, Louisiana, and Minnesota are changing the marketplace by creating a culture of preparedness.

FLASH understands that building code leadership is not possible in every state. The dynamics, either structurally or politically, may not lend themselves to stepping forward on building codes and making them a top priority. However, in those cases, many insurance commissioners have been integral to driving positive change in building policy.

FLASH believes that stronger building codes are a way of fixing the older housing stock. Simply talking about building codes and leading and supporting public awareness campaigns helps achieve these goals. The International Code Council (ICC) sponsors Building Safety Month every May. During this time, FLASH presents information regarding the link between resiliency codes, shorter recovery times, healthier insurance markets, and available discounts for retrofitting. During Building Safety Month, building code leadership can lead and support public awareness campaigns, as well as analyze and track the local building code adoption status.

Chapman-Henderson said that the states tracking building code status and adding that to their portfolio is something FLASH has seen commissioners do. While it is not an easy process, she said it is worthwhile if there is a level of interest to adopt current model codes and keep them intact. It is also necessary for states advocating for building codes to make sure there are resources to administer a program.

Chapman-Henderson said there are a lot of new resources available. FEMA has helpful publications, including *Building Codes Save: A Nationwide Study*, *Building Codes Strategy*, and a *Building Codes Adoption Playbook*. There are more incentives for building codes at the federal level. IBHS assesses residential building codes and enforcement systems in hurricane-prone regions, and the Insurance Services Office (ISO) has a national building code report. Additionally, FLASH has a study regarding why Americans are not concerned about building codes.

It used to be harder to find information regarding building codes. FLASH has worked with its partners to create a large dataset for the building code statuses in the U.S. The website is consumer-facing and provides a simple illustration. FEMA has a building code adoption tracking portal.

FLASH had a pilot in Florida in 2005 regarding retrofitting. Originally, the conversation around retrofitting focused on new construction. Initially, FLASH could not find a workforce interested in remodeling or retrofitting. FLASH learned that nearly 50% of the housing stock is pre-1980, and currently, homeowners are not moving and are remodeling instead. In 2011, 17% of the housing inventory was from new construction. However, in 2021, only 10% of the housing inventory was from new construction. Due to these decreases, the interest in the industry providing these services is increasing. Therefore, partnerships are being formed to retrofit homes being remodeled. This provides an opportunity to inject resilience into the remodeling trend.

FLASH will be looking at how it can work with the remodeling community to ensure Fortified is part of the conversation as an optional upgrade or for every roof where the code fits. FLASH received a grant from the RWJF to work on a project that supported DOIs in states wishing to participate in retrofitting programs.

FLASH asked three research questions: 1) What resource and knowledge gaps impede widespread retrofitting program implementation?; 2) What are the benefits/barriers for DOIs to implement a retrofitting program?; and 3) Can a losses avoided model focused on mental health, injury, and death be further refined for use by stakeholders?

FLASH started out by looking at existing retrofitting programs. It looked at state and local programs, although some were not DOI programs. FLASH looked at the Texas General Land Office (GLO) mitigation program and the Sonoma County wildfire program. It used the information about the programs to try to figure out what was missing and then conducted interviews and devised a plan for solutions. FLASH looked at the budgets, staffing, timing, timelines, etc. The interviews included those who were doing the programs and who were not doing the programs.

The lack of funding models was one of the resource gaps. However, there is money available, not just at the state level. Some work is happening with Department of Housing and Urban Development (HUD) dollars, where resilience is allowed to be included. There are different time horizons when resilience can be accomplished, namely when the home is built, retrofitting during blue-sky, but also knowing what the plan is for large-scale reconstruction to a higher standard. Some of the federal dollars available require reconstruction to a higher standard.

FLASH also discussed operational and administrative barriers, such as who will do the inspections, who is the builder, etc. It also discussed knowing what employees would staff the program; i.e., customer service representatives that could answer the phone, etc. States must also be aware of model language and policies, fraud prevention, outreach, and education.

Chapman-Henderson said the benefits of a mitigation program include improved availability and affordability of insurance, overall state economic stability, improved building performance, losses being avoided or reduced, a shorter recovery period, and safer communities overall.

Chapman-Henderson said the barriers that DOIs run into when wanting to implement a retrofitting program include funding availability and sustainability, administrative complexity, workforce availability, and the fact that this is a nontraditional DOI role.

Chapman-Henderson said FLASH's research conclusion was that states needed a resource available or a hub at the NAIC where DOIs could find information that has current information on retrofitting programs. She said this information might include easy access to resources and best practices and how other states are implementing retrofitting programs. Examples like North Carolina's success in retrofitting roofs likely come from their endorsement on their wind pool policy. Other items on the hub would provide information regarding the best standard inspection form, the type of training, what type of software is used, etc.

FLASH hopes to work with the Center for Insurance Policy and Research (CIPR) to create a resilience services hub that would work to host information for DOIs. DOIs could update information for their program or take the information down. The hub will focus on how FLASH can support the natural champions of resilience and make it easier to execute a vision for retrofitting as a program if desired. If not, there can be standby plans focused on recovery.

FLASH will be publishing its findings in the form of a playbook and resource guide in September.

Amy Bach (United Policyholders—UP) said that through its partnership with the California DOI and a grant from the governor's office of emergency services, it has established a Wildfire Risk Reduction and Asset Protection (WRAP) initiative. UP has been coordinating all of the fire-safe councils' fire-wise communities across the state, as well as some of the firefighting agencies. UP's resource center, which provides information at a county level, is a template that DOIs might be able to use as a resource. The resource center provides information regarding who is offering grants in various counties. Currently, UP has only had the funding to complete 30 counties but is hoping to eventually complete the entire state.

13. Discussed Ways to Create an Efficient Process for Proof of No Insurance to FEMA for Individual Assistance

Following a storm that qualifies for federal disaster assistance, property insurers are often asked to provide information on behalf of their insureds that can be shared with the FEMA to help the insureds obtain federal loans and grants.

FEMA often will not accept applications for federal aid from impacted consumers until their insurer or the state provides evidence of coverage. The lack of a uniform process leaves consumers with little or no disaster assistance for weeks.

Steve Simpkins (State Farm Insurance) said that during catastrophes, insurers work with DOIs and FEMA to support consumers following a catastrophic event. There is a requirement in the federal aid packages that does not allow citizens to receive duplicative benefits. This sometimes slows down the process, and it tends to differ from state to state or region to region. Insurers would like a process in place so that each time there is a catastrophic event, insurers are not required to revisit how they will provide information showing proof that consumers do not have other insurance covering their items or have exhausted their insurance benefits. Simpkins suggested getting a group together to work on a way to create a process for future events, allowing consumers to receive their individual assistance in a timelier manner.

Commissioner Clark said this should be a priority because, following a catastrophic event, consumers need help. She said consumers should not be mired in bureaucracy in such devastating situations.

Horigan asked what insurers were required to give to FEMA for proof of no insurance. Simpkins said it had become a letter in a record-only process from the insurer's perspective that provides the available coverages or has been paid. He said the letter often must be reapproved. Sometimes previous letters that were used have not been accepted, and it takes time to resolve this type of issue. The information must include proof of what has been paid, proof of what has not been paid, proof of the insured exceeding their limit, and items like this.

Jabourian said California has been hearing consumers say that they are afraid to apply for individual assistance because they do not want to file a flood claim, as they know that flood is not covered. However, FEMA does not require consumers to file a claim for flood with their normal homeowners insurance policy. Consumers have some misconceptions regarding some of the requirements.

Amann said the Working Group will work with its FEMA partners and bring information back to the Working Group during the Fall National meeting.

14. Heard from the CIPR COE on its Available Programs

Jeff Czajkowski (CIPR) said the Center of Excellence (COE) is now fully staffed. He said the COE has good relationships with the catastrophe modeling industry on the property/casualty (P/C) side, as well as has some agreements in place with the eight main modelers. The COE also has relationships with the International Society of Catastrophe Managers (ISCM), which is engaging with state insurance regulators at the annual Reinsurance Association of America (RAA) Catastrophe Risk Management conference.

There are three pillars to the COE: 1) vendor models; 2) education and tools; and 3) applied research. There is work moving across all of these pillars. Work includes the Catastrophe Modeling 101 course, a memorandum of understanding with IBHS, and research collaboration with FLASH.

Jennifer Gardner (NAIC) said the catastrophe models integrate property characteristics and then measure how the losses play out based on the perils. These tools can be used to see how risk mitigation factors can reduce losses over time, which is how insurers are pricing mitigation discounts. The COE is trying to identify the tools that insurers use to manage the risk and how regulators can use these tools to help improve their markets.

There is a regulator-only SharePoint site that provides model documentation from seven vendors, as well as the IBHS member-only research. The COE has participated in both the Southeast and Northeast Zone meetings. Before these meetings, the COE surveyed the states about their regulatory and legislative oversight of catastrophe models. The survey intended to develop and share information among the states about catastrophe models. The survey asked questions about where models have been approved, which models have been improved, and the common practices regarding reviewing the models in rate filings. The surveys are being conducted and shared by the zone.

The COE is developing a property and vendor model insights document that will provide information on catastrophe losses and relevant reports coming from the catastrophe modeling vendors. State insurance regulators interested in receiving information regarding catastrophe losses and product development should sign up for the SharePoint site.

The COE is developing education and training events. These events have been conducted for Colorado, Massachusetts, New York, and Puerto Rico. The Cat Modeling 101 course is being rolled out virtually for all insurance regulators. This course will be launched on Oct. 1 for all regulators.

The COE has an ongoing relationship with the ISCM. The ISCM offers training produced by the insurance industry for the insurance industry and is not geared specifically to state insurance regulators. Therefore, the COE decided to provide its own program. However, the COE provides access to the ISCM if any state insurance regulators are interested in learning more about what they produce.

The COE will conduct four sessions at the upcoming Insurance Summit. One of these sessions will focus on state insurance regulator financial oversight training related to catastrophe modeling. This is provided in conjunction with the referrals from the Climate and Resiliency (EX) Task Force to integrate more climate-specific data into the financial analysis tools. There will also be three sessions at the Insurance Summit focusing on research and current market trends. These sessions include: 1) an update on the reinsurance market; 2) a panel discussion on wildfire based on the wildfire risk assessments the COE has done; and 3) ways to reduce the risk of property loss due to fire propagation. Much of this information is obtained from the research conducted by IBHS in conjunction with

its Wildfire Prepared Home and Community programs. Finally, there will be a session at the Insurance Summit regarding research on the impact of roof age on claims and loss exposure over time.

The COE has been working with the Society of Actuaries (SOA) on a report focusing on how insurers are identifying their risk and using catastrophe models to assess and manage this risk. This report should be ready to be released in the next month or so.

15. Heard a Recap of the FEMA Region 1 Event Held in Maynard, MA

Amann said FEMA Region 1 met in Maynard, MA, on May 21–22. During the meeting, the group heard from several FEMA employees regarding items like:

- Historical disaster and emergency declarations for Region 1 and the surrounding regions.
- Response planning for flood risk in New England.
- The National Oceanic and Atmospheric Administration’s (NOAA’s) climate services.
- Tropical cyclone forecasting and threats in New England.
- FEMA’s disaster operations.
- FEMA’ public assistance and individual assistance.
- FEMA’s outreach and communication program.

Amann said the takeaways included:

- The improvement needed in consumer education.
- The need to continue working with FEMA on messaging.
- The need to strengthen relationships with agents through education.
- Interest from FEMA Region 1 members in discussing adjuster access to disasters.

Having no further business, the joint meeting of the Catastrophe Insurance (C) Working Group and the NAIC/FEMA (C) Advisory Group adjourned.

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CASUALTY ACTUARIAL AND STATISTICAL (C) TASK FORCE

Casualty Actuarial and Statistical (C) Task Force Aug. 12, 2023, Minutes..... 7-87
 Casualty Actuarial and Statistical (C) Task Force June 13, 2023, Minutes (Attachment One) 7-91
 Casualty Actuarial and Statistical (C) Task Force May 2, 2023, Minutes (Attachment Two)..... 7-95
 Property/Casualty (P/C) Industry Director and Officer (D&O) and Cyber Data from Irwin Goldfarb,
 May 2, 2023 (Attachment Two-A)..... 7-98
 Center for Insurance Policy and Research (CIPR) Catastrophe Modeling Center of Excellence (COE),
 May 2, 2023 (Attachment Two-B) 7-99
 Actuarial Opinion (C) Working Group Aug. 2, 2023, Minutes (Attachment Three)..... 7-104
 Actuarial Opinion (C) Working Group July 12, 2023, Minutes (Attachment Four) 7-106
 Referral Response to the Financial Analysis (E) Working Group (Attachment Four-A) 7-107
 Actuarial Opinion (C) Working Group May 25, 2023, Minutes (Attachment Five)..... 7-109
 Statistical Data (C) Working Group July 19, 2023, Minutes (Attachment Six) 7-110
 Comments on the Proposed Enterprise Risk Management (ERM) Actuarial Standard of Practice
 (ASOP) (Attachment Seven) 7-111
 American Academy of Actuaries (Academy) Presentation on Methods to Identify and/or Mitigate Bias in
 Property and Casualty Insurance (Attachment Eight) 7-113
 Society of Actuaries (SOA) Presentation on the Evolution of the Fellow of the Society of Actuaries
 (FSA) Pathway (Attachment Nine) 7-121

Draft: 8/25/23

Casualty Actuarial and Statistical (C) Task Force
Seattle, Washington
August 12, 2023

The Casualty Actuarial and Statistical (C) Task Force met in Seattle, WA, Aug. 12, 2023. The following Task Force members participated: D.J. Bettencourt, Chair, represented by Christian Citarella (NH); Chlora Lindley-Myers, Vice Chair, represented by Jo LeDuc (MO); Lori K. Wing-Heier represented by Sian Ng-Ashcraft (AK); Mark Fowler represented by Sanjeev Chaudhuri (AL); Ricardo Lara represented by Ken Allen and Lynne Wehmuller (CA); Andrew N. Mais represented by Wanchin Chou and Qing He (CT); Doug Ommen represented by Travis Grassel (IA); Dana Popish Severinghaus represented by Julie Rachford (IL); Vicki Schmidt represented by Nicole Boyd (KS); James J. Donelon represented by Nichole Torblaa (LA); Kathleen A. Birrane represented by Ron Coleman (MD); Timothy N. Schott represented by Sandra Darby (ME); Anita G. Fox represented by Kevin Dyke (MI); Grace Arnold represented by Phil Vigliaturo (MN); Mike Causey represented by Richard Kohen (NC); Eric Dunning represented by Michael Muldoon (NE); Judith L. French represented by Tom Botsko (OH); Glen Mulready represented by Andrew Schallhorn (OK); Andrew R. Stolfi represented by Raven Collins (OR); Michael Humphreys represented by Shannen Logue (PA); Michael Wise represented by Will Davis (SC); Cassie Brown represented by Miriam Fisk (TX); Kevin Gaffney (VT); Mike Kreidler represented by Eric Slavich (WA); and Allan L. McVey represented by Tom Whitener (WV).

1. Adopted its June 13, May 2, and Spring National Meeting Minutes

The Task Force met June 13 and May 2 to discuss the monitoring of other NAIC committee groups, the review of future actuarial papers, the loss cost multiplier (LCM) form implementation, the Director and Officer (D&O) Insurance Coverage Supplement, and the Cyber Insurance Supplement.

Chou made a motion, seconded by Dyke, to adopt the Task Force's June 13 (Attachment One), May 2 (Attachment Two), and March 7 (*see NAIC Proceedings – Spring 2023, Casualty Actuarial and Statistical (C) Task Force*) minutes. The motion passed unanimously.

2. Adopted the Report of the Actuarial Opinion (C) Working Group

Fisk said the Actuarial Opinion (C) Working Group met three times since its last report to the Task Force on June 13. The Working Group met June 14 in regulator-to-regulator session, pursuant to paragraph 3 (specific companies, entities or individuals) of the NAIC Policy Statement on Open Meetings, to discuss the 2022 Statement of Actuarial Opinion (SAO). No serious issues or trends were identified during that meeting.

The Working Group met July 12 to adopt its response to the Financial Analysis (E) Working Group's referral on predictive analytics in reserving, which had been exposed for a public comment period through June 26. The Actuarial Opinion (C) Working Group voted unanimously to adopt the response. The Working Group also began discussing potential changes to the *Regulatory Guidance on Property and Casualty Statutory Statements of Actuarial Opinion, Actuarial Opinion Summaries, and Actuarial Reports for the Year 2023* (2023 Regulatory Guidance) and the 2024 Opinion instructions during the July 12 meeting.

The Working Group also met Aug. 2 to continue the discussion of the 2023 Regulatory Guidance and 2024 Opinion instructions. A draft of the 2023 Regulatory Guidance document is exposed for public comment through Sept. 1. The draft includes changes to better reflect the instruction's language about what to do when a material error is found and to remove the section on guidance related to COVID-19. The most significant change discussed by the Working Group for the 2024 Property/Casualty (P/C) Opinion instructions would be to modify the requirement for

qualification documentation to be provided by appointed actuaries only upon initial appointment and eliminate the requirement to provide qualification documentation annually thereafter.

Fisk made a motion, seconded by Muldoon, to adopt the report of the Actuarial Opinion (C) Working Group, including its Aug. 2 (Attachment Three); July 12 (Attachment Four); and May 25 (Attachment Five) minutes, which adopted a Financial Analysis (E) Working Group referral on predictive analytics in reserving (Attachment Four-A), discussed actuarial opinion instructions, and exposed the 2023 Regulatory Guidance for a 30-day public comment period ending Sept. 1. The motion passed unanimously.

3. Adopted the Report of the Statistical Data (C) Working Group

Darby said the Statistical Data (C) Working Group has not met in open session since the Spring National Meeting.

The Working Group approved the adoption of the 2021 *Auto Insurance Database Report* (Auto Report) Average Premium Supplement, which is now at the Task Force for review and adoption. Darby mentioned that the Working Group will conduct an e-vote shortly after the Summer National Meeting to consider adoption of the 2021 *Dwelling, Fire, Homeowners Owner-Occupied, and Homeowners Tenant and Condominium/Cooperative Unit Owner's Insurance Report* (Homeowners Report). Darby mentioned that data requests for 2022 data for both reports will be sent at the end of August.

Darby said that the full 2020/2021 Auto Report, as well as the *Report on Profitability by Line by State* (Profitability Report) and *Competition Database Report* (Competition Report), will be sent to the Working Group for review, and they are on track to be adopted and released by December.

Darby made a motion, seconded by Chou, to adopt the report of the Statistical Data (C) Working Group, including its July e-vote adopting the 2021 Auto Insurance Database Report Average Premium Supplement (Attachment Six). The motion passed unanimously.

4. Considered Comments on the Proposed ERM ASOP

The Actuarial Standards Board (ASB) of the American Academy of Actuaries (Academy) approved an exposure draft of a new Actuarial Standard of Practice (ASOP) on enterprise risk management (ERM) in the spring of 2023. Regulators met informally on June 22 for an optional, regulator-to-regulator call regarding this proposed ASOP, and it determined that it would be reasonable to consider submitting written comments to the ASB. Julie Lederer (MO) drafted comments after the call for submission to the Task Force. The Task Force chair exposed the comments July 3, with feedback due July 21. No feedback was received by the Task Force via written or oral comment.

Chou made a motion, seconded by Botsko, to submit the comments on the proposed ERM ASOP (Attachment Seven). The motion passed unanimously.

5. Discussed its Work Plan Regarding the D&O and Cyber Supplements

Citarella said there appeared to be consensus in prior Task Force meetings for the transition of the Director and Officer (D&O) supplement from calendar year to accident year reporting, and he asked if anyone is willing to take leadership regarding a formal presentation to the Blanks (E) Working Group. No members came forward to volunteer. Citarella said the item can be revisited in a future meeting.

Citarella mentioned that there is an ad hoc group working with the Working Group on a proposal for changes to the Cyber Liability Supplement. The ad hoc group, led by Sara Robben (NAIC), includes some members of the Task

Force, other state insurance regulators, and interested parties. A small group of Task Force members met recently to discuss this proposal. That conversation centered on what types of information state insurance regulators want and/or need in the supplement. Citarella said these conversations will continue as the Task Force considers the ad hoc group's goal for exposure in October. He reiterated that the individual regulators are not acting on behalf of the Task Force; rather they are interested regulators acting on their states' behalf. He mentioned that members interested in joining these discussions should contact Robben, Michael McKenney (PA), Chou, or himself.

Citarella mentioned that the changes to the Cyber Liability Supplement proposal do not address the issues raised by Irwin Goldfarb (American International Group [AIG]–Retired) during the Task Force's May meeting. During that meeting, Goldfarb suggested that cyber be pulled out of the Other Liability line (and any other lines) in Schedule P of the annual statement. Alternatively, short of inclusion as a separate line in Schedule P, he proposed that the Cyber Supplement be reported on an accident-year basis, similar to his D&O Supplement proposal.

Citarella asked if any Task Force members had thoughts on how to move these proposals forward. No comments were received. Citarella mentioned that this item will be revisited in the future.

6. Received a Report on the Capital Adequacy (E) Task Force's Risk Evaluation Ad Hoc Group

Botsko gave an update on the Capital Adequacy (E) Task Force's Risk Evaluation Ad Hoc Group. He mentioned that the Ad Hoc Group is designed to evaluate risk-based capital (RBC), both from a holistic view, as well as considering any other factors that should be added or removed. He mentioned that three subgroups were created: 1) Geographic Concentration, which serves to identify localized companies; 2) Guidelines & Education, which serves to re-educate about the purpose of RBC and identify minimalized capital for companies; and 3) Asset Concentration, which serves to evaluate the need to have asset concentration factors.

Botsko asked if any members were interested in joining. No members came forward to volunteer.

7. Heard a Presentation from the Academy on its Approaches to Identify and/or Mitigate Bias in Property and Casualty Insurance White Paper

Mike Woods (Academy) gave a presentation titled "Methods to Identify and/or Mitigate Bias." Initially, ASOPs and definitions of unfair discrimination and disproportionate outcomes were discussed (Attachment Eight). Woods then outlined principles for approaches to identify and address unfair discrimination, and he discussed data collection, classification, and other considerations. Afterward, he listed and discussed methods for identifying, preventing, and addressing potential bias.

There were several questions posed. Citarella asked Woods to walk through how different methods would adjust rates given the following scenario: The industry has long known that people who drive 4-door cars have fewer and less expensive losses than those who drive 2-door cars. In one company's book of business, only People of Color drive 2-door cars. This would then show that in the end result, People of Color have higher rates than white policyholders for this company, even though industry-wide it has been proven to have nothing to do with race. Which methods would accept that differential as an acceptable rating and which would adjust rates so there is no difference in rates between 4-door and 2-door cars for this one company? Is there a different result if the People of Color group drive the 4-door cars and others drive the 2-door cars in this company?

Woods went through the six methods given for identifying bias and described whether each one would accept the rate differential as follows:

- Disproportionate Impact Analysis: The company would fail (i.e., Method indicates that rates need to be adjusted) since the method does not consider whether the losses are in proportion to the premiums.

- Fairness Metrics: The company would pass (i.e., Method indicates that rates don't need to be adjusted) since predicted losses are equal to actual losses.
- Insurance Data Disclosure: The public will see that protected classes are being charged higher premiums.
- Loss Ratio Test: The company would pass since the method looks at whether premiums are being charged in relation to expected losses.
- Proxy Test: The company would fail because the door variable is a proxy for protected class.
- Rational Explanation: Company would pass because 4-door cars have lower expected losses.

For the second question, Woods mentioned that the results would be similar but whoever is administering the test needs to determine whether it is appropriate for a protected class to receive a lower premium.

He then reiterated the importance of looking at different methods. There was also a discussion regarding the collection of protected class data by insurance companies and the effectiveness of the methods proposed for the purposes of identifying bias. The predictive power of protected characteristics for rating purposes and their potential use was also discussed by multiple parties.

8. Heard Reports from Professional Actuarial Organizations

The Academy, the Actuarial Board for Counseling and Discipline (ABCD), the ASB, the Casualty Actuarial Society (CAS), and the Society of Actuaries (SOA) provided reports on current activities and research.

9. Heard a Report from the SOA on Exam Changes

Stuart Klugman (SOA) gave a presentation titled "The Evolution of the FSA Pathway" (Attachment Nine). He mentioned that a current exam pathway challenge is that in-depth U.S. and Canadian regulatory material lacks relevance to global markets. To address this challenge, he mentioned that the SOA proposes to move detailed regulatory material outside of fellowship requirements and offer stand-alone, optional regulatory certificates. He further mentioned that the SOA is in contact with regulatory bodies to ensure that new fellows who complete the necessary certificates are qualified to sign SAOs in the U.S. No time was available for discussion.

Having no further business, the Casualty Actuarial and Statistical (C) Task Force adjourned.

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Draft: 6/28/23

Casualty Actuarial and Statistical (C) Task Force
Virtual Meeting
June 13, 2023

The Casualty Actuarial and Statistical (C) Task Force met June 13, 2023. The following Task Force members participated: Chris Nicolopoulos, Chair, represented by Christian Citarella (NH); Chlora Lindley-Myers, Vice Chair, represented by Julie Lederer (MO); Lori K. Wing-Heier represented by Sian Ng-Ashcraft (AK); Mark Fowler represented by Charles Hale (AL); Ricardo Lara represented by Mitra Sanandajifar (CA); Andrew N. Mais represented by Wanchin Chou (CT); Karima M. Woods represented by David Christhilf (DC); Michael Yaworsky represented by Greg Jaynes (FL); Doug Ommen represented by Travis Grassel (IA); Amy L. Beard represented by Larry Steinert (IN); Vicki Schmidt represented by Craig VanAalst (KS); James J. Donelon represented by Nichole Torblaa (LA); Kathleen A. Birrane represented by Ron Coleman and Walter Dabrowski (MD); Timothy N. Schott represented by Sandra Darby (ME); Anita G. Fox represented by Kevin Dyke (MI); Grace Arnold represented by Phil Vigliaturo (MN); Troy Downing represented by Mari Kindberg (MT); Eric Dunning represented by Michael Muldoon (NE); Alice Kane represented by Anna Krylova (NM); Scott Kipper represented by Gennady Stolyarov (NV); Judith L. French represented by Maureen Motter (OH); Glen Mulready represented by Cuc Nguyen (OK); Andrew R. Stolfi represented by Ying Liu (OR); Michael Humphreys represented by Michael McKenney (PA); Cassie Brown represented by Miriam Fisk (TX); Kevin Gaffney represented by Rosemary Raszka (VT); Mike Kreidler represented by Eric Slavich (WA); and Allan L. McVey (WV).

1. Adopted the Report of the Actuarial Opinion (C) Working Group

Fisk said the Actuarial Opinion (C) Working Group met May 25 to expose a draft response to the referral from the Financial Analysis (E) Working Group asking for discussion of the use of predictive analytics in reserving and consideration of drafting guidance for a 30-day public comment period ending June 26. The Actuarial Opinion (C) Working Group will meet June 14 in regulator-to-regulator session, pursuant to paragraph 3 (specific companies, entities, or individuals) of the NAIC Policy Statement on Open Meetings, to discuss individual companies' Statements of Actuarial Opinion (SAOs).

The Working Group will also meet July 12 to discuss potential changes to the *Regulatory Guidance on Property and Casualty Statutory Statements of Actuarial Opinion, Actuarial Opinion Summaries, and Actuarial Reports for the Year 2023* (2023 Regulatory Guidance) and 2024 opinion instructions.

Fisk made a motion, seconded by Darby, to adopt the oral report of the Actuarial Opinion (C) Working Group. The motion passed unanimously.

2. Adopted the Report of the Statistical Data (C) Working Group

The Statistical Data (C) Working Group reviewed data for the 2021 *Dwelling, Fire, Homeowners Owner-Occupied, and Homeowners Tenant and Condominium/Cooperative Unit Owner's Insurance Report* (Homeowners Report) and the 2021 Auto Insurance Average Premium Supplement. NAIC staff are compiling the reports for Working Group review and consideration of adoption.

The Working Group met May 25 in regulator-to-regulator session to discuss the Tableau dashboard created by NAIC staff using the *Report on Profitability by Line by State* (Profitability Report) data. NAIC staff are making suggested changes, and they will update the dashboard on StateNet soon. The Working Group will continue to meet in regulator-to-regulator session to review the development of auto and homeowners Tableau dashboards.

Darby made a motion, seconded by Dyke, to adopt the report of the Statistical Data (C) Working Group. The motion passed unanimously.

3. Discussed the D&O Insurance Coverage Supplement and the Cyber Insurance Supplement

Citarella said Irwin Goldfarb (American International Group [AIG]—Retired) presented at the Task Force’s May 2 meeting, proposing to improve the Director and Officer (D&O) Insurance Coverage Supplement and the Cyber Insurance Supplement to make the data more meaningful and appropriate for users. For the D&O Insurance Coverage Supplement, Goldfarb proposed that the data be changed from calendar to accident year. He proposed that Cyber become its own line in Schedule P; if that cannot be accomplished, the data should be changed from calendar to accident year in the Cyber Insurance Supplement.

The Task Force decided to continue to study the ideas. Citarella said he wants to know whether there are other supplements that require accident year reporting. The Task Force discussed a Cyber Insurance Supplement blanks proposal that is deferred at the Blanks (E) Working Group. Sara Robben (NAIC) said companies can write first-party and third-party cybersecurity insurance on one policy. Since there is not an option for reporting both first-party and third-party information on the Cyber Insurance Supplement, insurers must choose one. This means the numbers reported do not always truly reflect first-party and third-party information.

Tip Tipton (Thrivent) said state insurance regulators and interested parties are discussing the blanks proposal to find a solution that works for all. Rachel Underwood (Cincinnati Insurance Companies) said cyber can be reported in the annual statement on Annual Statement Line (ASL) 17 (Other Liability), but it can also be reported in other lines. She said commercial first party is usually reported on ASL 17, but endorsements are often reported in other lines, and theft is often reported on the theft line.

4. Discussed the Monitoring of Other NAIC Committee Groups

Citarella asked for volunteers to help monitor other NAIC committee groups that have some connection to the Task Force. He said in the normal course of work, the requirement would be to identify any issue that might be of interest to the Task Force and notify Citarella, Lederer, and Kris DeFrain (NAIC). The next step would be for someone to present the issues of interest about the other group’s project to the Task Force. The Task Force would then decide whether to get involved. He said on rare occasions, the volunteer may be asked to speak on behalf of the Task Force to the other group.

The following are the volunteers for each committee group:

EXECUTIVE (EX) COMMITTEE

- Special (EX) Committee on Race and Insurance—Phil Vigliaturo (MN)
- Climate and Resiliency (EX) Task Force—George Bradner (CT)

PROPERTY AND CASUALTY INSURANCE (C) COMMITTEE

- Catastrophe Insurance (C) Working Group—Wanchin Chou (CT)
- Workers’ Compensation (C) Task Force—Michael McKenney (PA), primary, and Sandra Darby (ME), alternate
- Title Insurance (C) Task Force—Anna Krylova (NM)

MARKET REGULATION AND CONSUMER AFFAIRS (D) COMMITTEE

- Speed to Market (D) Working Group—Tom Botsko (OH) in consultation with Maureen Motter (OH)

SERFF

- System for Electronic Rates & Forms Filing (SERFF) Product Steering Committee's (PSC's) SERFF Modernization Project—Sandra Darby (ME)

FINANCIAL CONDITION (E) COMMITTEE

- Capital Adequacy (E) Task Force and Property and Casualty Risk-Based Capital (E) Working Group—Tom Botsko (OH)
- Catastrophe Risk (E) Subgroup—Wanchin Chou (CT)
- Blanks (E) Working Group—Michael McKenney (PA)
- Statutory Accounting Principles (E) Working Group—OPEN

INNOVATION, CYBERSECURITY, AND TECHNOLOGY (H) COMMITTEE

- Innovation, Cybersecurity, and Technology (H) Committee; Algorithmic Bias Coordination Forum; and Big Data and Artificial Intelligence (H) Working Group—Christian Citarella (NH)
- Cybersecurity (H) Working Group—Cynthia Amann (MO)

Citarella said Tom Botsko (OH) provided a written report saying there is a new ad hoc group under the Capital Adequacy (E) Task Force that will be evaluating the risk-based capital (RBC) formula holistically, as well as specific factors that should be reviewed. Additionally, it will be evaluating whether factors ought to be added/deleted and whether there should be an adjustment to covariance in the RBC formula.

Citarella said he might add the Transparency and Readability of Consumer Information (C) Working Group to the list in the future.

Birny Birnbaum (Center for Economic Justice—CEJ) said the Working Group adopted a rate filing checklist, but it is not a filing checklist per se; it is a list of information needed by the state insurance regulators working in consumer service. The purpose was limited to providing the information state insurance regulators need to respond to consumer questions.

Citarella will contact Joy Hatchette (MD) to discuss future communication.

5. Discussed Reviews of Future Actuarial Papers

Lederer said state insurance regulators are invited to join ad hoc discussions about new American Academy of Actuaries (Academy), Actuarial Standards Board (ASB), or other professional actuarial papers. She said if those discussions uncover any regulatory concerns, then the Task Force will be informed and can discuss whether to submit comments to the actuarial organization and what those comments should be.

Lederer said there is a new exposure draft of an Actuarial Standard of Practice (ASOP) on enterprise risk management (ERM). She said the proposal is that the new ASOP would replace existing ASOPs 46 and 47 on ERM, and it would be made consistent with the new ASOP on capital adequacy standards. She said comments are due Sept. 15.

The ad hoc regulatory group will meet June 22 to discuss the new ERM ASOP and any regulatory implications. Please request a meeting invitation from DeFrain if you are interested.

6. Discussed LCM Form Implementation

Ng-Ashcraft said Alaska is implementing the new form to replace its old forms. McKenney said Pennsylvania notified insurers, allowing the new form to be used as an option.

Having no further business, the Casualty Actuarial and Statistical (C) Task Force adjourned.

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Draft: 6/6/23

Casualty Actuarial and Statistical (C) Task Force
Virtual Meeting
May 2, 2023

The Casualty Actuarial and Statistical (C) Task Force met May 2, 2023. The following Task Force members participated: Chris Nicolopoulos, Chair, represented by Christian Citarella (NH); Chlora Lindley-Myers, Vice Chair, represented by Julie Lederer (MO); Lori K. Wing-Heier represented by Sian Ng-Ashcraft (AK); Mark Fowler represented by Charles Hale (AL); Ricardo Lara represented by Mitra Sanandajifar and Lynne Wehmuller (CA); Andrew N. Mais represented by Wanchin Chou (CT); Michael Yaworsky represented by Greg Jaynes (FL); Dana Popish Severinghaus represented by Anthony Bredel and Judy Mottar (IL); Doug Ommen represented by Travis Grassel (IA); Vicki Schmidt represented by Nicole Boyd (KS); James J. Donelon represented by John Sobhanian (LA); Kathleen A. Birrane represented by Ron Coleman and Walter Dabrowski (MD); Timothy N. Schott represented by Sandra Darby (ME); Grace Arnold represented by Phil Vigliaturo (MN); Troy Downing represented by Mari Kindberg (MT); Mike Causey represented by Richard Cohen (NC); Jennifer Catechis represented by Anna Krylova (NM); Scott Kipper represented by Gennady Stolyarov (NV); Glen Mulready represented by Andrew Schallhorn (OK); Michael Humphreys represented by Michael McKenney (PA); Michael Wise represented by Will Davis (SC); Cassie Brown represented by J'ne Byckovski and Miriam Fisk (TX); Kevin Gaffney represented by Rosemary Raszka (VT); and Allan L. McVey represented by Juanita Wimmer (WV).

7. Adopted the Report of the Actuarial Opinion (C) Working Group

Fisk said the Actuarial Opinion (C) Working Group will meet to discuss the *Regulatory Guidance on Property and Casualty Statutory Statements of Actuarial Opinion, Actuarial Opinion Summaries, and Actuarial Reports for the Year 2023* (2023 Regulatory Guidance) and a draft response to the referral from the Financial Analysis (E) Working Group on the use of predictive analytics in reserving. The Actuarial Opinion (C) Working Group will hold a regulator-to-regulator meeting, pursuant to paragraph 3 (specific companies, entities or individuals) of the NAIC Policy Statement on Open Meetings, to discuss individual companies' statements of actuarial opinion.

Fisk made a motion, seconded by Darby, to adopt the report of the Actuarial Opinion (C) Working Group. The motion passed unanimously.

8. Adopted the Report of the Statistical Data (C) Working Group

The Working Group is reviewing data for the 2021 *Dwelling, Fire, Homeowners Owner-Occupied, and Homeowners Tenant and Condominium/Cooperative Unit Owner's Insurance Report* (Homeowners Report) and the 2021 Auto Insurance Average Premium Supplement. NAIC staff requested data from statistical agents for the 2020/2021 *Auto Insurance Database Report* (Auto Report), which is scheduled to be released in December 2023.

The Working Group continues to consider Arthur Schwartz's (LA) proposed changes to statistical reports. These will be discussed during an open meeting at the beginning of June.

The Working Group plans to meet in regulator-to-regulator session at the end of May to discuss the Tableau dashboard created by NAIC staff using the *Report on Profitability by Line by State* (Profitability Report) data. NAIC staff are also creating similar dashboards for the Auto Report and Homeowners Report. The dashboards are available on StateNet, labeled "Stat Data Reports" under the Property and Casualty Insurance heading.

Darby made a motion, seconded by Schallhorn, to adopt the report of the Statistical Data (C) Working Group. The motion passed unanimously.

9. Heard a Report on the D&O Insurance Coverage Supplement and the Cyber Insurance Supplement

Irwin Goldfarb (AIG-Retired) presented a proposal to improve the Director and Officer (D&O) Insurance Coverage Supplement and the Cyber Insurance Supplement and make the data more meaningful and appropriate for users. He said the quarterly D&O supplement is the only source of industry D&O data. The issue is that the data is by calendar year, yet this is a longer-tailed line. While the line is claims made, a calendar year loss ratio on a long-tail line can be slightly or significantly misleading. Goldfarb explained an exhibit (Attachment Two-A) showing the loss plus defense and cost containment (DCC) expense ratios. He said the by-year ratios show some volatility, but when compared, that volatility is a lot lower than volatility reported by companies for their public D&O business, where public D&O is a substantial part, 60–70%, of all D&O.

Within D&O, the largest drivers of losses in the public space have been securities class action lawsuits. An example of improper data use occurred when one publication compared the table of loss ratios to security class action cases to determine if the lawsuits were affecting losses. The problem with that is they were using calendar year loss ratios, so the impact of those lawsuits will lag and show up in later calendar years.

Goldfarb said naïve companies sometimes use the supplement's information to decide to enter the market. This can easily influence companies down the wrong path. Larger carriers have their own data, so they are likely not affected by the reporting of calendar year losses. Goldfarb said the supplement should show accident year losses.

Goldfarb said D&O may not be large enough in some companies to warrant its own actuarial analysis. Those companies may be using allocation methods, perhaps using professional liability, to allocate a portion of the incurred but not reported (IBNR) data to create the D&O supplement.

Answers to Task Force member questions included responses that Goldfarb believes: 1) insurers would be supportive of the change, and the report card would be more valid; 2) insurers' systems should already be in place to perform these calculations; 3) some companies may need allocations of IBNR data, but they are probably already doing that; 4) if someone has a small book of business, accident year data can still be volatile; and 5) if the market for the line of business is small, it might be easier to determine the experience for each company, but that is the same for Schedule P today.

Next, Goldfarb discussed the Cyber supplement. He said the cyber line of business has increased from \$2.7 billion to \$7.3 billion, and significant rate increases are being filed. With this growth and the shorter tail of cyber insurance compared to the other lines in the Other Liability Claims Made (OLCM) line of business, the OLCM Schedule P data is becoming less useful. Goldfarb recommended that Schedule P be modified so cyber is its own line of business. If that cannot be accomplished, he suggested that the Cyber supplement be changed to an accident-year basis. He said there would be added value because the supplement data can be used to take cybersecurity out of the OLCM Schedule P data before conducting reserve analyses. He said the remainder of OLCM is more homogeneous with longer tails compared to the shorter tail for cyber.

10. Heard a Report About the COE and NAIC Catastrophe Activities

Jeff Czajkowski (NAIC), Jennifer Gardner (NAIC), and Shaveta Gupta (NAIC) presented about the current activities at the Center for Insurance Policy and Research's (CIPR's) Center of Excellence (COE) regarding catastrophes (Attachment Two-B). Citarella asked them to update the Task Force on progress in the fall.

11. Discussed the Monitoring of Other NAIC Committee Groups

Citarella asked Task Force members who are active in other NAIC groups to volunteer to keep the Task Force updated on relevant issues and activities.

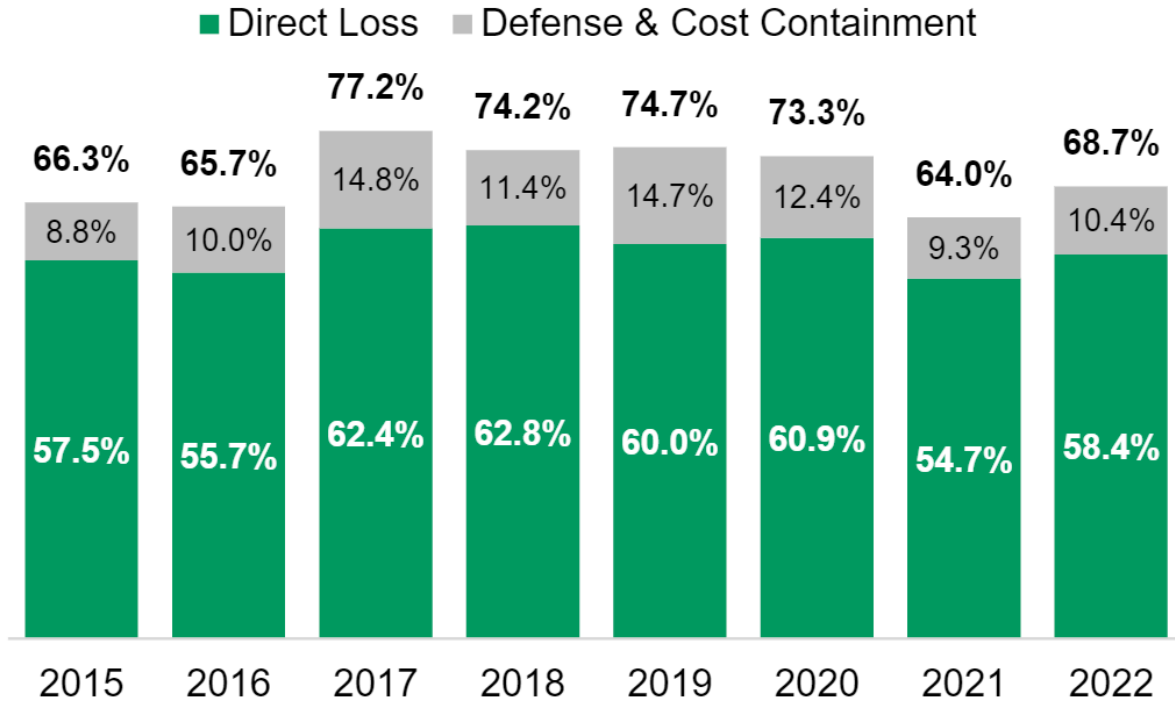
12. Discussed Reviews of Future Actuarial Papers

Lederer said state insurance regulators are invited to join discussions about new American Academy of Actuaries (Academy), Actuarial Standards Board (ASB), or other professional actuarial papers. She said if those discussions uncover any regulatory concerns, then the Task Force will be informed and can discuss whether to submit comments to the actuarial organization and what those comments should be.

Having no further business, the Casualty Actuarial and Statistical (C) Task Force adjourned.

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P/C Industry Monoline D&O Direct Loss & DCC Ratios



Source: Statutory Filings D&O Supplement

	Marsh		AON		AMWINS	EPLI	
	U.S. FinPro	Global FinPro	Primary Public D&O (Like For Like)	Public D&O Price per Million	Financial Services	D&O	EPLI
Q1-18	0.0%	1.8%	1.5%	1.6%	2.7%	1.0%	1.7%
Q2-18	0.9%	3.3%	2.6%	-1.5%	3.0%	1.3%	1.9%
Q3-18	1.1%	3.3%	3.2%	3.1%	1.8%	1.3%	1.4%
Q4-18	1.5%	4.7%	3.6%	8.6%	2.8%	1.5%	1.8%
Q1-19	2.8%	5.6%	4.6%	9.4%	3.4%	3.2%	2.6%
Q2-19	7.0%	9.7%	6.8%	9.1%	5.2%	4.3%	3.2%
Q3-19	11.2%	14.2%	12.1%	22.6%	6.7%	5.0%	3.2%
Q4-19	15.2%	17.8%	14.8%	44.2%	7.2%	7.0%	4.6%
Q1-20	23.0%	26.0%	26.2%	82.9%	7.2%	8.9%	5.5%
Q2-20	30.0%	37.0%	23.4%	61.2%	10.8%	16.8%	9.4%
Q3-20	28.0%	40.0%	22.2%	40.0%	12.8%	16.1%	10.1%
Q4-20	28.0%	47.0%	22.5%	37.4%	13.4%	14.7%	9.7%
Q1-21	25.0%	40.0%	18.2%	15.1%	14.5%	15.1%	10.8%
Q2-21	25.0%	34.0%	14.2%	9.0%	17.0%	13.4%	8.9%
Q3-21	27.0%	32.0%	7.3%	2.6%	21.1%	13.6%	10.3%
Q4-21	34.0%	31.0%	3.7%	-1.1%	22.0%	13.0%	10.8%
Q1-22	28.0%	26.0%	2.1%	-2.9%	22.8%	7.8%	5.8%
Q2-22	21.0%	16.0%	-0.5%	-6.5%	16.9%	7.9%	5.3%
Q3-22*	-6.0%	-1.0%	-4.0%	-15.3%	13.0%	7.3%	7.1%
Q4-22*	-10.0%	-6.0%	-5.1%	-17.6%	8.2%	4.4%	4.2%

Source: Amwins, Aon, CIAA, Marsh, D&P Analysis: *Cyber broken out from FinPro for MMC beginning in Q3-22 = Prior No Longer "Apples-To-Apples"



CENTER FOR INSURANCE POLICY AND RESEARCH

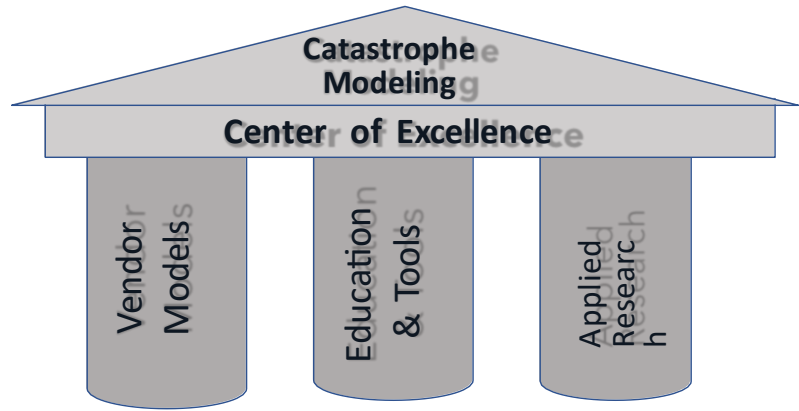
Key Points:

- CAT Model Center of Excellence (COE) fully operational and staffed with CAT risk modeling and resilience subject matter experts
 - *Broader and different mandate than the NAIC model rate review team*
- Integrated and aligned well with the CAT modeling community
- Regulator oriented tools, training, and research are all well underway
- Engaged with individual state departments and NAIC committees



MISSION STATEMENT

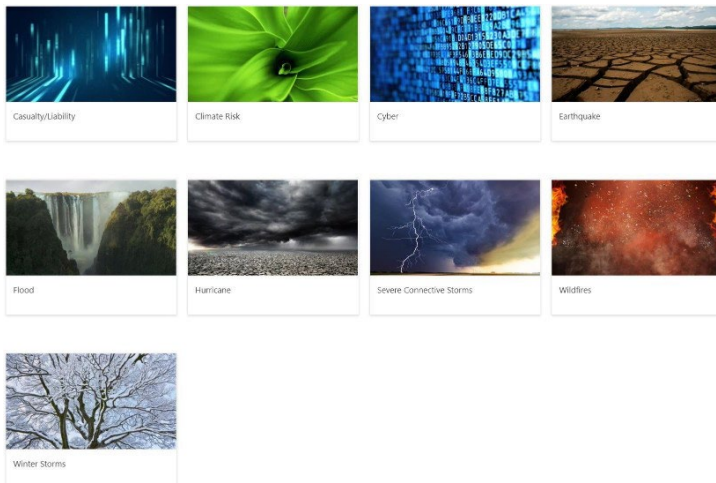
The purpose of the NAIC Catastrophe Modeling Center of Excellence (COE) is to **provide state insurance regulators with the necessary technical expertise, tools, and information to effectively regulate their markets.**



3



Regulator Access to Catastrophe Modeling Information – CAT COE SharePoint



- Access is restricted through a permissioned site and all regulators who wish to obtain access must sign a data use agreement.

SharePoint Access Statistics

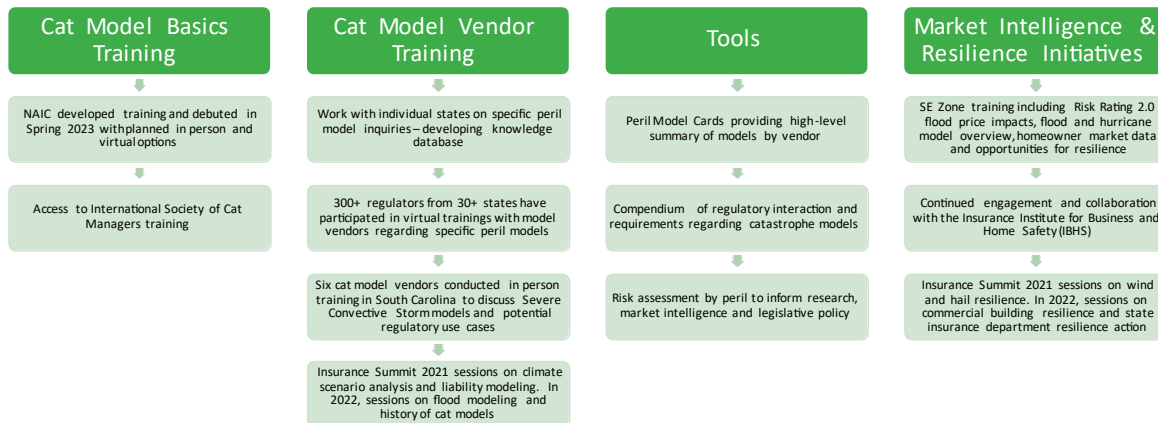
- Signed contracts with 7 catastrophe model vendors and added available technical documentation to the Sharepoint site
- Shared with 200 (+) identified regulators
- 27 States/Territories have obtained access to the site

Regulators who would like access to the material should send an email to Amy Lopez at alopez@naic.org requesting a link to sign the COE data use agreement.

Repository of model documentation, training materials, research papers and other tools for regulators.

4

EDUCATION AND TRAINING



NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

5

5

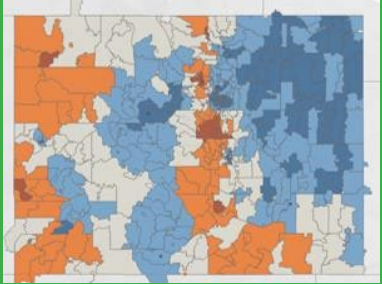
State Insurance Departments Focus on Improving Market Stability through Building Resilience





Colorado Wildfire Probabilistic Risk Assessment

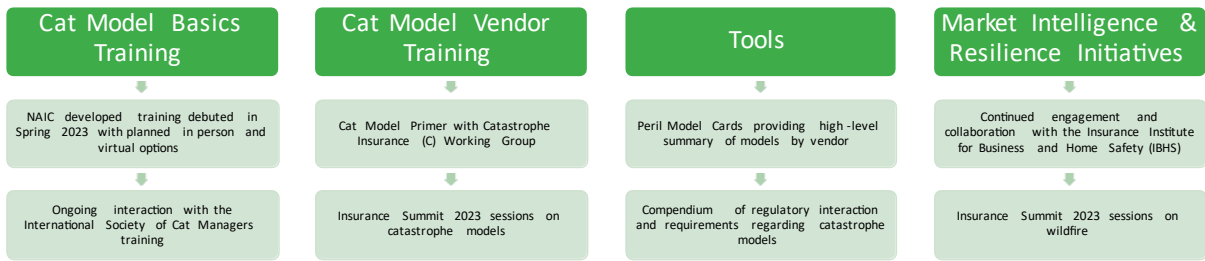
The CIPR CAT COE aims to provide insight to the Colorado Division of Insurance on the wildfire risk in Colorado by working with RMS.



NAIC NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

 CENTER FOR INSURANCE POLICY AND RESEARCH

NEXT STEPS



Let's more work to be done –we look forward to continued interaction & guidance

Catastrophe Modeling Center of Excellence

Providing regulators with technical expertise, tools, and information to effectively regulate their markets .

<https://content.naic.org/research/center-of-excellence>

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Draft: 8/10/23

Actuarial Opinion (C) Working Group
Virtual Meeting
August 2, 2023

The Actuarial Opinion (C) Working Group of the Casualty Actuarial and Statistical (C) Task Force met Aug. 2, 2023. The following Working Group members participated: Miriam Fisk, Chair (TX); Anna Krylova, Vice Chair (NM); Amy Waldhauer and Susan Andrews (CT); Chantel Long (IL); Julie Lederer (MO); Michael Muldoon (NE); Tom Botsko (OH); and Kevin Clark and James DiSanto (PA).

13. Exposed the 2023 Regulatory Guidance

The Working Group continued to discuss changes proposed at its July 12 meeting. A majority of the Working Group members want to modify the qualification documentation requirement in the 2024 instructions to: 1) only require qualification documentation on initial appointment; and 2) require Board review only at that time. With that as an expectation, the *Regulatory Guidance on Property and Casualty Statutory Statements of Actuarial Opinion, Actuarial Opinion Summaries, and Actuarial Reports for the Year 2023* (2023 Regulatory Guidance) would note the possibility of such a change for the following year.

The Working Group agreed to some changes, proposed by Lederer, to the 2023 Regulatory Guidance to better reflect the instruction language about what to do when a material error is found. State insurance regulators would also suggest that the company or Appointed Actuary contact the regulators if a less-than-material error is found because regulators might still advise the issuance of a corrected opinion. Michelle Larkowski (American Academy of Actuaries—Academy) asked whether the state insurance regulators wanted that requirement to be binding; if so, she suggested that regulators should revise the opinion instructions. She said some state insurance regulators have responded to the reissuance of the opinion because surplus numbers and materiality changed, and they instructed that the opinion should not have been reissued because the change was minimal. The Working Group decided to leave the guidance in the 2023 Regulatory Guidance and then consider adding it to the 2024 instructions.

Fisk informed the Working Group that she would expose the document, after adjusting for changes discussed, for a 30-day public comment period ending Sept. 1.

14. Discussed Actuarial Opinion Instructions

The Working Group discussed potential changes to instructions for the 2024 Property/Casualty (P/C) Statement of Actuarial Opinion (SAO). Long suggested removing the requirement for a Board review of qualification documentation because it is more of a compliance check that does not provide much additional value. She said life and health actuaries are not required to produce qualification documentation. Fisk said when the qualification documentation is done well, it is a valuable document. She said when done poorly, it is a red flag that the actuary does not appear knowledgeable about recent changes in instructions. She said it is also helpful to know how the actuary is qualified when conducting risk-focused financial exams.

Krylova said one reason the qualification documentation was created was to ensure that the actuaries passing exams through the Society of Actuary's (SOA's) general insurance track were qualified. Kris DeFrain (NAIC) said the SOA is making some changes to its examination process, which might need to be considered before making

decisions to eliminate the qualification documentation completely. Ann Weber (SOA) said the SOA can present to the Working Group the changes expected to be made in fall 2025.

Long proposed a change in the instructions for the “disagreement letter” when there is a change in appointed actuary. Long noted that appointed actuaries might have disagreements with companies about reserving issues at interim periods and not solely related to the SAO at year end. Long proposed adding wording to encourage the former appointed actuary to comment on reserving disagreements more broadly. Fisk said the company’s “disagreement letter” often says there are no disagreements regarding matters of opinion, and actuaries may believe they cannot disclose any more in their response letter. Andrews said a letter is probably not going to fix the issue and noted that this portion of the instructions was originally intended to be similar to the required notifications when there is a change in external auditor.

Long also proposed removing the Appointed Actuary’s address from the SAO signature block.

Fisk proposed changes to the instructions for the 2024 Title SAO, to make the title instructions more consistent with the P/C instructions and to correct a couple of instructions. The Working Group will discuss these changes after the 2023 Summer National Meeting, and it will likely expose the proposals for comment at that time.

Fisk said there is no plan to make any changes to the 2024 Actuarial Opinion Summary instructions.

Having no further business, the Actuarial Opinion (C) Working Group adjourned.

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Draft: 8/4/23

Actuarial Opinion (C) Working Group
Virtual Meeting
July 12, 2023

The Actuarial Opinion (C) Working Group of the Casualty Actuarial and Statistical (C) Task Force met July 12, 2023. The following Working Group members participated: Miriam Fisk, Chair (TX); Amy Waldhauer (CT); David Christhilf (DC); Chantel Long (IL); Sandra Darby (ME); Julie Lederer (MO); Michael Muldoon (NE); Tom Botsko (OH); Andrew Schallhorn (OK); and James Di Santo (PA).

15. Adopted a Financial Analysis (E) Working Group Referral on Predictive Analytics in Reserving

On May 9, 2022, the Financial Analysis (E) Working Group requested that the Actuarial Opinion (C) Working Group discuss the use of predictive analytics in reserving and consider drafting guidance. The Actuarial Opinion (C) Working Group exposed a draft response to the referral on May 25 for a 30-day public comment period ending June 26. No comments were received.

Waldhauer made a motion, seconded by Botsko, to adopt the referral response to send to the Financial Analysis (E) Working Group (Attachment Five-A) The motion passed unanimously.

16. Discussed Regulatory Guidance

The Working Group discussed 2023 Regulatory Guidance. Lederer suggested: 1) eliminating the detail about changes made in 2021 and 2022 and adding a statement that the 2023 instructions were not significantly modified; 2) removing the comment that qualification documentation might change in the 2023 instructions because it did not; 3) using wording in the instructions about material errors or making sure guidance does not contradict what is in the instructions; and 4) potentially eliminating the COVID-19 guidance. Fisk recommended adding guidance to contact the domestic regulator if unsure whether to reissue an opinion. Working Group members were asked whether any additional guidance should be offered, including whether there should be guidance about recent inflation. Clark suggested leaving the decision to include inflation as a risk factor to the Appointed Actuary.

17. Discussed Actuarial Opinion Instructions

The Working Group discussed potential changes to instructions for the 2024 Property/Casualty (P/C) Statement of Actuarial Opinion. Long suggested changing the qualification documentation requirements and removing the requirement for a Board review as she does not find it useful. Armon said the Casualty Actuarial Society (CAS) is auditing continuing education (CE) requirements for a percentage of the membership. Fisk said people who are not actuaries might believe that anyone with a credential would be qualified, but that is not the case. Michelle Larkowski (Risk & Regulatory Consulting—RRC) suggested having the requirements only at the initial appointment. Working Group members were asked to submit any proposed instruction changes.

Having no further business, the Actuarial Opinion (C) Working Group adjourned.

SharePoint/NAIC Support Staff Hub/Member Meetings/C CMTE/2023_Summer/CASTF/AOWG/AOWG 071223 min.docx

MEMORANDUM

TO: Judy Weaver, Chair, Financial Analysis (E) Working Group

FROM: Miriam Fisk, Chair, Actuarial Opinion (C) Working Group
Anna Krylova, Vice-Chair, Actuarial Opinion (C) Working Group

RE: Actuarial Opinion (C) Working Group Response to Enhanced Regulatory Guidance Referral

DATE: July 12, 2023

Background

On May 9, 2022, a memorandum from the Financial Analysis (E) Working Group (FAWG) was received by the Actuarial Opinion (C) Working Group (AOWG) requesting that the AOWG consider whether additional guidance is needed for regulatory actuaries and/or financial analysts/examiners to address concerns about additional solvency risks resulting from the use of predictive analytics in reserve setting.

FAWG noted that one of the factors contributing to the recent failure of an insurer was inadequate reserving due in part to the insurer's use of a customized, unproven predictive model for reserving and regulators' difficulty in reviewing/challenging the model's reserve estimates, due to lack of experience and expertise in this area.

It is our understanding that the situation leading to the referral involved a case reserving model using predictive analytics to establish ultimate case reserves for individual open claims based on the details of each claim. The company made significant changes to its claims handling processes to incorporate the results of the new model. Claim payment patterns dramatically accelerated and case reserve levels changed materially, so the company's data became more difficult for actuaries to use in reserve analyses and increased the uncertainty around any resulting estimates. Company management remained optimistic and expected the changes to have a favorable impact that ultimately did not materialize.

AOWG Response

Regulatory actuaries have not traditionally been involved in examining individual case reserves or companies' guidelines for setting case reserves.¹ Similarly, companies' reserving actuaries and Appointed Actuaries have not traditionally been involved in establishing claim handling guidelines or setting case reserves for individual claims.

Traditional actuarial reserve estimation methods are generally based on the assumption that future claims activity can be predicted based on historical claims activity to date. Therefore, significant changes to a company's operations, such as claims payment or handling practices, case reserve adequacy, or

¹ In fact, on a recent call of the Actuarial Opinion Working Group, no participants had ever performed an in-depth review of a case reserving predictive model. However, we recognize that the use of predictive analytics in insurance is growing, and regulators will be faced with reviewing an increasing variety of complex models.

underwriting, may result in historical patterns being less predictive of future patterns and may cause the results of the analysis to be highly uncertain or contain significant bias, regardless of whether predictive analytical models are involved in setting case reserves.

This issue is recognized in the current P&C claims handling/reserving risk repository in the NAIC Financial Condition Examiners Handbook, as reflected in the following risk statements:

- Changes in the legal environment or changes in the insurer’s underwriting, case reserving or claims-handling processes are not appropriately considered within the insurer’s reserving assumptions and methodologies.
- Actuarial analysis relied upon by the insurer’s management in determining carried reserves are not based on appropriate methods and/or reasonable assumptions.
- The loss and loss adjustment expense (LAE) reserve computations are not performed correctly or the selected estimates are unreasonable.

FAWG raised a valid concern that “the use of customized predictive analytical models without sufficient knowledge, actuarial adjustments of data, and reasonability checks could result in additional solvency risks at other insurers.” When the results of a complex model are reflected in a company’s financial statements, we believe it is most important for examiners to evaluate management’s understanding and use of any models relied upon in a financial reporting context, and examiners should not need to have extensive modeling expertise to do this.

We would suggest that the [“Model and Data Regulatory Questions” document](#) being developed by the Big Data and AI (H) Working Group will provide a good set of questions to ask about a model. These questions will have the benefit of being consistent and standardized for use by various regulator groups and are intended to apply to any type of predictive model – reserving or otherwise. The “Main General Questions” section of the document provides suggested questions that could be used by regulators to obtain a high-level understanding of a model. For example, this section recommends asking about the model’s intended purpose, data inputs, assumptions, testing/validation, and governance. The quality of management’s responses to these or similar questions might also indicate whether management has an adequate understanding of the model and could help regulators identify initial areas of concern.

We recognize that it may become necessary to compile more specific guidance to assist examiners and analysts in evaluating risk related to the use of predictive models in a reserving context. We would need to seek assistance from regulators and industry professionals with this specific expertise since, as noted above, the Actuarial Opinion Working Group members currently have no experience reviewing these models.

Draft: 6/6/23

Actuarial Opinion (C) Working Group
Virtual Meeting
May 25, 2023

The Actuarial Opinion (C) Working Group of the Casualty Actuarial and Statistical (C) Task Force met May 25, 2023. The following Working Group members participated: Miriam Fisk, Chair (TX); Anna Krylova, Vice Chair (NM); Susan Andrews (CT); David Christhlf (DC); Chantel Long (IL); Sandra Darby (ME); Julie Lederer (MO); Michael Muldoon (NE); Tom Botsko (OH); Andrew Schallhorn (OK); and James Di Santo (PA).

18. Discussed a Financial Analysis (E) Working Group Referral on Predictive Analytics in Reserving

The Working Group discussed a draft response to a referral from the Financial Analysis (E) Working Group asking for discussion of the use of predictive analytics in reserving and consideration of drafting guidance.

Krylova made a motion, seconded by Botsko, to expose the draft referral response for a 30-day public comment period ending June 26. The motion passed unanimously.

Having no further business, the Actuarial Opinion (C) Working Group adjourned.

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Draft: 8/28/23

Statistical Data (C) Working Group
E-Vote
July 19, 2023

The Statistical Data (C) Working Group conducted an e-vote that concluded July 19, 2023. The following Working Group members participated: Sandra Darby, Chair (ME); Charles Hale (AL); David Christhlf (DC); Arthur Schwartz (LA); Christian Citarella (NH); Carl Sornson (NJ); Tom Botsko (OH); and Brian Ryder (TX).

1. Adopted the Auto Database Report Average Premium Supplement

The Working Group reviewed and considered for adoption the 2021 *Auto Insurance Database Report Average Premium Supplement* (Auto Supplement).

A majority of the Working Group members voted in favor of adopting the Auto Supplement. The motion passed.

Having no further business, the Statistical Data (C) Working Group adjourned.

SharePoint/NAIC Support Staff Hub/Committees/C CMTE/2023_Summer/CASTF/SDWG/SDWG_0719_evote

Title of Exposure Draft: Proposed Actuarial Standard of Practice, Enterprise Risk Management**Comment Deadline: September 15, 2023**

Instructions: Please review the exposure draft, and give the ASB the benefit of your recommendations by completing this comment template. Please fill out the tables within the section below, adding rows as necessary. Sample for completing the template provided at the following link: <http://www.actuarialstandardsboard.org/email/2020/ASB-Comment-Template-Sample.docx>

Each completed comment template received by the comment deadline will receive consideration by the drafting committee and the ASB. The ASB accepts comments by email. Please send to comments@actuary.org and include the phrase 'ASB COMMENTS' in the subject line. Please note: Any email not containing this exact phrase in the subject line will be deleted by our system's spam filter.

The ASB posts all signed comments received to its website to encourage transparency and dialogue. Comments received after the deadline may not be considered. Anonymous comments will not be considered by the ASB nor posted to the website. Comments will be posted in the order that they are received. The ASB disclaims any responsibility for the content of the comments, which are solely the responsibility of those who submit them.

I. Identification:

Name of Commentator / Company
National Association of Insurance Commissioners' Casualty Actuarial and Statistical Task Force (CASTF)

II. ASB Questions (If Any). Responses to any transmittal memorandum questions should be entered below.

Question No.	Commentator Response

III. Specific Recommendations:

Section II (e.g. 3.2.a)	Commentator Recommendation (Please provide recommended wording for any suggested changes)	Commentator Rationale (Support for the recommendation)
1.2	Add "an ORSA Report or" between "reviewing" and "all" in this sentence: "If the actuary is performing actuarial services that involve reviewing all or part of an ERM framework, the actuary should use the guidance in this ASOP to the extent practicable within the scope of the review."	The reviewing actuary subject to this ASOP will often be a regulator reviewing an ORSA report, so we believe it would be appropriate to include specific mention of the ORSA report. In addition, the reviewing actuary may not be tasked with reviewing the ERM framework itself. Rather, the reviewer's principal (often, the state's insurance commissioner) may have asked the reviewing actuary to review the ORSA report to ensure compliance with state statutes. The proposed addition to the wording would allow for this possibility.
2.9	Recommended wording:	The Actuarial Standards Board sets standards for appropriate practice in the United States. Therefore,

	<p>"A report produced with the following objectives:</p> <p>a. To provide information on the organization's material and relevant risks; and</p> <p>b. To provide a group-level perspective on risk and capital."</p>	<p>when the ASOP refers to the ORSA report, the ASOP can (and maybe should) use a definition of the report that aligns with the NAIC's ORSA Guidance Manual.</p> <p>We are particularly concerned about parts b. and c. in the current definition because this could suggest that the ORSA report is a regulatory exercise whose main intended user is the insurance regulator. Rather, the ORSA process is an internal exercise that should benefit all stakeholders of the organization, not just provide information to the regulator.</p> <p>The recommended definition is adapted from page 1 of the ORSA Guidance Manual (https://content.naic.org/sites/default/files/publication-orsa-guidance-manual.pdf), which outlines the primary goals of the ORSA process.</p>
<p>3.3</p>	<p>We recommend providing a definition of "risk classification" in section 2.</p>	<p>In ASOP No. 12 ("Risk Classification (for All Practice Areas)," risk classification involves assigning risks to groups. In Section 3.3 of the proposed ERM ASOP, risk classification seems to entail prioritizing or ranking risks. Adding a definition to Section 2 would clarify the usage in this ASOP.</p>

IV. General Recommendations (If Any):

Commentator Recommendation (Identify relevant sections when possible)	Commentator Rationale (Support for the recommendation)

V. Signature:

Commentator Signature	Date

Methods to Identify and/or Mitigate Bias

Mike Woods, MAAA, FCAS, CSPA
Member, P/C Committee on Equity and Fairness

Casualty Actuarial and Statistical (C) Task Force—Summer National Meeting — August
12, 2022



Introduction

- [Issue brief](#) discusses principles to be considered that might assist regulators in selection of suitable methodologies for identifying and/or mitigating bias.
- Structure of issue brief
 - Actuarial standards of practice
 - Definitions of unfair discrimination and disproportionate outcomes
 - Principles for approaches to identify and address unfair discrimination
 - Data collection, classification, and other considerations
 - Methods of identifying potential bias
 - Methods of preventing and addressing potential bias



Actuarial Standards and Guidance

- ASOP No. 12, *Risk Classification*—Requires correlation between risk characteristics and losses and expenses, not the establishment of a cause-and-effect relationship
- ASOP No. 23, *Data Quality*—Provides guidance around the use of data
- ASOP No. 56, *Modeling*—Provides guidance with respect to designing, developing, selecting, modifying, using, reviewing, or evaluating models



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Principles for Identifying and/or Mitigating Bias

- Understandable to public
- Rates that continue to differentiate based on expected cost
- Adaptable to new data, innovation, and technology
- Consider intersectionality of protected classes
- Consistent application to all insurers
- Consider multivariate effects
- Assess impact to insurance marketplace
- Monitor results after initial approval
- Continually refresh data on protected classes



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Other Considerations

- Protected class data collection
 - Directly from insureds
 - Third-party databases
 - Impute using statistical methods
- Classification
 - Classes that are capable of being objectively determined
 - Practical limitations in data collection (e.g., cost, efficiency)
 - Credibility of results
 - Frequency of reviewing definitions
- Others
 - Unintended impact to insureds (affordability, availability)
 - Multiple methods could be considered
 - Small companies could face additional challenges

Methods for Identifying Bias

- **Disproportionate Impact Analysis**—Study the impact that each rating variable has on each protected class's premiums. How much does each rating attribute cause higher premiums for each class of insureds?
- **Fairness Metrics**—Compare model predictions to actual outcomes. Is there bias (by protected class) in the prediction error in the loss model that supports the rating plan?
- **Insurance Data Disclosure**—Require insurers to release data on protected classes (such as loss ratios, bind rates, rejection rates, etc.). Allow the public to see whether there is bias in an insurer's practices.

Methods for Identifying Bias

- **Loss Ratio Test**—Compare loss ratios by variable of interest to demonstrate whether they are materially different by protected class.
- **Proxy Test**—Include protected class data in the rating model and see if the variable of concern continues to have predictive power.
- **Rational Explanation**—Require carriers to describe a potentially causal relationship between the variable of concern and losses.



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Methods for Mitigating Bias

- **Allow Only Pre-Approved Variables**—States would provide a list of variables that companies are allowed to use in policy rating.
- **Prohibit Named Variables**—Each state would provide a list of variables that cannot be used in policy rating.
- **Limit Rate Spread**—Limit the spread of rating factors (e.g., no surcharge can exceed 30%) or limit the spread of premiums (e.g., the highest premium cannot be 3x greater than the lowest premium).



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Methods for Mitigating Bias

- **Rate Factor Adjustment**—Adjust rate factors (manually or algorithmically) until a test to identify bias has been passed.
- **Solidarity Tax and Rebate**—Collect a tax from all policyholders and redistribute that tax as a rebate to those that have been identified as deserving a subsidy.
- **Statistical Model**—Build an initial model using all rating variables and the protected class variables; then, algorithmically remove any proxy effects from the rating variables (and the protected class variables).



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Conclusion

- Growing discussion around unintended bias and unfair discrimination
- There are many potential methods to identify and/or mitigate bias that have been discussed
 - There are likely to be even more methods in the future as discussions continue
- The American Academy of Actuaries is ready to assist regulators in their review of the technical components of these methods as well as in identifying strengths and weaknesses, particularly in relation to the principles noted in this presentation
- We hope these observations are helpful and we welcome further discussion



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fischer@actuary.org



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Attachment Five
Casualty Actuarial and Statistical (C) Task Force
8/12/23

Rich Gibson, MAAA, FCAS
Academy Senior Casualty Fellow

Casualty Actuarial and Statistical (C) Task Force
Summer National Meeting—August 12, 2023



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Casualty Practice Council (CPC) Update

- Comment Letters
 - [Comments to the Actuarial Standards Board on ASOP No. 29](#)
 - [Comments to the California Department of Insurance for the workshop examining catastrophe modeling and insurance](#)
- PC RBC Report on new risk factors, investment income adjustments, and catastrophe adjustments (August 2023)
- [Navigating Workers' Compensation and Medical Marijuana](#) issue brief
- National Flood Insurance Program issue brief (Q3)
- *Cyber Risk Toolkit*
 - ["Digital Assets and Their Current Roles Within Cybercrime"](#)
 - Personal lines (Q3)



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Committee on Property and Liability Financial Reporting (COPLFR) Update

- Comment Letters
 - [Comments to CASTF on Schedule P](#)
 - [Comments to the IRS on the proposed rule involving micro-captive listed transactions and micro-captive transactions of interest](#)
 - [Comments to Blanks \(E\) Working Group on Proposal 2023-04BWG](#)
 - Comments to Actuarial Standards Board on ASOP No. 36 (Q3)
- Upcoming
 - 2023 Seminar on Effective P/C Loss Reserve Opinions (December 4–5), Charlotte, N.C.
 - 2023 Practice Note on Statements of Actuarial Opinion (SAOs) on P/C Loss Reserves (December)
 - P/C Loss Reserve Law Manual (December)



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The actuary is a professional, defined by statute.



Attachment 9B
Casualty Actuarial and Statistical (C) Task Force
8/12/23

The Evolution of the FSA Pathway

NAIC presentations

Stuart Klugman, FSA, CERA, PhD

SOA Senior Staff Fellow

August 2023



We've heard your feedback

FSA candidates encounter significant challenges along the pathway

Lack of flexibility or customization

Less relevant to global markets

Little guidance on what to study



Slow grading process

No exam feedback

Difficult source materials that lack focus



Introducing a range of improvements for a better candidate experience



-  Flexible pathway
-  Exams offered up to 3 times per year
-  Increased global relevancy
-  Faster grading
-  Local regulatory material moved outside of FSA
-  Exam feedback
-  Enhanced syllabus and better guidance
-  Improved source materials



SOCIETY OF ACTUARIES

3

Regulatory Material Shift

Current Challenge

- In-depth U.S. and Canadian regulatory material lacks relevance to global markets



SOA Shift

- Detailed local regulatory material moved outside of the current FSA requirements
- Fundamental regulatory principles and frameworks will still be covered in the FSA pathway
- FSA will qualify actuaries to sign General Statements of Actuarial Opinion

CERTIFICATES:

- Stand-alone, optional regulatory certificates will be offered. Certificates can be taken when needed.
- The SOA is collaborating with regulatory bodies to develop the certificates




SOCIETY OF ACTUARIES

4



Flexible Pathway

Current Challenge

- Forced track structure lacks flexibility and customization
- Highly specialized tracks are less relevant for developing markets



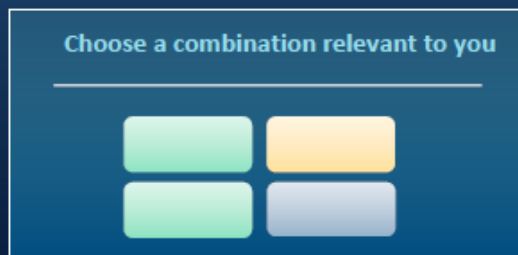
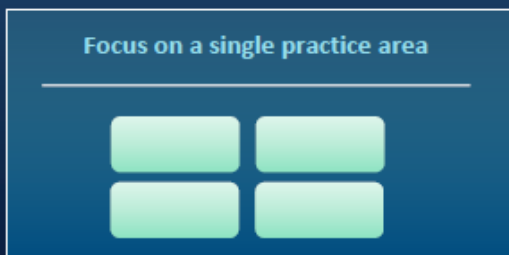
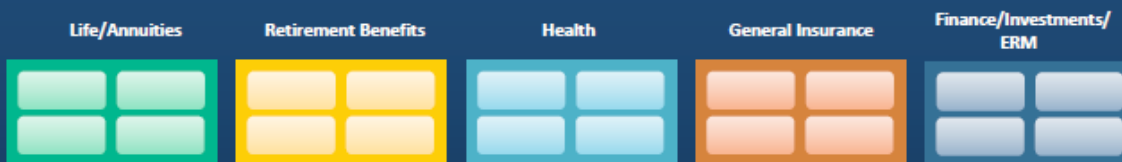
SOA Shift

- Shifting from “tracks” to a flexible pathway
- Flexibility to focus on a single practice area or create a combination of courses relevant to you
- 5 courses required:
 - 4 Technical courses (one must build on another)
 - 1 Decision Making and Communications (DMAC) Course
- + Fellowship Admissions Course (FAC)

5



Choose from About 20 Courses



6





Flexible Pathway

Current Challenge

- Forced track structure lacks flexibility and customization
- Highly specialized tracks are less relevant for developing markets



SOA Shift

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SURPLUS LINES (E) TASK FORCE

Surplus Lines (C) Task Force Aug. 13, 2023, Minutes.....	7-126
2024 Proposed Charges (Attachment One)	7-127
Year-End 2022 Surplus Lines Industry Results (Attachment Two).....	7-128

Draft: 8/17/23

Surplus Lines (C) Task Force
Seattle, Washington
August 13, 2023

The Surplus Lines (C) Task Force met in Seattle, WA, Aug. 13, 2023. The following Task Force members participated: James J. Donelon, Chair, and Stewart Guerin (LA); Larry D. Deiter, Vice Chair, and Tony Dorschner (SD); Mark Fowler represented by Jimmy Gunn (AL); Peni Itula Sapini Teo (AS); Ricardo Lara represented by Libio Latimer (CA); Michael Conway represented by Keilani Fleming (CO); Karima M. Woods represented by Angela King (DC); Michael Yaworsky represented by Bradley Trim (FL); Doug Ommen represented by Travis Grassel (IA); Dean L. Cameron represented by Randy Pipal (ID); Vicki Schmidt represented by Craig VanAalst (KS); Gary D. Anderson represented by John Turchi (MA); Kathleen A. Birrane represented by Lynn Beckner (MD); Troy Downing represented by Bob Biskupiak (MT); Mike Causey represented by Tracy Biehn (NC); Scott Kipper represented by Nick Stosic (NV); Glen Mulready represented by Diane Carter (OK); Michael Humphreys represented by Michael McKenney (PA); Michael Wise represented by Will Davis (SC); Carter Lawrence represented by Trey Hancock (TN); Cassie Brown represented by Jamie Walker (TX); and Mike Kreidler represented by David Forte (WA).

1. Adopted its Spring National Meeting Minutes

Director Deiter made a motion, seconded by Beckner, to adopt the Task Force's March 21, 2023, minutes (*see NAIC Proceedings – Summer 2023, Surplus Lines (C) Task Force*). The motion passed unanimously.

2. Adopted the Report of the Surplus Lines (C) Working Group

Guerin reported that the Surplus Lines (C) Working Group met May 22 in regulator-to-regulator session, pursuant to paragraph 3 (specific companies, entities or individuals) of the NAIC Policy Statement on Open Meetings, to approve three insurers for admittance to the NAIC *Quarterly Listing of Alien Insurers*.

VanAalst made a motion, seconded by Biehn, to adopt the report of the Surplus Lines (C) Working Group. The motion passed unanimously.

3. Adopted its 2024 Proposed Charges

Commissioner Donelon stated that the 2024 proposed charges for the Task Force and the Surplus Lines (C) Working Group included a few edits to add clarification regarding non-U.S. domiciled insurers participating in the U.S. market.

Walker made a motion, seconded by Biehn, to adopt the Task Force's 2024 proposed charges (Attachment One). The motion passed unanimously.

4. Heard a Summary on Surplus Lines Industry Results

Daleo summarized the year-end 2022 surplus lines industry results (Attachment Two). His summary included details on overall writings and trends in the industry. He also summarized market exposure for cybersecurity and private flood. Following his summary, he indicated that the results of the industry would be posted to the Surplus Lines (C) Working Group web page.

Having no further business, the Surplus Lines (C) Task Force adjourned.

Draft: 7/6/23

Adopted by the Property and Casualty Insurance (C) Committee—

Adopted by the Surplus Lines (C) Task Force—

2024 Draft Charges

SURPLUS LINES (C) TASK FORCE

The mission of the Surplus Lines (C) Task Force is to monitor the surplus lines market and regulation, including the activity and financial condition of U.S. and ~~alien non-U.S.~~ surplus lines insurers participating in the U.S. market by providing a forum for discussion of issues and to develop or amend relevant NAIC model laws, regulations and/or guidelines.

The **Surplus Lines (C) Task Force** will:

- A. Provide a forum for discussion of current and emerging surplus lines-related issues and topics of public policy, and determine appropriate regulatory response and action.
- B. Review and analyze ~~quantitative and qualitative industry~~ data on U.S. domestic and ~~alien non-U.S.~~ surplus lines ~~industry insurers participating in the U.S. market results and trends.~~
- C. Monitor federal legislation related to the surplus lines market, and ensure all interested parties remain apprised.
- D. Develop or amend relevant NAIC model laws, regulations, and/or guidelines.
- E. Oversee the activities of the Surplus Lines (C) Working Group.

The **Surplus Lines (C) Working Group** will:

- A. Operate in regulator-to-regulator session pursuant to paragraph 3 (specific companies, entities, or individuals) of the NAIC Policy Statement on Open Meetings, and ~~operate~~ in open session when discussing surplus lines topics and policy issues, such as amendments to the International Insurers Department (IID) Plan of Operation.
- B. Maintain and draft new guidance within the IID Plan of Operation regarding standards for admittance and continued inclusion on the NAIC *Quarterly Listing of Alien Insurers*.
- C. Review and consider appropriate decisions regarding applications for admittance to the NAIC *Quarterly Listing of Alien Insurers*.
- D. Analyze renewal applications of alien surplus lines insurers on the NAIC Quarterly Listing of Alien Insurers, and ensure solvency and compliance per the IID Plan of Operation guidelines for continued listing.
- E. Provide a forum for surplus lines-related discussion among jurisdictions.



IID Surplus Lines Industry Summary

U.S. Surplus Lines Overview							
Number of Surplus Lines Entities Writing Business							
	Change	12/31/2022	12/31/2021	12/31/2020			
U.S. Domestic Insurers	+11	250	239	226			
Lloyd's Syndicates	-4	86	90	87			
Non-U.S. Insurers	+1	79	78	75			
Total	+8	415	407	388			
Direct Surplus Lines Premium							
	Change	% of Total	2022	2021	2020		
U.S. Domestic Insurers	19.9%	75.6%	\$74,850,985,997	\$62,422,765,315	\$47,500,046,674		
Lloyd's Syndicates	12.6%	15.8%	\$15,617,968,016	\$13,871,953,030	\$12,710,842,755		
Non-U.S. Insurers	15.0%	8.6%	\$8,542,228,645	\$7,429,261,014	\$5,848,274,247		
Total	18.3%	100.0%	\$99,011,182,658	\$83,723,979,359	\$66,059,163,676		
% of Surplus Lines Market to Total U.S. DPW			11.3%	10.5%	9.1%		
Surplus Lines Reserves/Trust Values							
	Change %	Lloyd's Syndicates		Change %	Non-U.S. Insurers		
		2022	2021		2022	2021	
SL Gross Reserves	15.4%	\$26,146,423,684	\$22,648,328,252	13.1%	\$14,527,245,962	\$12,844,425,108	
SL Trust Funds Required	12.5%	\$6,484,343,893	\$5,762,657,938	11.8%	\$3,112,166,173	\$2,783,716,207	
% collateralized by Trust	24.8%		25.4%		21.4%	21.7%	
Cybersecurity							
	U.S. Domestic 2022		Non-U.S. 2022		Total Surplus Lines 2022	Total Admitted & Surplus Lines 2022	Total Admitted & Surplus Lines 2021
	Admitted	Surplus Lines	Lloyd's Syndicates	Alien Companies			
Total Direct Premiums Written	\$2,966,506,950	\$4,298,085,320	\$1,983,653,486	\$437,815,809	\$6,719,554,615	\$9,686,061,565	\$6,544,760,801
Stand-Alone	\$1,597,273,275	\$3,493,517,920	\$1,658,759,224	\$406,863,338	\$5,559,140,482	\$7,156,413,757	\$4,537,476,524
Package Policy	\$1,369,233,675	\$804,567,400	\$324,894,262	\$30,952,471	\$1,160,414,133	\$2,529,647,808	\$2,007,284,277
Total Direct Losses Paid	\$745,360,422	\$647,838,605	\$449,556,005	\$30,851,270	\$1,128,245,880	\$1,873,606,302	\$1,730,675,311
Stand-Alone	\$446,651,826	\$499,324,554	\$330,225,972	\$29,956,911	\$859,507,437	\$1,306,159,263	\$1,260,179,328
Package Policy	\$298,708,596	\$148,514,051	\$119,330,033	\$894,359	\$268,738,443	\$567,447,039	\$470,495,983
Number of Policies in Force	3,571,952	349,626	158,945	49,650	558,221	4,130,173	4,074,881
Stand-Alone	198,284	144,336	112,100	47,710	304,146	502,430	470,857
Package Policy	3,373,668	205,290	46,845	1,940	254,075	3,627,743	3,604,024
Number of Claims Reported	14,170	12,754	12,430	1,489	26,673	40,843	43,002
Stand-Alone	5,856	9,947	10,019	1,458	21,424	27,280	28,593
Package Policy	8,314	2,807	2,411	31	5,249	13,563	14,409
Number of Entities w/ Exposure ⁴	512	117	55	26	198	710	722
Stand-Alone	86	74	42	20	136	222	216
Package Policy	472	88	39	8	135	607	622
Private Flood							
	U.S. Domestic 2022		Non-U.S. 2022		Total Surplus Lines 2022	Total Admitted & Surplus Lines 2022	Total Admitted & Surplus Lines 2021
	Admitted	Surplus Lines	Lloyd's Syndicates	Alien Companies			
Total Direct Premiums Written	\$683,541,994	\$605,308,757	\$823,104,138	\$522,191,273	\$1,950,604,168	\$2,634,146,162	\$2,020,921,485
Residential	\$185,465,876	\$251,374,247	\$256,873,041	\$26,309,489	\$534,556,777	\$720,022,653	\$548,606,697
Commercial	\$498,076,118	\$353,934,510	\$566,231,097	\$495,881,784	\$1,416,047,391	\$1,914,123,509	\$1,472,314,788
Total Direct Losses Paid	\$242,650,411	\$161,257,118	\$213,770,864	\$33,654,317	\$408,682,299	\$651,332,710	\$479,158,404
Residential	\$104,173,373	\$89,870,022	\$94,125,092	\$9,913,653	\$193,908,767	\$298,082,140	\$195,963,360
Commercial	\$138,477,038	\$71,387,096	\$119,645,772	\$23,740,664	\$214,773,532	\$353,250,570	\$283,195,044
Number of Policies in Force	397,558	243,552	219,203	53,087	515,842	913,400	831,722
Residential	234,603	184,497	192,284	25,300	402,081	636,684	576,766
Commercial	162,955	59,055	26,919	27,787	113,761	276,716	254,956
Number of Claims Reported	1,841	1,029	5,254	1,508	7,791	9,632	10,172
Residential	1,536	969	2,779	246	3,994	5,530	4,169
Commercial	305	60	2,475	1,262	3,797	4,102	6,003
Number of Entities w/ Exposure ⁴	169	46	46	17	109	278	285
Residential	77	24	41	6	71	148	144
Commercial	103	37	46	15	98	201	191

⁴The total number of entities will not equal the sum of the sub-categories given there are entities that have exposure to both sub-categories

States & Territories					
2022 U.S. Surplus Lines Premiums					
State	U.S. Domestic Insurers	Lloyd's Syndicates	Non-U.S. Insurers	Totals	Rank
California	\$14,398,203,402	\$2,546,308,420	\$1,174,152,412	\$18,118,664,234	1
Texas	\$8,682,127,003	\$2,296,610,703	\$1,375,528,592	\$12,354,266,298	2
Florida	\$8,991,372,676	\$1,985,152,431	\$864,736,275	\$11,841,261,382	3
New York	\$5,947,642,852	\$1,095,152,445	\$760,967,922	\$7,803,763,219	4
Illinois	\$2,567,152,115	\$641,979,933	\$352,437,708	\$3,561,569,756	5
New Jersey	\$2,147,082,668	\$344,411,524	\$202,837,724	\$2,694,331,916	6
Georgia	\$2,012,454,242	\$435,963,571	\$221,439,701	\$2,669,857,514	7
Pennsylvania	\$1,950,256,297	\$316,476,169	\$292,517,392	\$2,559,249,858	8
Louisiana	\$1,942,258,935	\$391,298,200	\$171,658,372	\$2,505,215,507	9
Massachusetts	\$1,656,791,379	\$386,024,315	\$195,131,335	\$2,237,947,029	10
Washington	\$1,568,414,607	\$325,291,049	\$168,844,505	\$2,062,550,161	11
Ohio	\$1,300,442,856	\$304,136,180	\$203,081,238	\$1,807,660,274	12
Colorado	\$1,439,607,496	\$239,542,172	\$105,161,539	\$1,784,311,207	13
North Carolina	\$1,271,480,479	\$298,047,309	\$166,864,351	\$1,736,392,139	14
Virginia	\$1,105,492,668	\$246,403,146	\$206,277,213	\$1,558,173,027	15
South Carolina	\$1,045,783,335	\$260,460,907	\$100,276,481	\$1,406,520,723	16
Tennessee	\$1,044,142,541	\$259,673,404	\$96,448,466	\$1,400,264,411	17
Alabama	\$966,184,094	\$287,063,861	\$90,721,099	\$1,343,969,054	18
Missouri	\$978,504,111	\$206,529,797	\$156,701,006	\$1,341,734,914	19
Arizona	\$1,036,922,853	\$164,042,554	\$101,440,230	\$1,302,405,637	20
Michigan	\$979,698,416	\$145,121,706	\$127,775,389	\$1,252,595,511	21
Indiana	\$968,992,379	\$121,620,663	\$124,837,091	\$1,215,450,133	22
Minnesota	\$766,266,313	\$159,193,603	\$127,978,908	\$1,053,438,824	23
Connecticut	\$787,197,041	\$151,126,589	\$106,358,141	\$1,044,681,771	24
Maryland	\$770,972,373	\$169,573,754	\$63,653,074	\$1,004,199,201	25
Oklahoma	\$694,998,583	\$104,252,552	\$103,597,994	\$902,849,129	26
Oregon	\$661,682,019	\$137,549,833	\$83,759,893	\$882,991,745	27
Wisconsin	\$584,702,175	\$123,324,997	\$91,069,361	\$799,096,533	28
Nevada	\$568,040,233	\$100,327,058	\$70,267,873	\$738,635,164	29
Mississippi	\$592,884,822	\$108,802,972	\$35,418,877	\$737,106,671	30
Utah	\$551,506,511	\$143,632,267	\$38,245,494	\$733,384,272	31
Iowa	\$469,313,527	\$147,697,397	\$39,314,366	\$656,325,290	32
Dist. Columbia	\$437,887,141	\$46,998,041	\$53,150,183	\$538,035,365	33
Kentucky	\$393,148,835	\$111,509,819	\$21,152,721	\$525,811,375	34
Kansas	\$388,100,253	\$67,529,291	\$57,669,239	\$513,298,783	35
Arkansas	\$385,717,364	\$74,610,949	\$35,196,301	\$495,524,614	36
Hawaii	\$369,141,345	\$77,973,810	\$38,091,012	\$485,206,167	37
Delaware	\$287,688,610	\$62,251,973	\$46,084,232	\$396,024,815	38
Nebraska	\$275,108,507	\$51,340,533	\$30,773,159	\$357,222,199	39
Rhode Island	\$209,522,326	\$75,127,456	\$16,330,694	\$300,980,476	40
Idaho	\$215,054,442	\$49,411,940	\$31,814,837	\$296,281,219	41
Montana	\$198,606,956	\$29,379,376	\$24,060,690	\$252,047,022	42
New Mexico	\$210,316,943	\$23,358,990	\$14,360,849	\$248,036,782	43
Alaska	\$168,122,834	\$51,388,719	\$20,596,749	\$240,108,302	44
West Virginia	\$160,324,901	\$24,532,559	\$17,120,724	\$201,978,184	45
New Hampshire	\$147,292,774	\$22,385,026	\$20,468,120	\$190,145,920	46
Maine	\$132,561,831	\$29,399,252	\$9,059,848	\$171,020,931	47
North Dakota	\$114,822,699	\$15,778,532	\$39,590,147	\$170,191,378	48
Vermont	\$98,314,570	\$51,001,633	\$6,963,649	\$156,279,852	49
South Dakota	\$76,050,456	\$26,175,498	\$22,232,756	\$124,458,710	50
Wyoming	\$92,469,653	\$17,134,068	\$7,850,675	\$117,454,396	51
Puerto Rico	\$29,185,323	\$26,649,602	\$4,197,063	\$60,031,988	52
U.S. Virgin Islands	\$10,833,539	\$40,217,104	\$4,462,554	\$55,513,197	53
Guam	\$1,915,780	\$923,345	\$709,139	\$3,548,264	54
American Samoa	\$290	\$258,703	\$396,641	\$655,634	55
Northern Mariana Islands	\$227,624	(\$159,684)	\$396,641	\$464,581	56
Grand Total	\$74,850,985,997	\$15,617,968,016	\$8,542,228,645	\$99,011,182,658	
% of Total	75.6%	15.8%	8.6%	100.0%	

TITLE INSURANCE (C) TASK FORCE

Title Insurance (C) Task Force Aug. 14, 2023, Minutes 7-131

Draft: 8/18/23

Title Insurance (C) Task Force
Seattle, Washington
August 14, 2023

The Title Insurance (C) Task Force met in Seattle, WA, Aug. 14, 2023. The following Task Force members participated: Eric Dunning, Chair (NE); Kevin Gaffney, Vice Chair (VT); Mark Fowler represented by Erick Wright (AL); Karima M. Woods represented by Angela King (DC); Michael Yaworsky represented by Anoush Brangaccio, Jeffrey Joseph, and Bradley Trim (FL); Vicki Schmidt represented by Julie Holmes (KS); James J. Donelon represented by Chuck Myers (LA); Kathleen A. Birrane represented by Mary Kwei (MD); Grace Arnold represented by Paul Hanson (MN); Troy Downing (MT); Mike Causey represented by Tracy Biehn (NC); Judith L. French represented by Tom Botsko and Maureen Motter (OH); Glen Mulready represented by Erin Wainner and Diane Carter (OK); Michael Humphreys represented by Michael McKenney (PA); Elizabeth Kelleher Dwyer represented by Patrick Smock (RI); Michael Wise represented by Will Davis and Rachel Moore (SC); and Larry D. Deiter represented by Tony Dorschner (SD).

1. Adopted its Spring National Meeting Minutes

Commissioner Gaffney made a motion, seconded by Botsko, to adopt the Task Force’s March 23 minutes (see *NAIC Proceedings – Summer 2023, Title Insurance (C) Task Force*). The motion passed unanimously.

2. Heard an Update on the Administration of the Survey of State Insurance Laws Regarding Title Data and Title Matters

Director Dunning stated that after investigating various survey administrative tools, NAIC staff have decided that using Microsoft Forms for the survey questions would make the most sense. The survey is anticipated to be administered to states shortly following the Summer National Meeting.

3. Heard an Update on the Compiling of Consumer Complaint Data Related to the Title Industry

Myers stated that the Task Force is charged this year with “obtaining information on consumer complaints submitted to states regarding title insurance to determine if updates are needed to insurance regulatory best practices or standards.” He leads the subsequently formed drafting group. Other drafting members include Montana; Nebraska; Ohio; Pennsylvania; Rhode Island; Washington, DC.

A draft survey of questions to send to states to collect title-related complaint information was drafted. The survey was not sent to states, as the drafting group became aware of the NAIC Complaints Database System (CDS) maintained by the NAIC’s Market Regulation Department. NAIC staff were then directed to obtain the title-related complaint data from the CDS and compile it for analysis. Myers and NAIC staff then met with NAIC Market Regulation staff to better understand the submission process and how data is captured in the CDS. Additionally, Myers investigated how the Louisiana Department of Insurance (DOI) tracks and reports title-related complaints.

The drafting group met May 22 to review the draft survey of questions and four years of title complaint information compiled from the NAIC CDS. The drafting group found that more than 50% of complaint reasons were coded as “state-specific” for each year. Complaint dispositions can also be coded as “state-specific.” As this does not provide much information for analysis, NAIC staff were instructed to reach out to states reporting a significant number of complaint dispositions and reasons as “state-specific” for additional detail. Requests for additional information were sent to California, Florida, Missouri, and Texas.

California responded that all of its “state-specific” coded reasons for complaints were for escrow handling. Florida responded that more than half of its reasons for complaints came from agent handling, failure to disburse funds, and premium refunds. Texas reported that over half of its “state-specific” reasons were for closing, contract disputes, and earnest money. Texas also reported that over half of its “state-specific” dispositions were for contract language, information furnished, and questions of fact. Missouri declined to provide information citing the task as being too laborious.

The drafting group plans to meet again following the Summer National Meeting to discuss if additional detail is needed to identify trends. As part of its discussions, it will contemplate how reporting to the NAIC CDS could be enhanced to allow for more transparency on title-related complaints. Currently, title is captured under the CDS’s miscellaneous category, which does not offer the same coding options as those that have their own category.

4. Heard a Presentation on Issues with NTRAPS

Sylvia Smith-Turk (Stewart Title) stated that Non-Title Recorded Agreements for Personal Services (NTRAPS) are agreements that obligate the current owner to use the other party’s services in the future and further attempt to bind successor owners by purporting to create a real property interest. Failure to comply with these agreements may give rise to a lien against the property to secure liquidated damages. How these agreements are marketed to property owners and the terms, duration, and enforcement of these agreements are concerning. There are no regulatory disclosure requirements regarding these agreements. Consumers may not fully understand the implications of these agreements. The act of recording NTRAPS in property records can create a long-term barrier to the sale or refinancing of real estate or hamper estate administration. The practice of submitting NTRAPS for inclusion in property records characterized as liens, covenants, encumbrances, or security interests in exchange for money recently emerged throughout the country.

Smith-Turk stated that these agreements are harmful to consumers because they obligate current and future property owners to utilize the service providers for up to 40 years. Consumers do not have the expertise of real estate professionals or attorneys. They may not have the benefit of legal counsel and may not fully understand the agreement or the long-term implications of the ability to transfer or finance their property. Elderly homeowners or those in need of the financial incentives being offered are particularly at risk, and NTRAPS can result in a significant monetary loss when transferring or financing their home. Additionally, NTRAPS provisions allow the listing agreement to be assigned without notice to the property owner.

The American Land Title Association (ALTA) supports efforts to protect consumers by prohibiting the filing of unfair real estate fee agreements in property records, a practice that creates impediments and increases the cost and complexity of selling, refinancing, or transferring real estate.

ALTA advocates for state laws and regulations preventing the enforcement of NTRAPS. ALTA’s model legislative bill: 1) makes agreements unenforceable; 2) prohibits the recording of these agreements in property records; 3) creates penalties for recording these agreements in property records; and 4) provides for the recovery of damages and the removal of agreements from property records. The proposed legislation protects consumers and provides state insurance regulators with the ability and authority to assist consumers in seeking damages caused by NTRAPS. There have been over 30 bills introduced in 21 states and 15 laws passed.

Attorneys General from Florida, Massachusetts, New Jersey, North Carolina, Ohio, and Pennsylvania have filed complaints stating that NTRAPS being used in the marketplace are deceptive, unfair, and unconscionable business practices.

5. Heard a Presentation on Current Fraud Trends in the Title Space, Including Seller Impersonation Fraud

Thomas Cronkright (CertifID) stated that business email compromise (BEC) losses have increased four-fold over the past five years. BEC is a scam targeting businesses and individuals performing wire transfers of funds. Legitimate email accounts are compromised through social engineering and computer intrusion to conduct unauthorized wire transfers. Cryptocurrency has enabled accelerated funds movement, and compromises have evolved to include spoofed phone calls, videos, and websites. Open source of information, Multiple Listing Service (MLS) data syndication, and multiple transactional parties make real estate a top target. The pandemic led to rapid growth in digital closings without creating a safety net. Emerging technologies and expanded personal digital footprints create a growing divide between businesses that protect their customers and those that do not. Vulnerable businesses are reliant on the belief in trusted communications, focus on the manual detection of suspicious behavior, and believe they are too small to be a target. Protected businesses verify identities before sharing sensitive information, leverage technology to inspect every case thoroughly, and recognize that everyone is a target.

New technologies have led to advanced social engineering. SpoofCard is an application that offers users the ability to change what someone else sees on their caller ID display when they receive a phone call. A current practice in the industry to confirm identity has been to call someone and reach them live over the phone, which is known as the “call-back” procedure. Some errors and omissions insurance policies even require a call back before funds are initiated, or coverage may be denied if a loss occurs. The challenge is, you often cannot get a hold of someone in real time, so they need to call you back. As an example, a hacker could spoof a title company and call the buyer when it is time to wire funds to close. Likewise, a fraudster could impersonate a seller and call the title company and provide them fraudulent wiring information for net proceeds to be transferred after closing.

Deepfakes—artificial intelligence (AI) voice replication—can impersonate real estate professionals to gain access to sensitive information about clients and defraud them. All it requires is a short voice sample of the human voice you want to replicate for the AI to learn it instantly.

Fake AI-generated property tours online could deceive buyers and agents about property conditions. Influence Bots—open-source intelligence—use social media to influence users of social platforms. SIM swap—SS7 Network—is a type of account takeover fraud that generally targets a weakness in two-factor authentication and two-step verification, in which the second factor or step is a text message (SMS) or a call placed to a mobile telephone. AI-generated attack emails use ChatGPT AI text-generating interfaces to create malicious messages designed to spear phish, scam, harass, and spread fake news. These AI-based systems can also be used for BEC scams.

Seller impersonation fraud is a new type of scam hitting the real estate industry due to fewer opportunities for other fraud techniques from a decline in home sales. Fraudsters are impersonating an owner to sell unoccupied property, including vacant lots, they do not own. A fraudster will identify vacant lots using public records. Posing as the seller, the scammer contacts a real estate agent to list the property for below market value. The scammer quickly accepts the offer, with a preference for cash sales and then requests a remote notary signing and impersonates the notary. The funds are transferred to the scammer and not discovered until later. Florida and Texas have the highest percentage of vacant land sales as a percentage of total sales. The U.S. Secret Service and CertifID issued a joint bulletin recently advising of the rise in vacant land fraud.

Fraud attempts on mortgage payoffs increased by five times in the second quarter versus the prior three months. Payoff fraud is when fraudsters impersonate a lender or another title company to receive the funds from disbursement after the settlement process, either from refinancing or the sale of a property. Fraudsters use common tactics found in other wire fraud scams to send a falsified payoff statement with wiring instructions to the targeted settlement agent. Shifts in deposit relations stemming from the three high-profile bank failures opened the door for fraudsters.

The CertifID Fraud Recovery Services (FRS) team received an unprecedented number of reports of wire fraud in 2022. Cases increased by 145% year-over-year, with a \$158,000 average loss reported per case. Average wire fraud loss for businesses and consumer cases were \$295,000 and \$107,000, respectively. A layered protection process of education and engagement, technology, insurance coverage, and incidence response planning are needed to mitigate the impact.

Having no further business, the Title Insurance (C) Task Force adjourned.

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WORKERS' COMPENSATION (C) TASK FORCE

Workers' Compensation (C) Task Force July 20, 2023, Minutes 7-136

Draft: 8/2/23

Workers' Compensation (C) Task Force
Virtual meeting (*in lieu of meeting at the 2023 Summer National meeting*)
July 20, 2023

The Workers' Compensation (C) Task Force met July 20, 2023. The following Task Force members participated: Alan McClain, Chair, and Jimmy Harris (AR); John F. King, Vice Chair, and Steve Manders and Paula Shamburger (GA); Mark Fowler represented by Jimmy Gunn, Yada Horace, and Erick Wright (AL); Ricardo Lara represented by Yvonne Hauscarriague, Margaret Hosel, Giovanni Muzzarelli, Mitra Sanandajifar, and Sarah Ye (CA); Michael Yaworsky represented by Greg Jaynes (FL); Doug Ommen represented by Matthew Cunningham and Travis Grassel (IA); Dean L. Cameron represented by Maria Delvillar and Randy Pipal (ID); Vicki Schmidt represented by Chris Hollenbeck, Julie Holmes, and Sara Hurtado (KS); Sharon P. Clark and Sue Hicks (KY); James J. Donelon represented by Charles Hansberry (LA); Gary D. Anderson represented by Jackie Horigan and Matthew Mancini (MA); Timothy N. Schott represented by Brock Bubar, Sandra Darby, and Robert Wake (ME); Grace Arnold represented by Connor Meyer, and Phil Vigliaturo (MN); Chlora Lindley-Myers represented by Julie Lederer and Jo LeDuc (MO); Mike Causey represented by Sharon Thornton-Hall (NC); Scott Kipper represented by Anna Krylova and Gennady Stolyarov (NV); Glen Mulready represented by Cuc Nguyen (OK); Andrew R. Stolfi represented by TK Keen (OR); Michael Humphreys represented by Michael McKenney (PA); Elizabeth Kelleher Dwyer represented by Beth Vollucci (RI); Michael Wise represented by Will Davis and Melissa Manning (SC); Larry D. Deiter represented by Tony Dorschner (SD); and Kevin Gaffney, Rosemary Raszka, Zachary Rothammer, and Shane Silverman (VT). Also participating were: Tom Zuppan (AZ); Lucretia Prince (DE); Reid McClintock and Julie Rachford (IL); Linda Grant (IN); Paige Dickerson, and Tina Nacy, (MI); Christian Citarella (NH); Carl Sornson (NJ); Marianne Baker (TX); Rebecca Nichols, Lee Ann Robertson, and Zuhairah Tillinghast (VA); and David Haushalter (WI).

1. Adopted its Spring National Meeting Minutes

Commissioner King made a motion, seconded by Commissioner Clark, to adopt the Task Force's Spring National Meeting minutes (*see NAIC Proceedings – Spring 2023, Workers' Compensation (C) Task Force*). The motion passed unanimously.

2. Heard a Presentation from Lewis & Ellis on Workers' Compensation Rating

The Task Force heard a presentation from Katie Koch (Lewis & Ellis) on workers' compensation ratemaking. Workers' compensation laws, by design, protect workers by providing financial compensation. Workers' compensation payments include medical benefits for work-related injuries or illness, regardless of fault.

Workers' compensation insurance emerged in the early 20th century, and by mid-1900, most states had some form of legislation for workers' compensation. The National Council on Compensation Insurance (NCCI) and regional bureaus developed advisory rates that insurers widely adopted. The introduction of open competition in the workers' compensation market led to a reevaluation of pricing procedures.

The NCCI and other state rating bureaus typically provide loss costs instead of advisory rates today. Insurers must independently justify various components of the premium rate, including profit and contingency provisions, expense loads, investment income offsets, and other loss cost deviations. The loss cost variations include experience rating modifications and schedule rating, allowing insurers to deviate from bureau rates or loss costs.

Insurers consider the expense costs of participation in involuntary pools and special fund assessments. Additionally, insurers evaluate the cost implications of workers' compensation reforms enacted in state legislatures.

Pricing actuaries are often involved in determining rates that cover expected losses and expenses during the policy period while allowing the insurer to make a reasonable profit. Actuaries use two methods for determining rates. The first method is the loss ratio method, which quantifies needed revisions from current rates. The second method is the pure premium method, which quantifies the required rate per exposure unit and can be used in the deviation of rating factor relativities. Actuaries use the loss ratio methodology for an overall state rate indication and the pure premium methodology for classification ratemaking.

There are challenges when comparing workers' compensation rates across states. Experience rating, schedule rating, large deductible policies, and retrospective rating can significantly affect the final premium a policyholder pays under the existing overarching rating regime.

Experience rating involves identifying and collecting individual employers' payroll and loss information. It permits employer-specific deviations from manual rates with a foundation in a particular employer's historical loss experience.

Retrospective rating involves an endorsed insurance policy such that the final premium adjusts according to the losses experienced by the insured employer rather than according to industry-wide loss experience. This method takes actual losses during the policy period to modify the initial premium to one that more accurately reflects the loss experience of the individual employer.

Schedule rating refers to modifying manual rates either upward or downward to reflect the individual risk characteristics of the insured, generally done at the employer level.

The published loss costs of the state rating bureau (bureau), or NCCI, by industry code, are foundational to today's process. Typically, loss costs are reviewed and revised yearly. Insurers are permitted to use their own loss cost multipliers (LCMs), including a company-specific expense provision. Insurers may also use a loss cost modification factor (LCMF), which adjusts the rate level considering company-specific loss experience. There are often limitations on the degree to which an LCMF in a specific program is permitted to deviate.

Most states permit rating and schedule rating, which facilitates additional rate segmentation, but there may be some differences in specific rules. Some states are administrative pricing states, which may be the most restrictive in permitting insurers to deviate from a bureau filing. A workers' compensation model in a rate filing would likely not be allowed. Anyone can find state differences regarding laws and benefits by visiting the Workers Compensation Research Institute's (WCRI's) web page.

Workers' compensation rating laws can vary by state regarding the specific regulations and methodologies used to determine premium rates. Insurers use classification systems to establish the level of risk associated with each occupation. Classification systems influence premium rates. While many states have similar classification systems, some may have unique or more detailed classifications.

Many states permit insurers to use an experience modification factor, or an experience rating system, to adjust an employer's premium based on their historical claim experience. The experience modification factor compares an employer's actual claims history with the expected claims for companies in the same industry. A factor above 1.0 indicates higher-than-average claims, resulting in higher premiums. A factor below 1.0 indicates lower-than-average claims, leading to reduced premiums.

Some states have a competitive market where multiple insurers can provide workers' compensation insurance, allowing insurers to compete for business. Other states operate in a monopolistic system, where a state fund, or agency, is the sole provider of workers' compensation insurance.

Benefit levels provided under workers' compensation insurance, like medical coverage, disability payments, and vocational rehabilitation, can vary by state. Factors like average wage levels, cost of living, and specific state regulations may influence benefit levels.

Workers' compensation rating formulas consider factors such as industry classification, claims history, payroll, and other factors believed to be relevant. Although many states have similar risk classification plans, these formulas' specific components and weighting can differ.

IBM defines a predictive model as a statistical tool or algorithm that leverages patterns and relationships in historical data to make predictions or forecasts about future events. It involves training a model on a dataset and then using that model to make predictions about new, unseen data.

Insurers commonly use predictive models in personal lines products. The purpose of using the models is to promote more accurate risk segmentation, which correlates with expected costs. Predictive models must use a robust historical dataset. Using modeling approaches allows more formal control that eliminates some of the guesswork.

The use of workers' compensation models is lagging behind the use of personal lines models. The NCCI and rate bureau methods are sophisticated but not typically interpreted as applying a true "model" definition. Model usage is less prevalent in workers' compensation than in personal lines.

According to studies conducted by Robert Hartwig (University of South Carolina), there has been no statistically discernible relationship between workers' compensation underwriting performance and periods of recession over the past century. Workers' compensation rates have also been flat or decreased in recent years.

One hurdle to model rollouts in workers' compensation includes internal resource constraints and prioritization compared to other lines of insurance. Additionally, there may be pushback on regulatory or company management acceptance.

Workers' compensation has experience ratings and scheduled ratings built in. However, these components must be managed in a modeling process. The management of these components might increase the complexity of a model due to the extent there are differences by state.

There are some impacts of model usage on workers' compensation. One effect might be that if the regulatory framework permits models, insurers can conceivably use models to deviate from bureau loss cost plans and the current rating structure. Additionally, insurers could modify risk segmentation based on cost expectations. Due to state differences, there will likely be unique complexities in workers' compensation models that differ from personal lines pricing. However, workers' compensation models could offer risk management and pricing insights.

A good pricing model needs to comply with state laws and regulations. When used on a dataset not used in building the model, the model should predict the target variable, such as claim severity, claim frequency, pure premium, and loss ratio. A good model considers the dataset size; a more extensive dataset may permit a more complex model structure than a smaller dataset. Acknowledging that different data set sizes offer different credible insights is necessary. Finally, a good model uses appropriate input characteristics that meaningfully contribute to a model's ability to predict the target variable. For example, the input variable can be demonstrated to have statistical significance or influence on the model results and improve the predictions of the target variable.

A good pricing model has appropriate control and offset variables to mitigate the risk of predictions without influencing a particular variable's model contributions (e.g., policy year and state). Sometimes an insurer will put a policy year in for a control variable when using multiple years of data because they do not want to distort their model results. Another control variable would be the state because each state likely has differences. The control variable is the variable that the modeler does not want to influence their target variable predictions.

Another factor that makes a good pricing model is integrating it into the model process. Insurers will have a current rating plan, but introducing a model into the rating plan requires an approach to control how the model gets integrated. For example, this will ensure there is no double counting.

When stakeholders, like regulatory communities, and consumers are concerned about the black box aspect of pricing models, it is important to ensure they:

- Understand the data underlying the model.
- Understand how the model validation works.
- Have some model memorandum or write-up.
- Get intuitive results.
- Have measured reliance (i.e., how the model improves a situation and why building a model is important).

Insurers may have concerns about protecting their proprietary information. Additionally, there are concerns regarding the time and speed-to-market, as well as compliance costs.

Commissioner McClain said everyone wants good data and analytics, and predictive modeling speaks to this. He said he has heard from stakeholders that they like the methods in place for years, as they have proved reliable. Commissioner McClain also heard that some insurers apply the models differently. He has heard from Arkansas' local industry concerns about the uniform applicability of models.

McKenney said he thought the presentation was helpful and liked how it touched on state insurance regulator concerns and state-by-state differences. He said Pennsylvania has had some workers' compensation insurers try to come in with predictive models, and Pennsylvania does not think their law allows it. McKenney said their workers' compact uses words like a uniform classification system, a uniform experience rating plan, and exclusive means. He said bringing in something that is essentially another way of classifying risk provides prospective pricing that deviates from what is supposed to be the exclusive means of providing prospective pricing in Pennsylvania's Act. McKenney said he understands that state-by-state laws vary. However, predictive models are not used as often in workers' compensation as in other lines of business.

Grassel said the workers' compensation industry has thrived for five to 10 years. He asked Koch if the workers' compensation market would deteriorate if she thought there might be more pressure on predictive modeling products. Grassel said workers' compensation insurance was a line of insurance needing improvement, say 25 years ago, and now it is the one that is performing the best.

Koch said she believes if the risk segmentation abilities deteriorate and the experience starts to deteriorate, there will be more efforts to use modeling. She said if insurers see ways predictive modeling could improve results, they would do so in jurisdictions that permit it.

Wake said he questions whether the improved performance in workers' compensation is due to improved performance. Instead, he wonders if the improved performance is a different inflation and investment environment in recent decades.

Wake asked if insurers need lower combined ratios to sustain the same level of performance. He said that combined ratios are not the only thing determining success or failure in workers' compensation because it is a long tail line; so much of the probability depends on investment return. Wake asked if the structure of investment return changes in low inflation and if a low nominal return economy needs more profitability from underwriting than investment. Koch said that if the investment returns are coming in lower than expected, that will put upward pressure on rates and pricing.

3. Discussed Other Matters

Commissioner McClain said the Task Force would meet in a couple of months to hear a presentation regarding the unintended consequences of the legalization of cannabis on workers' compensation.

Having no further business, the Workers' Compensation (C) Task Force adjourned.

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MARKET REGULATION AND CONSUMER AFFAIRS (D) COMMITTEE

Market Regulation and Consumer Affairs (D) Committee Aug. 15, 2023, Minutes	8-2
Market Regulation and Consumer Affairs (D) Committee July 27, 2023, Minutes (Attachment One)	8-9
Chapter 4 of the <i>Market Regulation Handbook</i> (Attachment Two)	8-11
Voluntary Market Regulation Certification Program (Attachment Three).....	8-16
Other Health Market Conduct Annual Statement (MCAS) Standard Ratios (Attachment Four).....	8-61
Market Analysis Procedures (D) Working Group July 17, 2023, Minutes (Attachment Five).....	8-65
Market Analysis Procedures (D) Working Group June 12, 2023, Minutes (Attachment Five-A)	8-68
Market Analysis Procedures (D) Working Group May 8, 2023, Minutes (Attachment Five-A1)	8-72
Market Analysis Procedures (D) Working Group April 10, 2023, Minutes (Attachment Five-A1a)	8-74
Market Conduct Annual Statement Blanks (D) Working Group July 19, 2023, Minutes (Attachment Six) ...	8-78
Market Conduct Annual Statement Blanks (D) Working Group June 22, 2023, Minutes (Attachment Six-A)	8-80
Market Conduct Annual Statement Blanks (D) Working Group May 30, 2023, Minutes (Attachment Six-A1)	8-82
Market Conduct Annual Statement Blanks (D) Working Group May 22, 2023, Minutes (Attachment Six-A2)	8-83
Market Conduct Annual Statement Blanks (D) Working Group April 6, 2023, Minutes (Attachment Six-A2a)	8-86
Market Conduct Examination Guidelines (D) Working Group July 18, 2023, Minutes (Attachment Seven).....	8-88
Market Conduct Examination Guidelines (D) Working Group March 28, 2023, Minutes (Attachment Seven-A)	8-93
Market Regulation Certification (D) Working Group June 6, 2023, Minutes (Attachment Eight).....	8-95
Market Regulation Certification (D) Working Group May 9, 2023, Minutes (Attachment Eight-A)	8-96
Speed to Market (D) Working Group July 25, 2023, Minutes (Attachment Nine).....	8-97

Draft: 8/22/23

Market Regulation and Consumer Affairs (D) Committee
Seattle, Washington
August 15, 2023

The Market Regulation and Consumer Affairs (D) Committee met in Seattle, WA, Aug. 15, 2023. The following Committee members participated: Jon Pike, Chair (UT); Mike Causey, Co-Vice Chair, represented by Jackie Obusek (NC); Michael Humphreys, Co-Vice Chair, and David Buono (PA); Peni Itula Sapini Teo (AS); Karima M. Woods (DC); Trinidad Navarro and Susan Jennette (DE); Dean L. Cameron (ID); Sharon P. Clark (KY); Chlora Lindley-Myers represented by Cynthia Amann and Jo LeDuc (MO); Jon Godfread represented by John Arnold (ND); Michael Wise (SC); Cassie Brown, Matthew Tarpley, and Jamie Walker (TX); Kevin Gaffney represented by Karla Nuisl (VT); and Jeff Rude (WY). Also participating were: Dana Popish Severinghaus and Erica Weyhenmeyer (IL); Larry D. Deiter (SD); Rebecca Nichols (VA); and Mike Kreidler and John Haworth (WA).

1. Adopted its July 27 Minutes

Commissioner Pike said the Committee met July 27 and took the following action: 1) adopted the pet insurance Market Conduct Annual Statement (MCAS) data call and definitions; 2) adopted a new charge for the Producer Licensing (D) Task Force to amend the NAIC's *Public Adjuster Licensing Model Act* (#228); and 3) received the Voluntary Market Regulation Certification Program from the Market Regulation Certification (D) Working Group.

Commissioner Clark made a motion, seconded by Commissioner Navarro, to adopt the Committee's July 27 minutes (Attachment One). The motion passed unanimously.

2. Adopted Revisions to the *Market Regulation Handbook*

Tarpley said revisions to the NAIC *Market Regulation Handbook*, Chapter 4—Collaborative Actions, Section E. Conclusion of Collaborative Enforcement Actions are meant to provide non-regulators with transparency and insight regarding the multistate settlement process that occurs in the Market Actions (D) Working Group. The revisions were adopted by the Market Conduct Examination Guidelines (D) Working Group on July 18.

Director Cameron made a motion, seconded by Commissioner Humphreys, to adopt the revisions to Chapter 4 of the *Market Regulation Handbook* (Attachment Two). The motion passed unanimously.

3. Adopted the Voluntary Market Regulation Certification Program

Commissioner Pike said during the Committee's call, the Market Regulation Certification (D) Working Group reported that it had completed its work, and the final draft of the Voluntary Market Regulation Certification Program, guidelines, checklist, and implementation plan have been exposed on its web page since May 9.

Commissioner Kreidler said the completed Voluntary Market Regulation Certification Program consists of 11 requirements; checklists and guidelines for each requirement; a scoring matrix; and the implementation plan. He said the program is a long-needed response to the federal government's critiques of market conduct regulation in the separate states and territories of the U.S. It is also a step forward to promoting best practices and consistency for all NAIC members' market regulation activities, and it promotes collaboration among the NAIC members.

Haworth presented an overview of the contents of the program to the Committee. He said the program has 11 requirements that are broken into five major categories, including: 1) the appropriate statutory authorities for

market regulation departments to conduct market regulation activities and maintain the confidentiality of information obtained from their own activities and received from other NAIC jurisdictions; 2) staffing resources and qualifications to conduct market regulation activities and/or to oversee contractors; 3) the use of the *Market Regulation Handbook*; 4) the reporting of timely, accurate, and complete data to NAIC databases and participation MCAS; and 5) collaboration with other jurisdictions through NAIC working groups.

Haworth said in the first three years of the program, jurisdictions will have the ability to self-certify themselves using the program checklist and scoring matrix. After three years, jurisdictions will have the option to either self-certify or be fully certified by an independent panel of state insurance regulators. Re-certification would occur every five years.

Commissioner Clark made a motion, seconded by Director Cameron, to adopt the Voluntary Market Regulation Certification Program and Scoring Definitions (Attachment Three). The motion passed unanimously.

4. Adopted its Task Force and Working Group Reports

A. Antifraud (D) Task Force

Commissioner Navarro said the Antifraud (D) Task Force met Aug. 14. The Task Force discussed its current charges in preparation for developing its 2024 charges, and he requested that suggestions be submitted by Sept. 22. He said the Task Force will meet in October to adopt its 2024 proposed charges.

Commissioner Navarro said the Task Force heard a presentation concerning Workers' Compensation Premium Fraud from the United Brotherhood of Carpenters and Joiners of America (UBC). He said the Task Force discussed the importance of workers' compensation insurance fraud related to the construction industry and agreed that additional discussions in regulator-to-regulator and open meetings are necessary to further address this type of insurance fraud.

Commissioner Navarro said the Task Force received a report from the Improper Marketing of Health Insurance (D) Working Group. The Working Group met July 27 to discuss the revised draft amendments to the NAIC's *Unfair Trade Practices Act* (#880). He said the Working Group also met Aug. 14 to discuss the revised draft and comments and adopt the amendments to Model #880. He said the Task Force will expose the adopted amendments for comment and meet in September to consider them for adoption.

Commissioner Navarro said the Task Force received an update from the Antifraud Technology (D) Working Group. He said the Working Group chair is working with NAIC staff concerning the redesign of the NAIC's Online Fraud Reporting System (OFRS). The Working Group will be holding conference calls to discuss necessary enhancements to the OFRS to include fields provided from the National Insurance Crime Bureau (NICB) data.

Commissioner Navarro also said the Task Force heard a presentation from the Coalition Against Insurance Fraud (CAIF) regarding a research study on who commits insurance fraud and why. The study showed how different generations across the nation view insurance fraud. He said the Task Force also received reports on matters of interest from the CAIF and the NICB.

B. Market Information Systems (D) Task Force

Director Severinghaus said the Market Information Systems (D) Task Force met July 31. She said this year, the Task Force is beginning work on implementing the recommendations contained in the Artificial Intelligence (AI) report it adopted last year. She said the Market Information Systems Research and Development (D) Working Group is working on the first recommendation to develop methods to ensure better MIS data quality, and the Market

Analysis Procedures (D) Working Group is working on the second recommendation to assess MIS data and scoring methodologies for its effectiveness and make suggestions for needed improvements. The Task Force heard reports from both working groups on their progress with their charges related to the AI report.

Director Severinghaus said the Task Force also heard a report from NAIC staff regarding the progress on a variety of projects that affect the MIS, including those that are incorporated into the *State Connected* strategic plan and those prioritized through the Uniform System Enhancement Request (USER) forms.

C. Producer Licensing (D) Task Force

Director Deiter said the Producer Licensing (D) Task Force met May 31 and adopted a new charge to review and amend, as needed, Model #228 to enhance consumer protections in the property/casualty (P/C) claims process. He said the Task Force also adopted new Continuing Education Recommended Guidelines for Instructor Approval to create a more uniform process for the approval of continuing education (CE) instructors and a quicker process for such approval. He said these items were adopted by the Committee during its July 27 meeting.

Director Deiter said if the new charge is adopted by the Committee, the Task Force will move forward with drafting proposed revisions to Model #228. He said the model will be amended to strengthen regulatory standards for the following four issues: 1) individuals acting as unlicensed public adjusters; 2) contractors who are also acting as public adjusters on the same claim; 3) limiting the assignment of benefit rights to the contractor; and 4) limits on public adjuster compensation. He said Commissioner Navarro has agreed to lead this effort due to recent legislative changes regarding public adjusters in Delaware. He also said because some of the issues to be discussed on potential fraudulent practices, it will be helpful to have Commissioner Navarro, who chairs the Antifraud (D) Task Force, lead this effort.

Director Deiter said during its May 31 meeting, the Task Force continued its discussion of the template for the review of 1033 requests, which are required by the federal Violent Crime Control and Law Enforcement Act of 1994. He said the Task Force discussed the following three issues: 1) whether the definition of “conviction” should include pleas of abeyance and expungements should be excluded from this definition; 2) whether states use the long-form or short-form for requests and why one form is preferred; and 3) the factors a jurisdiction may consider when evaluating a 1033 waiver request and how states inform individuals about the 1033 waiver application process. He said NAIC staff are working with a small group of subject matter experts (SMEs), and the Task Force will continue its discussions in the coming months.

Director Deiter said the Task Force also received a report from the National Insurance Producer Registry (NIPR) Board of Directors. He said NIPR’s year-to-date (YTD) revenue was \$24 million, which is 3.7% over budget. The NIPR senior team and Board of Directors have begun work on the NIPR strategic plan for 2024–2026, and a vote on the final plan is scheduled for the end of the year. Director Deiter said NAIC staff are coordinating with NIPR and states, including any back-office system support vendors, to conduct an analysis of how long it will take to implement proposed changes and the cost to implement. The Task Force will be discussing the time and cost estimates in the coming months to determine the next steps.

Director Deiter said the Task Force also adopted the reports for the Adjuster Licensing (D) Working Group and the Uniform Education (D) Working Group.

D. Market Analysis Procedures (D) Working Group

LeDuc said the Market Analysis Procedures (D) Working Group will meet July 17. She said the Working Group was assigned a new charge to “assess current market analysis data to identify needed improvements in the effectiveness of the data for market analysis and the predictive abilities of the market scoring systems utilizing

the data.” She said in considering this charge, the Working Group began by compiling a list of what data market analysts use. She said the list is not exhaustive, but it is extensive and covers data provided through the NAIC MIS, data available within the states, and data obtained from sources outside the NAIC and states. She said the Working Group will continue to add to the list as data sources continue to be identified, but it will also begin identifying how market analysts use the data and discuss the data’s effectiveness.

LeDuc said the Working Group will also begin its assessments of the scoring systems that are in the NAIC MIS, which includes the Market Analysis Prioritization Tool (MAPT) and the MCAS-MAPT rankings.

LeDuc said the Working Group also adopted the Other Health MCAS standard ratios (Attachment Four) to be posted publicly after each annual filing. She said they will be effective for the 2023 data year collected in 2024.

LeDuc said the Working Group is also discussing the inclusion of fraternal insurance organizations in the MCAS. She said fraternal are exempted from filing the MCAS, and the Working Group is discussing whether the exemption should remain.

LeDuc said the Working Group is also putting together a plan to provide regulator-only training on market analysis tools and methods using the tools for market analysis. She said the training sessions will be informal and address topics most in demand. She noted that there are quite a few new market analysts that will benefit from informal sessions with more experienced market analysts.

E. Market Conduct Annual Statement Blanks (D) Working Group

Weyhenmeyer said the Market Conduct Annual Statement Blanks (D) Working Group met July 19. She said the Working Group is discussing revisions to the homeowners and private passenger auto (PPA) blanks to clarify to companies which closed claims to report and how to report them. She said a proposal will be considered for adoption during the Working Group’s next meeting.

Weyhenmeyer said the Working Group also received a request to permanently move the MCAS filing deadline for the short-term limited-duration (STLD) and other health MCAS blanks to May 31 to match the deadline already established for the health MCAS blank.

Weyhenmeyer also said in the last couple years, the Working Group adopted two MCAS blanks with less than 30 days of exposure after the final draft was complete. She said to avoid this in the future, the Working Group is working on adding guidelines to the written process for adopting new blanks and revising data elements. She said the guidelines will encourage a 60-day exposure prior to the June 1 deadline date for adoption.

F. Market Conduct Examination Guidelines (D) Working Group

Tarpley said the Market Conduct Examination Guidelines (D) Working Group met March 28 and July 18.

Tarpley said during its March 28 meeting, the Working Group discussed its 2023 charges and items to be carried forward from 2023 to 2024, including the travel insurance in-force policy standardized data request (SDR), the travel insurance claims SDR, and an exposure draft of the *Market Regulation Handbook’s* Chapter 23—Conducting the Life and Annuity Examination.

Tarpley said during its July 18 meeting, the Working Group adopted revisions to the *Market Regulation Handbook’s* Chapter 4, Section E. He said the revisions provide non-regulators with insight on the multistate settlement process that occurs in the Market Actions (D) Working Group. He said the Working Group also discussed a June 6 draft of Chapter 23 and reviewed comments received on the draft. The comment period was

extended to Sept. 4. Tarpley said revisions to Chapter 23 arise from the changes recently made to the *Suitability in Annuity Transactions Model Regulation* (#275). He said the Working Group also received updates on the SDRs for travel insurance in-force policies and claims.

G. Market Regulation Certification (D) Working Group

Commissioner Kreidler said the Market Regulation Certification (D) Working Group met June 6 and adopted the Voluntary Market Regulation Certification Program. He said the Working Group is on hold until further instruction from the Committee.

H. Speed to Market (D) Working Group

Nichols said the Speed to Market (D) Working met July 25. She said the Working Group reviewed suggested changes to the uniform product coding matrices (PCMs). She said three suggestions for additional types of insurance (TOIs)/sub-TOIs were submitted for the P/C matrix and the Life, Health, and Annuity matrix. She said the Working Group adopted new sub-TOIs for paid family medical leave products for the Life, Health, and Annuity matrix. She said alternative solutions, such as new filing types were also discussed for a couple of the suggestions. She said two suggestions for the P/C matrix were tabled to see if a solution can be provided by the System for Electronic Rates & Forms Filings (SERFF) Modernization project.

Nichols said the Working Group's revisions to the *Product Filing Review Handbook* are nearly complete. She said the next steps are to expose the revisions and ask for Working Group member volunteers to review a few of the chapters for any technical gaps or inaccuracies. She expressed appreciation to Petra Wallace (NAIC) for her support, hard work, and commitment to the work on the *Product Filing Review Handbook*.

LeDuc made a motion, seconded by Commissioner Navarro, to adopt the other health MCAS standardized ratios and the following reports: 1) the Antifraud (D) Task Force; 2) the Market Information Systems (D) Task Force; 3) Producer Licensing (D) Task Force; 4) the Market Analysis Procedures (D) Working Group (Attachment Five); 5) the Market Conduct Annual Statement Blanks (D) Working Group (Attachment Six); 6) the Market Conduct Examination Guidelines (D) Working Group (Attachment Seven); 7) the Market Regulation Certification (D) Working Group (Attachment Eight); and 6) the Speed to Market (D) Working Group (Attachment Nine). The motion passed unanimously.

5. Heard an Update on International Issues Regarding Market Regulation

Commissioner Pike said the Committee has a standing charge to coordinate with the International Insurance Relations (G) Committee to develop input and submit comments to the International Association of Insurance Supervisors (IAIS) or other related groups on issues regarding market regulation concepts.

Nikhail Nigam (NAIC) said the NAIC is a member of the IAIS and serves on its Market Conduct Working Group (MCWG). He said the MCWG is tasked with developing and enhancing high-level principles-based supervisory and supporting material in relation to market conduct supervision. He said the MCWG coordinates with other international bodies dealing with the market conduct of insurers and intermediaries and financial consumer protection. The MCWG reports to the IAIS Policy Development Committee, and it is composed of representatives of IAIS members with experience in market conduct supervision and regulation.

Nigam said in June, the MCWG finalized a Members Report on the Use of Conduct Indicators in Insurance Supervision. He said the report provides members with guidance on the identification, assessment, and appropriateness of specific types of indicators and data-gathering techniques. He said the report puts an emphasis on adopting more outcomes-based approaches to conduct supervision in many jurisdictions. He said the MCWG

believes the ability to draw informative, actionable, and well-targeted “indicators” from data is central to achieving this objective. He said the report follows a member survey conducted in 2021 and 2022 focusing on current supervisory approaches and challenges regarding the use of data and key indicators to assess conduct-related outcomes. He said the NAIC provided two examples. The first focused on claims handling and a review of the NAIC MCAS and the data it collects on claims and underwriting for various lines of business. The second NAIC example reviewed the use complaints index.

Nigam said another project the MCWG has been focusing on is related to Diversity, Equity, and Inclusion (DE&I), and the NAIC has been involved in these efforts at both the MCWG, as well as the Governance Working Group (GWG) of the IAIS. He said the project focuses on the link between DE&I and insurers’ governance, risk management, and corporate culture. He said the project is exploring the hypothesis that applying a DE&I paradigm to the Insurance Core Principle (ICP) 19 requirement of fair treatment of customers can result in better outcomes and fairer treatment for diverse consumers. He said the NAIC has regularly updated the IAIS on the work of the Special (EX) Committee on Race and Insurance, and it held a special session where the NAIC’s DE&I Director, Evelyn Boswell, presented on the work of her team and the assistance they provide to NAIC members.

Nigam said a few other initiatives being worked on at the MCWG include work to incorporate climate risk into ICP 19. He said the IAIS’s Climate Risk Steering Group and the MCWG are working on an application paper for supervisors that will focus on instances when sustainability-related risks and considerations can lead to the unfair treatment of consumers.

Nigam said the MCWG is focused on supporting the parent committees and secretariat at the IAIS in developing its strategic plan for the next five years. He said one initiative has been proposed by the MCWG to share Suptech tools and initiatives.

6. Heard a Presentation on the Use of Visualization in Market Analysis

Commissioner Pike said the Market Analysis Procedures (D) Working Group has a charge this year to assess the effectiveness of data used by market analysts. He said to provide some background on this work, he asked LeDuc to provide the Committee with an overview of the current state of market analysis techniques, especially regarding the use of tools to provide visualizations of the data used by analysts.

LeDuc said the visualization of data leverages human perception skills to allow the analyst to absorb more information and remember it more easily. She said this allows analysts to analyze a large quantity of data more quickly and identify more complex issues. The analyst can identify new trends, patterns and anomalies when they are able to visualize data using visualizations incorporating graphs, charts, and the deliberate use of color instead of viewing a mere dataset of numbers. LeDuc said this gives analysts a better understanding of the data, removes subjectivity, and creates repeatable outcomes for verification. Additionally, LeDuc noted that this is further enhanced when incorporating text analytics, machine learning, predictive analytics, and network analysis. She said to fully utilize visualizations and advanced analytics, the data needs to be available, accessible, usable, consumable, reliable, consistent, and complete.

LeDuc provided examples illustrating how to create effective visualizations used to provide comparisons of data over time, the relationships between different categories and data points, the composition of data over multiple periods of time, and the distribution of data points. She gave examples of the best ways to create visualizations to answer the different questions that can be asked about the data.

LeDuc said there are best practices to keep in mind when creating data visualizations. She said the visualization should be kept as simple as possible to answer the question being asked. It should direct the focus of the user to the most relevant points in the data. The data and visualization should be clearly explained and identified to the

user reviewing the visualization. LeDuc also emphasized that the use of color must be intentional and with the purpose of clearly bringing out the meaning in the data.

LeDuc showed how the MAPT and the MCAS data can be made more useful by presenting the data into visualizations.

LeDuc concluded with things to consider: 1) the visualization should add value; 2) it is important to consider the cost and benefits of obtaining and creating new data sources; 3) visualizations change both the process and mindset in the analysis of data; and 4) using visualizations moves market analysis from an examiner's skillset to an analyst's skillset.

Having no further business, the Market Regulation and Consumer Affairs (D) Committee adjourned.

SharePoint/NAIC Support Staff Hub/Committees/D Cmte/2023 Summer/_Final Minutes/08_D Cmte T.docx

Draft: 8/8/23

Market Regulation and Consumer Affairs (D) Committee
Virtual Meeting
July 27, 2023

The Market Regulation and Consumer Affairs (D) Committee met July 27, 2023. The following Committee members participated: Jon Pike, Chair (UT); Mike Causey, Co-Vice Chair, represented by Jackie Obusek (NC); Michael Humphreys, Co-Vice Chair (PA); Trinidad Navarro (DE); Dean L. Cameron represented by Shannon Hohl (ID); Sharon P. Clark (KY); Chlora Lindley-Myers (MO); Michael Wise (SC); Cassie Brown represented by Leah Gillum (TX); Kevin Gaffney and Karla Nuisl (VT); and Jeff Rude (WY). Also participating were: Erica Weyhenmeyer (IL); and John Haworth (WA).

1. Adopted its Spring National Meeting Minutes

Director Lindley-Myers made a motion, seconded by Commissioner Clark, to adopt the Committee's March 24 minutes (see *NAIC Proceedings – Spring 2023, Market Regulation and Consumer Affairs (D) Committee*). The motion passed unanimously.

2. Adopted the Pet Insurance MCAS Data Call and Definitions

Weyhenmeyer said the Market Conduct Annual Statement Blanks (D) Working Group developed the Pet Insurance Market Conduct Annual Statement (MCAS) data call and definitions as requested by the Market Analysis Procedures (D) Working Group and the Committee. She said the data call and definitions were developed by a group of subject matter experts (SMEs), which included state insurance regulators, industry representatives, and consumer representatives. She said Matt Gendron (RI) led the discussions of the SMEs, who presented the draft Pet Insurance MCAS data call and definitions to the Market Conduct Annual Statement Blanks (D) Working Group to solicit public comments. The Working Group adopted the Pet Insurance MCAS data call and definitions on May 30. The Pet Insurance data call includes the collection of data for underwriting, claims, marketing and sales, lawsuits, and complaints.

Commissioner Clark made a motion, seconded by Director Lindley-Myers, to adopt the Pet Insurance MCAS data call and definitions. The motion passed unanimously.

3. Adopted the Revised Producer Licensing (D) Task Force Charges

Commissioner Clark said the National Association of Public Insurance Adjusters (NAPIA) requested that the Producer Licensing (D) Task Force amend the NAIC's *Public Adjuster Licensing Model Act* (#228) to address the following issues: unlicensed public adjusters, contractors who are also acting as public adjusters on the same claim, and the assignment of benefit rights to contractors. She said the Task Force will also consider additional consumer protections regarding compensation limits for public adjusters, and this will also be included as part of the model law review if the proposed charge is adopted today.

Commissioner Clark said the Task Force adopted the charge to "Review and amend, as needed, the *Public Adjuster Licensing Model Act* (#228) to enhance consumer protections in the property and casualty claims process" during its May 31 call, and it is now presenting the charge to the Committee for its considerations. She said if the charge is adopted today, Commissioner Navarro, who chairs the Antifraud (D) Task Force, will lead this work under the Producer Licensing (D) Task Force since Delaware recently considered new legislation regarding the public adjusters and the issues to be reviewed potentially touch on fraudulent activities.

4. Adopted the Continuing Education Recommended Guidelines for Instructor Approval

Commissioner Clark said the guidelines being presented today were developed by the Uniform Education (D) Working Group after industry representatives approached the Working Group to discuss the difficulties of obtaining approval for continuing education (CE) instructors in some jurisdictions and the lack of uniformity across jurisdictions. The Working Group responded to the feedback by surveying jurisdictions regarding requirements for CE instructor approval and moved forward to develop the guidelines. Commissioner Clark said the members of the Producer Licensing (D) Task Force hope the guidelines create a more uniform process for approval of CE instructors and a quicker process for such approval.

Commissioner Clark made a motion, seconded by Commissioner Navarro, to adopt: 1) the following charge for the Producer Licensing (D) Task Force: “Review and amend, as needed, the *Public Adjuster Licensing Model Act* (#228) to enhance consumer protections in the property and casualty claims process”; and 2) the Continuing Education Recommended Guidelines for Instructor Approval. The motion passed unanimously.

5. Received the Voluntary Market Regulation Certification Program

Haworth, on behalf of Commissioner Kreidler, chair of the Market Regulation Certification (D) Working Group, said the Working Group met June 6 and completed its work to revise the Voluntary Market Regulation Certification Program, which includes a checklist, guidelines, and scoring matrix. The revisions are a result of a pilot program involving 18 states. Haworth said each of the states reviewed the certification program, and using the guidelines and checklists, they attempted to self-certify themselves. He said each of the states was requested to provide input on what worked, what did not work, and what changes could be made to improve the program and make it more useful for market regulation activities in the departments of insurance (DOIs).

Haworth thanked the 18 pilot states and the SMEs that compiled the changes to finish the work of revising the program. The redline and clean versions of the Voluntary Market Regulation Certification Program and its implementation plan are posted on the Working Group’s web page. Haworth said the Voluntary Market Regulation Certification Program is now ready for the Committee’s consideration.

Commissioner Pike said the Committee would be receiving the Voluntary Market Regulation Certification Program, but it is not prepared to consider the adoption of the program today. He requested that the Committee members review the Voluntary Market Regulation Certification Program prior to the Summer National Meeting, where the Committee will engage in a lengthier review of the program with the goal of considering a motion to consider the adoption of the program.

Having no further business, the Market Regulation and Consumer Affairs (D) Committee adjourned.

[SharePoint/NAIC Support Staff Hub/Committees/D Cmte/2023 Summer/July 27 Call](#)

Chapter 4—Collaborative Actions

E. Conclusion of Collaborative Enforcement Actions

When a collaborative effort produces findings for which a regulatory penalty or sanction is contemplated, such action should be memorialized in a written consent order, voluntary settlement agreement or similarly titled settlement document. States may contemplate a collaborative enforcement action at the same time as a pending civil court action concerning similar issues, such as a class action lawsuit. Such an enforcement action may or may not occur simultaneously with a settlement of the civil action. Negotiations for coordinated regulatory and civil settlement should be the responsibility of the Lead State(s).

In the event a collaborative effort is challenged, or Lead States cannot reach a settlement, they should develop a resolution strategy. Lead States should outline their strategy and recommendations to ensure violations are appropriately addressed in the correct jurisdictions. Examiners from Participating States must be made available for follow-up proceedings, if required. Expenses associated with the appearance of any examiners at a proceeding arising out of the examination must be borne by the states conducting the action.

1. *Best Practices for Multistate Settlement Agreements*

The purpose of this document is to outline best practices that will meet the needs of multiple jurisdictions affected by the business practices of regulated persons/entities. It is important to recognize that although state departments of insurance have the authority to perform multistate examinations and investigations of potential violations of insurance law, the states cannot require regulated persons/entities to participate in a multistate settlement agreement (MSA). Thus, multistate settlement agreements are commonly entered into by way of mutual agreement with the applicable regulated entity as a way to uniformly and efficiently resolve regulatory matters.

The *Best Practices for Multistate Settlement Agreements* document is intended to provide guidance to regulators with respect to engaging in multistate settlement negotiations and drafting multistate settlement agreements. It is recognized that the terms of the agreement may vary depending on the subject matter of the examination/investigation, the nature of the violation, the duration of noncompliance, the number of consumers affected, and the number of states in which the regulated entity is doing business, among other considerations. However, agreements should be negotiated and drafted in a manner that is intended to promote participation by regulators and effectively address the issues of concern to regulators. With this in mind, best practices have been developed to effectuate the greatest amount of participation among the states in multistate settlement agreements. A complete copy of the *Best Practices for Multistate Settlement Agreements*, adopted by the Market Actions (D) Working Group, is available to regulators. Below are some provisions of the document, which have been provided in order to promote transparency about the MSA process.

A. Procedure

Who Leads Settlement Negotiations?

States seeking to initiate a multistate settlement are encouraged to bring such matters to the attention of the Market Actions (D) Working Group (MAWG). MAWG's main role is to support collaborative actions among the states to address common regulatory compliance issues. MAWG reviews submissions from state regulators or other sources that identify regulated entities that have a current or potential market regulatory issue that impacts multiple jurisdictions. MAWG determines if it will take a role in initiating regulatory action.

If MAWG does take a role in initiating a multistate regulatory action, according to established procedures, MAWG will participate in determining whether the Managing Lead State (MLS) in any MAWG initiative should be the state of domicile or another state. More than one Lead State may be designated by MAWG. The Lead State(s) will assume the responsibility for developing final action, including developing any MSA.

Provide Periodic MAWG Updates

At least one Lead State should be available to participate in MAWG and Collaborative Action Designee (CAD) conference calls. Participation in these calls will provide an opportunity for the Lead State(s) to address issues and questions presented by MAWG members and CADs and to update the states on the progress and direction of active collaborative actions.

B. Contents of MSAs**1. Background****a. Statutory Authority**

The MSA should include any and all relevant statutory authority of the MLS.

b. The Parties

The MSA should define the parties to the agreement:

1. Regulated Entity – The MSA should state the name of each and every company and/or individual that is party to the agreement. Because state databases, as well as NAIC databases, are populated on a company level, insurance companies that are a party to the agreement should be listed separately rather than as a group;
2. Lead State(s) – The MSA should indicate the states that have taken a leadership role in the examination/investigation and development of the MSA;
3. Domestic Regulators – The MSA may indicate the state where the regulated entity is domiciled;
4. Participating State(s) – Often defined in an MSA as “the insurance regulators of each of the remaining jurisdictions and the District of Columbia that agree to and approve the MSA;
5. Signatory Regulators – Often defined in an MSA to include the Lead State(s) and Participating State(s) collectively; and
6. Monitoring Regulators – If the regulators who will be overseeing corrective action plans, claims reassessments, progress reports, or follow up examinations subsequent to the MSA are different from the Lead State(s), a set of monitoring regulators should be defined.

c. Recitals/Recitation of Events Leading Up to the Action

The MSA should include a statement of the facts that gave rise to the necessity of an MSA. The recitals should contain:

1. A statement regarding the jurisdiction of the Lead State(s) over the regulated entity;
2. An explanation as to the commencement or initiation of the action that gave rise to the MSA;
3. Identification of multistate areas of concern. The MSA should list the issues that gave rise to collaborative action; and
4. Violations that are being pursued by the Lead State(s).

d. Scope of the MSA

The MSA should include a statement as to the scope of the agreement with as much specificity as possible. As part of determining the scope of the MSA, the Lead State(s) should review the particular company’s corporate governance to determine if the agreement should include corporate governance features.

The parties to the MSA may agree that specific issues will not be addressed by the MSA. Any stipulations between the parties to reserve an issue from consideration should be specifically stated in the MSA. Any potential Participating State that wishes to reserve an issue yet participate in the collaborative action must notify the MLS of the state’s conditions for participation. Such reservation should be for good cause and

as limited as possible. The reservation of an issue should be communicated to the regulated entity by the MLS. Such a reservation may require a separate written agreement between the potential Participating State and the regulated entity. It should be understood that the regulated entity is not required to accept the reservation. In such instances, the state and regulated entity may choose to handle that state's issues in a separate action.

2. Remedies/Remediation

a. Corrective Action

A primary goal of any MSA should be to achieve compliance with the regulated entity on a national basis. The MSA should define any required corrective action with specificity, including a specified period of time for completion. Corrective actions should be reasonably calculated to undo past harm, where possible, and to eliminate future violation of the insurance laws in the Participating State(s).

The Lead State(s) or Monitoring Lead State(s) should retain the authority to oversee any compliance efforts that require communication with policyholders/consumers to ensure that the regulated entity communicates directions, instructions and information in a manner that is easily understood by affected consumers. Further, the corrective action plan should incorporate contact information that affords policyholders/consumers an opportunity to seek information from persons with knowledge over the subject matter.

b. Follow-up Audits/Examinations

A follow-up audit or examination process in an MSA should proceed in a timely manner after any period of corrective action and should be as objective and transparent as possible. The MSA should indicate:

1. The regulators that will be responsible for the follow-up audit or examination;
2. The date the follow-up audit or examination is scheduled to begin;
3. The time period that the follow-up audit or examinations is expected to cover;
4. The examination standards from the handbook that will be applied during the audit/examination;
5. The compliance expectations of the examination team;
6. Consequences that will be applied as a result of the regulated entity failing to meet specified compliance thresholds; and
7. Whether participating regulators are precluded from conducting their own examinations until the adoption of the follow-up examination for the issues involved.

c. Self-Reporting

The MSA may provide for periodic self-reporting. If self-reporting is required as a condition of the MSA, the Lead State(s) or Monitoring State(s) must be prepared to review and provide feedback to the regulated entity that is required to provide the reports. Should the Lead State(s) determine that self-reporting is a condition to settlement, the MSA should specify the following:

1. Reporting deadlines;
2. Required contents of the reports;
3. The regulator(s) responsible for receiving the reports;
4. The expectations of the regulator(s) responsible for receiving the reports;
5. Expected compliance standards;
6. Any penalties or other consequences for failing to meet compliance standards based solely on reporting; and
7. Any penalties or other consequences for failing to meet reporting deadlines without obtaining an extension.

d. Penalties/Fines Costs

Penalty and fine provisions should be structured in a manner that is consistent with the laws of the Participating States. For instance, many states do not permit penalties to be designated as “administrative costs” or “assessments.” Further, some states do not have a mechanism that allows a penalty to be paid to a third party in the form of a contribution or charitable donation.

C. Consent Orders of Other Adoption Orders

A Participating State may elect or be required by law to execute a Consent Order or other type of Adoption Order that adopts an MSA. Any Consent Order or other Adoption Order executed should be consistent with the terms of the MSA and should not include any additional duties or obligations upon the parties to the agreement that are not specifically required by that state’s law. A Participating State should not reserve any issues from inclusion in the MSA that were not communicated to the MLS at the time of indicating a willingness to participate in the collaborative action.

Any required or elected Consent Order or other Adoption Order shall be executed and final within any participation deadlines established by the MSA.

Any state that had indicated a willingness to participate in the collaborative action but does not intend to execute or participate in the MSA shall advise the MLS of the Participating State’s intent to not participate. The Participating State is encouraged to explain the reasons for not intending to participate in the MSA. By doing so, the Lead State(s) may be in a position to renegotiate with the regulated entity in order to address the outstanding reservations or concerns of the Participating State.

D. Confidentiality

1. Report

Final examination/investigation reports establish the foundation for future administrative action. These reports should be shared with participating regulators as soon as is practicable after they are completed.

Where permitted by law, final examination/investigation reports should be open for public disclosure after final administrative action has been taken. Any limitation to the public distribution of final examination/investigation reports should be clearly stated in the MSA, including any waiting period required prior to public disclosure. It may be practical to include the report as an exhibit in the MSA. Reasons for any limitations for making documents public should be listed.

2. Exhibits

In many instances, final examination/investigation reports include exhibits. Exhibits attached to reports should be handled with the same confidentiality and public disclosure standards applied to the final examination/investigation reports.

a. MSA and Other Adoption Orders

Unless otherwise required by law, the MSA and any other order entered into by the Participating State adopting the MSA should not be confidential after the order is executed and final. Rather, final actions of regulators, as well as duties imposed upon regulated persons/entities pursuant to the MSA, should be transparent and available for public disclosure.

b. Settlement Offers/Negotiations

Notes, materials, draft documents, discussions, and any other information developed during the course of settlement negotiations should be considered a component of the examination/investigation work papers and should not be subject to public disclosure after the MSA has been finalized. The release of preliminary settlement information to the public that is an integral part of negotiations would have a detrimental effect on future settlement negotiations.

Draft: 5/9/23

Guidelines and Checklist adopted by the Market Regulation and Consumer Affairs (D) Committee – 8/15/23
Guidelines and Checklist adopted by the Market Regulation Certification (D) Working Group – 6/6/2023

Voluntary Market Regulation Certification Program Self-Assessment Guidelines, and Checklist Tool

Contents

Purpose	3
Definitions	3
Requirement 1 – Department’s Authority	4
Objective	4
Measurement	4
Guidelines.....	4
Checklist.....	5
Requirement 2 – Department’s Authority Regarding the <i>Market Regulation Handbook</i>	6
Objective	6
Measurement	6
Guidelines.....	6
Checklist.....	6
Requirement 3 – Department Staffing: Resources	8
Objective	8
Measurement	8
Guidelines.....	8
Checklist.....	9
Requirement 4 – Department Staffing: Qualifications	12
Objective	12
Measurement	12
Guidelines.....	12
Checklist.....	15
Requirement 5 – Confidentiality and Information-Sharing.....	16
Objective	16
Measurement	16
Guidelines.....	16
Checklist.....	16
Requirement 6 – Collaboration with Other Jurisdictions	17

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Guidelines and Checklist adopted by the Market Regulation Certification (D) Working Group – 6/6/2023

- Objective 17
- Measurement 18
- Guidelines..... 18
- Checklist..... 19
- Requirement 7 – Market Conduct Annual Statement..... 21
 - Objective 21
 - Measurement 21
 - Guidelines..... 21
 - Checklist..... 21
- Requirement 8 – Electronic Data Entry with the NAIC 23
 - Objective 23
 - Measurement 23
 - Guidelines..... 23
 - Checklist..... 24
- Requirement 9 – Participation in NAIC Market Conduct and Market Analysis Working Groups 25
 - Objective 25
 - Measurement 25
 - Guidelines..... 25
 - Checklist..... 25
- Requirement 10 – Collaborative Action Designee 27
 - Objective 27
 - Measurement 27
 - Guidelines..... 27
 - Checklist..... 27
- Requirement 11 – Interdivisional Collaboration 28
 - Objective 28
 - Measurement 28
 - Guidelines..... 28
 - Checklist..... 28

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Guidelines and Checklist adopted by the Market Regulation Certification (D) Working Group – 6/6/2023

Purpose

The mission of the NAIC Market Regulation Certification Program is to establish and maintain minimum standards that promote sound practices relating to the market conduct examination, market analysis and related continuum activity functions performed for insurance consumer protection. Insomuch as the program is anticipated to evolve and improve over time, it is anticipated that additional functions necessary for sound consumer protection may be developed in the future. The certification program is designed to provide an initial process that facilitates each jurisdiction's ability to conduct self-evaluation. An ultimate goal is to develop measurable and meaningful standards that can be independently evaluated and monitored.

Program standards, assessment checklist items and guidelines should:

- Provide a roadmap regarding resources, abilities and functions for jurisdictions wishing to build, maintain, or improve upon, their market regulation program.
- Promote consistency while respecting individual jurisdictional differences and circumstances by promoting use of NAIC resources.
- Demonstrate accountability and responsiveness to those impacted by the business of insurance, and to others that are charged with evaluating and assessing the effectiveness of state-based insurance regulation.
- Promote an environment of continuous process improvement for enhancing outcomes relating to insurance consumer protection.
- Improve predictability and understanding of processes for regulated entities.
- Enhance jurisdictional coordination and information-sharing.
- Enhance protection of insurance consumers through promotion of sound market regulation processes.

Definitions

When referenced in this document, the following terms mean:

- **Chief Market Regulator** is either elected or appointed and is the Commissioner of Insurance, Superintendent, Director, Secretary of Commerce, or other chief who oversees the regulation of insurance in each state or jurisdiction.
- **Department** is the chief governmental office invested with the responsibility of regulating the insurance industry within a jurisdiction.
- **Jurisdiction** is the territory within which power can be exercised. Within this document, jurisdiction will include but is not limited to: Departments of Insurance, Insurance Divisions, and other state specific agency titles which may include terms such as: Administration, Bureau, Commerce, Financial Services, Business Regulation, and Other Departments/Divisions that include the regulation of insurance. For example: Department of Professional and Financial Regulation, Office of Consumer Affairs and Business Regulation, Business and Industry, Banking and Insurance.

NOTE: When responding to checklist items for each requirement, if the response is N/A (not applicable), please provide an explanation for the "N/A" response in the comments.

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Guidelines and Checklist adopted by the Market Regulation and Consumer Affairs (D) Committee – 8/15/23
Guidelines and Checklist adopted by the Market Regulation Certification (D) Working Group – 6/6/2023

Voluntary Market Regulation Certification Guidelines and Checklists

Requirement 1 – Department’s Authority

The jurisdiction or department shall have the statutory authority to conduct market regulation activities, including market analysis; comprehensive and targeted market conduct examinations; the continuum of market regulation actions, including enforcement; and collaboration and coordination with other regulatory jurisdictions.

Objective

The objective of this requirement is to ensure the department has the statutory authority to effectively fulfill its market regulation responsibilities.

Measurement

To evaluate whether the jurisdiction “passes” Requirement 1, the jurisdiction must have the general authority to collect and analyze information and have authority to coordinate with other jurisdictions. If the jurisdiction does not have the authority to coordinate with other jurisdictions, it will not pass this requirement. Additionally, a jurisdiction should have authority to conduct analysis, examinations, and enforcement. Requirements to have reasonable cause to conduct an examination does not negatively impact the evaluation. Ability to perform these items without having the ability to perform continuum actions should be considered as “marginally passing but with strong recommendations for additional authority.”

Guidelines

When determining the department’s authority for conducting market regulation activities, several different considerations should be evaluated. Direct legal authority may exist in the jurisdiction’s insurance code or within its regulations. Insurer examination acts, specific market regulation acts, acts that outline the authority and duties of the department are all potential items to review. Generally, such authority is cited when requesting documents from an insurer. Jurisdictions may also have broad oversight authority within other consumer protection laws.

Additional authority may be implied or may exist on a less direct basis. Examples could include insurance consumer protection-related insurance laws or regulations and their associated enforcement provisions. Other potential areas of authority are activities performed pursuant to the powers or orders of the insurance commissioner, director, or superintendent (i.e., the applicable chief market regulator of the jurisdiction).

When evaluating checklist items for Requirement 1, it may be beneficial to look beyond the mere capability to perform the listed functions. If not directly addressed within the insurance code or regulations, consider whether direct authority for all mentioned items would be desirable (most continuum items would fall under examination, investigation, or analysis categories). Having direct authority may provide valuable guidance on such issues as application of administrative procedure act requirements, status of examination, investigational or analysis records, handling of associated costs, etc.

Consider which consumer protections model laws and regulations have been adopted in the jurisdiction. Investigation, subpoena, and cease and desist powers are found in most unfair trade and producer laws. Most chief market regulators also have a general powers statute that may contain similar enforcement authorities.

The key basic models or similar versions should include:

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Guidelines and Checklist adopted by the Market Regulation and Consumer Affairs (D) Committee – 8/15/23
Guidelines and Checklist adopted by the Market Regulation Certification (D) Working Group – 6/6/2023

- *Unfair Trade Practices Act (#880)*
- *Unfair Claims Settlement Practices Act (#900)*
- *Health Carrier Grievance Procedure Model Act (#72)*
- *Uniform Health Carrier External Review Model Act (#76)*
- *Producer Licensing Model Act (#218)*
- *Suitability in Annuity Transactions Model Regulation (#275)*
- *Life Insurance Illustrations Model Regulation (#582)*
- *Life Insurance and Annuities Replacement Model Regulation (#613)*
- *Standard Nonforfeiture Law for Life Insurance (#808)*
- *Standard Nonforfeiture Law for Individual Deferred Annuities (#805)*
- *Unfair Discrimination Against Subjects of Abuse in Health Benefit Plans Model Act (#895)*
- *Unfair Discrimination Against Subjects of Abuse in Life Insurance Model Act (#896)*
- *Unfair Discrimination Against Subjects of Abuse in Disability Income Insurance Model Act (#897)*
- *Unfair Discrimination Against Subjects of Abuse in Property and Casualty Insurance Model Act (#898)*
- *Model Law on Examinations (#390) or Market Conduct Surveillance Model Law (#693)*

Checklist

Please provide the statutory reference(s) the department relies on for the following:

	YES	NO
1a. Does the department have the general authority to collect and analyze information whenever it is deemed necessary?	_____	_____
REFERENCE _____		
1b. Does the department have the authority to collaborate and coordinate with other regulatory agencies?	_____	_____
REFERENCE _____		
1c. Is the department’s authority broad enough to cover market analysis, comprehensive and targeted market conduct examinations and the continuum of market regulation actions, including enforcement?	_____	_____
If yes, provide the citation reference(s) in the table below	_____	_____

	Citation
Market analysis	
Comprehensive and targeted market conduct exams	
Continuum of market regulation actions (including enforcement)	

Complete the following if this is an Interim Annual Review:

	YES	NO
Have there been any significant changes to the procedures since last year’s review? If “Yes,” please provide an explanation.	_____	_____

COMMENTS:

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Requirement 2 – Department’s Authority Regarding the *Market Regulation Handbook*

The department shall have sufficient authority by appropriate statute, regulation, rule, or other authority to utilize the most recent version of the *Market Regulation Handbook*. When a department initiates a market conduct examination or continuum activity, it shall be guided by the version of the *Market Regulation Handbook* in effect at the time the examination was initiated.

Objective

The objective of this requirement is to promote guidance and consistent handling of examination processes and continuum activities through the use of the *Market Regulation Handbook*. Additionally, this promotes guidance and consistent handling of examination processes and continuum activities within each jurisdiction on an individual basis when it is deemed appropriate to deviate from the *Market Regulation Handbook*.

Measurement

To evaluate whether the jurisdiction “passes” Requirement 2, the jurisdiction must at a minimum have sufficient authority by appropriate statute, regulation, rule, or other authority to utilize the most recent version of the *Market Regulation Handbook*, and be able to demonstrate when conducting examinations or continuum activities their use of applicable *Market Regulation Handbook* review standards and related materials to the extent they are consistent with jurisdictional law. The department’s policies and procedures should properly reference the use of those materials set forth in the *Market Regulation Handbook*.

Guidelines

When determining the department’s authority by appropriate statute, regulation, rule, or other authority to utilize the most recent version of the *Market Regulation Handbook*, the department should identify the statute, regulation, rule, or other authority to use the *Market Regulation Handbook* within their response.

When evaluating checklist items for Requirement 2, a jurisdiction should be able to demonstrate, on an individual basis, when it is deemed appropriate to deviate from, or necessary to use an earlier version of, the *Market Regulation Handbook*. The jurisdiction must also be able to demonstrate that it has followed its own established policies and procedures for adopting processes that deviate from the *Market Regulation Handbook*.

Checklist

	YES	NO
2a. Does the department have authority by statute, rule or other authority to utilize the <i>Market Regulation Handbook</i> ?	_____	_____

REFERENCE _____

2b. When conducting examinations or continuum activities, does the department incorporate applicable <i>Market Regulation Handbook</i> review standards and related materials to the extent they are consistent with state laws?	_____	_____
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2c. Does the department have examination-specific policies and procedures in addition to those guidelines set forth in the *Market Regulation Handbook*?

2d. If the answer to item 2c. is “Yes”, is the jurisdiction able to demonstrate that it has followed its own established policies and procedures in adopting any process that deviates from the *Market Regulation Handbook*?

Complete the following if this is an Interim Annual Review:

Have there been any significant changes to the procedures since last year’s review? If “Yes,” please provide an explanation.

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Requirement 3 – Department Staffing: Resources

The department must have either, or a combination of:

- Its own staff sufficient to perform market regulation work, including market analysis, examinations and other continuum actions.
- Statutory authority sufficient to engage competent contractors on an as-needed basis and appropriate department staff to oversee and manage such contractors.

Objective

The objective of this requirement is to ensure the department has sufficient resources to meet the needs of the department's market regulation activities.

Measurement

To evaluate whether the jurisdiction “passes” Requirement 3, the jurisdiction, must be able to respond “Yes” to each of the following checklist items:

- Item 3a.
- Item 3d. and/or 3e.
- Item 3n.

Furthermore, if the answer to checklist item 3e. is “Yes”, then a “Yes” response is required for item 3k., item 3l., and item 3m.

All remaining Requirement 3 checklist items should be collected and evaluated from year-to-year to evaluate the jurisdiction's abilities.

Guidelines

Requirement 3 provides guidance on whether a jurisdiction has resources and capabilities to conduct market analysis, market conduct examinations and/or continuum activities. The standard recognizes that some jurisdictions use contracted services to perform these functions. In the event that contracted services are used, the standard inquires if the jurisdiction has the authority to hire contractors, established processes for selecting contractors and whether the jurisdiction engages in oversight of the contracted services. It is understood that jurisdictions vary in their usage of examinations versus continuum activities.

This requirement anticipates that some data will be obtained through the *Insurance Department Resources Report*. Those results should be reviewed in the event that classifications differ. Additionally, it is anticipated that each jurisdiction will evaluate changes in its level of resources from year to year.

The number of staff listed below should be expressed in terms of full-time equivalent (FTE) positions. The use of FTEs recognizes that most employees perform multiple functions within a department, for example, if two employees each spend half their time doing market analysis that would equate to 1 full-time equivalent position.

To evaluate its own status regarding the checklist for Requirement 3, each jurisdiction determines its specific appropriate level of staffing and or use of contracted services. Levels will vary from jurisdiction to jurisdiction. Factors such as population size, premium volume, complexity of insurance issues with a particular jurisdiction, complaints, legal requirements, directives for conducting market conduct activities and ability to keep abreast of emerging market issues are valid factors when evaluating the jurisdiction's needs. Jurisdictions are encouraged to establish resource levels that permit them to meet their obligations or needs for market analysis, market conduct examinations and/or continuum actions.

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During each jurisdiction’s evaluation of its staffing levels, it may also be helpful to determine what NAIC resources are relied upon for market regulation functions and how the use of those resources has changed over time. If additional NAIC resources are identified that may be beneficial, it is a good idea to bring forth those suggestions to NAIC staff. This will help to provide opportunities and diagnostic tools for improvement.

Where independent contractors are used to fulfill staffing needs, the department must be engaged and responsible throughout the examination and be responsive to issues and concerns that might arise.

Checklist

Sufficient Staff and Resources (Market Analysis)

The department should have the resources to analyze effectively on a periodic basis the market behavior of insurers doing business in the jurisdiction.

- | | YES | NO |
|--|-------|-------|
| 3a. Does the department have analysts on staff or under contract whose responsibility is to conduct market analysis of insurers doing business in the jurisdiction? | _____ | _____ |
| 3b. If the department utilizes contract analysts, please describe in a separate attachment the manner and extent of utilization in the department’s recent activities. | | |
| 3c. Indicate below the number of FTE contract and staff analysts for each of the last three years. | | |

	In-house Market Analysts	Contract Market Analysts
Current Year (CY)		
CY-1		
CY-2		

Indicate below the number of market analysis reviews for which market analysis was performed in the prior review period. Market analysis means formal review of a company through existing processes (e.g., Level 1, Level 2).

	Total Reviews
Current Year (CY)	
CY-1	
CY-2	

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Sufficient Staff and Resources (Examinations and/or Continuum Actions)

The department should have resources to effectively examine and/or conduct continuum actions of insurers as deemed appropriate by the department based upon its market analysis or as prescribed by jurisdiction laws.

- | | YES | NO |
|--|-------|-------|
| 3d. Does the department have examiners on staff whose responsibility is to examine and/or conduct continuum actions of insurance companies as indicated by the department’s market analysis or as prescribed by jurisdiction laws? | _____ | _____ |
| 3e. Does the department utilize contract examiners to examine and/or conduct continuum actions of insurance companies as indicated by the department’s market analysis or as prescribed by jurisdiction laws? | _____ | _____ |
| 3f. If the department utilizes contract examiners, please describe in a separate attachment the manner and extent of utilization in the department’s recent activities. | | |
| 3g. Indicate below the number of FTE market examiners, including supervisory personnel on the department’s staff and/or the number of individual contract examiners used compared to the last three years. | | |

	In-House Examiners	Contract Examiners	
Current Year (CY)			
CY-1			
CY-2			

- | | YES | NO |
|--|-------|-------|
| 3h. Has the department performed any targeted exams or market continuum actions in the prior two years? | _____ | _____ |
| 3i. If the answer to item 3h. is “Yes,” please provide a list of such exams or market continuum actions and the scope of the exams/actions. | | |
| 3j. If the answer to item 3h. is “No,” does the department have the on-staff resources or the ability to contract additional resources to perform targeted exams/actions, if deemed necessary? | _____ | _____ |

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Sufficient Staff and Resources (Contractor Selection and Oversight)

- | | YES | NO |
|--|-------|-------|
| 3k. Does the department have the authority to hire contractors as specialists to perform market regulation? | _____ | _____ |
| 3l. If the department has authority to hire contractors, does it have either a statewide or departmental established process it follows for selecting contractors for market regulation purposes? Briefly explain. | | |
| 3m. Does the department oversee and manage contractors? Briefly explain. | | |

Policies & Procedures and Output

- | | | |
|---|-------|-------|
| 3n. Does the department have policies and procedures, subject to periodic review and updates, for identifying and addressing market conduct issues using market analysis and market conduct continuum activities, including examinations? | _____ | _____ |
| 3o. If the answer to item 3n. is “Yes,” what quantitative and subjective measurements are available to evaluate whether the department is adhering to its policies and procedures? | | |
| 3p. Based on the review of staff resources, please provide an explanation of any significant changes in resources and/or workload over the three-year period covered in the data above. | | |

Complete the following if this is an Interim Annual Review:

- | | YES | NO |
|--|-------|-------|
| Have there been any significant changes to the procedures since last year’s review? If “Yes,” please provide an explanation. | _____ | _____ |

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Requirement 4 – Department Staffing: Qualifications

With respect to qualifications, the department:

- Shall ensure market regulation staff and contractors are qualified by establishing qualifications consistent with the standards for experience, education (including designations) and licenses in the *Market Regulation Handbook Core Competencies* (“Appendix D – Core Competencies – Resources – Staff and Training, Standard 2” and Appendix D – Core Competencies – Resources – Contractor Examiner, Standard 2” or successor documents).
- Should have a policy that encourages the professional development of all staff involved with market regulation through job-related college courses, professional designation programs or other training programs.

Objective

The objective of this requirement is to ensure the department staff is properly qualified to perform the market regulation functions for which they are responsible and have access to training and professional development opportunities.

Measurement

In order to successfully meet this requirement, the department must have policies and procedures in place regarding the appropriate credentials or minimum educational and experience requirements for selecting and hiring contractors. Furthermore the department should be able to demonstrate that it supports the hiring qualified staff and contractors; that it encourages and supports educational and training pursuits; that Examiners-in-Charge possess or are making progress toward completing appropriate designations; that the department recognizes licenses and other highly technical credentials of professionals and experts to perform certain market regulation activities where appropriate; and that it has a succession plan in place to ensure the maintenance of skills and records.

Guidelines

Notes to Evaluators:

- Equivalent substitutions may be considered with appropriate justification.
- Employees are exempt from this requirement if they have more than 20 years of service with the department or are less than five years from retirement.
- If collective bargaining or jurisdictional personnel policies prohibit any portion of such requirements, the department must show evidence that it has made good faith attempts to include such requirements.
- Evidence of good faith activities include, but are not limited to, the following:
 - The department adopts procedures to include a statement encouraging professional education.
 - The department has made arrangements to be a testing location for organizations such as Life Office Management Association (LOMA) or The Institutes.
 - The department attempts to secure funds for the professional development of market regulation personnel.

Hiring of Staff and Contractors

This area evaluates the effort of the department as it relates to the hiring of qualified staff and/or contractors. The department should have a policy or procedure in place on necessary credentials or minimum educational and experience requirements for selecting and hiring staff and contractors.

- The policies/procedures of the department should call for the inclusion of preferences for relevant experience, education and credentials in its job announcements/descriptions. In addition, the department should include in its specifications in requests for proposals (RFPs) requirements that contracted personnel (*with emphasis on supervisory personnel*) have relevant experience, and credentials.

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Relevant credentials would include a Market Conduct Management (MCM)¹ designation and any of the following designations:

- Certified Insurance Examiner (CIE)
- Accredited Insurance Examiner (AIE)
- Chartered Life Underwriter (CLU)
- Fellow, Life Management Institute (FLMI)
- Chartered Property Casualty Underwriter (CPCU)
- Certified Insurance Counselor (CIC)
- Fellow, Academy for Healthcare Management (FAHM)
- Professional in Insurance Regulation (PIR)
- Chartered Healthcare Consultant (ChHC)

Staff Development

The department should have a staff development program that encourages and supports educational and training pursuits, including training, courses, webinars, and certifications offered by the NAIC. Successful completion of this aspect of the requirement varies depending on an employee's length of service in insurance regulation.

(1) Staff Examiners/Analysts with More than Five Years of Service in Insurance Regulation

Examiners and analysts with more than five years of service with the department are “presumed qualified” and should be rated as a pass if they meet either of the following:

- Hold a juris doctor degree (J.D.) and an MCM designation.
- Hold an MCM designation and either an AIE or CIE designation.

Examiners and analysts with more than five years of service in the position of market conduct analyst or market conduct examiner who specialize in a particular line of business are “presumed qualified” and should be rated as a pass if they meet either of the following:

- Hold an MCM designation and either a CLU, FLMI, CPCU, CIC, FAHM or ChHC designation.
- Hold an MCM designation, a PIR designation and an associate's level designation from either The American College of Financial Services, The Institutes, America's Health Insurance Plans (AHIP) or similar organization such as LOMA or the Society of Financial Examiners (SOFE).

If all examiners and analysts with more than five years of service do not have the above qualifications, rate a pass if:

- The department has a training policy and/or job specifications that require completion and/or experience to attain the next highest level in their job classification series.
- The department has a policy that allows voluntary access to NAIC designation programs, and the department must show good faith attempts for encouragement and budgetary allowances to provide for voluntary training

¹ NAIC market conduct examination training may substitute for an MCM designation.

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at other sources of professional education such as the Insurance Regulatory Examiners Society (IRES), The American College of Financial Services, The Institutes, LOMA or AHIP.

(2) Staff Examiners/Analysts with Less than Five Years of Service

When the department has staff with less than five years of service, the department should:

- Have a formal training program whereby new personnel have a clear requirement to attain, within five years, an MCM designation and either a CIE, AIE, CLU, FLMI, CPCU, CIC, FAHM, PIR or ChHC designation.
 - Personnel with a J.D. and five years of regulatory experience are exempt, with the exception they must earn an MCM designation or complete NAIC market conduct examination training.
- The department must have a policy that allows voluntary access to NAIC designation programs and the department must show good faith attempts for encouragement and budget allowances to provide for voluntary training at other sources of professional education such as IRES, The American College of Financial Services, The Institutes, LOMA or AHIP.

Examiner-in-Charge Qualifications

Examiners-in-Charge (EICs) should possess (or be making progress towards completion of) relevant designations. Relevant designations would include a Market Conduct Management (MCM) designation and any of the following designations as appropriate by lines of business:

- CIE
- AIE
- CLU
- FLMI
- CPCU
- CIC
- FAHM
- PIR
- ChHC

When an EIC with specific qualifications is not available, other qualifications are acceptable so long as the department is compliant with checklist item 4c. (development program).

Recognition of Licenses & Technical Credentials of Professionals & Experts

The department should recognize licenses and other highly technical credentials of professionals and experts such as attorneys, actuaries, cybersecurity experts, certified public accountants, IT experts and other professionals and specialists as qualified to perform certain market regulation activities.

In evaluating this aspect of the requirement, it is important to determine if the department retained and utilized appropriate staff or contractors with highly technical credentials when appropriate. Note: it is possible that no examinations or continuum activities requiring highly technical specialties were conducted during the review period.

Succession Plan

The department should have a succession plan in place to ensure maintenance of skills and records. At a minimum, the department should maintain written procedure manuals and cross-train employees.

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Guidelines and Checklist adopted by the Market Regulation Certification (D) Working Group – 6/6/2023

Checklist

	YES	NO
4a. Does the department have policy and procedures in place on necessary credentials or minimum educational and experience requirements for selecting and hiring staff consistent with the detailed credentials listed in the Certification guidelines?	_____	_____
4b. Does the department have policy and procedures in place on necessary credentials or minimum educational and experience requirements for selecting and hiring contractors consistent with the detailed credentials listed in the Certification guidelines?	_____	_____
4c. Does the department have a staff development program that encourages and supports educational and training pursuits, including training, courses, webinars and certifications offered by the NAIC?	_____	_____
4d. Does each Examiner-in-Charge possess or is the Examiner-in-Charge making progress towards completion of noted designations?	_____	_____
4e. Does the department recognize licenses and other highly technical credentials of professionals and experts such as attorneys, actuaries, cybersecurity experts, certified public accountants, information technology (IT) experts and other professionals and specialists as qualified to perform certain market regulation activities?	_____	_____
4f. Does the department maintain written procedure manuals to demonstrate a succession plan?	_____	_____
4g. As a separate attachment, provide a list of market analysts/examiners that includes the following: name; professional designation(s); title; years employed by the department (include functional area); type of college degree; and prior regulatory or insurance experience. Also indicate those market conduct analysts/examiners that are contractual and whether each is full-time with the department.		

Complete the following if this is an Interim Annual Review:

	YES	NO
Have there been any significant changes to the procedures since last year’s review? If “Yes,” please provide an explanation.	_____	_____

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Requirement 5 – Confidentiality and Information-Sharing

The department shall have the authority and capability to:

- Request, hold and produce examination, investigation, and continuum workpapers, on a confidential basis and protect it from subpoena, as permitted by jurisdictional law.
- Maintain confidentiality of confidential information shared by other jurisdictional or federal agencies; and only share confidential information with jurisdictional and federal agencies that agree, in writing, to adequately protect such confidential information.

Objective

The objective of this requirement is to ensure the department is able to maintain the confidentiality of its own work product and the work product of jurisdictions with which it collaborates. This is foundational to all collaborative efforts.

Measurement

To evaluate whether the jurisdiction “passes” Requirement 5, the jurisdiction must answer “Yes” to checklist item 5a., item 5b., item 5c and item 5d.

Guidelines

The jurisdiction’s treatment of examination, investigation, and continuum workpapers and information shared by or with other jurisdictions has a significant impact on the various jurisdictions’ ability to communicate and collaborate on confidential matters. The provisions within each jurisdiction’s laws, regulations or case law may vary regarding the extent to which workpapers are confidential or to timing which such information becomes a public document. Some laws may extend beyond workpapers and apply to examination reports, as well. Research and documentation of the applicable jurisdiction’s confidentiality provisions should provide clear guidance for individuals within the market regulation division. Checklist item 5a. does not anticipate a uniform confidentiality framework among jurisdictions, but rather is viewed as a necessity to adequately fulfill the requirements of checklist item 5c.

Entering into the Multi-State Information-Sharing Agreement with other jurisdictions and the NAIC is also a necessary part of being able to adequately maintain confidentiality of information shared by other jurisdictions.

Checklist

	YES	NO
5a. Does the jurisdiction have laws, regulations or case law that specify how the confidentiality of market conduct examination workpapers is to be handled?	_____	_____

REFERENCE _____

5b. Has the department entered into the Multi-State Information-Sharing Agreement with other departments and the NAIC and does the department have written policies/procedures and communicate such policies/procedures to staff?	_____	_____
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Guidelines and Checklist adopted by the Market Regulation Certification (D) Working Group – 6/6/2023

5c. Does the department have written policies and procedures and communicated such policies and procedures to employees relating to the protection of confidential information which includes PII and PHI, handling of public records requests and requirements for confidentiality agreements when it becomes necessary to share confidential information with other federal and international regulatory or law enforcement agencies, not otherwise covered by the multi-state agreement? _____

5d. Does the department have a records retention schedule which outlines plans for secure storage and timeline for destruction of work papers? _____

Information-sharing agreements with federal or international regulatory agencies or law enforcement agencies may be handled either on a case-by-case basis or by way of properly executed memorandums of mutual understanding.

Complete the following if this is an Interim Annual Review:

Have there been any significant changes to the procedures since last year’s review? If “Yes,” please provide an explanation. **YES** **NO**

COMMENTS:

Requirement 6 – Collaboration with Other Jurisdictions

The department participates in collaborative actions with other jurisdictions.

The department follows the referral or reporting procedures outlined in the Market Actions (D) Working Group’s Policies and Procedures for any material action that has a potential for collaborative action. In order to determine if a referral or reporting to the Market Actions (D) Working Group is necessary, the department will notify all other Collaborative Action Designees (CADs) via meeting, bulletin board, or other method, of proposed activities that have the potential for collaboration.

In addition, the Market Analysis Chief (MAC), MAWG member, CAD and/or CAD alternate shall actively monitor the Market Regulation and Market Analysis Bulletin Boards.

The department will consider joining called Market Actions (D) Working Group collaborative actions relevant to its jurisdiction and provide a response indicating whether or not it will join the collaborative action.

[Collaboration-National Analysis. Formerly Req. 11] The department participates* in the review of national analysis data annually.

*Participation means either performing analysis on one of the selected companies or participating in the selection process. Please note if none of the selected companies wrote business in the jurisdiction. It should be noted that the national analysis process is subject to change. Therefore, it is understood that in the future it may be necessary to revisit what it means to “participate.”

Objective

The objective of this requirement is to encourage collaboration with other jurisdictions to help to keep market regulation more effective and efficient by preventing duplication of effort. Sharing of key information among jurisdictions helps to identify

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marketplace issues as they arise. By encouraging a multi-jurisdictional response to issues when practical, jurisdictions can more effectively direct their resources. Also, this requirement promotes collaboration and the sharing of perspectives and approaches to analyzing data among jurisdictions.

Measurement

To evaluate whether the jurisdiction “passes” Requirement 6, the jurisdiction must answer “Yes” to checklist item 6a. The jurisdiction should answer yes to item 6b. and item 6c., and item 6e. and item 6f. unless there is an applicable explanation given in checklist item 6g.

When evaluating checklist items for the MAWG national analysis process, it is important to remember that participation means either performing analysis on one of the selected companies or participating in the selection process.

To evaluate whether the jurisdiction “passes” the national analysis portion of this requirement, the jurisdiction should answer “Yes” to checklist item 6i., in addition to providing a name of the individual (or individuals) who participate in the annual national analysis project .

Drafting Note: Assumes at least one company to be reviewed is licensed or conducting business in the jurisdiction.

Guidelines

The first portion of Requirement 6 relates to participation in the Market Actions (D) Working Group and is followed by checklist item 6a., item 6b., item 6c. and item 6d. The second portion of Requirement 6 relates to how the jurisdiction joins or considers joining Market Actions (D) Working Group actions and is followed by checklist item 6e., item 6f. and item 6g.

For regulators to fully adhere with Requirement 6, especially as it relates to handling of referrals, it is important to become familiar with both the *Market Regulation Handbook*, Chapter 6—Collaborative Actions, and the Market Actions (D) Working Group’s Policies and Procedures.

Actively monitoring includes responding to posts or responding directly to the sender of a posting.

Examples of actively monitoring the bulletin boards could include regularly:

- Responding substantively to a bulletin board post.
- Reaching out directly to the poster.
- Communicating with other divisions within the department.
- Raising the issue to the Chief Market Regulator Forum (CMRF).

Examples of reasonable explanations for checklist item 6d. and item 6g. may include, but are not limited to, such justifications as:

- The issue has minimal or no consumer impact.
- The issue is not yet sufficiently defined, investigated, or analyzed.
- There are no known laws or regulations to address the issue.
- There are reasons why expediency to address the matter in the jurisdiction is of utmost concern.
- Significant differences in the jurisdiction’s particular insurance laws or regulations.

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- The matter has been previously addressed in a satisfactory manner by the jurisdiction.
- An executive decision made at the chief market regulator or general counsel level.

The MAWG national analysis process involves multiple jurisdictions conducting detailed analysis on companies that are shown as outliers. The approach to detailed analysis may differ among jurisdictions; therefore, participation encourages the sharing of ways to analyze data. The national analysis process is an evolving one that uses NAIC staff to provide information to the states. The states that participate in national analysis ultimately decide what to do with companies subject to their national analysis. Their results and recommendations are presented to the Market Actions (D) Working Group.

Additionally, it is important to know that the Market Action (D) Working Group’s annual national analysis process uses the Market Conduct Annual Statement (MCAS) and other existing data to identify companies of national (or multi-jurisdictional) interest that exhibit potential market conduct issues. The goal is to find and address issues common across jurisdictions, while reducing the strain on single jurisdictional resources.

Overall, jurisdictions should work together to test the results of the market analysis process against their findings to refine the process. By doing this, the jurisdictions can develop a more efficient market analysis process that will provide more useful information about companies’ market activities. By working together in this manner, jurisdictions will achieve the goal referenced above.

Checklist

Participation in the Market Actions (D) Working Group

	YES	NO
6a. Does the department have procedures for staff to follow when reporting potential collaborative actions to the department’s CAD?	_____	_____
6b. If the department identified a potential collaborative action, did the department notify all CADs—via meeting, bulletin board or other communication—of the activities identified that may have the potential for collaboration?	_____	_____
6c. If the department received a positive response to its inquiries to other CADs regarding a potential collaborative action, did the department refer the action to Market Actions (D) Working Group using the reporting procedures outlined in the Market Actions (D) Working Group’s Policies and Procedures, including completing the Request for Review form and submitting the form to the designated NAIC support staff?	_____	_____
6d. If the answer to item 6b. or item 6c. is “No,” please provide a brief explanation.		

Examples of reasonable explanations:

- The issue has minimal/no consumer impact.
- The issue is not yet sufficiently defined, investigated, or analyzed.

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Guidelines and Checklist adopted by the Market Regulation and Consumer Affairs (D) Committee – 8/15/23
Guidelines and Checklist adopted by the Market Regulation Certification (D) Working Group – 6/6/2023

- There are no known laws/regulations to address the issue.
- There are reasons why expediency to address the matter in the jurisdiction is of utmost concern.
- Significant differences in the jurisdiction’s insurance laws/regulations.
- The matter has been previously addressed in a satisfactory manner by the jurisdiction.
- An executive decision made at the chief market regulator/General Counsel level.

Consideration of Market Actions (D) Working Group Actions	YES	NO
6e. Does the department have written procedures for reviewing and evaluating its participation in potential collaborative actions brought to its attention, either through the Market Actions (D) Working Group or by another department?	_____	_____
6f. For any collaborative action for which the department declined participation, has the department provided a response to the Market Actions (D) Working Group?	_____	_____
6g. If the answer to item 6e. or item 6f. is “No,” please provide a brief explanation.		
6h. Does the MAC, Market Actions (D) Working Group member, CAD and/or CAD alternate actively monitor the bulletin board discussions?	_____	_____
6i. Does the department participate in the review of national analysis data on an annual basis?	_____	_____
6j. If the answer to item 6i is “Yes”, who in the department, by functional title, participates in the annual national analysis project?	_____	_____
Complete the following if this is an Interim Annual Review:	YES	NO
Have there been any significant changes to the procedures since last year’s review? If “Yes,” please provide an explanation.	_____	_____

COMMENTS:

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Guidelines and Checklist adopted by the Market Regulation Certification (D) Working Group – 6/6/2023

Requirement 7 – Market Conduct Annual Statement

The department participates in the centralized collection of the Market Conduct Annual Statement (MCAS) and utilizes the data in its market analysis process.

Objective

The objective of this requirement is to encourage utilization of the centralized collection of the MCAS to enhance each jurisdiction’s market analysis process. By using the data collected in the MCAS process, departments are able to reduce expenses and resources that would have to be used if data was requested and companies had to submit data to multiple jurisdictions.

Measurement

In order to successfully meet this requirement, jurisdictions should be able to verify that they utilize the data obtained from MCAS for market analysis. This verification can be accomplished by producing evidence of completed baseline analysis and Level 1 analysis which pull data from MCAS. Documentation of completed analysis will ensure usage of the MCAS data.

Guidelines

The department has written procedures that show that the use of MCAS data is a part of their market analysis process and assists in making decisions as to the next step in their regulation process.

In the event the department participates but does not require each line of insurance that is part of the MCAS program, a one-year “grace period” is allowed for newly adopted lines of insurance as being acceptable for a “pass.” Additionally, intention to perform analysis for newly adopted lines that have not yet been reported is acceptable for a “Yes” response to item 7c. If the department participates in MCAS but does not participate in all lines after the one-year grace period has elapsed, consider that the jurisdiction has passed with a strong recommendation to add the additional line(s).

In the event a department conducts its own individualized MCAS program, consider that scenario as marginally passing with a strong recommendation to participate in the standardized NAIC program.

Checklist

	YES	NO
7a. Does the department require eligible companies to file the MCAS with the NAIC?	_____	_____
7b. Does the department require that the MCAS be prepared in accordance with the NAIC MCAS user guides and instructions?	_____	_____
7c. Does the department utilize the data obtained from the MCAS for market analysis? (Examples of utilization include, but are not limited to, such activities as performing baseline or Level 1 analysis.)	_____	_____

Draft: 5/9/23

Guidelines and Checklist adopted by the Market Regulation and Consumer Affairs (D) Committee – 8/15/23
Guidelines and Checklist adopted by the Market Regulation Certification (D) Working Group – 6/6/2023

Complete the following if this is an Interim Annual Review:

Have there been any significant changes to the requirements since last year’s review? If “Yes,” please provide an explanation.

YES

NO

COMMENTS:

Draft: 5/9/23

Guidelines and Checklist adopted by the Market Regulation and Consumer Affairs (D) Committee – 8/15/23
Guidelines and Checklist adopted by the Market Regulation Certification (D) Working Group – 6/6/2023

Requirement 8 – Electronic Data Entry with the NAIC

The department enters data no less frequently than on a quarterly basis (but preferably monthly) to all NAIC systems, including, but not limited to, the Complaint Database System (CDS) and the Regulatory Information Retrieval System (RIRS). Except for immediate concerns as defined in the *Market Regulation Handbook*, the department enters data into the Market Actions Tracking System (MATS) concerning upcoming examinations. Additionally, the department enters continuum actions into MATS when initiating the action.

Objective

The objective of this requirement is to ensure that regulators in other jurisdictions are completely and timely informed of market conduct actions that have occurred, are ongoing, or that are anticipated.

Measurement

To evaluate whether the jurisdiction “passes” Requirement 8, the jurisdiction must answer “Yes” to checklist item 8a., item 8b and 8d., unless there is an applicable explanation, briefly explained, in applicable checklist item 8e. With respect to checklist item 8c., further clarification of what continuum items must be entered will be forthcoming; however, any item resulting in a formal order must be entered into RIRS. Source documents should be reviewed in order to ensure timeliness. Only entries after the certification program is adopted should be measured.

Guidelines

The Market Information Systems Research and Development (D) Working Group report on reporting timeliness, accuracy and completeness will be attached.

- Timeliness, accuracy and completion standards may be implemented upon consideration by the Market Regulation Certification (D) Working Group.
- Only entries after the certification program is adopted should be measured. De minimis variations (i.e., less than five business days) should be given a “pass.”

Any back-end system that auto-populates the referenced NAIC systems will meet this requirement. If a jurisdiction is using a back-end system which does not currently auto-populate the referenced NAIC systems, that jurisdiction must ensure that the information is entered in the NAIC systems. This may require dual entry until such time as the back-end system auto-populates the NAIC systems.

Significant Market Actions:

The *Market Regulation Handbook* provides guidance on continuum actions for example, “The continuum of market actions includes such initiatives as office-based information gathering, interview with the company, correspondence, policy and procedure reviews, interrogatories, desk audits, on-site audits, investigations, enforcement actions, company self-audits and voluntary compliance programs.” Such significant actions should be reported in MATS as determined by the department.

- If checklist item 8d. is answered “Yes,” ensure each examination is called 60 days prior to the start of the examination unless there is reason (noted in item 8e.) of “immediate concern” as set forth in the *Market Regulation Handbook*). Examples of immediate concerns include, but are not limited to:
 - Fraud allegations.
 - Imminent consumer harm.
 - Blatant disregard of a department order.
 - Imminent solvency concern.

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Guidelines and Checklist adopted by the Market Regulation and Consumer Affairs (D) Committee – 8/15/23
Guidelines and Checklist adopted by the Market Regulation Certification (D) Working Group – 6/6/2023

Checklist

	YES	NO
8a. Does the department enter or transmit data at least quarterly into the CDS?	_____	_____
8b. Does the department enter or transmit data at least quarterly into RIRS?	_____	_____
8c. Does the department enter non-examination continuum actions into MATS when initiated and the resulting applicable final status reports or updates (if applicable) at least quarterly?	_____	_____
8d. Did the department enter at least 75% of examinations into MATS at least 60 days before the start of the examination as set forth in the <i>Market Regulation Handbook</i> ? (Note: The start of the examination is the date the department began work on the examination materials received from the examined entity.)	_____	_____
8e. If the answer to item 8a., item 8b., item 8c., or item 8d. is “No,” please provide an explanation.		

Complete the following if this is an Interim Annual Review:

Have there been any significant changes to the requirements since last year’s review? If “Yes,” please provide an explanation.

YES **NO**

COMMENTS:

Draft: 5/9/23

Guidelines and Checklist adopted by the Market Regulation and Consumer Affairs (D) Committee – 8/15/23
Guidelines and Checklist adopted by the Market Regulation Certification (D) Working Group – 6/6/2023

Requirement 9 – Participation in NAIC Market Conduct and Market Analysis Working Groups

The department participates in or monitors NAIC market conduct and market analysis-related working groups as a member or interested regulator.

Objective

The objective of this requirement is to ensure jurisdictions are aware of market conduct and market analysis initiatives, and stay abreast of developments and improvements with respect to market analysis and examination tools, techniques and standards so that they can be applied in jurisdictions’ ongoing market regulation efforts.

Measurement

To evaluate whether the jurisdiction “passes” Requirement 9, the jurisdiction must, at a minimum, be able to answer “Yes” to checklist item 9a. and item 9c., as well as document who in the department or jurisdiction participates in or monitors the Market Analysis Procedures (D) Working Group and the Market Conduct Examination Guidelines (D) Working Group.

Guidelines

NAIC market conduct and market analysis-related working groups provide a national forum for jurisdictions to share and coordinate efforts.

When evaluating checklist items for Requirement 9, it is important to remember participation in the working group and task force meetings is tracked through the NAIC. In the absence of the ability to participate in every applicable meeting or conference call, it is anticipated that a passing jurisdiction will monitor the applicable working group activities through a review of available materials, minutes, and regulator materials.

At each jurisdiction’s discretion, consideration may be given to monitoring the Market Information Systems (D) Task Force and applicable working groups, task forces reporting to the Market Regulation and Consumer Affairs (D) Committee and other working groups, task forces and Committee relevant to consumer issues and market regulation.

Checklist

	YES	NO
9a. Does the department participate in or monitor the Market Analysis Procedures (D) Working Group as a working group member or interested regulator either by conference calls or by attending meetings?	_____	_____
9b. If the answer to item 9a. is “Yes”, who in the department, by functional title, participates in or monitors the Market Analysis Procedures (D) Working Group?		
9c. Does the department participate in or monitor the Market Conduct Examination Guidelines (D) Working Group as a working group member or interested regulator either by conference calls or by attending meetings?	_____	_____
9d. If the answer to item 9c. is “Yes”, who in the department, by functional title, participates in or monitors the Market Conduct Examination Guidelines (D) Working Group?		

Draft: 5/9/23

Guidelines and Checklist adopted by the Market Regulation and Consumer Affairs (D) Committee – 8/15/23
Guidelines and Checklist adopted by the Market Regulation Certification (D) Working Group – 6/6/2023

9e. List any other market conduct or market analysis-related working groups and/or task forces that the department participates in or monitors.

Complete the following if this is an Interim Annual Review:

Have there been any significant changes to the procedures since last year’s review? If “Yes,” please provide an explanation.

YES

NO

COMMENTS:

Draft: 5/9/23

Guidelines and Checklist adopted by the Market Regulation and Consumer Affairs (D) Committee – 8/15/23
Guidelines and Checklist adopted by the Market Regulation Certification (D) Working Group – 6/6/2023

Requirement 10 – Collaborative Action Designee

The department appoints a collaborative action designee (CAD). The department’s Market Actions (D) Working Group member, CAD and/or CAD alternate attends at least 50% of the discussions, either telephonically or in person, of the Market Actions (D) Working Group meetings they are eligible to attend every year.

Objective

The objective of this requirement is to promote collaboration with other CADs.

Measurement

To evaluate whether a jurisdiction “passes” Requirement 10, the jurisdiction must answer “Yes” to checklist item 10a., and item 10c. If the answer to item 10b is “No,” the jurisdiction is strongly encouraged to appoint a CAD alternative when possible.

Guidelines

When evaluating checklist items for Requirement 10, it is important to remember that the CAD is the one contact identified by the chief market regulator of each jurisdiction to have full responsibility for all communications related to collaborative efforts, including, but not limited to, multi-jurisdictional issues. This includes participating in, or assigning a designee to participate in, certain meetings or conference calls of the Market Actions (D) Working Group. While the market analysis chief (MAC) oversees the internal jurisdictional process of identifying entities with potential market regulatory issues, the CAD oversees the process of communicating about those entities and collaborating with other CADs, potentially through the Market Actions (D) Working Group.

The CAD is the person identified with authority to receive information regarding collaborative actions from the Market Actions (D) Working Group. Additionally, the department’s Market Actions (D) Working Group member, CAD or CAD alternate must attend at least 50% of the discussions, either telephonically or in person, of the Market Actions (D) Working Group meetings they are eligible to attend every year.

Checklist

	YES	NO
10a. Has the department appointed a CAD?	_____	_____
10b. Has the department appointed a CAD alternate?	_____	_____
10c. Does the CAD and/or CAD alternate attend at least 50% of all meetings and conference calls of the Market Actions (D) Working Group they are eligible to attend?	_____	_____

Complete the following if this is an Interim Annual Review:

Have there been any significant changes to the procedures since last year’s review? If “Yes,” please provide an explanation.	_____	_____
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COMMENTS:

Draft: 5/9/23

Guidelines and Checklist adopted by the Market Regulation and Consumer Affairs (D) Committee – 8/15/23
Guidelines and Checklist adopted by the Market Regulation Certification (D) Working Group – 6/6/2023

Requirement 11 – Interdivisional Collaboration

The Department of Insurance has established and follows a systematic procedure for interdivisional communication (as referenced in the *Market Regulation Handbook*).

Objective

The objective is to establish and maintain a systematic procedure for interdivisional communication, as well as specific guidance regarding which requirements govern or define interdivisional collaboration. This includes identifying warning signs that all staff should share with the market analysis chief (MAC). In particular, all insurance department staff should report to the MAC when information of concern that may result in consumer harm is received in the department.

Measurement

To evaluate whether the jurisdiction “passes” Requirement 11, the jurisdiction must answer “Yes” to checklist item 11a., item 11b., and item 11c.

Guidelines

Insurance department staff should effectively communicate and coordinate with various areas within the department or other jurisdiction agencies/legislature, as appropriate. Such communication should consist of information shared by other areas of the department as well as key findings resulting from research conducted by the staff. Evidence of this communication should be clearly documented. The communication process should include a formal method that allows for pertinent information from other areas (e.g. legal, rates and forms, actuarial, etc.) within the department that could impact market conduct to be shared with the staff. Examples may include regularly scheduled department head meetings, department managers’ meetings, information requests to other areas of the department, etc.

As a means of improving the sharing of information among the jurisdictions, at the conclusion of an investigation that resulted from interdivisional communication, all jurisdictions are encouraged to contact the jurisdiction’s market analysis chief (MAC) in an affected jurisdiction and inform them of the results of the investigation.

When evaluating checklist items for Requirement 11, it is important to remember that market conduct problems do not occur in a vacuum. Complaint activity, legal issues, financial concerns or irregularities in rate and form filings often accompany them. At the same time, market conduct problems may be an early warning sign of other problems with a company, so it is essential for information to be shared and discussed between the MAC and other department staff. This should be done on a systematic basis, including, at a minimum, a quarterly meeting or questionnaire requesting other work areas within the department to report unusual activity that may be of interest to the MAC, such as patterns of adverse financial data, consumer complaints, policy termination activity, producer misconduct or use of noncompliant forms or rates.

Checklist

	YES	NO
11a. Has the department established procedures for the market analysis chief (MAC), or appropriate designee, to communicate interdepartmentally with the appropriate staff, either through written channels or by sufficient demonstration of action (such as regularly scheduled department head meetings, department managers’ meetings, or information requests to other areas of the department)?	_____	_____

Draft: 5/9/23

Guidelines and Checklist adopted by the Market Regulation and Consumer Affairs (D) Committee – 8/15/23
Guidelines and Checklist adopted by the Market Regulation Certification (D) Working Group – 6/6/2023

11b. Does the MAC, or appropriate designee provide the appropriate interdepartmental staff with market concerns such as, but not limited to, financial data, consumer complaints, policy termination activity, producer misconduct or use of noncompliant forms or rates, related to the following functional areas:

- i. Consumer Services
- ii. Enforcement
- iii. Legal
- iv. Forms and Filing
- v. Financial
- vi. Market Analysis
- vii. Market Conduct

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

11c. On a quarterly basis, does the MAC, or appropriate designee, solicit information from the above functional areas regarding adverse patterns on, but not limited to, financial data, consumer complaints, policy termination activity, producer misconduct, or use of noncompliant forms or rates?

_____	_____
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Complete the following if this is an Interim Annual Review:

Have there been any significant changes to the procedures since last year’s review? If “Yes,” please provide an explanation.

_____	_____
-------	-------

COMMENTS:

1st assessment	all mandatory must be met
1st 5-year re-assessment	50% of remaining available points
2nd 5-year re-assessment	90% of remaining available points

Question	Text	Mandatory Condition Met	(Primary)	(Secondary)
Requirement 1				
1a	Does the department have the general authority to collect and analyze information whenever it is deemed necessary?			
1b	Does the department have the authority to collaborate and coordinate with other regulatory agencies?			
1c	Is the department's authority broad enough to cover market analysis, comprehensive and targeted market conduct examinations and the continuum of market regulation actions, including enforcement?			
Requirement 2				
2a	Does the department have authority by statute, rule or other authority to utilize the <i>Market Regulation Handbook</i> ?			

Question	Text	Mandatory Condition Met	(Primary)	(Secondary)
2b	When conducting examinations or continuum activities, does the department incorporate applicable <i>Market Regulation Handbook</i> review standards and related materials to the extent they are consistent with state laws?			
2c	Does the department have examination-specific policies and procedures in addition to those guidelines set forth in the <i>Market Regulation Handbook</i> ?			
2d	If the answer to item 2c. Is "Yes", is the jurisdiction able to demonstrate that it has followed its own established policies and procedures in adopting any process that deviates from the <i>Market Regulation Handbook</i> ?			
Requirement 3				
3a	Does the department have analysts on staff or under contract whose responsibility is to conduct market analysis of insurers doing business in the jurisdiction?			
3b	If the department utilizes contract analysts, please describe in a separate attachment the manner and extent of utilization in the department's recent activities.			

Question	Text	Mandatory Condition Met	(Primary)	(Secondary)
3c(1)	Indicate below the number of FTE contract and staff analysts for each of the last three years.			
3c(2)	Indicate below the number of market analysis reviews for which market analysis was performed in the prior review period. Market analysis means formal review of a company through existing processes (e.g., Level 1, Level 2).			
3d	Does the department have examiners on staff whose responsibility is to examine and/or conduct continuum actions of insurance companies as indicated by the department's market analysis or as prescribed by jurisdiction laws?	Read 3d and 3e together. Satisfaction of one satisfies both.		
3e	Does the department utilize contract examiners to examine and/or conduct continuum actions of insurance companies as indicated by the department's market analysis or as prescribed by jurisdiction laws?	Read 3d and 3e together. Satisfaction of one satisfies both.		
3f	If the department utilizes contract examiners, please describe in a separate attachment the manner and extent of utilization in the department's recent activities.			

Question	Text	Mandatory Condition Met	(Primary)	(Secondary)
3g	Indicate below the number of FTE market examiners, including supervisory personnel on the department's staff and/or the number of individual contract examiners used compared to the last three years.			
3h	Has the department performed any targeted exams or market continuum actions in the prior two years?			
3i	If the answer to item 3h. is "Yes," please provide a list of such exams or market continuum actions and the scope of the exams/actions.			
3j	If the answer to item 3h. is "No," does the department have the on-staff resources or the ability to contract additional resources to perform targeted exams/actions, if deemed necessary?			
3k	Does the department have the authority to hire contractors as specialists to perform market regulation?	If 3e is "yes"		
3l	If the department has authority to hire contractors, does it have either a statewide or departmental established process it follows for selecting contractors for market regulation purposes? Briefly explain.	If 3e is "yes"		

Question	Text	Mandatory Condition Met	(Primary)	(Secondary)
3m	Does the department oversee and manage contractors? Briefly explain.	If 3e is "yes"		
3n	Does the department have policies and procedures, subject to periodic review and updates, for identifying and addressing market conduct issues using market analysis and market conduct continuum activities, including examinations?			
3o	If the answer to item 3n. is "Yes," what quantitative and subjective measurements are available to evaluate whether the department is adhering to its policies and procedures?			
3p	Based on the review of staff resources, please provide an explanation of any significant changes in resources and/or workload over the three-year period covered in the data above.			
Requirement 4				
4a	Does the department have policy and procedures in place on necessary credentials or minimum educational and experience requirements for selecting and hiring staff consistent with the detailed credentials listed in the Certification guidelines?		Allows for unions*. Continue to discuss	

Question	Text	Mandatory Condition Met	(Primary)	(Secondary)
4b	Does the department have policy and procedures in place on necessary credentials or minimum educational and experience requirements for selecting and hiring contractors consistent with the detailed credentials listed in the Certification guidelines?			
4c	Does the department have a staff development program that encourages and supports educational and training pursuits, including training, courses, webinars and certifications offered by the NAIC?			
4d	Does each Examiner-in-Charge possess or is the Examiner-in-Charge making progress towards completion of noted designations?			
4e	Does the department recognize licenses and other highly technical credentials of professionals and experts such as attorneys, actuaries, cybersecurity experts, certified public accountants, information technology (IT) experts and other professionals and specialists as qualified to perform certain market regulation activities?			

Question	Text	Mandatory Condition Met	(Primary)	(Secondary)
4f	Does the department maintain written procedure manuals to demonstrate a succession plan?			
4g	As a separate attachment, provide a list of market analysts/examiners that includes the following: name; professional designation(s); title; years employed by the department (include functional area); type of college degree; and prior regulatory or insurance experience. Also indicate those market conduct analysts/examiners that are contractual and whether each is full-time with the department.			
Requirement 5				
5a	Does the jurisdiction have laws, regulations or case law that specify how the confidentiality of market conduct examination workpapers is to be handled?			
5b	Has the department entered into the Multi-State Information Sharing Agreement with other departments and the NAIC and does the department have written policies/procedures and communicate such policies/procedures to staff?			

Question	Text	Mandatory Condition Met	(Primary)	(Secondary)
5c	Does the department have written policies and procedures and communicated such policies and procedures to employees relating to the protection of confidential information which includes PII and PHI, handling of public records requests and requirements for confidentiality agreements when it becomes necessary to share confidential information with other federal and international regulatory or law enforcement agencies, not otherwise covered by the multi-state agreement?			
5d	Does the department have a records retention schedule which outlines plans for secure storage and timeline for destruction of work papers?			
Requirement 6				
6a	Does the department have procedures for staff to follow when reporting potential collaborative actions to the department's CAD?			
6b	If the department identified a potential collaborative action, did the department notify all CADs—via meeting, bulletin board or other communication—of the activities identified that may have the potential for collaboration?			

Question	Text	Mandatory Condition Met	(Primary)	(Secondary)
6c	If the department received a positive response to its inquiries to other CADs regarding a potential collaborative action, did the department refer the action to Market Actions (D) Working Group using the reporting procedures outlined in the Market Actions (D) Working Group's Policies and Procedures, including completing the Request for Review form and submitting the form to the designated NAIC support staff?			
6d	If the answer to item 6b., or item 6c. is "No," please provide a brief explanation.			
6e	Does the department have written procedures for reviewing and evaluating its participation in potential collaborative actions brought to its attention, either through the Market Actions (D) Working Group or by another department?			
6f	For any collaborative action for which the department declined participation, has the department provided a response to the Market Actions (D) Working Group?			
6g	If the answer to item 6e. or item 6f. is "No," please provide a brief explanation.			
6h	Does the MAC, Market Actions (D) Working Group member, CAD and/or CAD alternate actively monitor the bulletin board discussions?			

Question	Text	Mandatory Condition Met	(Primary)	(Secondary)
6i	Does the department participate in the review of national analysis data on an annual basis?			
6j	If the answer to item 6i is "Yes", who in the department, by functional title, participates in the annual national analysis project?			
6k	Does your state participate in one national analysis team at least every other year?			
		Pam's Note - 6.k. and 6.l. should be deleted to track changes we made elsewhere in Requirement 6 , since the natic		
6l	Who in the department, by functional title, participates on a national analysis team at least every other year?			
Requirement 7				
7a	Does the department require eligible companies to file the MCAS with the NAIC?			
7b	Does the department require that the MCAS be prepared in accordance with the NAIC MCAS user guides and instructions?			
7c	Does the department utilize the data obtained from the MCAS for market analysis? (Examples of utilization include, but are not limited to, such activities as performing baseline or Level 1 analysis.)			
Requirement 8				
8a	Does the department enter or transmit data at least quarterly into the CDS?			
8b	Does the department enter or transmit data at least quarterly into RIRS?			

Question	Text	Mandatory Condition Met	(Primary)	(Secondary)
8c	Does the department enter non-examination continuum actions into MATS when initiated and the resulting applicable final status reports or updates (if applicable) at least quarterly?			
8d	Did the department enter at least 75% of examinations into MATS at least 60 days before the start of the examination as set forth in the <i>Market Regulation Handbook</i> ? (Note: The start of the examination is the date the department began work on the examination materials received from the examined entity.)			
8e	If the answer to item 8a., item 8b., item 8c., or item 8d. is "No," please provide an explanation.			
Requirement 9				
9a	Does the department participate in or monitor the Market Analysis Procedures (D) Working Group as a working group member or interested regulator either by conference calls or by attending meetings?			
9b	If the answer to item 9a. is "Yes", who in the department, by functional title, participates in or monitors the Market Analysis Procedures (D) Working Group?			

Question	Text	Mandatory Condition Met	(Primary)	(Secondary)
9c	Does the department participate in or monitor the Market Conduct Examination Guidelines (D) Working Group as a working group member or interested regulator either by conference calls or by attending meetings?			
9d	If the answer to item 9c. is "Yes", who in the department, by functional title, participates in or monitors the Market Conduct Examination Guidelines (D) Working Group?			
9e	List any other market conduct or market analysis-related working groups and/or task forces that the department participates in or monitors.			
Requirement 10				
10a	Has the department appointed a CAD?			
10b	Has the department appointed a CAD alternate?			
10c	Does the CAD and/or CAD alternate attend at least 50% of all meetings and conference calls of the Market Actions (D) Working Group they are eligible to attend?			
Requirement 11				
11a	Does your state participate in the review of national analysis data on an annual basis?			
11b	Who in the department, by functional title, participates in the annual national analysis project?			

moved to 6

Question	Text	Mandatory Condition Met	(Primary)	(Secondary)
11e	Does your state participate in one national analysis team at least every other year? Has the department established procedures to ensure participation on a national analysis team at least every other year?			
11d	Who in the department, by functional title, participates on a national analysis team at least every other year?			
Requirement 11				
11a	Has the department established procedures for the market analysis chief (MAC), or appropriate designee, to communicate interdepartmentally with the appropriate staff, either through written channels or by sufficient demonstration of action (such as regularly scheduled department head meetings, department managers' meetings, or information requests to other areas of the department?)			

Question	Text	Mandatory Condition Met	(Primary)	(Secondary)
11b	Does the MAC, or appropriate designee provide the appropriate interdepartmental staff with market concerns such as, but not limited to, financial data, consumer complaints, policy termination activity, producer misconduct or use of noncompliant forms or rates, related to the following functional areas: i. Consumer Services ii. Enforcement iii. Legal iv. Forms and Filing v. Financial vi. Market Analysis vii. Market Conduct			
11c	On a quarterly basis, does the MAC, or appropriate designee, solicit information from the above functional areas regarding adverse patterns on, but not limited to, financial data, consumer complaints, policy termination activity, producer misconduct, or use of noncompliant forms or rates?			
11d	Does the MAC participate in communication with other insurance departments regarding market analysis by posting and responding to NAIC Market Regulation and Market Analysis Electronic Bulletin Board inquiries?		eted as it is covered in Req-6	

Question	Text	Mandatory Condition Met	(Primary)	(Secondary)
Certification Score Total				
Total Points Possible				
Score				
Pass/NoPass				
Points needed to pass		0		

29 THIS SCORE SHOULD BE THE TOTAL OF MANDATORY ITEMS IDENTIFIED IN THE CHART ABOVE -- its not necessary to assign a score value for meeting expectations	17 The PRIMARY GOALS should be given a scorable point basis that is weighted by the total of primary goals inside each REQUIREMENT; this would include the requirements needed of any secondary goals == this would achieve the 100% assigned overall points to each REQUIREMENT;	17 Secondary goals that are "working toward" meeting the requirements of the Red Mandatory or Yellow Primary goals should be partial point values that equal up to 75% of the total score value that is assessed for the primary goals in this REQUIREMENT AREA. (All other green tagged secondary goals are designed to be supportive of requirements to meet red and yellow -- so those would not be given a partial score value at all when used to support only).
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Question	Text	Mandatory Condition Met	(Primary)	(Secondary)
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1st assessment	all mandatory must be met
1st 5-year re-assessment	50% of remaining available points
2nd 5-year re-assessment	90% of remaining available points

Adopted by Market Regulation and Consumer Affairs (D) Committee – Aug, 15, 2023
Adopted by the Market Analysis Procedures (D) Working Group – July 17, 2023,

MCAS Ratios

Other Health

Ratio 1. **The number of claims denied, rejected or returned to the total number of claims closed**

$$\left(\frac{[\text{Total \# of claims denied, rejected or returned (68)}]}{\left[\begin{array}{l} \text{\# of claims pending at beginning of period (66)} \\ + \text{\# of claims received (include non-clean claims) (67)} \\ - \text{\# of claims pending at end of period (74)} \end{array} \right]} \right)$$

Ratio 2. **Pre-existing Condition Denials to Total Denials**

$$\left(\frac{[\text{\# of denied, rejected, or returned as subject to pre – existing condition exclusion (70)}]}{[\text{Total \# of claims denied, rejected or returned (68)}]} \right)$$

Ratio 3. **Inadequate Documentation Denials to Total Denials**

$$\left(\frac{[\text{\# of denied, rejected or returned due to failure to provide adequate documentation (71)}]}{[\text{Total \# of claims denied, rejected or returned (68)}]} \right)$$

Ratio 4. **Average Number of Days to a Decision on Denied Claims**

$$\left(\frac{\left[* \frac{[\text{Total \# of claims denied, rejected or returned (68)}]}{[\text{\# of days from receipt of claim to decision for denied claims (76)}]} \right]}{[\text{Total \# of claims denied, rejected or returned (68)}]} \right)$$

- *Note: The above calculation is the total number of days for all insurers to a decision on denied claims divided by the total number of denied claims for all insurers to produce the statewide average time to a decision.*

Adopted by Market Regulation and Consumer Affairs (D) Committee – Aug, 15, 2023
Adopted by the Market Analysis Procedures (D) Working Group – July 17, 2023,

MCAS Ratios

Ratio 5. **Average Number of Days to a Decision on Approved Claims**

$$\left(\frac{\begin{array}{l} \text{[# of claims pending at beginning of period (66)]} \\ + \text{[# of claims received (include non-clean claims) (67)]} \\ - \text{[# of claims pending at end of period (74)]} \\ - \text{[Total # of claims denied, rejected or returned (68)]} \end{array}}{\begin{array}{l} \text{[# of claims pending at beginning of period (66)]} \\ + \text{[# of claims received (include non-clean claims) (67)]} \\ - \text{[# of claims pending at end of period (74)]} \\ - \text{[Total # of claims denied, rejected or returned (68)]} \end{array}} \right) * \text{[Average # of days from receipt of claim to decision for approved claims (78)]}$$

- *Note: The above calculation is the total number of days for all insurers to a decision on denied claims divided by the total number of denied claims for all insurers to produce the statewide average time to a decision.*

Ratio 6. **Cancellations During Free Look Period**

$$\left(\frac{\text{[# of policies/certificates cancelled during free look period (55)]}}{\text{[# of new policies/certificates issued during the period (50)]}} \right)$$

Ratio 7. **Cancellations by Policyholder to Total Policies/Certificates During the Period**

$$\left(\frac{\text{[# of policy/certificate terminations and cancellations initiated by the policyholder/certificate holder during the period (53)]}}{\begin{array}{l} \text{[# of policies/certificates in force at beginning of period (47)]} \\ + \text{[# of new policies/certificates issued during the period (50)]} \end{array}} \right)$$

Ratio 8. **Cancellations by Company to Total Policies/Certificates During the Period**

$$\left(\frac{\text{[# of policies/certificates cancelled by the company for any reason other than non-payment during the period (59)]}}{\begin{array}{l} \text{[# of policies/certificates in force at beginning of period (47)]} \\ + \text{[# of new policies/certificates issued during the period (50)]} \end{array}} \right)$$

Adopted by Market Regulation and Consumer Affairs (D) Committee – Aug, 15, 2023
Adopted by the Market Analysis Procedures (D) Working Group – July 17, 2023,

MCAS Ratios

Ratio 9. Loss Ratio

$$\left(\frac{[\text{Aggregate dollar amount of paid claims during the period (80)}]}{[\text{Direct written premium (45)}]} \right)$$

Ratio 10. Number of Complaints received per 1,000 Policies/Certificates In Force During the Period and Claims During the Period

$$\left(\frac{\left[\frac{[\# \text{ of complaints received by company (other than through the DOI) (83)} + [\# \text{ of complaints received through DOI (84)}]}{[\# \text{ of policies/certificates in force at beginning of period (47)}] + [\# \text{ of new policies/certificates issued during the period (50)}]} \right] + \left[\frac{[\# \text{ of claims pending at beginning of period (66)}] + [\# \text{ of claims received (include non-clean claims) (67)}]}{[\# \text{ of claims pending at end of period (74)}]} \right] / 1,000 \right)$$

Ratio 11. Number of Complaints Resulting in Claims Reprocessing to Total Complaints

$$\left(\frac{[\# \text{ of complaints resulting in claims reprocessing (85)}]}{\left[\frac{[\# \text{ of complaints received by company (other than through the DOI) (83)}]}{[\# \text{ of complaints received through DOI (84)}]} \right]} \right)$$

Ratio 12. Percentage of Lawsuits Closed with Consideration for the Consumer

$$\left(\frac{[\# \text{ of lawsuits closed during the period with consideration for the consumer (89)}]}{[\# \text{ of lawsuits closed during the period (88)}]} \right)$$

Adopted by Market Regulation and Consumer Affairs (D) Committee – Aug, 15, 2023
Adopted by the Market Analysis Procedures (D) Working Group – July 17, 2023,

MCAS Ratios

Ratio 13. **Lawsuits opened per 1,000 Policies/Certificates In Force During the Period and Claims During the Period**

$$\left(\frac{[\# \text{ of lawsuits opened during the period (87)}]}{\left[\frac{[\# \text{ of policies/certificates in force at beginning of period (47)}] + [\# \text{ of new policies/certificates issued during the period (50)}]}{\left[\frac{[\# \text{ of claims pending at beginning of period (66)}] + [\# \text{ of claims received (include non-clean claims) (67)}] - [\# \text{ of claims pending at end of period (74)}]}{1,000} \right]} \right)$$

Ratio 14. **Average Dollars of Commission Per Policy/Certificate**

$$\left(\frac{\left[\frac{[\text{Commissions paid during the reporting period (101)}] - [\text{Unearned commissions returned to company on policies/certificates sold during the period (102)}]}{[\# \text{ of new policies/certificates issued during the period (50)}]} \right)}{1} \right)$$

Ratio 15. **Percentage Commissions to Written Premium**

$$\left(\frac{\left[\frac{[\text{Commissions paid during the reporting period (101)}] - [\text{Unearned commissions returned to company on policies/certificates sold during the period (102)}]}{[\text{Direct written premium (45)}]} \right)}{1} \right)$$

- *Note: It is unclear to what extent commissions are paid on events other than new business (e.g., such as renewals)*

Draft: 7/24/23

Market Analysis Procedures (D) Working Group
Virtual Meeting
July 17, 2023

The Market Analysis Procedures (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met July 17, 2023. The following Working Group members participated: Jo LeDuc, Chair (MO); John Haworth, Vice Chair (WA); Crystal Phelps (AR); Maria Ailor and Tolanda Coker (AZ); Don McKinley (CA); Steve DeAngelis (CT); Susan Jennette (DE); Scott Woods and Pamela Lovell (FL); Erica Weyhenmeyer (IL); Shannon Lloyd (KS); Lori Cunningham (KY); Nina Hunter (LA); Salama Karim-Camara (MD); Timothy N. Schott (ME); Jeff Hayden (MI); David Dachs (MT); Martin Swanson and Robert McCullough (NE); Maureen Belanger (NH); Ralph Boeckman and Erin Porter (NJ); Leatrice Geckler (NM); Larry Wertel (NY); Landon Hubbard (OK); Karen Veronikis (PA); Brett Bache (RI); Rachel Moore (SC); Melissa Gerachis (VA); Karla Nuisl (VT); Rebecca Rebholz and Mary Kay Rodriguez (WI); and Theresa Miller (WV). Also participating was: Tony Dorschner (SD).

1. Adopted its June 12 Minutes

LeDuc said the Working Group met June 12 to discuss data sources for market analysis, the standardized ratios for the Other Health Market Conduct Annual Statement (MCAS), and the exemption of fraternal from MCAS reporting.

Gerachis made a motion, seconded by Jennette, to adopt the Working Group's June 12 minutes (Attachment Five-A). The motion passed unanimously.

2. Adopted Other Health Insurance MCAS Ratios

LeDuc said clarifications were added to the proposed ratios and re-posted to the Working Group's web page. She said the changes were not substantive, and the ratios have been exposed for about six weeks.

Samantha Burns (America's Health Insurance Plans—AHIP) suggested that ratio 4 measuring the average days to a decision on denied claims should be limited to decisions made on clean claims because the time to receive the appropriate documentation to make a decision is often outside the control of the insurance company. She also suggested that ratio 10 measuring the number of complaints received per 1,000 policies should be limited to complaints received by the department of insurance (DOI).

Rodriguez said the complaint ratio is the same formula as used in other MCAS lines. She said the Other Health MCAS blank does not collect information on clean claims, only denied claims, and the days to make a decision on denials are collected in the MCAS blank. LeDuc noted that the ratios are used to determine whether an analyst needs to look more closely at a company, not to determine compliance.

Birny Birnbaum (Center for Economic Justice—CEJ) said the CEJ supports the proposed Other Health ratios, and there was no lack of clarity even if others may disagree with them. He said they are useful.

Rebholz made a motion, seconded by Geckler, to adopt the Other Health MCAS standard ratios. The motion passed unanimously.

3. Discussed Lunch and Learn Trainings

LeDuc said she would like to continue the work Haworth began last year to determine what training needs exist and how best to meet the demand. She proposed that the Working Group sponsor “lunch and learn” trainings to all market analysts on a regular schedule. She said the name of these sessions could be something different than “lunch and learn” trainings. She said it would be regulator-only training, so actual live data can be used, and the attendees can bring in actual analysis for discussion. She said she is using the Casualty Actuarial and Statistical © Task Force’s book club as a model. It would not be presentations as much as get-togethers to discuss and learn from fellow market analysts.

LeDuc said it could begin with a basic overview of a specific tool (e.g., the Market Analysis Prioritization Tool [MAPT], the Market Analysis Review System [MARS], or the Complaints Database System [CDS], depending on demand), the design of the tool itself, what the data means, and how the tool weighs and scores data. She said once that basic understanding is shared, additional lunch and learns could build on that groundwork and move into doing actual analysis using the tool.

LeDuc said it is best to keep very flexible and address topics that are most in demand, and then find an experienced state insurance regulator, or regulators, who can provide the training to meet that demand. She said she envisions this to be a monthly event.

Veronikis said it is a fabulous idea and would be helpful for training new analysts. Moore agreed that extra training is always welcome. Dorschner said this is a great idea for the smaller states who do not have the resources. Rodriguez said she supports the idea, and the iSite+ summary reports should be included as well. LeDuc said she agrees, and there are so many topics that the sessions could be daily and not get through everything.

Geckler said monthly is a good idea, and she asked when this would be implemented. LeDuc said she wants to start as quickly as possible, but in August there is the NAIC Summer National Meeting and the Insurance Regulatory Examiners Society (IRES) Career Development Seminar (CDS). Jennette said the NAIC Insurance Summit is in September.

Weyhenmeyer, Miller, Lovell, Gerachis, and Belanger expressed support for the idea.

LeDuc said she would work with Haworth and NAIC support staff to set up a schedule, and she will contact state insurance regulators to assist.

4. Discussed the Inclusion of Fraternal Insurance Companies in the MCAS

LeDuc said the attachment to the agenda helps get a big picture of how much premium fraternal account for by jurisdiction in actual dollars and as compared to non-fraternal business. She said in some jurisdictions, there is a very significant presence of business written by fraternal, but as a percentage of the market nationally, fraternal only account for about 2.5% of the written premium. She said the 2.5% is nearly \$10 billion in premium. She said she sent each member of the Working Group state-specific information on the fraternal marketplace in their states.

LeDuc said comments were received from Maine, Pennsylvania, the CEJ, and several fraternal companies and trade associations.

Schott said Maine is statutorily unable to collect data from fraternal. They are not opposed to including them in MCAS reporting, but Maine could not require them to report.

Veronikis said she is still waiting to hear from the Pennsylvania department's legal staff to see if they have the authority to require fraternal to report the MCAS. She said the fraternal in Pennsylvania range in premium size from only \$12 to up to \$273 million. She said she always assumed the fraternal were small, and this surprised her. She said she wants to dig deeper.

Todd Martin (American Fraternal Alliance—AFA) said there should be a reason for making a change to the MCAS. He said nothing has changed in the fraternal marketplace since the last time fraternal were considered for inclusion in the MCAS by the Working Group. He said there is a very low incidence of market conduct incidents with fraternal, and other means are available for assessing and addressing market conduct issues. LeDuc said Missouri does not receive the complaint logs of fraternal. She asked if that was being offered. Martin said he thinks it could be.

Birnbaum said Martin's comments show a misunderstanding of the purpose of the MCAS. He said the purpose of the MCAS is not to respond to issues that arise, but to identify problems. He said it is in the company and state insurance regulator's interests to identify problems without the time and resources required for examinations. He said he reviewed the websites of the fraternal that submitted comments. He said some of them are larger than many life insurance companies that are required to file an MCAS. Additionally, the companies are no longer distinguished for special treatment by financial analysts, and they now file their financial annual statement on the Life statement blank. He said small fraternal companies would be exempt from reporting an MCAS due to the premium threshold, just as small life companies are.

Ailor said if fraternal are required to file an MCAS, analysts should have the ability to review them in the MARS. She said the analysts in Arizona were unable to open an MARS review on any fraternal. She said given the amount of business generated by fraternal, they should be seriously considered for inclusion in the MCAS. She also noted that the \$50,000 premium threshold in the MCAS should be looked into to see if it is still the correct amount for a threshold. LeDuc said the threshold was set around 2004 when the MCAS was first developed, and she agreed that it should be reconsidered in a separate conversation.

Swanson said Nebraska's position is unchanged from the 2019 position expressed by Director Bruce R. Ramage (NE) in his comments to the Working Group in 2019. Nebraska has very few complaints, and it utilizes its examination authority to do a good job in monitoring the fraternal market. He said adding fraternal to the MCAS is not needed.

Nuissl asked what the impact will be on fraternal to report the MCAS. She asked if fraternal capture all the data elements that need to be reported in the MCAS and whether it may be an undue hardship on the fraternal companies. Ailor said if the Working Group required them to file, they would be permitted adequate time to prepare. Martin said he would be happy to look at the Life MCAS blank to see what the lift may be for fraternal. Birnbaum said fraternal range in size, and whereas some small companies may have difficulties, the large fraternal would have the same systems in place as large life companies. He suggested that if the fraternal indicate that the data will be difficult for them to collect, they should be required to specify which data and the reasons.

Le Duc said this discussion will continue at the Working Group's next meeting.

Having no further business, the Market Analysis Procedures (D) Working Group adjourned.

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Draft: 6/21/23

Market Analysis Procedures (D) Working Group
Virtual Meeting
June 12, 2023

The Market Analysis Procedures (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met June 12, 2023. The following Working Group members participated: Jo LeDuc, Chair (MO); John Haworth, Vice Chair (WA); Teri Ann Mecca (AR); Maria Ailor and Tolanda Coker (AZ); Don McKinley (CA); Tracy Garceau (CO); Steve DeAngelis (CT); Susan Jennette (DE); Scott Woods (FL); Erica Weyhenmeyer (IL); Shannon Lloyd (KS); Lori Cunningham (KY); Mary Lou Moran (MA); Raymond Guzman (MD); Timothy N. Schott and Connie Mayette (ME); Jeff Hayden (MI); Martin Swanson and Robert McCullough (NE); Maureen Belanger (NH); Ralph Boeckman and Erin Porter (NJ); Hermoliva Abejar (NV); Larry Wertel (NY); Guy Self (OH); Landon Hubbart (OK); Karen Veronikis (PA); Matt Gendron and Brett Bache (RI); Rachel Moore (SC); Tracy Klausmeier (UT); Melissa Gerachis (VA); Karla Nuisl (VT); and Mary Kay Rodriguez (WI). Also participating was: Lance Hirano (HI).

1. Adopted its May 8 Minutes

LeDuc said the Working Group met May 8 to discuss data sources for market analysis, the standardized ratios for the Other Health Market Conduct Annual Statement (MCAS), and the exemption of fraternal from MCAS reporting.

Haworth made a motion, seconded by Gendron, to adopt the Working Group's May 8 minutes (Attachment Five-A1). The motion passed unanimously.

2. Discussed NAIC MIS Data

LeDuc said the Working Group is identifying what data sources market analysts use as the first part of its charge to "assess currently available market analysis data to identify needed improvements in the effectiveness of the data for market analysis and the predictive abilities of the market scoring systems utilizing the data." She said the current version contains the additions and re-ordering discussed in May. She said once the Working Group has satisfactorily identified these sources, it will begin the task of assessing the data.

Veronikis said the use of artificial intelligence (AI) techniques in market analysis is new and promising. She said there are large quantities of data available for examinations in the Regulatory Information Retrieval System (RIRS) and the Market Actions Tracking System (MATS), and AI analysis techniques will enable analysts to sort through the large quantities of data to find correlations between effects and possible causes, such as changes in company leadership. She cautioned about biases that can re-enforce themselves by the AI technique focusing only on issues that have repeated. She recommended that AI be limited in its self-learning and require human intervention as algorithms are developed.

Birny Birnbaum (Center for Economic Justice—CEJ) said any data source could be useful for market analysis when used at the right time and in the right context. Data can be useful in some circumstances but not useful in other circumstances. Birnbaum said a question to ask is whether the data are available and in a format that is useful. He said creating a list of data sources is useful, but the Working Group needs to determine if a data source could be available for AI applications. He said it should also be considered whether the source could be used by itself or if it would need to be used in conjunction with other sources and how easily that can be accomplished. LeDuc asked the Working Group as it moves through the list of sources to consider whether each source can be used alone, in conjunction with other sources, or if it must be used in conjunction with other data. She said a good example

would be the American Community Survey (ACS) data, which by itself would not provide much useful information, but adds insight when used with other market analysis data.

Ailor asked for identification of where the data on the list can be obtained. She said newer and even experienced analysts do not necessarily know where to find the sources of data listed. LeDuc said an additional column will be added with information on where the data source can be located.

LeDuc asked for comments to be sent to Helder by July 7.

3. Discussed Proposed Other Health Insurance MCAS Ratios

LeDuc asked Rodriguez to review the draft proposed standard ratios for the Other Health MCAS blank.

Rodriguez said the subject matter expert (SME) group met four times, and it is proposing the adoption of 15 ratios.

Rodriguez said ratio 1 provides the percentage of closed claims denied, rejected, or returned. She said the SME group changed the title of the ratio for clarity.

Rodriguez said ratios 2 and 3 look at the total number of denials and determine the percentage of denials for pre-existing conditions and due to inadequate documentation. Hirano asked if there was a definition for inadequate documentation. LeDuc said the MCAS blank has a set of definitions that is available. Rodriguez said that term was not specifically defined. Birnbaum noted that these are only ratios. If there are definitional issues, they will show up in the reported data rather than the ratio. Ailor suggested that this could be addressed in training.

Rodriguez said ratios 4 and 5 allow analysts to measure the average number of days to decide on a denied claim and an approved claim. She said both ratios are new. She said a note was added to clarify that the average is determined as a sum of all company data, and it is a true average for the state. She said that is the case for all ratios, and she asked why a note needed to be added to these two. Birnbaum said the two ratios are different in that the numerator is first calculated per company and then calculated using those individual results to determine the statewide number of days to a decision.

Rodriguez said ratios 6, 7, and 8 are measurements of cancellations. She said ratio 6 measures free look cancellations; ratio 7 is the percentage of cancellations initiated by the policyholder; and ratio 8 is the percentage of cancellations initiated by the company.

Rodriguez said ratio 9 was unchanged, and it provides analysts with the loss ratio.

Rodriguez said ratios 10 and 11 are complaint measurements. She said ratio 10 is the number of complaints per 1,000 policies in force and claims handled during the period.

Rodriguez said ratio 11 is a new ratio, and it measures the percentage of complaints that lead to claims reprocessing.

Rodriguez said ratios 12 and 13 are lawsuit ratios that measure the number of lawsuits per 1,000 policies and claims handled, as well as the percentage of those lawsuits that were closed with consideration to the consumer.

Rodriguez said ratios 14 and 15 utilize data elements that have never been collected before in the MCAS. She said since this MCAS blank has data on commissions, the SME group agreed that it would be helpful to measure the average commission per policy and average commission as a percentage of written premium. She said the SME

group also recognized that there was some uncertainty on how, and whether, commissions were paid on renewals, so it added a caveat to the ratio. She said even with the caveat, the SME group believed it was a worthwhile ratio to add to the set of standard ratios, but she suggested re-visiting them in a couple years.

LeDuc said Birnbaum was a member of the SME group and submitted some suggested improvements that the SME group did not have time to consider, so she would like the Working Group to consider them. She said they do not change the substance of the ratios.

Birnbaum said the CEJ supports the ratios, and it is not suggesting any changes to the ratios themselves. He proposed that the language, “the above calculation is the total number of days for all insurers to a decision on denied claims divided by the total number of denied claims for all insurers to produce the statewide average time to a decision” be appended to ratios 4 and similar language to ratio 5 for approved claims. He said he agrees with the denominator chosen for ratios 7 and 8, but he said the title needs to be changed to accurately reflect what the denominator is. He suggested using the term “policies during the period” rather than “policies in force.” He also suggested new titles for ratios 14 and 15 to better reflect what the ratios measure. For ratio 14, he suggested “Average Dollars of Commission per Policy,” and for ratio 15, he suggested “Percentage Commissions to Written Premium.” Haworth asked if language similar to what was added to ratios 4 and 5 needs to be added to ratios 14 and 15 since those two are also averages. Birnbaum said it was not necessary since no separate calculation needs to be made per company to derive ratios 14 and 15. There were no objections to the recommendations.

LeDuc said the ratios with Birnbaum’s suggestions will be posted to the Working Group web page. She asked for comments by July 7, and they will be considered for adoption during the Working Group meeting.

4. Discussed the Inclusion of Fraternal Insurance Companies in the MCAS

LeDuc said during the May meeting of the Working Group, Virginia asked the Working Group to again consider whether to require fraternal companies to file MCAS data to participating states. She said in the past, the MCAS has excluded fraternal companies because they are not uniformly regulated across the states.

LeDuc said the Working Group last considered lifting the exemption in late 2019 because at that time, fraternal companies began filing their financial annual statements on the life, health, and property/casualty (P/C) statement types. She said this enabled them to access the MCAS to report their data. However, she noted that since no motion was made to require fraternal companies to file, fraternal companies continued to be exempt.

LeDuc said regardless of what is ultimately decided, an individual state can always require a fraternal company licensed in their state to file an MCAS. She said the MCAS data belongs to the state to which it is reported, and that state can require any company licensed in its jurisdiction to file an MCAS. Overall, however, on a national basis, the MCAS requirements exempt fraternal companies from filing an MCAS.

LeDuc said numerous comments from fraternal insurers were sent to both the Working Group and individual states. She said for the most part, the comments were the same. She invited any fraternal organizations that submitted comments to address the Working Group.

Allison Koppel (American Fraternal Alliance—AFA) said fraternal companies typically serve the middle market of life and annuity customers, and their insureds are members of the fraternal society and participate in the governance of the society. She said this close relationship between the members and the fraternal insurer results in fewer complaints and market conduct issues. She said MCAS reporting would be unduly burdensome, and there are more effective ways to collect market conduct data from fraternal companies, such as complaint logs and routine market

conduct examinations. She said fraternal are committed to their members and eager to work with departments of insurance (DOIs) to protect consumers.

Swanson said the current exemption for fraternal is appropriate. He said fraternal are regulated differently in different states, and it has never been a concern to get needed market conduct information from fraternal. He said in 2019, Nebraska's Director of Insurance, Bruce R. Ramge, sent a comment letter that still reflects Nebraska's position. LeDuc said it would be re-posted for the current discussion.

LeDuc said in the last meeting, she asked the state insurance regulators to look at the landscape of fraternal in their jurisdictions. She said in Missouri, the majority of fraternal are very small, but there are a handful of fraternal that are very large, with one writing over \$96 million in premium. Gerachis said in Virginia, there were 18 fraternal that wrote more than the \$50,000 MCAS reporting threshold, and nine wrote in excess of \$1 million dollars in premium each. She said there are many small companies that report an MCAS, and it seems unfair to exempt fraternal because of their size. Ailor said in Arizona, there are quite a few fraternal with insignificant amounts of premium, but there is one fraternal with more than \$67 million.

Birnbaum said an MCAS was designed for the efficient analysis of consistent and regularly reported data. He said market conduct examinations and complaints do not provide consistent data. He said it makes no more sense to exempt fraternal from reporting an MCAS than it would to exclude them from reporting their financial annual statements. He said state insurance regulators cannot assume that there are no market conduct issues with fraternal. Complaints are not a good substitute for MCAS data since many consumers are unaware that they can file a complaint with DOIs. Regarding an exemption due to size, he said many mutual insurers are small, but they are not exempt. He said market conduct examinations are not a good substitute for regular, consistent reporting, and it is not as efficient as an MCAS. He said reporting to an MCAS is more in the interest of fraternal than relying on examinations, as it is less costly to routinely report data.

Todd Martin (AFA) said there should always be a cost/benefit analysis for any regulatory burden by the state insurance regulators and industry. He said the reasons to remain exempt are the same as they were historically and in 2019.

Le Duc said the discussion will continue at the July meeting. She asked for comments by July 7.

Having no further business, the Market Analysis Procedures (D) Working Group adjourned.

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Draft: 5/30/23

Market Analysis Procedures (D) Working Group
Virtual Meeting
May 8, 2023

The Market Analysis Procedures (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met May 8, 2023. The following Working Group members participated: Jo LeDuc, Chair (MO); John Haworth, Vice Chair (WA); Crystal Phelps (AR); Tolanda Coker (AZ); Don McKinley (CA); Tracy Garceau (CO); Steve DeAngelis (CT); Cheryl Wade (DC); Scott Woods (FL); Erica Weyhenmeyer (IL); Shannon Lloyd (KS); Mary Lou Moran (MA); Raymond Guzman (MD); Connie Mayette (ME); Jeff Hayden (MI); Troy Smith and David Dachs (MT); Robert McCullough (NE); Maureen Belanger (NH); Ralph Boeckman and Erin Porter (NJ); Hermoliva Abejar (NV); Larry Wertel (NY); Ben Hauck (OH); Landon Hubbart (OK); Karen Veronikis (PA); Matt Gendron and Brett Bache (RI); Rachel Moore (SC); Tanji J. Northrup (UT); Will Felvey and Melissa Gerachis (VA); Isabelle Turpin Keiser (VT); Darcy Paskey, Rebecca Rebholz, and Mary Kay Rodriguez (WI); and Theresa Miller (WV). Also participating was: Shane Quinlan (NC).

1. Adopted its April 10 Minutes

LeDuc said the Working Group met April 10. The Working Group discussed its charges and goals for 2023 and the standardized ratios for the Other Health Market Conduct Annual Statement (MCAS).

Haworth made a motion, seconded by Mayette, to adopt the Working Group's April 10 minutes (Attachment Five-A1a). The motion passed unanimously.

2. Discussed NAIC Market Information Systems Data

LeDuc said the Working Group is charged with assessing currently available market analysis data to identify needed improvements in the effectiveness of the data for market analysis and the predictive abilities of the market scoring systems utilizing the data. This includes looking at the predictive power of current market scoring systems, assessing how much each variable should be weighted in its productiveness, and dropping any variables that have no utility. Once the data sources are identified, the Working Group can then consider how to improve the scoring systems through the inclusion of additional data or more rigorous statistical methods, such as those accomplished through artificial intelligence (AI) technologies. To help begin the discussion, LeDuc said she, Haworth, and Randy Helder (NAIC) began drafting a list of data sources used in market analysis. She said the list includes NAIC data, state data, and non-NAIC data sources. She said the list is not exhaustive, and she invited all interested state insurance regulators and other parties to add to it. She noted that some of the NAIC data sources are used more frequently than others, and some of the state sources of data overlap with the NAIC but provide more specific detail or types of data, such as consumer inquiries in addition to complaints. She said the non-NAIC sources of market analysis data may be helpful to market analysts as state insurance regulators look to make more robust and predictive scoring mechanisms. Garceau said she appreciates having the list started, and it will help her and others to focus their efforts.

Jules Bonk (unknown affiliation) asked whether the NAIC data includes lawsuits. LeDuc said she is unaware of an NAIC source for lawsuits other than the data element in the MCAS requirement for a company to report the number of lawsuits. She said LexisNexis and Westlaw are listed in the non-NAIC sources.

Haworth suggested looking into Google Play and the Apple App Store as possible sources to obtain and review company telematics devices and applications, as well as interviewing companies concerning the reliability of the devices. He noted that there are also customer reviews of the applications on both application stores. LeDuc said these can be added to the list. Miller suggested adding the state's data on rate and form filings.

Birny Birnbaum (Center for Economic Justice—CEJ) said this is a good list of data sources, and the Working Group is tasked with looking for what data is amenable to predictive analytics and AI applications for market analysis. He said some of the identified sources are excellent for extensive investigation, but they are not timely enough for market analysis. Regarding lawsuits, he said there are companies that track lawsuits, and there is statistical data reported to statistical agents on a quarterly basis. He said expanding this to all companies on a transactional data source would provide data amenable to predictive analytics. Additionally, he said testing in the marketplace is a good source of data. He asked how the Working Group wants to proceed. LeDuc said she is looking for feedback on whether there are sources that were missed and should be included on the list and whether the data source is effective and timely for market analysis, whether with AI or more rigorous statistical techniques. She said the lawsuit and statistical agent information would be good suggestions to add to the list.

Gendron suggested adding Demotech to the section on rating agencies. He also suggested moving the Financial Industry Regulatory Authority (FINRA) up the list next to the U.S. Securities and Exchange Commission (SEC) because it examines broker-dealers that can be affiliated with insurers and issues a report of actions against securities licensees, which can be checked against lists of insurance agents and insurance agent applications. Bache suggested adding MCAS dashboards. LeDuc said she can add that, but she said she struggles with the difference between the actual source of the data and the reports generated with the source. LeDuc asked for comments to be sent to Helder by June 2.

3. Discussed Proposed Other Health Insurance MCAS Ratios

Rodriguez said the subject matter expert (SME) group met and began discussions on the proposed ratios. She said the SME group also considered comments received from Birnbaum and Delaware. She said the title for ratio 1 was changed for clarity. She said ratios 3 and 4 were deleted because of system issues with performing the calculations necessary for developing an average of the reported median days. She said another meeting is scheduled to review the second half of the proposed ratios. Birnbaum said he agrees with eliminating ratios 3 and 4, but he said it would be helpful to have ratios to measure the length of time to settle claims. Rodriguez agreed and said it would be looked into.

4. Discussed Other Matters

Gerachis said Virginia would like the Working Group to reconsider the MCAS exemption of fraternal insurance companies. She said there are fraternal with large premium amounts in Virginia that are not in its line of sight. LeDuc said Virginia is not alone in having fraternal with large premiums. She said historically, fraternal were exempt from MCAS because they were not regulated like insurance companies across all jurisdictions. She asked Helder if this should be considered at the Market Conduct Annual Statement Blanks (D) Working Group or with the Market Analysis Procedures (D) Working Group. Helder said the Market Conduct Annual Statement Blanks (D) Working Group is concerned with the blanks, not who is reporting to the MCAS. He said the last time fraternal were considered was by the Market Analysis Procedures (D) Working Group. LeDuc said the discussion will be on the next agenda.

Having no further business, the Market Analysis Procedures (D) Working Group adjourned.

Draft: 4/25/23

Market Analysis Procedures (D) Working Group
Virtual Meeting
April 10, 2023

The Market Analysis Procedures (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met April 10, 2023. The following Working Group members participated: Jo LeDuc, Chair (MO); John Haworth, Vice Chair (WA); Teri Ann Mecca (AR); Maria Ailor (AZ); Don McKinley (CA); Tracy Garceau (CO); Nick Gill (CT); Pratima Lele (DC); Scott Woods (FL); Erica Weyhenmeyer (IL); Lori Cunningham (KY); Mary Lou Moran (MA); Dawna Kokosinski (MD); Timothy N. Schott and Connie Mayette (ME); Jeff Hayden (MI); Troy Smith (MT); Robert McCullough (NE); Maureen Belanger (NH); Ralph Boeckman and Erin Porter (NJ); Larry Wertel (NY); Ben Hauck (OH); Landon Hubbard (OK); Karen Veronikis (PA); Matt Gendron and Brett Bache (RI); Rachel Moore (SC); Tanji Northrup (UT); Will Felvey (VA); Isabelle Turpin Keiser (VT); Darcy Paskey, Rebecca Rebholz, and Mary Kay Rodriguez (WI); and Theresa Miller (WV). Also participating was: Shane Quinlan (NC).

1. Adopted its Aug. 22, 2022, Minutes

LeDuc said the Working Group met Aug. 22, 2022, and adopted pet insurance as the next line of business in the Market Conduct Annual Statement (MCAS).

Haworth made a motion, seconded by Ailor, to adopt the Working Group's Aug. 22, 2022, minutes (*see NAIC Proceedings – Fall 2022, Market Regulation and Consumer Affairs (D) Committee, Attachment Three*). The motion passed unanimously.

2. Discussed its Charges and Goals for 2023

LeDuc said all last year's charges remain, but one additional charge was added by the Market Regulation and Consumer Affairs (D) Committee. She said the new charge is to, "assess currently available market analysis data to identify needed improvements in the effectiveness of the data for market analysis and the predictive abilities of the market scoring systems utilizing the data." She said this charge is also included in the Market Information Systems (D) Task Force charges, and the Working Group will report to the Task Force its progress throughout the year.

LeDuc reminded the Working Group that the Task Force charged the Market Information Systems Research and Development (D) Working Group to research and make recommendations surrounding the incorporation of artificial intelligence (AI) techniques into the NAIC's Market Information Systems (MIS). She said the Working Group's recommendations were discussed by the Task Force and ultimately adopted by the Task Force at the 2022 Summer National Meeting. She said while the report was generally favorable to incorporating AI techniques into the MIS, it recognized that the data used in the MIS is not as complete as would be needed for AI to be useful. Additionally, the effectiveness of the data collected and the scoring systems likely need improvement.

LeDuc said she and Haworth are suggesting that the best place to start is to hear from the Working Group members and other interested state insurance regulators about what data they use, how they use the data, and their thoughts on the data's effectiveness. She said the only scoring systems currently in the MIS are the Market Analysis Prioritization Tool (MAPT) scoring and the Market Conduct Annual Statement (MCAS)-MAPT rankings. She said the Working Group will consider these later in the year, but the Working Group should first dedicate itself to the effectiveness of the data, because if the effectiveness of the data is not good, the scoring will also be lacking.

LeDuc proposed that the Working Group dedicate this year to this charge alone. She said this charge intersects with the Working Group's charges to, "Recommend changes to the market analysis framework based on results over the past five years," and "Discuss other market data collection issues and make recommendations, as necessary." She said the other charge is to, "Consider recommendations for new lines of business for the MCAS." She said in the last couple years, the Working Group has added other health insurance, travel insurance, and pet insurance to the MCAS, and a pause on this charge will assist participating states to incorporate these new MCAS lines into their baseline analyses.

Ailor said the pause on considering new lines was a good idea. She asked if the pause was just for this year or open-ended. LeDuc said it can only be for the year. She said the Market Conduct Annual Statement Blanks (D) Working Group has a charge to review the older lines of business in the MCAS every three to five years. Weyhenmeyer noted that the pet insurance line of business is still being drafted and may not make the deadline for adopting for use with the 2024 data year. Quinlan said his department still has staffing concerns, and the new lines of business in the MCAS feel like force-feeding their analysts.

Haworth said the newer lines of business have still not been incorporated into the current MIS tools, such as the Market Analysis Review System (MARS). LeDuc suggested that with a pause, perhaps the resources used to incorporate the new lines of business can be re-assigned to incorporate the new incoming data into the MIS tools.

Birny Birnbaum (Center for Economic Justice—CEJ) said consideration of MCAS lines of business is a charge given to the Working Group from the Market Regulation and Consumer Affairs (D) Committee, and it cannot just be paused without getting approval from the Committee. He said a new line of business added this year would not be implemented until the 2025 data year and collected for the first time until 2026. He said pausing puts the implementation dates out even further. He said regarding the resource issues, the MCAS enables departments to quickly review companies in a specific line of business and avoid the resource needs of investigations and ad hoc data calls. He also noted that there were market conduct issues with business owners' policies during the COVID-19 pandemic that could have been addressed with the type of data available in the MCAS, and title insurance has many market conduct issues to be investigated. LeDuc said these discussions are necessary before the Working Group goes to the Committee regarding pausing on MCAS line of business considerations.

Lisa Brown (American Property Casualty Insurance Association—APCIA) said there have been years that the Working Group considered lines of business but decided not to add a line of business. She said it could be done the same way this year. Birnbaum said he agrees.

LeDuc asked for comments to be sent to Randy Helder (NAIC) by April 28 regarding the data used by jurisdictions and the effectiveness of the data. Birnbaum asked how a current inventory of data in the MIS relates to what is needed to incorporate AI techniques in the MIS. He said to evaluate potential AI applications, the Working Group should start with identifying AI applications that would be useful for market analysis and then determine the data needs required for those AI applications. He said the Working Group could then compare what MIS data is available against the data needs for the AI applications. LeDuc said Birnbaum's suggestion was a good second step, but the Working Group needs to know what data is available and how it is being used. She said that is the charge of the Working Group. Birnbaum said he agrees, and his suggestion and the approach outlined by LeDuc are not mutually exclusive and could be worked on at the same time.

Haworth said the Working Group needs to also consider the format in which the data is presented to analysts. He said the data tables for the analysis of private passenger auto (PPA) insurance analysis are different than those for health insurance analysis. Additionally, he said, the NAIC is reformatting the data table to make them for useful for queries. He cautioned against building applications for databases that may become obsolete.

3. Discussed Proposed Other Health Insurance MCAS Ratios

LeDuc said in 2022, the Market Conduct Annual Statement Blanks (D) Working Group adopted the Other Health MCAS blank. She said after a new MCAS blank is adopted, it is the responsibility of the Market Analysis Procedures (D) Working Group to develop and adopt scorecard ratios for the new blank. She said the scorecard ratios are the ratios that are publicly made available on the MCAS web page, and they are usually on a state-wide basis, so no individual company ratios are identifiable. She said there are typically about 10 ratios that are identified for publication on the MCAS scorecard for a line of business, but the Working Group can adopt however many ratios that make sense.

LeDuc said a set of proposed ratios was prepared to begin the discussion of which ratios the Working Group will adopt for the Other Health MCAS blank. She said the ratios are just suggestions, and the Working Group can adopt all or just some of them. She said the Working Group could also come up with different ratios or different ways of calculating the ratios. She said there are 10 proposed ratios. She said they are the typical ratios found in the MCAS blanks, but four of them are different than what the Working Group has adopted in the past. She referenced that the proposed ratios include a loss ratio, as well as a suggestion to post the median days to make decisions to approve and make decisions to deny claims. She noted that the median day ratio may be a little strange, as it would be, in effect, an average of the median days that are reported. She said the Working Group could decide not to include these on the scorecard. She also referenced a proposed ratio for the average commission paid on policies issued. She said for the first time, the MCAS is asking companies to report on commissions paid and the commissions that were returned on canceled policies. She said any scorecard ratio discussion should consider the usefulness of the ratios being posted.

LeDuc said she was not certain whether the ratio results will include enough companies in each state to make the ratios meaningful and ensure confidentiality. She said a concern to address should be whether the ratios are posted only on a national basis like is done for the health insurance MCAS ratio.

Ailor asked how soon the ratios need to be adopted. Helder said by September, but no later than October. Ailor asked if a subject matter expert (SME) group would be formed to review the proposal and make recommendations for the Working Group to consider. LeDuc said SME groups have been used in the past.

Garceau said she is fairly new to the MCAS. She said the proposed ratios look good, but she cannot find any information on what a good ratio would be. She said she had not received a response from the NAIC on her question regarding ratios. LeDuc said that was a good question, and training is needed for new market regulation analysts. She said there is no bright line on what is a good ratio or a bad ratio. Helder noted that most of the proposed ratios are also found on most of the MCAS lines of business, and they are likely considered useful by market analysts. The other ratios were included because there were data elements that were unique to the Other Health blank, so it was assumed that the drafters believed the data elements were useful.

Brown said there is no target ratio that companies are supposed to reach to be determined as a good or bad market participant. The market analysts are comparing a company's ratios to other company ratios to find the outliers. LeDuc said that is how she has used ratios. She said each state and ratio is different, so the market analysts look for companies that are outliers with either a high or low ratio.

LeDuc asked for volunteers to form an SME group to work on the Other Health MCAS ratios. Garceau, Rodriguez, and Birnbaum volunteered. LeDuc asked others who would like to volunteer to contact Helder.

4. Discussed Other Matters

Haworth said the MCAS Filing Status report in iSite+ does not include any travel insurers because there is nowhere on the financial annual statement for companies to report their travel insurance premiums, and it is not possible to know if a company is required to file a travel insurance MCAS blank. However, he said all companies received a call letter in December 2022, which listed all the lines of business to be reported in the MCAS and the participation requirements. LeDuc said there may need to be extra diligence on the part of the participating MCAS jurisdictions to ensure that all companies that need to file actually do file.

Having no further business, the Market Analysis Procedures (D) Working Group adjourned.

Sharepoint/Member Meetings/D CMTE/2023 Summer National Meeting/MAPWG/0410/04 MAPWG .docx

Draft: 8/2/23

Market Conduct Annual Statement Blanks (D) Working Group
Virtual Meeting
July 19, 2023

The Market Conduct Annual Statement Blanks (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met July 19, 2023. The following Working Group members participated: Erica Weyhenmeyer, Chair (IL); Rebecca Rebholz, Vice Chair (WI); Crystal Phelps (AR); Scott Woods (FL); Paula Shamburger (GA); Shannon Lloyd (KS); Salama Karim-Camara (MD); Jeff Hayden (MI); Jennifer Hopper, Teresa Kroll, and Jo LeDuc (MO); Robert McCullough (NE); Leatrice Geckler (NM); Ben Hauck (OH); Karen Veronikis (PA); Rachel Moore (SC); Tony Dorschner (SD); Shelli Isiminger (TN); Shelley Wiseman (UT); Melissa Gerachis (VA); John Kelcher (WA); and Letha Tate (WV). Also participating was: Brett Bache (RI).

1. Adopted its June 22 Minutes

The Working Group met June 22 to: 1) discuss Market Conduct Annual Statement (MCAS) directions for determining when a claim is closed on the personal property and homeowners lines of business; and 2) discuss the MCAS data element revision process timeline.

Kelcher made a motion, seconded by Wiseman, to adopt the Working Group's June 22 minutes (Attachment Six-A). The motion passed unanimously.

2. Discussed the Reporting of Closed Claims for PPA and Homeowners Lines of Business

Bache proposed to edit the wording of the data related to the reporting of claims closed with payment so that they read "number of claims closed in your system with the date of final payment within X days."

Weyhenmeyer asked for any comments or thoughts from the Working Group, state insurance regulators, or other interested parties regarding this proposal. No thoughts or comments were made. She said that this will be left open for comments through Aug. 18 and that the Working Group's next meeting will be set for the week of Aug. 21.

3. Discussed the MCAS Data Element Revision Process Timeline

Weyhenmeyer said that Pennsylvania and Missouri submitted comments on this topic. She said that these comments can be found on the Working Group's web page.

Veronikis proposed that there be a 30-day timeline to review what the subject matter expert (SME) group has submitted.

LeDuc said that comments were on the same line as Pennsylvania and suggested a longer timeline for review. She suggested the SMEs have their work and additions available by April 1 to the full Working Group, to give adequate time for Working Group members and interested parties to read, digest, and provide thoughtful feedback on any proposals.

Weyhenmeyer proposed to keep the current timeline and list some best practices in the revision process document.

Weyhenmeyer said that she and Rebholz have drafted some suggestions for these revisions. These best practices incorporate many of the comments that Pennsylvania and Missouri made, including: 1) asking more states to participate in the SME group, with a minimum of five states; 2) exposing the draft to the Working Group at least 60 days before the voting deadline of June 1; 3) as LeDuc suggested, exposing the SME draft documents at each Working Group meeting; and 4) encouraging that the Working Group start those weekly SME groups at the beginning of the discussion rather than at the end. Comments to these suggestions need to be submitted no later than Aug 18. to Hal Marsh (NAIC).

4. Discussed Filing Deadlines for Other Health and STLD Lines of Business

Weyhenmeyer received a letter from the health industry representatives, America's Health Insurance Plans (AHIP) and Blue Cross Blue Shield Association (BCBSA), asking to consider May 31 as the uniform filing deadline in order to be in line with the health filing deadline.

Demetria Tittle (BCBSA), representing the Health Industry Parties (HIP) group, said that in addition to the comprehensive major medical products covered under the health MCAS, many carriers under the HIP group also offer products covered under other health MCAS lines. The HIP group shares the NAIC's goal to deliver accurate and timely MCAS reports that serve as a tool for regulatory oversight. With the MCAS submission deadline, specifically for the short-term, limited-duration (STLD) and other health MCAS filings, these are scheduled to divert from their June 30 deadline to April 30 beginning in 2024 and 2025, respectively, for these filings. Tittle requested that the Working Group consider a uniform MCAS filing date that is consistent with the May 31 deadline, previously approved for health MCAS in 2022. Tittle presented two points for consideration: 1) a consistent billing date for all health care will promote a consistent review for health carriers' MCAS filings for the regulators, as well as carriers, in their workflow process; and 2) states may face receiving health carrier submissions across three different deadline dates in 2024. Here there is an opportunity to help avoid confusion and create consistency related to these filing dates. This is being brought up now so that the Working Group could consider adoption of this recommendation at the Summer National Meeting. Then the Executive (EX) Committee and Plenary can consider it for adoption at the Fall National Meeting. This is detailed further in the comment letter submitted.

Weyhenmeyer asked that comments on this topic be submitted no later than Aug. 18.

Having no further business, the Market Conduct Annual Statement Blanks (D) Working Group adjourned.

SharePoint/NAIC Support Staff Hub/Committees/D CMTE/2023 Summer/MCAS Blanks WG/Document 1.doc

Draft: 7/6/23

Market Conduct Annual Statement Blanks (D) Working Group
Virtual Meeting
June 22, 2023

The Market Conduct Annual Statement Blanks (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met June 22, 2023. The following Working Group members participated: Erica Weyhenmeyer, Chair (IL); Rebecca Rebholz, Vice Chair (WI); Tolanda Coker (AZ); Pamela Lovell (FL); Shannon Lloyd (KS); Lori Cunningham (KY); Raymond Guzman (MD); Jeff Hayden (MI); Jennifer Hopper, Teresa Kroll, and Jo LeDuc (MO); Martin Swanson (NE); Karen Veronikis (PA); Rachel Moore (SC); Shelli Isiminger (TN); Melissa Gerachis (VA); John Haworth (WA); and Theresa Miller (WV). Also participating was: Brett Bache (RI).

1. Adopted its May 30 and May 22 Minutes

The Working Group met May 30 to: 1) adopt the Pet Market Conduct Annual Statement (MCAS) Data Call and Definitions; and 2) discuss MCAS directions for determining when a claim is closed on the personal property and homeowners lines of business. The Working Group also met May 22 to adopt the Pet Insurance MCAS Data Call and Definitions.

Haworth made a motion, seconded by Martin, to adopt the Working Group's May 30 (Attachment Six-A1) and May 22 (Attachment Six-A2) minutes. The motion passed unanimously.

2. Discussed MCAS Directions for Determining When a Claim is Closed on the PPA and Homeowners Lines of Business

Bache stated that when doing the Market Analysis Review System (MARS) and looking at data from various companies, the Working Group is finding outlying data with potential concerns with claims delays. The Working Group has been going back to companies who have claims closed with payments and asking what their interpretation of the data is. It is finding that companies differ on how data is reported and how and when a claim is closed within the system. Other companies have found that the system automatically closes after around 30, 60, or 90 days. Therefore, when the final payment is made, it does not close in the system; rather, it stays open for a period of time, which is ultimately used for reporting the MCAS. When going back, it was noticed within the Data Call and Definitions document that there are two definitions for claims closed with a payment : 1) claims closed with payment; and 2) median days. This may be causing confusion for the companies. Companies using different ways of reporting when their claims are closed in the system is not indicative of whether there are actual issues with their claims payments, causing room for additional questions. A suggestion was made to clarify these definitions or add interrogatories and require companies to state how they determine when a claim is closed. This would give more info on instances of extreme claims delays.

Haworth stated that there is space on line 24 for claims comments in the interrogatories, but it is optional. He suggested adding instructions on how to fill that out.

Weyhenmeyer asked for a volunteer from the Working Group to draft this interrogatory.

Hopper reminded the Working Group that the definitions are on all the MCAS links, and they need to be updated there as well.

Randy Helder (NAIC) asked for clarification regarding whether this would say the company has the option to report one way or the other and then put that into the interrogatories. He said he believes giving companies this option would not allow the companies to be compared equally.

Hayden stated that companies have system limitations on how they report the data. When going back, it appears that there are a lot of claims closed late or delayed, when it is actually a limitation of reporting when a claim is paid. Giving them the opportunity to explain the data they are providing will help clarify the data. Hayden asked the Working Group if it is experiencing companies manually going into that level of detail when they are reporting MCAS data. He said in his experience, the Working Group is getting that info, and it is a cause for investigation into things that are not necessarily issues.

Haworth answered that the Working Group spent months asking the same questions. Often, companies have it listed as a reserve, and the claim is not closed until 30 or 60 days after the final payment. There are some situations where it gives a false positive. This is happening with small and large companies. What the number represents is known, so it is run anyway.

Bache stated that after talking to companies, it does not appear that they can manually look up the final payment date. Instead, they have the close date. The states would have to do that. Adding some clarification in the interrogatories is more for when the claim is closed in the system, as it would help the states with some of those false positives.

Birny Birnbaum (Center for Economic Justice—CEJ) said he believes the definitions are clear, but because of company systems, they cannot comply with the instructions. If the companies need to adjust their systems to meet the reporting requirements, then they need to do that. Birnbaum stated that he wants to ensure that companies are reporting consistently regardless of what they say their system capabilities are.

Weyhenmeyer and Bache agreed that there needs to be a more specific language request.

Katie Dzurec (Regulatory Insurance Advisors LLC—RIA) asked if this will be applied to all lines of business or just home and auto. Weyhenmeyer said the Working Group will start with home and auto and see how that goes.

3. Discussed the MCAS Data Element Revision Process Timeline

Weyhenmeyer stated that the timeline requires adoption by the Working Group prior to June 1 to implement or the following day and year. Since the development of new lines of business takes time, the Working Group is not able to move that deadline. It would be beneficial to have more state insurance regulators participate in subject matter expert (SME) group discussions. One option to consider is encouraging participation from the beginning and not delaying the start of that work. Another suggestion is that when SME updates are provided, the Working Group's meetings include a current draft in the meeting materials. The third idea is that reporting changes for existing lines of business could have a later deadline for approval.

LeDuc proposed that the SME group has a deadline for getting the final product to the Working Group in time to give a 45-day public comment period.

Weyhenmeyer asked that comments on this topic be submitted no later than July 14.

Having no further business, the Market Conduct Annual Statement Blanks (D) Working Group adjourned.

Draft: 6/15/23

Market Conduct Annual Statement Blanks (D) Working Group
Virtual Meeting
May 30, 2023

The Market Conduct Annual Statement Blanks (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met May 30, 2023. The following Working Group members participated: Erica Weyhenmeyer, Chair (IL); Rebecca Rebholz, Vice Chair (WI); Crystal Phelps (AR); Tolanda Coker (AZ); Scott Woods (FL); Paula Shamburger (GA); Shannon Lloyd (KS); Ron Kreiter (KY); Mary Lou Moran (MA); Salama Camara (MD); Jeff Hayden (MI); Jennifer Hopper and Teresa Kroll (MO); Jonathan Wycoff (NV); Guy Self (OH); Rachel Moore (SC); Shelli Isiminger (TN); Shelley Wiseman (UT); John Haworth (WA); and Theresa Miller (WV). Also participating was: Brett Bache (RI).

1. Adopted Revisions to the Pet MCAS Data Call and Definitions

Weyhenmeyer discussed the revisions made to the draft Pet Market Conduct Annual Statement (MCAS) data call and definitions as a result of comments received by the Working Group. In two instances, there was a copy-and-paste error where “travel” was used instead of “pet.” Those errors were corrected. Other revisions include: 1) the question referenced in interrogatory 15 was changed from 13 to 14; and 2) the Policy/Certificate was added to the definition of “Right to Examine and Return the Policy (Free Look).” Additionally, as a result of the discussion around the definition of “wellness program,” the term being defined was changed from “wellness program” to “noninsurance wellness program.” The middle section of the definition was also removed.

Birny Birnbaum (Center for Economic Justice—CEJ) stated his support for the draft edits.

Weyhenmeyer asked for a motion to adopt the draft Pet MCAS data call and definitions. The draft will be moved to the Market Regulation and Consumer Affairs (D) Committee for consideration for the 2024 data year reporting.

Rebholz made a motion, seconded by Haworth, to adopt the revisions to draft Pet MCAS data call and definitions. The motion passed unanimously.

2. Discussed MCAS Directions for Determining When a Claim is Closed on the Personal Property and Homeowners Line of Business

Bache said regarding claims displays, it has been noticed that different companies interpret when to report something as closed differently. Some companies are reporting claims as closed when they are closed in their internal systems. Other companies are reporting that claims are closed when the final payment is made. When looking at the MCAS definition, there were different definitions of when a claim is closed with payment. The definition of “median days” is when the final payment is made. This definition was put into place so all companies would have the same interpretation so the median days would be calculated correctly. The definition for “private passenger” and “homeowners” explains when the claim is closed in the system. That is where the difference of interpretation was coming from, and the actual data that was needed was not being received. Bache asked the Working Group to see if there was any clarification. Bache’s comments will be shared with the Working Group for review.

Having no further business, the Market Conduct Annual Statement Blanks (D) Working Group adjourned.

SharePoint/Market Regulation - Home/D Working Groups/MCAS Blanks WG/2023/WG Mtg 0530/MCAS Blanks WG Minutes May 30.docx

Draft: 5/30/23

Market Conduct Annual Statement Blanks (D) Working Group
Virtual Meeting
May 22, 2023

The Market Conduct Annual Statement Blanks (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met May 22, 2023. The following Working Group members participated: Erica Weyhenmeyer, Chair (IL); Rebecca Rebholz, Vice Chair (WI); Crystal Phelps (AR); Maria Ailor and Tolanda Coker (AZ); Scott Woods (FL); Paula Shamburger (GA); Ron Kreiter (KY); Mary Lou Moran (MA); Jennifer Hopper, Teresa Kroll, and Jo LeDuc (MO); Martin Swanson (NE); Ben Hauck (OH); Karen Veronikis (PA); Shelli Isiminger (TN); Shelley Wiseman (UT); Melissa Gerachis (VA); John Haworth (WA); and Letha Tate (WV). Also participating was: Brett Bache (RI).

1. Adopted its April 6 Minutes

The Working Group met April 6 to: 1) adopt revisions to the Market Conduct Annual Statement (MCAS) participation requirements; and 2) adopt a clarification to the Other Health MCAS blank.

Haworth made a motion, seconded by Rebholz, to adopt the Working Group's April 6 minutes (Attachment Six-A2a). The motion passed unanimously.

2. Considered Adoption of the Pet Insurance MCAS Data Call and Definitions

Bache said the drafting group held about 15 meetings over six months to complete the drafting of the Pet Insurance MCAS blank. He said there were 40 to 45 participants, including state insurance regulators, industry members, consumer representatives, and media. He said the drafting group began with Other MCAS blanks and tailored them to the pet insurance line of business. He said the drafting group tried to balance the needs of state insurance regulators with the work required by companies to file the MCAS.

Birny Birnbaum (Center for Economic Justice—CEJ) said he supports the Working Group's adoption of the proposed MCAS pet insurance data elements and definitions. He acknowledged the constructive participation of several pet insurance industry representatives. He identified two issues that surfaced during the subject matter experts' (SME's) work. First, in pet insurance policies, there is an initial claimant request in which eligibility is determined, and then there are subsequent benefit requests following the establishment of claimant eligibility. Birnbaum said industry members represented during SME discussions that they do not track claims in this manner, and they are not able to report the overall claim eligibility separately from individuals' line items within a claim request. He said industry members represented that all items are reviewed when claims come in, and some parts may be approved, some may be approved in part, and some may be disqualified or denied. He said this resulted in data elements asking the company to represent a percentage of the dollar amount they approved. He said he believes it is important for state insurance regulators to understand the limitations of this way of reporting.

Second, Birnbaum noted that the MCAS blank requires companies to report claims experience by type of policy form rather than coverage. He said there are three major coverages found in a pet insurance policy—accident, illness, and wellness. He said the *Pet Insurance Model Act* (#633) identifies and treats accident claims differently from wellness claims. He said industry members represented that they do not track claims experience by coverage, and to do so would be a major effort. He said industry offered to report by type of policy, which effectively means one policy type—accident and illness—because all pet insurance policies include accident and illness benefits. He said there is a separate category for stand-alone insurance just for wellness, but this is rare. He said virtually all the experience is going to be reported in the accident and illness policy category, whether that benefit request is

for accident, illness, or wellness. He said more meaningful MCAS reporting would require claims experience reporting by all three separate coverages. He said this was suggested during the SME group meetings, but industry argued that this would be unreasonable for them in the short term. He said Pet Insurance MCAS reporting by coverage would be more useful for state insurance regulators.

Ailor said Arizona's comments were technical in nature. The only comment that required more discussion was the definition of "wellness program." It appears to allow for differentiation based on whether states have different definitions within their laws. Ailor asked if that is to change, how it is going to be treated, how insurance companies will know what to report to which state, and how that will be taken into consideration when developing the ratios. She said if there are going to be differences in the definition by state, that may affect the data reported by the insurers.

Bache stated that this is something NAIC staff added to the definition afterward, so he is not sure how they would track that or change it within the MCAS and whether that is going to be changed from year-to-year or how it would work. Teresa Cooper (NAIC) stated that the language was taken from Model #633. She suggested removing the state-specific references and only using the first and last sentences of the definition.

Birnbaum stated that the entire definition of "wellness program" can be deleted. Wellness is defined in Model #633, and it is well understood. MCAS reporting is limited to wellness as insurance. Birnbaum said it does not make a difference because the MCAS blank does not break out claims by coverage. Everything is reported in the accident and illness policy category, whether it provides accident, illness, or wellness coverage. For a wellness claim to be reported, the company will have to have filed and gotten approval for a separate insurance policy with wellness. He said if the company did that, it clearly understands what wellness is. He suggested deleting the definition.

Rebholz said she agrees with Cooper, and he suggested taking out the middle part and leaving the definition as is. She said it provides a little more description and clarity. She said there are frequently asked questions (FAQ) that can be used in case questions start coming in on wellness programs. Bache said he agrees.

Birnbaum said the definition will lead people to believe a wellness program can be part of the policy. He said the first sentence of the definition is inconsistent with what is understood to be in a pet insurance policy.

Weyhenmeyer said the definition distinguishes a wellness program from wellness coverage in a policy. She said a wellness program is not part of the insurance policy, but it is referenced in the blank and should be defined.

Cooper said if the definition does not specifically define a particular data element, it can be addressed in an FAQ or adjusted later for clarity. Rebholz said interrogatory question 1.19 asks if a non-insurance wellness program is offered. She said this may be why the definition was included. Rodriguez said data element 2.34 also references wellness included in the policy as opposed to wellness only.

Birnbaum suggested changing the title from "Wellness Program" to "Non-Insurance Wellness Program." Rebholz and Bache said they agree. Ailor said she agrees, and she suggested that the state-specific statements in the definition also be removed, leaving only the first and last sentences.

Weyhenmeyer asked if the consensus is to remove the state-specific portions in the middle of the definition and re-title it "Non-Insurance Wellness Program." Bache said that is correct.

LeDuc said she is uncomfortable making changes without time to consider the ramifications when there is a deadline to be met. She said she does not recall seeing the comments and does not have time to think about the

suggested revisions. She asked that copies of the comments be distributed to the Working Group, interested state insurance regulators, and interested parties. Cooper said they would be, and she noted that they are also posted on the Working Group's web page. Rebholz asked if Cooper could redline this as an open suggested change that resulted from the Working Group's discussion. Cooper said she would do so.

Cari Lee (North American Pet Health Insurance Association—NAPHIA) said NAPHIA would like to be part of standardized ratio development. She said the data coming in may be a bit challenging in some areas, but NAPHIA will be able to provide a lot of assistance. She said she also encourages the Working Group to re-evaluate the Pet Insurance MCAS on a regular basis after it has been adopted to determine the usefulness of the data being reported. She said if there are interrogatories or data elements that state insurance regulators are not using, they should be addressed and potentially removed from the MCAS, but she also suggested caution in making revisions or additions in the initial years of data collection. She said it could take a couple of years to see what is happening with the data.

Weyhenmeyer said there will be another meeting scheduled prior to June 1 to consider adoption of the Pet Insurance MCAS blank.

3. Discussed Other Matters

Bache said Rhode Island would like to discuss some definitions in the Private Passenger Auto (PPA) and Homeowners MCAS blanks. He said it can wait until the Working Group finishes its considerations of the Pet Insurance MCAS blank.

Having no further business, the Market Conduct Annual Statement Blanks (D) Working Group adjourned.

SharePoint/Market Regulation - Home/D Working Groups/MCAS Blanks WG/2023/WG Mtg 0522/MCAS Blanks WG Minutes May 22.docx

Draft: 04/17/23

Market Conduct Annual Statement Blanks (D) Working Group
Virtual Meeting
April 6, 2023

The Market Conduct Annual Statement Blanks (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met April 6, 2023. The following Working Group members participated: Erica Weyhenmeyer, Chair (IL); Rebecca Rebholz, Vice Chair (WI); Tolanda Coker (AZ); Scott Woods (FL); Tia Taylor (GA); Shannon Lloyd (KS); Lori Cunningham (KY); Mary Lou Moran (MA); Jeffrey Hayden (MI); Jo LeDuc (MO); Martin Swanson (NE); Leatrice Geckler (NM); Karen Veronikis (PA); Rachel Moore (SC); Shelli Isiminger (TN); Melissa Gerachis (VA); John Haworth (WA); and Letha Tate (WV). Also participating were: Matt Gendron (RI).

1. Discuss Market Conduct Annual Statement (MCAS) Participation Requirements

Rebholz stated the first agenda item is to discuss the MCAS Participation Requirements document. She said NAIC staff received a question related to a sentence in the document and they have asked for insight from the Working Group. The document has been updated through the years to accommodate new lines of business and thresholds established for the new lines of business. There is one sentence in the document that is being questioned. The entire bulleted item reads as follows, “Each company in a holding company system must file separately for each state in which it does business. Data for the members of a group or insurance holding company cannot be combined into a single filing for the purposes of this project. Data must be reported separately for each group member unless it involves only inter-company arbitration.” The last sentence is in question.

Rebholz asked the working group members and other state regulators if anyone recalls the intent or meaning of the sentence. Hearing no response, Rebholz asked for a motion to remove the sentence from the Participation Requirements document. Haworth moved and Geckler seconded to have the sentence removed.

Birnbaum (Center for Economic Justice – CEJ) suggested that the first part of the sentence to be eliminated was still wanted “Data must be reported separately for each group member” and only the last part of the sentence should be deleted “unless it involves only inter-company arbitration” as that was the confusing part. Rebholz acknowledged that Birnbaum made a fair point and asked for thoughts from the group. Rebholz went on to say that the line right before the sentence in question says “Data for the members of a group or insurance holding company cannot be combined into a single filing...” and asked Birnbaum if that met the need of saying that companies must report separately. Birnbaum conceded the point and stated he had no objections to deleting the sentence. Hearing no further discussion, the motion passed unanimously.

2. Hear a Pet Subject Matter Expert (SME) Group Update

Rebholz asked Matt Gendron (RI) to provide an update on the work being done to create the PET MCAS Reporting Blank and definitions.

Gendron stated that the SME Group has been working for several months, meeting every other week, and has decided to start meeting weekly. There are five or six Regulators who are attending every call. There are consumer representatives that are on most of the calls and several trade associations and insurance company professionals helping to flush out details and put specificity into the interrogatories and schedules. Gendron identified that there are several schedules in the draft Pet MCAS reporting blank. He said the work was being done in tandem with both Regulators, keeping in mind what they need, and also keeping in mind the potential of

creating cost for insurers which will be passed on to consumers. He said the SME Group is trying to be circumspect in their requests. Gendron stated he was happy to take any questions.

Rebholz thanked Gendron and asked the group if there were any questions. No questions were asked.

3. Review the Other Health Data Element

Rebholz reviewed an adopted data element for the Other Health MCAS that is to be reported for the 2023 data year. Rebholz identified that NAIC staff has received questions related to claims question 3-80 and its intent. The data element in question reads, "Aggregate dollar amount of paid claims during the period". Rebholz said Mary Kay Rodriguez (WI) led the SME group in developing the Other Health MCAS. Rodriguez was consulted and it is proposed that the proper wording should be "Total dollar amount of paid claims during the period". Where the word "Total" replaces the word "Aggregate". Rebholz said this edit is outside the date guidelines for updates to MCAS reporting, but the intent here is not being changed. We are asking for the wording to be edited for clarity only. No comments were made regarding the proposed wording change.

Haworth made a motion to replace the word "Aggregate" with "Total" so that the sentence reads "Total dollar amount of claims paid during the period." Isiminger seconded the motion. The motion passed unanimously.

4. Hear an Update on MCAS Filings

Rebholz reminded state regulators to be on the lookout for MCAS waiver and extension requests. She recommended that those responsible for decisioning MCAS waivers and extensions set up Personalized Information Capture System (PICS) events so they will receive notification of the requests as they are submitted through the MCAS application. Rebholz said any questions about how to set up PICS events, can be directed to Hal Marsh (NAIC) or Teresa Cooper (NAIC). Rebholz said state regulators can also view extension and waiver requests using the Extension and Waiver Tableau dashboard that can be accessed through iSite+. This year the extension process has been updated to provide companies with two-week intervals for requesting extensions. This was done at the request of the Market Analysis Procedures (D) Working Group. Companies will now be able to submit more than one extension request, but each request will be limited to a two-week period. Filings are coming in as anticipated. All lines of business except Health and Short Term Limited Duration (STLD) will be due April 30th. Health is due May 31st and STLD is due June 30th.

5. Discuss Any Other Matters Brought Before the Working Group

Rebholz asked if there were any other items to be brought before the working group. No additional items were brought forward.

Having no further business, the Market Conduct Annual Statement Blanks (D) Working Group adjourned.

SharePoint/Market Regulation - Home/D Working Groups/MCAS Blanks WG/2023/WG Mtg 0406/MCAS Blanks WG Minutes April 6.docx

Draft: 8/1/23

Market Conduct Examination Guidelines (D) Working Group
Virtual Meeting
July 18, 2023

The Market Conduct Examination Guidelines (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met July 18, 2023. The following Working Group members participated: Matthew Tarpley, Chair, Thomas Morgan and Stacie Parker (TX); Erica Weyhenmeyer, Vice Chair (IL); Steven Matlock and Teri Ann Mecca (AR); Catherine O'Neil (AZ); Kurt Swan (CT); Pratima Lele (DC); Susan Jennette (DE); Paula Shamburger and Tia Taylor (GA); Paula Wallin (IA); Ron Kreiter (KY); Mary Lou Moran (MA); Airic Boyce, Jeff Hayden, and Danielle Torres (MI); Cynthia Amann, Julie Hesser, Jennifer Hopper, Teresa Kroll, and Win Nickens (MO); Tracy Biehn (NC); Ralph Boeckman and Erin Porter (NJ); Myra L. Morris (NM); David Cassetty (NV); Sylvia Lawson (NY); Rodney Beetch (OH); Landon Hubbard and Shelly Scott (OK); Sandra Emanuel and Tashia Sizemore (OR); Paul Towsen (PA); Brett Bache and Matt Gendron (RI); Andrea Baytop, Julie Fairbanks, Melissa Gerachis, Joy Morton, and Bryan Wachter (VA); John Kelcher and Jeanette Plitt (WA); and Barbara Belling, Darcy Paskey, Mark Prodoehl, Mary Kay Rodriguez, and Jody Ullman (WI).

1. Adopted its March 28 Minutes

The Working Group met March 28 and took the following action: 1) heard opening remarks made by the Working Group chair, which included a welcome to returning Working Group members and to new members; 2) discussed its 2023 charges; and 3) discussed next steps on carry over items from 2022, which include a travel in-force policy standardized data request (SDR), a travel claims SDR, and an Aug. 22 exposure draft of Chapter 23—Conducting the Life and Annuity Examination of the *Market Regulation Handbook* (Handbook).

Weyhenmeyer made a motion, seconded by Kreiter, to adopt the Working Group's March 28 minutes (Attachment Seven-A). The motion passed unanimously.

2. Discussed Revisions to the June 6 Draft Chapter 23—Conducting the Life and Annuity Examination of the Handbook

Tarpley said the revisions to the Chapter 23 exposure draft relate to the revisions to the *Suitability in Annuity Transactions Model Regulation* (#275) that the NAIC adopted in early 2020.

Tarpley said revisions to Chapter 23 were first circulated April 19, 2022, and they were first presented during the Working Group's April 21, 2022, meeting. The subject matter experts (SMEs) who prepared that initial exposure draft of Chapter 23 reviewed comments received on the chapter in late May 2022 from Virginia, Missouri, and the Insured Retirement Institute (IRI). They created a revised draft, which was posted and distributed on Aug. 22, 2022, and discussed during the Working Group's Sept. 8 meeting. The SMEs' Aug. 22 revisions to that draft were shown in yellow highlight to differentiate them from the revisions occurring prior to their review.

In September 2022, the Working Group received comments on the draft from the IRI; from the Center for Economic Justice (CEJ); and jointly from the CEJ/Independent Insurance Agents & Brokers of America (IIABA). Individuals who submitted those comments presented them at the Working Group's Oct. 20 meeting, which was the last Working Group meeting of 2022. The SMEs reviewed the draft that carried over from 2022 and made edits to marketing and sales examination standards 9 and 10, which were distributed on June 6 for a public comment period ending July 6.

Bache said the SMEs reviewed the Aug. 22 draft, taking into consideration the comments received in September 2022. He said that the Annuity Suitability (A) Working Group is still discussing the issues surrounding the safe harbor provision of Model #275 and that the SMEs added the following language to marketing and sales examination standards 9 and 10:

“As of June 2023, the Annuity Suitability (A) Working Group is still discussing the issue of how the Safe Harbor provisions of the *Suitability in Annuity Transactions Model Regulation (#275)*, Section 6E may apply. This examination standard may be revisited after those discussions are complete.”

The purpose of the added language is to include a placeholder in the examination standards affected by the safe harbor so that when the Annuity Suitability (A) Working Group eventually issues safe harbor guidance, marketing and sales examination standards 9 and 10 can subsequently be revised to include additional examiner guidance. Then they can be reopened for exposure and discussion during a future Market Conduct Examination Guidelines (D) Working Group meeting.

Kroll presented comments submitted July 6 regarding the placement of the new Marketing and Sales Supplemental Checklists, K, L, M, and N. The new checklists are located after marketing and sales examination standards 10, 12, 16, and 17, respectively. Kroll suggested that the new checklists be included together as a group and in alphabetical sequence, with the already existing checklists in Chapter 23. Bache agreed, saying that checklists K–N would be better placed at the end of Chapter 23 so that they are included after checklists A–J.

Sarah Wood (IRI) presented comments submitted July 6. Wood said that the IRI had provided comments in 2022, some of which were reiterated in its July 6 comments, regarding language that should be incorporated within Chapter 23 to better align the examiner guidance with the February 2020 updates to Model #275.

Wood suggested that the language the IRI provided in its comment letter regarding annuity suitability training requirements be added as a new criteria to Supplemental Checklist L:

“A producer who has completed an annuity training course approved by the department of insurance prior to the effective date of the regulation shall, within six (6) months after the effective date of the regulation, complete either: (a) A new four (4) credit training course approved by the department of insurance after the effective date of the regulation; or (b) An additional one-time one (1) credit training course approved by the department of insurance and provided by the department of insurance-approved education provider on appropriate sales practices, replacement and disclosure requirements under the amended regulation.”

Wood suggested that in marketing and sales standards 2, 3, and 9, the bullet “The consumer has had another annuity exchange or replacement and, in particular, an exchange or replacement within the preceding 36 months” be changed to “... within the preceding 60 months.” Wood also suggested that in Supplemental Checklist K, the edited sentence “Nothing in this subsection restricts an insurer from delegating performance of a function (including maintenance of procedures) required under this subsection” be changed back to “Nothing in this subsection restricts an insurer from contracting for performance of a function (including maintenance of procedures) required under this subsection.” Bache recommended adopting all of the IRI’s suggested changes to the draft.

Birny Birnbaum (CEJ) said that he was speaking not only on behalf of the CEJ, but also on behalf of the Consumer Federation of America (CFA) and the (IIABA), both of whom were unable to attend the meeting. Birnbaum said that it is premature for the Working Group to adopt the draft with the SMEs’ suggested changes “As of June

2023...” in marketing and sales examination standards 9 and 10 since the Annuity Suitability (A) Working Group continues to have ongoing discussions on the application of the safe harbor provisions of Model #275. Birnbaum said that the added language, which states that guidance is in flux, compromises the guidance provided in the draft. Birnbaum said the exposure draft, in its current form, would lead to: 1) insurers and producers claiming safe harbor and contesting efforts by market conduct examiners; and 2) inconsistency in regulatory oversight among the states because of the lack of substantive guidance.

Birnbaum said the requirements of Marketing and Sales Examination 16 only contain one of the requirements of Model #275; the model specifies four obligations: 1) care; 2) disclosure; 3) conflict of interest; and 4) documentation. He asked that the Working Group refrain from adopting the exposure draft until the Annuity Suitability (A) Working Group has developed safe harbor guidance. Birnbaum stated that an alternative resolution to that suggestion would be to remove all references to safe harbor provisions from the draft and adopt, so that the non-safe harbor guidance items in the draft can be implemented and used by examiners.

Tarpley said that the purpose of adopting the exposure draft as currently written is to establish new tools/examination standards for examiners to use while the Working Group awaits guidance from the Annuity Suitability (A) Working Group on the safe harbor issue. Tarpley asked if Birnbaum had submitted written comments stating his objections to the June 6, 2022, draft. Birnbaum said that he had last provided written comments relating to Chapter 23 in 2022.

Tarpley said that he would not want the Working Group to adopt a draft that contains an open or unresolved issue. Therefore, he extended the comments due date to Sept. 4. Tarpley asked that Birnbaum submit written comments by the comments due date containing specific suggested changes to the draft chapter. Tarpley said that the SMEs will reconvene after that date to review all comments received and prepare a revised exposure draft for exposure and the Working Group’s review during its next scheduled meeting.

Wood said the IRI is supportive of the current language in the exposure draft of Chapter 23. Wood asked if the IRI should resubmit its comments from 2022. Tarpley said that all comments received in 2022 were already taken into consideration and discussed during Working Group meetings in September and October 2022. Tarpley asked the CEJ and the IRI and any others who intend to submit comments not to reiterate previously submitted comments; all entities are asked to identify new issues/concerns they have not previously submitted.

3. Adopted the June 6 Exposure Draft of Chapter 4—Collaborative Actions of the Handbook

Tarpley said the purpose of the exposure draft of Chapter 4—Collaborative Actions of the Handbook is to incorporate changes to provide non-regulators with transparency and insight regarding the multistate process that occurs at the Market Actions (D) Working Group. Tarpley said the draft was circulated June 6 for a public comment period ending July 6.

Tarpley said that comments on the draft were received from Kroll. Kroll suggested adding the following language as a new last paragraph to Subsection A. Procedure, of Section E. Conclusion of Collaborative Enforcement Actions, to ensure that all lead states have an opportunity to weigh in on the language before presenting it to the company(ies):

“Prior to sharing the MSA with the Company, the MSA should be provided to the lead states for review. A period of at least 10 working days should be allowed for the lead states to provide feedback. All feedback should be considered by the group in drafting a final version of the MSA.

The final MSA should be agreed to by all lead states prior to sharing with the entity(ies) examined.”

Tarpley said that he will present Kroll’s suggested change to Subsection A. Procedure during the 2023 Market Actions (D) Working Group’s annual meeting for consideration, and if it decides to incorporate the language into its procedures, as is, or revised, Chapter 4 can be subsequently changed to align with the language MAWG incorporated. Chapter 4 can then be re-exposed for the Market Conduct Examination Guidelines (D) Working Group’s consideration.

Kroll suggested removing “a follow-up audit, examination,” from the first sentence of Subsection B.2.c. Self-Reporting of Section E. Conclusion of Collaborative Enforcement Actions so that the sentence would then read: “The MSA may provide for periodic self-reporting.” Tarpley agreed with Kroll’s change.

Kroll said that some state laws may not treat exhibits the same as the report. Missouri law considers exhibits to be workpapers, and exhibits are, therefore, confidential. The final report is a public document in Missouri. Kroll therefore asked whether Subsection 2. Exhibits of Subsection D. Confidentiality of Section E. Conclusion of Collaborative Enforcement Actions should be changed to allow consistency with each state’s laws or if the intention of Subsection D.2. is to follow the managing lead state’s laws. Tarpley said that he will present this suggested change during the Market Actions (D) Working Group’s annual meeting and obtain its feedback. Depending on the Market Actions (D) Working Group’s reply, changes can be incorporated into Chapter 4, which will subsequently be re-exposed for the Market Conduct Examination Guidelines (D) Working Group’s consideration.

Kroll said that the sentence “The release of preliminary settlement information to the public that is an integral part of negotiations would have a chilling effect on future settlement negotiations.” in Subsection D.2.b. Settlement Offers/Negotiations should be changed to: “The release of preliminary settlement information to the public that is an integral part of negotiations would have a detrimental effect on future settlement negotiations.” Tarpley agreed with Kroll’s change.

Weyhenmeyer made a motion, seconded by Kroll, to adopt the Chapter 4 draft, as revised during the meeting, to include Kroll’s suggested edits to Subsection B.2.c. Self Reporting and to Subsection D.2.b. in Section E. Conclusion of Collaborative Enforcement Actions. The motion passed unanimously.

4. Discussed Other Matters

Tarpley said that SMEs are working on revisions to a travel insurance in-force SDR and a travel insurance claims SDR. A revised exposure draft of each will be circulated for review and discussion during a future Working Group meeting.

Tarpley said that the Working Group had identified in 2022 a need for a short term, limited-duration (STLD) in-force SDR and a STLD claims SDR. Tarpley said that due to recently proposed federal rule changes relating to STLD plans, the Working Group will table that work and consider developing the SDRs when federal guidance is finalized.

Tarpley said that he would like to begin focusing on two of the Working Groups charges to:

- Discuss the development of uniform market conduct procedural guidance (e.g., a library, depository or warehouse with market conduct examination templates, such as an exam call letter, exam exit agenda, etc.) for inclusion in, or for use in conjunction with, the *Market Regulation Handbook*.

- Coordinate with the Innovation, Cybersecurity and Technology (H) Committee to develop market conduct examiner guidance for the oversight of regulated entities' use of insurance and non-insurance consumer data and models using algorithms and artificial intelligence (AI).

Tarpley said that Wallace will be sending an email inquiry to Working Group members, with the purpose of creating regulator-only SMEs for each of the above subject areas, to begin discussing the charges. Should there not be enough Working Group volunteers, Tarpley said Wallace will then reach out to interested regulators to volunteer to join the discussion.

Tarpley said a notice of the day and time of the next Market Conduct Examination Guidelines (D) Working Group meeting will be sent as soon as it is available.

Having no further business, the Market Conduct Examination Guidelines (D) Working Group adjourned.

[07-18.docx](#)

Draft: 4/11/23

Market Conduct Examination Guidelines (D) Working Group
Virtual Meeting
March 28, 2023

The Market Conduct Examination Guidelines (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met March 28, 2023. The following Working Group members participated: Matthew Tarpley, Chair (TX); Erica Weyhenmeyer, Vice Chair, and Patrick Tallman (IL); Chris Erwin and Teri Ann Mecca (AR); Tolanda Coker (AZ); Nick Gill (CT); Pratima Lele and Cheryl Wade (DC); Susan Jennette and Frank Pyle (DE); Simone Edmonson, Paula Shamburger, and Tia Taylor (GA); Paula Wallin (IA); Ron Kreiter (KY); Mary Lou Moran (MA); Airic Boyce and Jeff Hayden (MI); Teresa Kroll, Jo LeDuc, and Win Nickens (MO); Tracy Biehn and Teresa Knowles (NC); Maureen Belanger and Ellen Walsh (NH); Ralph Boeckman and Erin Porter (NJ); Leatrice Geckler and Myra L. Morris (NM); Rodney Beetch (OH); Landon Hubbard and Shelly Scott (OK); Sandra Emanuel, Brian Fordham, and Tashia Sizemore (OR); Paul Towsen (PA); Brett Bache, Segun Daramola, and Brian Werbeloff (RI); Julie Fairbanks and Bryan Wachter (VA); Isabelle Turpin Keiser and Karla Nussl (VT); Jeanette Plitt (WA); and Barbara Belling, Diane Dambach, Darcy Paskey, Mark Prodoehl, Rebecca Rebholz, and Jody Ullman (WI).

1. Heard Opening Remarks

Tarpley extended a welcome to all returning Working Group members and to new members, Gill and Walsh, representing Connecticut and New Hampshire. Tarpley said the Working Group will meet approximately every four to six weeks, and it does not meet at national meetings or in lieu of national meetings.

2. Discussed its 2023 Working Group Adopted Charges

Tarpley said the Working Group charges are on its web page. He mentioned that there was one change from its 2022 charges. Charge #4 to, “Develop market conduct procedural guidance ...” was changed to, “Discuss the development of market conduct procedural guidance” Tarpley said charges #1–3 to develop examination standards, monitor NAIC models, and develop standardized data requests (SDRs) are related to the carry-over items; i.e., exposure drafts from 2022. Regarding charge #5 to, “Coordinate with the Innovation, Cybersecurity, and Technology (H) Committee ... ,” he and Weyhenmeyer are monitoring the initiatives of the Innovation, Cybersecurity, and Technology (H) Committee to ascertain if guidance in the *Market Regulation Handbook* (Handbook) will be affected. He said he would like to focus on the 2022 carry-over items before working on new material and Working Group charges #4 to, “Discuss the development of uniform market conduct procedural guidance ... ,” charge #6 to, “Discuss the effectiveness of group supervision of market conduct risks ... ,” and charge #7 to, “Discuss the role of market conduct examiners in reviewing insurers’ corporate governance”

Tarpley said he and Weyhenmeyer are monitoring the activity of the Accelerated Underwriting (A) Working Group, which is considering making a referral to the Market Conduct Examination Guidelines (D) Working Group pertaining to the addition of state insurance regulator guidance to the Handbook regarding the use of artificial intelligence (AI) for life insurance underwriting. Birny Birnbaum (Center for Economic Justice—CEJ) said he placed a related link about AI into the chat of the meeting regarding a vendor that purports to use behavioral data in a database of over 250 million individuals for risk assessment for health insurance and homeowners insurance. He said the vendor claims that by using this data, its customers can have a better understanding of the stratification of risk for their book of business, underwriting, pricing, and claims settlement.

Tarpley said he welcomed the Working Group’s input regarding other lines of business and/or subject areas that could potentially be addressed in the Handbook. He said the Market Actions (D) Working Group identified

additional information regarding regulatory settlement agreements that can be added to the corresponding chapter in the Handbook. Tarpley said he will add this as a topic in a future Working Group meeting.

3. Discussed Carry-Over Items from 2022

Tarpley said carry-over items from 2022 include: 1) a travel in-force policy SDR; 2) a travel claims SDR; and 3) revisions to Chapter 23—Conducting the Life and Annuity Examination of the Handbook related to the best interest provisions of the *Suitability in Annuity Transactions Model Regulation* (#275). He said the two travel SDRs were first discussed at the Working Group’s Sept. 8, 2022, meeting, and there was discussion at its Oct. 20, 2022, meeting about the SDRs, as well. He said he is asking the subject matter experts (SMEs) that developed the initial SDR exposure drafts to reconvene to consider the comments received in 2022 from Missouri, Virginia, and the CEJ and revise the SDRs, as they deem appropriate. He said the revised exposure drafts will then proceed to the Working Group for a new exposure period. After the exposure period concludes, if additional comments are received, additional revisions may be made at that time, after which, the Working Group may consider the SDRs for adoption.

Tarpley said since the Working Group received numerous comments on the draft Chapter 23 of the Handbook in 2022, he has asked the SMEs that developed the initial draft Chapter 23 to revise the chapter, as they deem appropriate, considering the comments the Working Group received in 2022. He said the revised exposure draft will then proceed to the Working Group for a new exposure period for the Working Group’s review and further consideration.

Birnbaum said the issue raised in the comments received by the Working Group in 2022 about the Chapter 23 exposure draft was regarding the safe harbor provisions of Model #275, what they signify, and how they should be implemented. He said the Annuity Suitability (A) Working Group was working in 2022 on a frequently asked questions (FAQ) document that was also tied to this same issue; i.e., safe harbor enforcement, supervision, etc. He said the Annuity Suitability (A) Working Group’s work on the FAQ document has ceased due to the comments it has received from interested parties—that Working Group has not met since 2022.

Tarpley discussed the importance of coordination with the Annuity Suitability (A) Working Group regarding this issue. He said he will ask the SMEs to discuss the safe harbor issue, as it affects the draft revisions to Chapter 23, and identify a way of moving forward on the exposure draft, perhaps by carving out content that is applicable to the safe harbor and adding it in later when those issues are resolved.

4. Discussed Other Matters

Tarpley said a notice of the day and time of the next Market Conduct Examination Guidelines (D) Working Group meeting will be sent as soon as it is available.

Having no further business, the Market Conduct Examination Guidelines (D) Working Group adjourned.

[03-28.docx](#)

Draft: 6/13/23

Market Regulation Certification (D) Working Group
Virtual Meeting
June 6, 2023

The Market Regulation Certification (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met June 6, 2023. The following Working Group members participated: Mike Kreidler, Chair, and John Haworth (WA); Chelsy Maller (AK); Crystal Phelps (AR); Mary Kwei (MD); Jo LeDuc (MO); Tracy Biehn (NC); Robert McCullough (NE); Maureen Belanger (NH); Ralph Boeckman (NJ); Don Layson (OH); Glynda Daniels (SC); Shelley Wiseman (UT); Don Beatty (VA); Karla Nuisl (VT); Theresa Miller (WV); and Bryan Stevens (WY).

1. Adopted its May 9 Minutes

Commissioner Kreidler said the Working Group met May 9 to discuss the revisions to the Market Regulation Certification Program.

Beatty made a motion, seconded by Biehn, to adopt the Working Group's May 9 minutes (Attachment Eight-A). The motion passed unanimously.

2. Reviewed the Pilot Program Suggested Revisions to the Market Regulation Certification Program

Haworth said the revisions to the Market Regulation Certification Program include the requirements, guidelines, and checklist. They also include the scoring matrix, which was created to give jurisdictions an understanding of how a certification review would be scored.

Haworth said the revisions were first exposed in April, and the Working Group made some minor changes suggested by Julie Fairbanks (VA) that were incorporated and exposed for the May meeting. He said there were no comments during the May meeting, and no written comments were received since the May meeting, so he said the Working Group was ready to consider the revisions for adoption. LeDuc said she had minor typographical corrections to suggest, such as a closing parenthesis and other similar suggestions. Haworth said those could be made after the adoption of the revisions since they are minor.

Stevens made a motion, seconded by LeDuc, to adopt the revision to the Market Regulation Certification Program. The motion passed unanimously.

Haworth said the adoption will be reported at the Market Regulation and Consumer Affairs (D) Committee during the Summer National Meeting in Seattle, WA.

Commissioner Kreidler thanked Haworth and the Working Group for its efforts in finishing the work on the Market Regulation Certification Program.

Having no further business, the Market Regulation Certification (D) Working Group adjourned.

SharePoint/NAIC Support Staff Hub/Member Meetings/D Cmte/2023 Summer National Meeting/MRCWG/0606/06 MRCWG

Draft: 5/26/23

Market Regulation Certification (D) Working Group
Virtual Meeting
May 9, 2023

The Market Regulation Certification (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met May 9, 2023. The following Working Group members participated: Mike Kreidler, Chair, and John Haworth (WA); Sarah Bailey (AK); Crystal Phelps (AR); Erica Weyhenmeyer (IL); Jo LeDuc (MO); Teresa Knowles (NC); Martin Swanson and Robert McCullough (NE); Maureen Belanger (NH); Ralph Boeckman (NJ); Don Layson (OH); Shelly Scott (OK); Shelley Wiseman (UT); Don Beatty and Katie Johnson (VA); Karla Nuisl (VT); Theresa Miller (WV); and Bryan Stevens (WY).

1. Adopted its Spring National Meeting Minutes

Commissioner Kreidler said the Working Group met Feb. 27 in lieu of meeting at the Spring National Meeting.

LeDuc made a motion, seconded by Beatty, to adopt the Working Group's Feb. 27 minutes (*see NAIC Proceedings – Spring 2023, Market Regulation and Consumer Affairs (D) Committee, Attachment One*). The motion passed unanimously.

2. Reviewed the Pilot Program Suggested Revisions to the Market Regulation Certification Program

Haworth said the revisions to the Market Regulation Certification Program documents come primarily from the suggestions received by the states that participated in the pilot program. He said last year, the Working Group appointed a subject matter expert (SME) group to go over all the suggestions and incorporate them into the Market Regulation Certification Program. He thanked the SME group for their hard work. He said the group included Bailey, LeDuc, Nuisl, Chelsy Maller (AK), Pam O'Connell (CA), Tracy Biehn (NC), Hermoliva Abejar (NV), Andrea Baytop (VA), Marcia Violette (VT), and Bill Cole (WY).

Haworth said the documents to be adopted are the requirements, guidelines, checklist, and scorecard. He said the Working Group previously adopted the scorecard, but since changes to the requirements, guidelines, and checklists necessitated changes to the scorecard, the Working Group will need to adopt those changes to the scorecard as well.

Haworth said the documents have been exposed on the Working Group web page for a month, and they were attached to the notice for this meeting on April 21. He said the Working Group received some comments from Julie Fairbanks (VA) with some grammatical changes, which have been posted and changed within the document.

Having no further business, the Market Regulation Certification (D) Working Group adjourned.

SharePoint/NAIC Support Staff Hub/Member Meetings/D Cmte/2023 Summer National Meeting/MRCWG/05 MRCWG

Draft: 8/12/23

Speed to Market (D) Working Group
Virtual Meeting
July 25, 2023

The Speed to Market (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met July 25, 2023. The following Working Group members participated: Rebecca Nichols, Chair (VA); Jimmy Harris (AR); Shirley Taylor and Susan Buth (CO); Trinidad Navarro and Frank Pyle (DE); Shannon Hohl (ID); Julie Rachford (IL); Tammy Lohmann (MN); Camille Anderson-Weddle (MO); Ted Hamby (NC); Cuc Nguyen (OK); Mark Worman (TX); Tracy Klausmeier (UT); and Lichiou Lee (WA). Also participating was: Maureen Motter (OH).

1. Adopted its Nov. 10, 2022, Minutes

The Working Group met Nov. 10, 2022, to: 1) adopt its July 12, 2022, minutes; 2) receive an update on edits to the *Product Filing Review Handbook* (Handbook); and 3) receive an update in the System for Electronic Rates and Forms Filings (SERFF) and the Product Steering Committee (PSC).

Lohmann made a motion, seconded by Lee, to adopt the Working Group's Nov. 10, 2022, minutes (*See NAIC Proceedings – Fall 2022, Market Regulation and Consumer Affairs (D) Committee, Attachment Seven*). The motion passed unanimously.

2. Discussed Suggestions Received for the PCM and the UTD

Motter started with three suggestions made for the Life, Health, and Annuities Product Coding Matrix (PCM): 1) there should be a new type of insurance (TOI) code to deal with mental health parity filings. The question of whether someone is making a change just to the mental health parity piece of the health filing or if this is a certification finding of some sort came up when reviewing for clarification.

Lee said mental health is part of form and rate filings. This would not be a new TOI if the company submitted just a mental health coverage; it would be a violation of their law, and it needs to be part of our health care benefit. Lee questioned why this would be a new TOI; it would just be part of a certification as part of a health plan, which has a separate TOI.

Hamby said North Carolina has seen filings that were specific to address the compliance matter. To be able to identify these individually, North Carolina is using a filing label. A new TOI is not the way that it should go. It is not a product type; it is in relation to a product.

Motter stated that comments were received from the SERFF Modernization Team, and these may be things that can be incorporated in the modernization. Regarding the first suggestion, she asked if there is anyone who believes the new TOI is the way to go. No comments were received. The second suggestion was from Colorado; it is seeing a paid family medical leave product submitted. The question would be whether there would be interest in having these as a new TOI or continuing to have them as H21 other filing types.

Lee said this is not a benefit; this is a state-paid benefit. The department of insurance (DOI) does not receive the filing for paid family medical leave; this is part of disability filing.

Harris has added this line, and it will be available Aug. 1. For now, they are filed under Health Other, but he is in support of adding this new TOI for paid family medical leave. This would pay a benefit if Family Medical Leave Act (FMLA) was needed. This is a product that would pay a benefit as a result of someone else's situation. Since this does not fit under Health products and it is not a life insurance product, this was added in the statute that any company admitted in Arkansas with life or health can market the product. This was brought to Arkansas by a couple of companies who wanted to sell the product but were not allowed because it would require a law change.

Hamby has seen this type of filing, but like Arkansas, he did not have the coding for it. It came down to who the beneficiary of the benefit is. North Carolina was seeing that the benefit was paying the employer when they had to accommodate an employee for family medical leave.

Lohmann said Minnesota has a new statute. Companies are not required to provide the coverage; under the statute, they will be able to purchase coverage and offer it as an option for companies that are required. It will be a variation of disability. Filings for this coverage will be received. Minnesota considers this a disability, and it is using filing labels to flag them.

Motter said this sounds like something that will be seen more. She asked what the appropriate TOI would be, if it would be limited one and added to the end of the Hs, or if this will fall under health as opposed to any where else in the credit coding matrix for life health and annuity.

Buth said Colorado has a statutory law, similar to what Washington mentioned. Large companies can opt out if they have their own; i.e., where companies enter the market to sell to large companies to have their own family leave. This is similar to disability; i.e., where we are putting this now with some state labels. Butth said Colorado would support this.

Motter asked if the name "paid family medical leave" would be the appropriate name for this new TOI. This will be an individual product or group product. Motter asked if filers would put this where it needs to be if this is the name it is given. She asked if there is a description for the product, similar to what is in the PCMs today.

Buth said Colorado believes that would be appropriate. She said most would be a group product.

Motter asked if this would be a sub-TOI H11g, group health disability income in the H11i individual health disability income, and have family medical leave also be one of your sub-TOI under those, or whether it should stand on its own and be an H27. If it is a sub-TOI would be looking at H11, G006, and H11i, it would be at 10 for I's.

Lohmann said Minnesota would like it as a sub-TOI, individual and group. It sounds like there may be interest from several states due to the fact that these types of filings are becoming more prevalent, especially by the effective date of Jan. 1.

Motter asked if we move forward with these two new sub-TOIs, how everyone would feel taking this offline to come up with a description and then sharing it with everyone.

Lohmann agreed to a call for the descriptions.

Motter moved on to the third suggestion. The life and health would be having a new TOI for an occupational accident product, similar to workers' compensation for independent workers (e.g., truckers). It is a benefit similar to workers' compensation that is offered on an individual basis, and it only covers the independent worker, no passengers or new family members. The question posed is whether this is not the same as what was recently

added to the PCM 16.005 on the property/casualty (P/C) side called occupational accident workmen's comp. It is insurance that covers the occupational accident to include comparable workers' compensation. Motter asked if this is also needed on the life and health side. It was already thought that a lot of accident and health (A&H) already provides 24/7 coverage.

Klausmeier said this is filed under the life and health instance, not the P/C instance, for Utah.

Lohmann said that is the same in Minnesota. Minnesota does not use 16.005 because it does not want this mixed in with workers' compensation. There have been legal issues with that, so it has to be on the life and health side on an individual basis only. When they come in as group, they get rejected.

Motter asked those that receive these types of products on the life and health instance whether it is a problem to continue to receive them this way or to perhaps add a label (e.g., truckers or whatever it may be). If there is a need for this granularity, she asked if others would also see this same need.

Lohmann said Minnesota would not see the need right now. There has been some thought of legal changes, but at this time, there would be no need for this sort of granularity.

Motter this can also be brought up at another time as these start to roll in. As of now, it seems there is no desire to move forward with this one. It sounds like there is agreement for two new sub-TOIs for paid family medical leave; a description is to be determined, including those in H11, G006, and H11lo10.

Rachford asked for clarification on the third proposal to add a TOI of occupational accidents on the life and health side, so filings associated with occupational accident could be identified as such. It receives these on the life and health side, so she asked why we would not want do to that if it allows it to show additional granularity.

Motter said yes, some are saying they do not want that additional granularity at this time; they are receiving them as H02I and continue to use a filing label.

Buth said Colorado is receiving operational accident under H21 and would like to see an additional TOI in the life and health instance.

Motter said Colorado is receiving these as H21, and others are receiving them as H02I. The question would be how many states would turn this on.

Lee said Washington would not turn it on; it does not allow these due to independent contracts.

Hamby said North Carolina has had a filing relative to this kind of product. There was a question of why this is limited to individual truckers; the answer at the time was that there was some sponsoring association related to independent truckers that was pushing for a benefit plan like this. Any self-employed individual may want this type of coverage.

Buth said Colorado uses the term "self-employed contractor" as well.

Motter asked whether with these self-employed persons, they have 24/7 coverage under their health policy or if there is something different about these products.

Klausmeier said Utah specifically includes them, as they are doing their job, so it allows for workers' compensation type of coverage.

Motter asked if these are individual policies and whether it would make sense to have a sub-TOI under individual health accident only that ends up covering these or if this would be a separate TOI.

Buth said Colorado does not allow work-related injuries under health. The separate TOI would give a spot to out it, and yes, it is for while they are working.

Motter said there are only one or two states that want to turn this on. She asked how the Working Group feels about holding this off until next year to see if other states are interested. It sounds like a couple states feel very strongly about the need for this. We also need to be mindful that we do not create TOIs and sub-TOIs that do not get turned on by multiple states. If we were to deadline and make changes to the PCM for an effective date of Jan. 1, Motter asked how much time would be needed for the approval process and implementation. The following suggestions were made: 1) we are holding off at this present time; 2) we are going to move forward with the sub-TOI, working on a description to provide to the PCM; and 3) sharing information in our minutes to let folks know that there seems to be strong consideration, but we need more buy in. If we know there is interest, we can move forward and pass it before the end of the year.

Rachford made a motion, second by Buth, to move forward with all three suggestions. The motion passed unanimously.

Motter said moving on to the P/C suggestions, they are taking the first two suggestions together. This would allow filings to be received from rating bureaus and ratio organizations as an advisor of their rates rules, forms, or loss costs in SERFF, but also allow them to submit licensing material. States suggest that there be a new TOI for the rating organizations and the other for advisor organizations and possibly some sub-TOIs, depending on what documentation is coming in.

Bridget Kieras (NAIC) said an item intended for SERFF modernization is the processes that allow you to accept content that is not traditional rate and form product filing, so we can keep this in one system.

Motter made the suggestion to table adding a TOI, keep this on the radar, and have states work with the SERFF Modernization Team to think this through. The last P/C suggestion is to add a TOI just for third-party models: one for the initial filing and a second for any subsequent revision of the model. Motter asked if there is any interest in requiring these models to be separate from the filing submission and having an un-granular TOI or having them all fall under one TOI instead of the product TOI. Not hearing any input on that with respect to P/C filing submission suggestions for the PCM, she said suggestions one and two will be put on the SERFF modernization wish list, but there is no interest in suggestion three.

Klausmeier made a motion, second by Lohmann, to move forward with the P/C PCM suggestions. The motion passed unanimously.

3. Heard a Report from the Compact

Karen Schutter (Interstate Insurance Product Regulation Commission—Compact) said North Dakota will be joining the Compact on Aug. 1, and it will be open for filings on Aug. 16, opted out of long-term care (LTC). There are 47 compacting states, including Washinton, DC and Puerto Rico. States that are not Compact members include New York, California, Florida, South Dakota. The Compact is speaking with them and South Carolina, who repealed the Compact last year. One of the important things the Compact does is develop uniform standards, which are the product requirements, with over 100 product standards in place. The Product Standards Committee (PSC) has in

place new individual disability income standards for key person and buying and selling. The PSC has drafted a new suite of standards for the group whole life for employer group life that is going to be recommended in the near future. Members are working on index-linked variable annuity (ILVA), as well as opening up the group standards to accommodate non-employer groups. The states will fire PCM firmly in charge of approving whether the non-employer group needs the eligibility requirement in their states. Once they decide that, then they can use the Compact to pre-product. The Working Group is in the process of asking what new or amended standards the PSC should consider working on next year. The Compact has held three roundtables, which led to the creation of the Adjunct Services Committee, looking at the idea of whether the Compact provides additional adjunct services, given its platform and the expertise of life annuity, LTC, and disability income fields. The Compact will meet Aug. 15 to discuss a briefing of this new standard, discuss strategic planning, and make an amendment to group annuity. In the site redesign, there is a collaborative space through iSite+.

4. Heard a Report on the SERFF Modernization Project

Kieras said the first two phases of SERFF modernization are in production. Phase one, involving improving the legacy search, should now be seeing significantly faster response times. All user notes have a document search that includes support for phrases and document comparison. Phase Two, an introduction of Tableau dashboards, also involved a move of SERFF's legacy historical data to the enterprise data warehouse. These dashboards are available to all states; they are being piloted to industry. The Compact will be the first to move to the new platform, closely working with them, an industry filer focus group, and a Compact member state focus group, as that functionality is being redesigned. This should be released in the first or second quarter of 2024, and then moved to the life business type. SERFF will now recognize three business types, instead of two, adding something called a TOI Group to improve search and reporting. As the Working Group reviews the PCM, in the future, not everything will have to have a TOI to be submitted and served, in the hopes that new ways will be designed to get information that does not fall into the PCM. SERFF is planning a state workshop in October 2023, targeting users in the life and annuity and credit area, as well as P/C workshops in 2024.

Having no further business, the Speed to Market (D) Working Group adjourned.

SharePoint/NAIC Support Staff Hub/Committees/

ANTIFRAUD (D) TASK FORCE

Antifraud (D) Task Force Aug. 14, 2023, Minutes..... 8-103
Improper Marketing of Health Insurance (D) Working Group July 27, 2023, Minutes (Attachment One).... 8-106

Draft: 8/25/23

Antifraud (D) Task Force
Seattle, Washington
August 14, 2023

The Antifraud (D) Task Force met in Seattle, WA, Aug. 14, 2023. The following Task Force members participated: Trinidad Navarro, Chair (DE); John F. King, Vice Chair (GA); Lori K. Wing-Heier represented by Kayla Erickson (AK); Mark Fowler represented by Jimmy Gunn (AL); Alan McClain represented by Russ Galbraith (AR); Barbara D. Richardson represented by Maria Ailor (AZ); Ricardo Lara represented by George Mueller (CA); Andrew N. Mais represented by Kurt Swan (CT); Doug Ommen represented by Andria Seip (IA); Dean L. Cameron represented by Randy Pipal (ID); Sharon P. Clark represented by Rob Roberts (KY); Kathleen A. Birrane represented by Joe Smith (MD); Anita G. Fox represented by Joseph Garcia and Michele Riddering (MI); Grace Arnold represented by Tony Ofstead (MN); Chlora Lindley-Myers represented by Carrie Couch and Marjorie Thompson (MO); Mike Chaney represented by Vanessa Miller (MS); Troy Downing represented by Ted Bidon (MT); Mike Causey represented by Angela Hatchell (NC); Jon Godfread represented by Colton Schulz (ND); Eric Dunning represented Martin Swanson (NE); Alice T. Kane represented by Leatrice Geckler and Roberta Baca (NM); Judith L. French represented by Laura Miller (OH); Glen Mulready represented by Brian Downs (OK); Andrew R. Stolfi represented by Dorothy Bean and Stephanie Noren (OR); Michael Wise represented by Joshua Underwood (SC); Jon Pike represented by Armand Glick (UT); Scott A. White represented by Juan A. Rodriguez Jr. and Richard Tozer (VA); and Kevin Gaffney represented by Mary Block (VT).

1. Adopted its Spring National Meeting Minutes

Commissioner King made a motion, seconded by Mueller, to adopt the Task Force's March 23 minutes (*see NAIC Proceedings – Spring 2023, Antifraud (D) Task Force*). The motion passed unanimously.

2. Discussed its 2023 Charges

Commissioner Navarro said it is that time of year when the Task Force will be reviewing its charges for 2024. He said NAIC staff will distribute the Task Force's 2023 charges for review and suggestions with a deadline of Sept. 22. He said the Task Force will meet in October to review the suggested revisions and potentially adopt its 2024 charges.

3. Heard a Presentation on Workers' Compensation Premium Fraud

Matthew Capece (United Brotherhood of Carpenters and Joiners of America—UBC) provided a presentation concerning the construction industry's fraud schemes. He said construction employees who are not cheating the system on their premiums are punished in the marketplace, while crooked contractors take over the market. He said involvement from state insurance departments is important to entertain further discussions to assist with putting practices into place that protect the market. He said there are billions of dollars worth of premium fraud taking place in the construction industry, with a study showing that in 2021, there were \$5 billion lost in premium fraud. He provided simple and complex labor broker fraud schemes that use the current system to profit. He said these bad actors include insurance brokers, attorneys, accountants, and money service businesses. He said the laws broken by these fraudulent actions include tax fraud, wage theft, child labor, money laundering, mail and wire fraud, labor trafficking, racketeering, and conspiracy. The Task Force discussed the presentation and agreed that further discussions would need to take place within open- and closed-door settings.

4. Received a Report from the Improper Marketing of Health Insurance (D) Working Group

Greg Welker (NAIC) said the Working Group met July 27. He said prior to the meeting, the Working Group had been working on its charge to “Review existing NAIC Models and Guidelines that address the use of lead generators for sales of health insurance products, and identify models and guidelines that need to be updated or developed to address current marketplace activities.” He said following the Spring National Meeting, a group of subject matter experts (SMEs) met to discuss and finalize draft amendments. Prior to the July 27 meeting, the Working Group distributed the revised draft for comments. Welker said during the July 27 meeting, the Working Group discussed comments received. The Working Group agreed on suggested revisions and updated the draft amendments. Welker said a new draft was distributed for review and comments following the July 27 meeting and before the Summer National Meeting. He said the Working Group will meet at the Summer National Meeting to discuss comments received and finalize the revisions. The Task Force adopted the report (Attachment One).

5. Heard an Update from the Antifraud Technology (D) Working Group

Glick said the Working Group has not met, but he has continued to work with NAIC staff concerning the Online Fraud Reporting System (OFRS) redesign efforts. He said the redesign is completed; however, the NAIC is internally working to update the web services used to electronically transfer data to the states using that service. He said the Working Group will be meeting to discuss the necessary enhancements that states would like the OFRS to contain to assist with the referrals system.

6. Heard a Presentation from the CAIF

Matthew J. Smith (Coalition Against Insurance Fraud—CAIF) said the focus of this presentation is to bring awareness to the psychology of insurance fraud. He said a study was completed by surveying 1,500 U.S. consumers with 29 questions regarding how they perceive insurance fraud. He said the results showed that more than 53 million Americans do not view insurance fraud as a crime. He said compared to tax fraud or stealing, the results show that depending on age, the perception of insurance fraud may be considered a business practice and not a real crime. He said the older the generation, the more severe insurance fraud is considered a crime. The study showed that younger generations do not feel they are directly affected by insurance fraud that is committed by others across the U.S. Smith said the study asked questions on what type of insurance fraud individuals would be willing to commit, including auto claims, homeowners, workers’ compensation, and medical services. He said it is a routine moral failure that the millennial generation does not perceive theft the same as others. He said due to the advancement in technology, the lines of ownership and the concept of whether theft is bad have blurred. He said the CAIF’s research showed that 35.8 million Americans admit to lying in order to get lower auto insurance rates, which is a 204.8% increase in only two years. He said when viewing the generations—Generation Z, millennials, Generation X, baby boomers, and Silent Generation—the acceptance of lying is much lower with older generations. He said Generation Z and millennials are the most sought-after policyholders given their age. The Working Group discussed and agreed to have further discussions with the CAIF concerning its study.

7. Heard Reports from Interested Parties

A. CAIF

Smith said the CAIF is celebrating its 30th anniversary this year. He said the CAIF is working on its next study, “Keys to Unlocking SIU Success.” He said this study will be for industry only to assist insurers so they have adequate resources and employees. He said this will be delivered in December. He said the Global Insurance Fraud Summit will take place in October in Edinburgh, Scotland, and there will be two open spots on the agenda for the NAIC to participate in a panel and provide an update on the movement within the NAIC and the Task Force. He said during the Global Insurance Fraud Summit, the CAIF will be continuing its work with others to create a standard definition

of insurance fraud, as there is not a standard definition. He said the CAIF, and the International Association of Special Investigation Units (IASIU) have adopted the current working definition. Lastly, he said the CAIF's Annual Meeting will take place Dec. 7–8 in Washington, DC.

B. NICB

Rich DiZinno (National Insurance Crime Bureau—NICB) said there are three topics he would like to focus on for his update. He said the goal for the NICB is not just to provide fraud directors with more data in terms of fraud reporting, but to provide more effective data to help better tailor information that can be used to advance their investigations and prosecutions. He said as the Antifraud Technology (D) Working Group continues to determine what technological improvements are needed, the NICB and the NAIC will continue to work together to ensure we build on those moving forward. He said he met in Kansas City, MO, with Welker and NAIC staff to discuss some of the issues on both sides. He said the meeting was a good foundation, and the NICB walked away with a better understanding of both sides so it can achieve meeting the desirables that fraud directors need.

DiZinno said the next issue he wants to highlight is the significant development in Wisconsin. He said this past legislative session, the NICB worked with industry partners and the Wisconsin Department of Insurance (DOI) to help create a new fraud investigator statute. He said the NICB applauds the work completed by industry and the Wisconsin DOI. The NICB will continue to work with Wisconsin to build out the fraud unit.

DiZinno said the NICB National Conference of Insurance Crime Attorneys (NCICA) is coming up Oct. 18–19, taking place in Schomburg, IL. He said the basic idea is to discuss more effective means to facilitate the investigation and prosecution of insurance crimes and fraud.

8. Discussed Other Matters

Welker said the NAIC Insurance Summit will take place Sept. 11–14. He said the Insurance Summit will cover a wide range of insurance topics, including antifraud, market regulation, finance, producer licensing, and communication. He said for the past few years, there has been a separate antifraud track. He said this year, which will continue, with six sessions Sept. 13 and 14. He said the Insurance Summit information can be found on the NAIC's web page.

Having no further business, the Antifraud (D) Task Force adjourned.

[AFTF 8.14.23 Minutes.docx](#)

Draft: 8/9/23

Improper Marketing of Health Insurance (D) Working Group
Virtual Meeting
July 27, 2023

The Improper Marketing of Health Insurance (D) Working Group of the Antifraud (D) Task Force met July 27, 2023. The following Working Group members participated: Martin Swanson, Chair, Laura Arp, Michael Anderson, and Robert McCullough (NE); Frank Pyle, Vice Chair, represented by Susan Jennette and Trinidad Navarro (DE); Cheryl Hawley and Maria Ailor (AZ); Amy Stegall and Kurt Swan (CT); Andria Seip (IA); Erica Weyhenmeyer (IL); Danielle Torres and Kristie Taber (MI); Cam Jenkins (MN); Amy Hoyt (MO); Tony Dorschner and Travis Jordan (SD); Monica L. Pinon and Thomas Morgan (TX); and John Haworth and Tyler Robbins (WA).

1. Discussed Draft Amendments for Model #880

Swanson said the Working Group has been focusing on its charge to “Review existing NAIC Models and Guidelines that address the use of lead generators for sales of health insurance products, and identity models and guidelines that need to be updated or developed to address current marketplace activities.” He said throughout 2022, the Working Group worked on draft amendments to the *Unfair Trade Practices Act* (#880) and distributed each revised exposure draft to the Working Group, interested state insurance regulators, and interested parties for review and comment. The Working Group met as necessary to review the comments and revise the amendments as appropriate per its charge. During the Spring National Meeting, the Working Group met to review the current draft and any comments received to date. Following the Spring National Meeting, the Working Group met with subject matter experts (SMEs) to review and finalize the draft amendments. Swanson said on July 10, a revised draft was distributed for comment with a deadline of July 21. He said three comments were received from Missouri, the American Health Insurance Plans (AHIP), and the NAIC Consumer Representatives. He said for the purpose of today’s meeting the Working Group will discuss the comments received and finalize the draft amendments.

Hoyt said Missouri reviewed the draft amendments and has submitted comments. She said the first set of comments was concerning Section 2—Definitions. She said Model #880 currently contains a definition of the term “customer.” She said items E.1, E.2, and E.3 under the definition of “Health Insurance Lead Generator” each contain the term “consumer” or “consumers.” She said if the intent is that consumer means something different from customer, Missouri suggests adding a definition of the term “consumer.” The Working Group discussed and agreed that the language for “Health Insurance Lead Generator” should be changed to only use the term “customer.” In addition, the Working Group agreed to add a drafting note to include language stating, “Public means all the general public and any person.”

Hoyt said the next suggestion was to include a definition for “lead-generating device.” She said under the current proposal, it appears that an employer providing information about available health plan choices to its employees would be considered a “health insurance lead generator.” She said the normal activities of non-licensed or regulated entities, such as a State Health Insurance Assistance Program (SHIP) providing Medicare information and counseling services, would also be considered “health insurance lead generators.” She said item E.3 of the current definition does not appear to be limited in any way to health insurance. She said the concern is that this lack of limitation could bring other potential entities under the definition of “Health Insurance Lead Generator.” She said the language within the *Advertisements of Accident and Sickness Insurance Model Regulation* (#40) and the *NAIC Model Rules Governing Advertisements of Medicare Supplement Insurance with Interpretive Guidelines* (#660) currently include a definition related to lead generators. She said these models define “Lead-generating device” as any communication directed to the public that, regardless of form, content, or stated purpose, is

intended to result in the compilation or qualification of a list containing names and other personal information to be used to solicit residents of this State for the purchase of [accident and sickness/Medicare supplement] insurance. The Working Group discussed this and agreed to add the new definition with the language supplied by Missouri.

Hoyt said the next suggestion concerns Section 3—Unfair Trade Practices Prohibited. She said Missouri believes the addition of “or any entity engaged in the business of insurance” to this section significantly broadens the scope of Model #880. She said it is Missouri’s understanding that the charge is limited to addressing the use of lead generators for sales of health insurance products. Including “any entity engaged in the business of insurance” appears to go beyond the scope of the charge, as the new language is not limited to health insurance. The Working Group discussed and agreed to remove the language “or any person engaged in the business of insurance.”

Hoyt said the next suggestion concerns Section 4—Unfair Trade Practices Defined. She said the inclusion of the new paragraph C in Section 4, “Failure to Maintain Marketing and Performance Record,” specific to “health insurance lead generators” is duplicative. She said Missouri recommends that the new paragraph be removed and the existing provision for “Failure to Maintain Marketing and Performance Records,” paragraph J, be revised to incorporate “health insurance lead generators.” The Working Group discussed this change.

Jenette said Delaware has used the definition of “records” in its language and could provide that to be inserted into Model #880. The Working Group agreed. Jeanette said she would send the language to NAIC staff to be inserted into Model #880.

Swanson said these revisions would be applied to the current draft, and a new draft would be distributed prior to the Working Group meeting at the Summer National Meeting. He said the plan for the Working Group would be to distribute the new draft and finalize the revisions at the Summer National Meeting. If necessary, the Working Group will hold a call following the Summer National Meeting to adopt the draft amendments. Swanson said once adopted, it would be exposed to the Task Force.

Having no further business, the Improper Marketing of Health Insurance (D) Working Group adjourned.

[IMHIWG 7.27.23 Minutes.docx](#)

MARKET INFORMATION SYSTEMS (D) TASK FORCE

Market Information Systems (D) Task Force July 31, 2023, Minutes 8-109

Draft: 8/8/23

Market Information Systems (D) Task Force
Virtual Meeting (*in lieu of meeting at the 2023 Summer National Meeting*)
July 31, 2023

The Market Information Systems (D) Task Force met July 31, 2023. The following Task Force members participated: Dana Popish Severinghaus, Chair (IL); Chlora Lindley-Myers, Vice Chair (MO); Barbara D. Richardson represented by Cheryl Hawley (AZ); Ricardo Lara represented by Pam O'Connell (CA); Andrew N. Mais represented by Kurt Swan (CT); Sharon P. Clark (KY); James J. Donelon represented by Adam Patrick (LA); Grace Arnold represented by Teresa Fischer (MN); Justin Zimmerman represented by Ralph Boeckman (NJ); Scott Kipper (NV); Cassie Brown represented by Rachel Cloyd (TX); Nathan Houdek represented by Rebecca Rebholz (WI); and Allan L. McVey represented by Jeannie Tincher (WV). Also participating were: Brad Gerling and Jo LeDuc (MO).

1. Considered its Charges and Goals for 2023

Director Severinghaus said much of the Task Force's work this year will be to monitor the work of the Market Information Systems Research and Development (D) Working Group and the Market Analysis Procedures (D) Working Group. The Task Force will also be overseeing the enhancements to the Market Information Systems (MIS) that have been requested by members, as well as those that are part of the NAIC's *State Connected* strategic plan.

Director Severinghaus said the Task Force has two new charges related to the artificial intelligence (AI) recommendations it adopted last year. The Task Force is charging the Market Information Systems Research and Development (D) Working Group to address the first recommendation, which is to develop methods to ensure better data quality.

Director Severinghaus said the Market Analysis Procedures (D) Working Group does not report to the Task Force, but the Market Regulation and Consumer Affairs (D) Committee has given the Working Group the charge to address the second AI report recommendation to assess the current market analysis data and its effectiveness and identify any needed improvements. She said the Task Force will hear regular reports from the Working Group on its progress.

Director Severinghaus said the remaining charges for the Task Force and the Market Information Systems Research and Development (D) Working Group remain the same.

2. Adopted the Report of the Market Information Systems Research and Development (D) Working Group

Director Severinghaus said the Market Information Systems Research and Development (D) Working Group has a new chair, Gerling. She said the Working Group's long-time chair, Brent Kabler (MO), retired in June. She said the Task Force appreciated the leadership that Kabler provided the Working Group. She said the Task Force is fortunate that Gerling worked with Kabler for the last few years in Missouri, and she noted that he comes highly recommended by Director Lindley-Myers.

Gerling said the Working Group met May 22 in regulator-to-regulator session, pursuant to paragraph 6 (consultations with NAIC staff members related to NAIC technical guidance) of the NAIC Policy Statement on Open Meetings and reviewed its goals for 2023. He said the Working Group has a new charge related to the AI recommendations report that was adopted last year. The Working Group will be assessing the quality of the market information data and providing recommendations for methods to ensure better data quality in order to make the current data more useable for the effective use of AI.

Gerling said the Working Group also heard a report from NAIC staff support regarding iSite+ tools and reports to consider for sunset in light of other tools and data that are now available. He said this includes Tableau dashboards, ThoughtSpot, and the NAIC Enterprise Data Warehouse. NAIC staff will be developing a survey of the states regarding the states' usage of current reports available on iSite+. Gerling said the goal is to be sure the states have improved reports and visualizations of all the data and reports that they currently use and need but do not maintain multiple reports that duplicate each other or are not used.

Finally, Gerling said NAIC staff reported on the status of the MIS Data Analysis Metrics Report, which measures the accuracy, completeness, and timeliness of data uploaded into the MIS. Due to resource concerns, the Working Group is discussing whether the reports can be provided on an annual basis and still meet the needs of the Working Group.

Commissioner Clark made a motion, seconded by Rebholz, to adopt the report of the Market Information Systems Research and Development (D) Working Group. The motion passed unanimously.

3. Heard a Report from the Market Analysis Procedures (D) Working Group

LeDuc said the Market Analysis Procedures (D) Working Group was assigned a charge from the Market Regulation and Consumer Affairs (D) Committee to "assess current market analysis data to identify needed improvements in the effectiveness of the data for market analysis and the predictive abilities of the market scoring systems utilizing the data." She said this charge arises from the AI recommendations adopted by the Task Force, so the Working Group will regularly report to the Task Force on its progress.

LeDuc said the Working Group began by compiling a list of what data market conduct analysts use. She said this list is not exhaustive, but it covers data provided through the NAIC MIS, data available within the states, and data obtained from sources outside the NAIC and the states.

LeDuc said the Working Group will continue to add to the list as data sources continue to be identified, but now that that list is quite extensive, the Working Group will begin identifying how market analysts use the data and discuss the data's effectiveness.

LeDuc said the Working Group will also begin its assessments of the scoring systems that are in the NAIC MIS. She said this includes the Market Analysis Prioritization Tool (MAPT) and the Market Conduct Annual Statement (MCAS) rankings.

Director Severinghaus asked how the Working Group is going to make the assessments of the effectiveness and predictive abilities of the data. She asked if there would be informational interviews conducted. LeDuc said the Working Group would start with the most prominently used sources and discuss them at the Working Group level, but she expects that there will also be one-on-one interviews.

4. Received an Update on MIS Projects and USER Forms

Chris Witt (NAIC) began with the status of *State Connected* projects that affect the MIS. He said *State Connected* Project 3.4 is the MCAS modernization project. He said the MCAS utilizes the Financial Data Repository (FDR) system backend. The FDR is being rewritten, and that rewrite is in the investigative phase. Much of what happens with the MCAS modernization will come out of the FDR rewrite. He said there should be work on a proof of concept for the FDR rewrite within six months.

Witt said the *State Ahead* project for the Enterprise Data Asset Management Phase II is nearly complete. He said

there are six states—Florida, Georgia, Michigan, Minnesota, Mississippi, and Ohio—that the NAIC is still working with to set up database connections. It is anticipated that the completion of all states will be by the end of 2023.

Witt said the Market Actions Tracking System (MATS) Web Service interface with State Based Systems (SBS) is on hold while the SBS focuses on improving the performance of the SBS Market Regulation services. The SBS plans to resume work on the MATS interface in the fourth quarter of this year.

Witt said *State Connected* Project 3.2 encompasses all the USER forms related to the Regulatory Information Retrieval System (RIRS), including the implementation of new codes and the support for attachments in the RIRS. He said work on the common architecture should begin in August. That needs to be done before the new coding can be implemented. The NAIC will be reaching out to the SBS states, the Vertafore states, and the states that send data to the NAIC directly to begin the work of implementing the new RIRS codes.

Witt said the Market Analysis Review System (MARS) merger work needs to wait until the RIRS coding and MCAS work are completed because the resources are not available to do them concurrently.

Having no further business, the Market Information Systems (D) Task Force adjourned.

SharePoint/NAIC Support Staff Hub/Member Meetings/D Cmte/2023/Summer National Meeting/MISTF

PRODUCER LICENSING (D) TASK FORCE

Producer Licensing (D) Task Force May 31, 2023, Minutes	8-113
Uniform Education (D) Working Group May 18, 2023, Minutes (Attachment One)	8-117
Adjuster Licensing (D) Working Group March 29, 2023, Minutes (Attachment Two)	8-119

Draft: 7/13/23

Producer Licensing (D) Task Force
Virtual Meeting (*in lieu of Meeting at the 2023 Summer National Meeting*)
May 31, 2023

The Producer Licensing (D) Task Force met May 31, 2023. The following Task Force members participated: Larry D. Deiter, Chair (SD); Sharon P. Clark, Vice Chair (KY); Alan McClain (AR); Barbara D. Richardson (AZ); Ricardo Lara represented by Tyler McKinney (CA); Andrew N. Mais represented by Jill Marocchini (CT); Doug Ommen represented by Mathew Cunningham (IA); Dean L. Cameron represented by Lori Thomason (ID); Amy L. Beard represented by Steve Embree (IN); Vicki Schmidt represented by Monicka Richmeier and Dan Klucas (KS); James J. Donelon represented by Lorie Gasior (LA); Kathleen A. Birrane represented by Lorelei Brillante (MD); Anita G. Fox represented by Jill Huisken (MI); Chlora Lindley-Myers represented by Brenda Horstman (MO); Troy Downing (MT); Mike Causey represented by Angela Hatchell (NC); Jon Godfread represented Janelle Middlestead (ND); Eric Dunning represented by Kevin Schlautman (NE); Judith L. French represented by Karen Vourvopoulos (OH); Glen Mulready represented by Courtney Khodabakhsh (OK); Michael Humphreys represented by Adriane Force (PA); Elizabeth Kelleher Dwyer represented by Rachel Chester (RI); Cassie Brown represented by Jodie Delgado (TX); Jon Pike represented by Randy Overstreet (UT); Scott A. White represented by Richard Tozer and (VA); Mike Kreidler represented by Jeff Baughman (WA); Nathan Houdek represented by Rebecca Rebholz (WI); Allan L. McVey represented by Greg Elam and Robert Grishaber (WV); and Jeff Rude represented by Bryan Stevens (WY).

1. Adopted its Dec. 8, 2022, Minutes

Commissioner Clark made a motion, seconded by Tozer, to adopt the Task Force's Dec. 8, 2022, minutes (*see NAIC Proceedings – Fall 2022, Producer Licensing (D) Task Force*). The motion passed unanimously.

2. Discussed the Template for the 1033 Process

Director Deiter said the next item is to continue the discussions regarding the 1033 template for consideration of 1033 waiver requests, which are required by the federal Violent Crime Control and Law Enforcement Act of 1994. He said there are three issues he would like to raise due to the written comments that were submitted. He said the first issue is the definition of "conviction" and whether pleas of abeyance and expungements should be excluded from this definition. The second issue is whether states use the long-form or short-form for requests and why one form is preferred. The third issue is about the factors a jurisdiction may consider when evaluating a 1033 waiver request and how states inform individuals about the 1033 waiver application process.

Wes Bissett (Independent Insurance Agents & Brokers of America—IIABA) said expungements should not be included in the definition of "conviction," and the exclusion of expungements would be consistent with the standard used by federal financial service regulators, such as the Federal Deposit Insurance Corporation (FDIC). He said it is important to have a consistent interpretation of the federal statute, and the inclusion or exclusion of expungements should not be based on how a state insurance department interprets a state law. David Leifer (American Council of Life Insurers—ACLI) and Maeghan Gale (National Association of Insurance and Financial Advisors—NAIFA) said they support Bissett's comments on the exclusion of expungements from the definition of "conviction." Gale said including expungements in the definition of "conviction" would expand the scope of individuals who need to obtain a waiver and would result in an unnecessary barrier to entry into the business of insurance. Chester said she agrees that expungements should be excluded from the definition of "conviction." Overstreet said the definition of "conviction" is consistent with the definition used in Utah.

Stevens said Wyoming also considers crimes against individuals, such as aggravated assault or attempted murder. Bissett said he is not defending individuals who have committed these types of crimes. He said these types of crimes should be considered as part of the normal state licensing process, and the review of a 1033 waiver request is probably not the correct mechanism for considering these types of crimes in determining whether an individual should be granted a producer license. Director Richardson agreed that the 1033 waiver process should focus on felonies involving breach of trust and not all felonies.

Stevens said Wyoming uses the long-form to discourage individuals who are not serious about entering into the business of insurance. Vourvopoulos said Ohio uses the long-form. Delgado said Texas does not use the long-form or short-form and considers 1033 waiver requests as part of the licensing application process. Baughman and Chester said their states use the short-form to simplify the process. Khodabakhsh said Oklahoma uses the long-form because this helps eliminate applications from individuals who do not qualify for a waiver.

Regarding factors to review when considering a 1033 waiver request, Commissioner Clark said Kentucky considers the length of time since the felony, whether any restitution was made, and the applicant's job history since the conviction. Tozer said Virginia considers the items referenced by Commissioner Clark, whether the applicant had his/her civil rights restored, and whether the applicant has a pattern of unlawful activity. He said Virginia also reviews an applicant's references and whether the criminal conviction had an impact on the insurance industry.

Commissioner Clark suggested that additional discussions of the template for the 1033 waiver process should include a regulator with law enforcement expertise in addition to regulators with licensing expertise. She said she agrees with a Kentucky regulator with law enforcement expertise participating in future discussions. Director Deiter requested that NAIC staff continue working with the small group of subject matter experts (SMEs) from Connecticut, Kentucky, Missouri, Pennsylvania, and Rhode Island to review the comments and provide an updated draft for further consideration by the Task Force.

3. Adopted a New Public Adjuster Licensing Charge

Director Deiter said the National Association of Public Insurance Adjusters (NAPIA) requested that the NAIC *Public Adjuster Licensing Model Act* (#228) be amended to address the following issues: 1) unlicensed public adjusters; 2) contractors who are also acting as public adjusters on the same claim; and 3) the assignment of benefit rights to contractors. Because the amendment of this model falls outside the scope of the Task Force's changes, he said the following charge is being proposed: "Review and amend, as needed, Model #228 to enhance consumer protections in the property/casualty (P/C) claims process." If adopted today, he said Commissioner Trinidad Navarro (DE), who chairs the Antifraud (D) Task Force, will lead this workstream under the Producer Licensing (D) Task Force since the issues also touch on potentially fraudulent activities.

Baughman made a motion, seconded by Tozer, to adopt the proposed public adjuster licensing charge. The motion passed unanimously.

4. Adopted the NAIC *Continuing Education Recommended Guidelines for Instructor Approval*

Tozer said industry representatives approached the Uniform Education (D) Working Group to discuss the difficulties of obtaining approval for continuing education (CE) instructors in some jurisdictions and the lack of uniformity across jurisdictions. This led to the Uniform Education (D) Working Group surveying jurisdictions regarding requirements for CE instructor approval. Tozer said this led to the development of the *Continuing Education Recommended Guidelines for Instructor Approval*, which the Uniform Education (D) Working Group unanimously adopted in November 2022.

Baughman made a motion, seconded by Stevens, to adopt the *Continuing Education Recommended Guidelines for Instructor Approval*. The motion passed unanimously.

5. Adopted the Reports of the Adjuster Licensing (D) Working Group and the Uniform Education (D) Working Group

Tozer said the Uniform Education (D) Working Group met May 18 to discuss: 1) its 2023 charges; 2) state producer licensing examination pass rates; 3) continued efforts to obtain state signatures for the Continuing Education Reciprocity (CER) Agreement, which 47 jurisdictions have signed; 4) denial of CE credit for online courses; 5) how jurisdictions accommodate individuals with a disability or medical waiver; and 6) the approval and denial of courses across jurisdictions and whether jurisdictions have experienced CE providers forum shopping for a home state to approve a CE course.

Greg Welker (NAIC) said the Adjuster Licensing (D) Working Group met March 29 to discuss: 1) adjuster licensing reciprocity; 2) the uniform application of a Designated Home State license; 3) whether the NAIC *Independent Adjuster Licensing Guideline* (#1224) should be amended and converted to an NAIC model act; and 4) how to have more consistent and uniform state reporting of adjuster licensing information to the NAIC. For example, he said the Working Group is discussing whether an adjuster who lives in Rhode Island but works remotely in Texas should be permitted to report Texas as his/her home state. Another example is whether all adjusters who work for a company with a corporate office in Rhode Island should be issued a home state license in Rhode Island regardless of the residency of each individual.

Stevens made a motion, seconded by Overstreet, to adopt the reports of the Uniform Education (D) Working Group (Attachment One) and the Adjuster Licensing (D) Working Group (Attachment Two). The motion passed unanimously.

6. Received a Report from the NIPR Board of Directors

Director Deiter said the National Insurance Producer Registry's (NIPR's) year-to-date revenue is \$24 million, which is 3.7% over budget. The NIPR senior team and Board of Directors have begun work on the NIPR strategic plan for 2024–2026, with a vote on the final plan scheduled for the end of the year.

Director Deiter said Superintendent Adrienne A. Harris (NY) has approved the expansion of NIPR services for New York. With the New York implementation and the work currently underway with Washington, NIPR will have implemented all states on NIPR for major products by year-end.

Director Deiter said NIPR continues to implement the Contact Change Request (CCR) application for business entities. To date, 34 states have implemented CCR for business entities, which allows industry to update address, email, and telephone changes through NIPR. NIPR has processed over 76,000 transactions since the initial implementation of CCR for business entities.

Director Deiter said NIPR is continuing to expand electronic solutions for the states and industry to process additional licensee updates, including name changes and changes to Designated Responsible Licensed Producers (DRLPs). To date, NIPR has implemented the ability for licensees to change a name for the states of Connecticut, Missouri, and Rhode Island, and it has processed over 1,300 transactions for these states. In a few weeks, NIPR will implement Connecticut as a pilot state for DRLP changes.

Director Deiter said NIPR and the NAIC continue to offer producer licensing zone training for states. The program covers producer licensing practices and current and emerging industry issues, and it encourages dialogue among peer regulators. The two-and-a-half-day training is intended for state and U.S. territory producer licensing personnel.

Having no further business, the Producer Licensing (D) Task Force adjourned.

<https://naiconline.sharepoint.com/sites/NAICSupportStaffHub/Member%20Meetings/D%20CMTE/2023%20Summer/PLTF/May%2031%20Call/ProdLic%20Minutes%205.31.23.docx>

Draft: 5/26/23

Uniform Education (D) Working Group
Virtual Meeting
May 18, 2023

The Uniform Education (D) Working Group of the Producer Licensing (D) Task Force met May 18, 2023. The following Working Group members participated: Richard Tozer, Chair (VA); Lorelei Brillante, Vice Chair (MD); Charlene Ferguson (CA); Vanessa Miller (MS); Otis Phillips (NM); Karen Vourvopoulos (OH); Pat Murray (VT); and Jeff Baughman (WA). Also participating were: Jackie Russo (IA); Lee Ellen Webb (KY); Rachel Chester (RI); and Bryan Stevens (WY).

1. Discussed its 2023 Charges

Tozer said that the Working Group's 2023 charges have remained the same since 2022. However, the Producer Licensing (D) Task Force will be meeting May 31, so the Working Group could get additional direction.

2. Discussed Exam Pass Rates

Tozer said he has continued to work with NAIC staff to collect pass rate data from the continuing education (CE) vendors for all states. He said Commissioner Sharon P. Clark (KY) requested that the Working Group display pass rate information for in-person and virtual meetings. Tozer said he will also work with NAIC staff to begin collecting 2022 data at the first of the year. Tozer said this request will be included in reports moving forward. The Working Group discussed the process of collecting this data and changes that may assist the NAIC in obtaining this information from state CE vendors.

3. Discussed Recommended Guidelines for CE Instructor Approval

Tozer said that on Nov. 30, 2022, the Working Group adopted the *Continuing Education Recommended Guidelines for Instructor Approval*. He said the guidelines passed unanimously and will be on the agenda for consideration of adoption by the Producer Licensing (D) Task Force meeting May 31.

4. Discussed Producer Declining CE Credit (Online Course)

Tozer said he was contacted concerning individuals taking CE courses through a vendor after Virginia declined the CE courses. Tozer said the vendor was offering individuals the CE courses and individuals were then requesting CE credit from Virginia.

Baughman said Washington encountered the situation with a provider which was informed by the department that they had to check a specific box to receive credit. Baughman said Washington kept having issues with producers thinking that they completed a course for CE credit when they did not. Baughman said Washington is working with the vendor so CE credit will automatically be given unless the applicant unchecks a specific box. The Working Group members said they have encountered the same situation in their states.

5. Discussed Accommodations for Disabilities/CE/Medical Waivers

Tozer said the next agenda item concerns accommodations for individuals with disabilities. He said in the past, requests have been received for waivers based on a disability, such as a hearing impairment. He said in Virginia,

the CE board administers the CE program in the commonwealth. Therefore, the insurance department does not actually control the CE programs. Tozer said Virginia also had an issue where the CE board referenced a request for waiving CE due to a medical situation concerning vision issues. He said this was denied because the CE providers can offer alternative ways of delivering the instructions for CE.

Baughman said Washington regulations allow waivers for medical and military reasons; however, medical waivers require a statement from an attending physician.

Vourvopoulos said Ohio has requirements in place for all CE vendors to meet the federal Americans with Disabilities Act of 1990 (ADA) accommodations. Additionally, they must meet language requirements regarding medical extensions, much like Washington's regulations.

6. Discussed Other Matters

Brilliante said she has questions specific to course approval in home states she would like to present to the Working Group, including: 1) What happens when the home state does not approve a course and then submit the course to another state as the home state? How do providers select this other state?; and 2) What should the process be when a company changes provider vendors? Should the courses maintain the previous home state or change to the new vendor's home state, which would mean another substantive review of the course?

Chester said Rhode Island would not want individuals shopping for a home state to approve their course if their original home state has already denied the course. Barb Gavitt (A.D. Banker & Company) said there are circumstances where another state would approve a course when the home state does not. Therefore, the vendor would need to use the approving state as their home state. Tozer said this should fall under true reciprocity since one state has already denied approval.

The Working Group discussed the online course approval guidelines and formula for establishing credit hours offered per course.

Having no further business, the Uniform Education (D) Working Group adjourned.

SharePoint/NAIC Support Staff Hub/Committees/D Committees/2023 Summer/PLTF/UEWG ...

Draft: 4/23/23

Adjuster Licensing (D) Working Group
Virtual Meeting
March 29, 2023

The Adjuster Licensing (D) Working Group of the Producer Licensing (D) Task Force met Mar. 29, 2023. The following Working Group members participated: Rachel Chester (RI); Peggy Dunlap (AR); Charlene Ferguson (CA); Lee Ellen Webb (KY); Lorie Gasior (LA); Vanessa DeJesus (NM); Courtney Khodabakhsh (OK); Jodie Delgado (TX); Richard Tozer (VA); Jeff Baughman (WA) and Bryan Stevens (WY).

1. Discussed 2023 Charges

Chester said the Working Group last met in September and we touched on the discussions which took place at the 2022 Securities and Insurance Licensing Association (SILA) Education Conference. She said during that meeting we focused on state laws and procedures that are affecting licensing reciprocity. Chester said the direction for this meeting is to continue an open discussion concerning adjuster licensing reciprocity. Chester inquired if there were any states that would like to speak with changes or hot topics taking place in their state.

Fromholtz said Arizona has issues continuing to emerge where insurers are trying to get substantive policy statements. Fromholtz said Arizona statutes will not permit Arizona to license adjusters who are employed by an insurer. Fromholtz said because Washington and New Mexico require a resident license prior to the issuance on a non-resident license, insurers are requesting Arizona to issue a substantive policy statement that Arizona will not license adjusters who are employed by an insurer. Fromholtz said Arizona statutes exempt a company adjuster from licensure; however, there is nothing prohibiting a company adjuster from obtaining an adjuster license.

Dunklin said it is the same for Alabama, per state statutes Alabama is not allowed to license staff adjusters. Dunklin said if a staff adjuster applies for an independent adjuster license, Alabama will issue them that license. Dunklin said the insurance department has run into some confusion for nonresident licensees who hold a resident staff adjuster license. Some states issue both staff adjuster licenses and independent adjuster licenses and some states do not differentiate between the two.

Chester said the next topic for discussion is Designated Home State (DHS). Chester said Rhode Island checks every person's DHS selection because there is no electronic way to complete that process. Chester said an applicant can apply and select any state as the DHS and then the insurance department must determine if the DHS is correct.

Chester said it is important for the Working Group to review how our decisions affect the availability of adjusters. Chester said the Working Group should focus on the goal of achieving a uniform and reciprocal licensing process for adjusters. Chester said the Working Group should review the NAIC 2008 *Independent Adjuster Licensing Guideline* and the 2011 *Independent Adjuster Reciprocity Best Practices & Guidelines*. Chester said she would like the 2008 Independent Adjuster Licensing Guideline converted into an NAIC model act. Chester said she will work with NAIC staff to determine the next steps for this process.

2. Discussed Public Adjusters

Chester said there was a question concerning public adjusters and the discussion of creating a Public Adjusters (D) Working Group. Greg Welker (NAIC) said Commissioner Sharon P. Clark (KY) mentioned this during the Producer Licensing (D) Task Force report to the Market Regulation and Consumer Affairs (D) Committee at the NAIC Spring

National meeting. Welker said Commissioner Trinidad Navarro (DE) will lead the Working Group because some of the issues to be address touch on potential insurance fraud.

3. Any Other Matters

Chester said she will work with NAIC staff support to develop a schedule to continue the Working Group's discussions focusing on 1) creating greater adjuster licensing efficiencies though electronic processing of adjuster licenses and 2) converting the 2008 *Independent Adjuster Licensing Guideline* converted into an NAIC model act.

Having no further business, the Adjuster Licensing (D) Working Group adjourned.

FINANCIAL CONDITION (E) COMMITTEE

Financial Condition (E) Committee Aug. 15, 2023, Minutes	9-2
Financial Condition (E) Committee July 19, 2023, Minutes (Attachment One).....	9-6
Life Risk-Based Capital Proposals 2023-09-IRE (Residuals Factor) and 2023-10-IRE (Residual Sensitivity Test Factor for Residuals) (Attachment One-A).....	9-8
New Charge and a New Group Titled the Generator of Economic Scenarios (GOES) (E/A) Subgroup of the Life Risk-Based Capital (E) Working Group (Attachment One-B).....	9-12
<i>Mortgage Guaranty Insurance Model Act (#630)</i> (Attachment One-C).....	9-13
Group Capital Calculation (E) Working Group July 27 and June 13, 2023, Minutes (Attachment Two)	9-41
Scalar Methodology Proposal for Life Insurance Companies (Attachment Two-A).....	9-49
Mortgage Guaranty Insurance (E) Working Group July 13, 2023, Minutes (Attachment Three).....	9-52
Amendments to the <i>Mortgage Guaranty Insurance Model Act (#630)</i> (Attachment Three-A)	9-54
Comment Letters from the Center for Economic Justice (CEJ) and the Mortgage Guaranty Consortium (MGC) (Attachment Three-B).....	9-67
Restructuring Mechanisms (E) Working Group May 4 and April 4, 2023, Minutes (Attachment Four)	9-74
Comment Letters Regarding Exposed Draft Best Practices Guidance (Attachment Four-A).....	9-84
Risk-Focused Surveillance (E) Working Group Aug. 14, 2023, Minutes (Attachment Five)	9-120
Macprudential Reinsurance Worksheet (Attachment Six).....	9-124
<i>Interpretation (INT) 23-01: Net Negative (Disallowed) Interest Maintenance Reserve (IMR)</i> (Attachment Seven)	9-128
Presentation from the Office of the Superintendent of Financial Institutions (OFSI) on the Use of Artificial Intelligence (AI) (Attachment Eight).....	9-136

Draft: 8/17/23

Financial Condition (E) Committee
Seattle, Washington
August 15, 2023

The Financial Condition (E) Committee met in Seattle, WA, Aug. 15, 2023. The following Committee members participated: Elizabeth Kelleher Dwyer, Chair (RI); Nathan Houdek, Vice Chair, and Amy Malm (WI); Mark Fowler (AL); Michael Conway (CO); Michael Yaworsky represented by Virginia Christy (FL); Amy L. Beard and Roy Eft (IN); Doug Ommen, Carrie Mears and Kevin Clark (IA); Timothy N. Schott and Vanessa Sullivan (ME); Mike Chaney represented by David Browning (MS); Chlora Lindley-Myers and John Rehagen (MO); Justin Zimmerman (NJ); Adrienne A. Harris represented by John Finston and Bob Kasinow (NY); Michael Wise (SC); Cassie Brown and Jamie Walker (TX); and Scott A. White (VA).

1. Adopted its July 19 and Spring National Meeting Minutes

The Committee met July 19 and took the following action: 1) adopted life risk-based capital (RBC) proposals 2023-09-IRE (Residuals Factor) and 2023-10-IRE (Residual Sensitivity Test Factor for Residuals); 2) adopted the *Mortgage Guaranty Insurance Model Act* (#630); and 3) adopted a new charge for a new group titled the Generator of Economic Scenarios (E/A) Subgroup of the Life Risk-Based Capital (E) Working Group.

Commissioner Houdek made a motion, seconded by Commissioner White, to adopt the Committee's July 19 (Attachment One) and March 24 minutes (*see NAIC Proceedings – Spring 2023, Financial Condition (E) Committee*). The motion passed unanimously.

2. Adopted the Reports of its Task Forces and Working Groups

Superintendent Dwyer stated that the Committee usually takes one motion to adopt its task force and working group reports that are considered technical, noncontroversial, and not significant by NAIC standards; i.e., they do not include model laws, model regulations, model guidelines, or items considered to be controversial. She reminded Committee members that after the Committee's adoption of its votes, all the technical items included within the reports adopted will be sent to the NAIC Members for review shortly after the conclusion of the Summer National Meeting as part of the Financial Condition (E) Committee Technical Changes report. Pursuant to the technical changes report process previously adopted by the Executive (EX) Committee and Plenary, the Members will have 10 days to comment. Otherwise, the technical changes will be considered adopted by the NAIC and effective immediately. With respect to the task force and working group reports, Superintendent Dwyer asked the Committee: 1) whether there were any items that should be discussed further before being considered for adoption and sent to the Members for consideration as part of the technical changes; and 2) whether there were other issues not up for adoption that are currently being considered by task forces or workings groups reporting to this Committee that require further discussion. The response to both questions was no.

In addition to presenting the reports for adoption, Superintendent Dwyer noted that the Financial Analysis (E) Working Group met Aug. 12, July 20, June 14 and 21, May 24, and May 25 in regulator-to-regulator session, pursuant to paragraph 3 (specific companies, entities, or individuals) of the NAIC Policy Statement on Open Meetings, to discuss letter responses and financial results. Additionally, the Valuation Analysis (E) Working Group met Aug 12, July 20, and May 18 in regulator-to-regulator session, pursuant to paragraph 3 (specific companies, entities, or individuals) of the NAIC Policy Statement on Open Meetings, to discuss valuation items related to specific companies. Finally, the National Treatment and Coordination (E) Working Group met in regulator-to-regulator session Aug. 2, July 26, and June 15, pursuant to paragraph 6 (consultations with NAIC staff members related to NAIC technical guidance), to continue work on its goals.

Walker made a motion, seconded by Acting Superintendent Schott, to adopt the following task force and working group reports: Accounting Practices and Procedures (E) Task Force; Capital Adequacy (E) Task Force; Examination Oversight (E) Task Force; Financial Stability (E) Task Force; Receivership and Insolvency (E) Task Force; Reinsurance (E) Task Force; Valuation of Securities (E) Task Force; Group Capital Calculation (E) Working Group (Attachment Two); Mortgage Guaranty Insurance (E) Working Group (Attachment Three); Restructuring Mechanisms (E) Working Group (Attachment Four); and Risk-Focused Surveillance (E) Working Group (Attachment Five). The motion passed unanimously.

3. Adopted the Macroprudential Reinsurance Worksheet

Kasinow summarized the work by the Macroprudential (E) Working Group leading up to its adoption of the reinsurance worksheet in June. He emphasized that the worksheet was designed for regulators to assess cross-border reinsurance treaties where there are different regulatory systems involved and is intended to assist in identifying if there are true economic impacts from the reinsurance transaction. He noted that it is not intended to be used for every reinsurance contract and that it should be used in a way to avoid duplicating requested information. It is geared toward life insurance contracts. However, there is no reason to limit the tool to life; it can be used on property/casualty (P/C) reinsurance contracts. The worksheet is an optional tool and will not be included in the *Financial Analysis Handbook*, but it is available on StateNet to be used when deemed appropriate.

Rehagen made a motion, seconded by Commissioner Ommen, to adopt the macroprudential reinsurance worksheet (Attachment Six). The motion passed unanimously.

4. Adopted INT 23-01: Net Negative (Disallowed) IMR

Dale Bruggeman (OH), Chair of the Statutory Accounting Principles (E) Working Group, summarized Interpretation (INT) 23-01: Net Negative (Disallowed) IMR. Bruggeman started with a timeline of the work. He noted that the Working Group exposed the idea of an initial project as a short-term Interpretation at the 2022 Fall National Meeting, and it heard comments at the 2023 Spring National Meeting. At that meeting, the Working Group gave NAIC staff directions for a proposed interpretation to be exposed. The Working Group heard comments on that exposure at a meeting in June and re-exposed a revised interpretation at that time. On Aug. 13, the Working Group adopted INT 23-01. Bruggeman noted the adopted interpretation is effective immediately and through year-end 2025, which gives industry, regulators, and others a few years to develop a long-term approach. The adopted INT reflects the following:

- The requirement for RBC to be over 300% authorized control level (ACL) RBC after adjustment to remove admitted positive goodwill, EDP equipment and operating system software, deferred tax assets (DTAs), and admitted negative interest maintenance reserve (IMR) (referred to as softer assets).
- Allowance to admit up to 10% of adjusted capital and surplus (excluding those softer assets), first in the general account, and then if all disallowed IMR in the general account is admitted and the percentage limit is not reached, then to the separate account proportionately between insulated and non-insulated accounts—those that have assets at book value. (The adjustments are the same that occur for the RBC adjustment and reduce capital and surplus before applying the 10% percentage limit.)
- Application guidance for admitting/recognizing IMR in both the general and separate accounts, including a specific name to use in each. Also, reporting entities shall allocate an amount equal to the general account admitted net negative (disallowed) IMR from unassigned funds to an aggregate write-in for special surplus funds (line 34) (named as “Admitted Disallowed IMR”). Although dividends are contingent on state-specific statutes and laws, the intent of this reporting is to provide transparency and preclude the ability for admitted negative IMR to be reported as funds available to dividend.

- No exclusion for derivatives losses included in negative IMR if the reporting entity can demonstrate historical practice in which realized gains from derivatives were also reversed to IMR (as liabilities) and amortized.
- Inclusion of a new reporting entity attestation, which continues the existing practice that losses cannot be deferred as a result of a forced sale due to liquidity issues, along with commentary that assets were sold as part of prudent asset management, following documented investment or liability management policies.

Bruggeman said that it was important to note that this interpretation does not place key reliance on asset adequacy testing (AAT) as requested by the Life Actuarial (A) Task Force. AAT performed by actuaries will still use the IMR as a natural liability or as an admitted asset. He said it is important to note that the larger the admitted asset within AAT, the greater the chance of having an additional AAT reserve requirement. Bruggeman also noted that the Working Group started the longer-term project through exposure of agenda item 2023-14. The Working Group also exposed some blanks instructional provisions for when interest related realized gains/losses go through IMR (that is deferred from the income statement) and when the result goes through the asset valuation reserve (AVR) calculation and thus through the income statement. There were some holes in how the instructions read. The Working Group intends to use an ad hoc technical group, and with any required approvals from the parent groups, to nail down the issues and get any needed help from the Life Actuarial (A) Task Force and/or the American Academy of Actuaries (Academy).

Commissioner Houdek made a motion, seconded by Acting Superintendent Schott, to adopt INT 23-01 (Attachment Seven). The motion passed with New York abstaining.

5. Heard a Presentation from the OFSI on the Use of AI

Jacqueline Friedland (Office of the Superintendent of Financial Institutions—OFSI) provided an overview of some of the work that OFSI had conducted relative to data analytics, including its use of artificial intelligence (AI) (Attachment Eight). Friedland emphasized a number of areas during her presentation, including that her presentation and her approach to things were influenced by her background as an actuary, where data is a powerful source of information that can enhance efficiency and effectiveness. She discussed Canada's financial condition testing (FCT) report that is required annually of insurers and how it is the single most important report used for prudential regulation in Canada. She described her past experience, starting with Canada and the expectations she set out for her staff in using the reports, and how using natural language generation AI can increase efficiencies and effectiveness in such reviews by her staff.

Friedland also discussed her work and that of her staff in retooling the reports for their use with International Financial Reporting Standard (IFRS) 17 *Insurance Contracts*. Her greatest emphasis was placed on the next topic, the Risk Assessment Data Analytics Report (RADAR), which is an interactive dashboard of common financial risk indicators across insurance and banking. At its core, the report pulls in various data elements and color codes the area of data to indicate, based upon industry data, whether the area being reviewed by the regulator is an area of concern or where follow-up is needed. The system uses a comprehensive and interactive training program that was developed using various inputs, including the NAIC's Insurance Regulatory Information System (IRIS) ratios manual.

Additionally, Friedland discussed OFSI's use of the Meltwater media monitoring tool, which allows insurance supervisors to monitor media and social media across companies, industries, and topics. It is particularly helpful for parent company monitoring. Finally, Friedland discussed the use of natural language processing (NLP) for reinsurance. OFSI is seeking more details about the use of reinsurance across the industry, in terms of attachment points, participation, limits, etc. NLP allows OFSI to extract unstructured data that lacks consistency from actuarial reports to where it is more usable.

6. Exposed the Framework for Regulation of Insurer Investments

Superintendent Dwyer reminded meeting participants that included with the materials for the meeting was a draft *Framework for Regulation of Insurer Investments*. She explained that the purposes of this document are to: 1) provide a holistic overview of what various working groups and task forces are doing in this area; and 2) state that this work is under the purview of the commissioners and other regulators making up the Committee. Superintendent Dwyer said she intends to hear from all interested parties as the Committee finalizes this document, but the Committee does not plan to stop any of the work that is currently underway related to this project. The three main pieces of that work that are underway are: 1) work at the Risk-Based Capital Investment Risk and Evaluation (E) Working Group to modify the life RBC formula; 2) work at the Valuation of Securities (E) Task Force that authorized the Structured Securities Group (SSG) to begin financially modeling collateralized loan obligations (CLOs) beginning December 2024; and 3) work at the Valuation of Securities (E) Task Force that proposes to establish processes and procedures by which the Securities Valuation Office (SVO) would be authorized to challenge the credit rating for a filing exempt (FE) security. Superintendent Dwyer noted that during this meeting, she wanted to hear comments from regulators.

Rehagen noted that the document is good, especially the enhancements and the different regulatory initiatives regulators are undertaking because they need this type of ability with the increasing complexity of investments—specifically, having services that assist regulators in determining how risky a security it is. Superintendent Dwyer noted that it was drafted by a small ad hoc group of committee members and that having everyone’s input on it will be helpful.

Mears noted the document would have a major impact on the Valuation of Securities (E) Task Force. She said that speaking for Iowa, she supports the framework and wanted to reiterate that none of the existing work will be pausing. Mears said the Valuation of Securities (E) Task Force, which she chairs, will continue its deliberative process, and take into account all the feedback received from interested parties, but the Task Force will still be moving forward in that direction. Mears noted that the framework, if supported, provides a future vision of what centralized investment expertise is available to U.S. regulators. She said that it is understandable that many of these initiatives will be costly and will take some time as issues arise. She said that whether it is with the Valuation of Securities (E) Task Force or the Risk-Based Capital Investment Risk and Evaluation (E) Working Group, the framework looks beyond the different economic cycles or stresses that could be in place and allows regulators to be thoughtful and deliberative. Mears said this is an opportune time for the document given the work ahead.

Commissioner Beard thanked Superintendent Dwyer for her leadership on this document. She noted the Committee took a measured approach and was able to expedite this important issue in discussions. Commissioner Beard stated appreciation for the non-prescriptive approach that the framework will allow the regulators to take. She said it gives peace of mind knowing that the Committee participates in the process and that the Committee will be able to rely on the subject matter experts (SMEs) for their expertise.

Commissioner White made a motion, seconded by Commissioner Houdek, to expose the framework draft for a 45-day public comment period ending Oct. 2. The motion passed unanimously.

Having no further business, the Financial Condition (E) Committee adjourned.

SharePoint/NAICSupportStaffHub/Member Meetings/E CMTE/2023-2-Summer/081523 E Minutes.docx

Draft: 7/24/23

Financial Condition (E) Committee
Virtual Meeting
July 19, 2023

The Financial Condition (E) Committee met July 19, 2023. The following Committee members participated: Elizabeth Kelleher Dwyer, Chair (RI); Nathan Houdek, Vice Chair (WI); Mark Fowler (AL); Michael Conway represented by Rolf Kaumann (CO); Michael Yaworsky represented by Chris Struk (FL); Doug Ommen (IA); Amy L. Beard represented by Roy Eft (IN); Timothy N. Schott (ME); Chlora Lindley-Myers represented by John Rehagen (MO); Mike Chaney represented by Chad Bridges (MS); Justin Zimmerman represented by David Wolf (NJ); Adrienne A. Harris represented by John Finston and Bob Kasinow (NY); Michael Wise (SC); Cassie Brown represented by Jamie Walker (TX); and Scott A. White represented by Doug Stolte (VA). Also participating were: Philip Barlow (DC); Jackie Obusek (NC); and Tom Botsko (OH).

1. Adopted Life RBC Proposals 2023-09-IRE (Residuals Factor) and 2023-10-IRE (Residual Sensitivity Test Factor for Residuals)

Superintendent Dwyer stated that this item related to the topic of residual interest investments, which the Committee began discussing a couple of years ago and in early 2022, asked the newly formed Risk-Based Capital (RBC) Investment Risk and Evaluation (E) Working Group to address. Barlow described how the Working Group had been working on this issue since early 2022 and on into the first half of the year until it was recently adopted. He described that earlier in the year, the Working Group adopted the structure in the Life RBC formula that created a new reporting line for residual investments within the formula. He stated that the Working Group also adopted a structure earlier this year for a sensitivity test related to the residual tranches. Factors for both of these structures were not adopted until more recently, which went through a lot of discussion at the Working Group level before ultimately being adopted. Barlow noted that the two proposals before the Committee collectively represent a proposal submitted by the Texas Department of Insurance (DOI), and that was unanimously adopted by the Working Group. He discussed the features of the proposal, including a factor for residual investments starting at 30% for 2023 and 45% for 2024 and going forward but leaving space for a proposal to be submitted that supports either a higher or lower factor for 2024 if deemed more acceptable based upon data provided by the sponsor of the proposal. The sensitivity test for the residual investments for 2023 is set at 15%, and 0% for 2024 since the factor already reflects the full 45%. Botsko commended Barlow for the great work done on this project and to all of the Working Group members that provided the Capital Adequacy (E) Task Force with the proposal that was unanimously adopted at that level.

Walker made a motion, seconded by Stolte, to adopt proposals 2023-09-IRE and 2023-10-IRE (Attachment One-A). The motion passed unanimously.

2. Adopted a New Charge and a New Group Titled the Generator of Economic Scenarios (E/A) Subgroup of the Life Risk-Based Capital (E) Working Group

Barlow described that this was an issue the Life Risk-Based Capital (E) Working Group had been working on with the Life Actuarial (A) Task Force for some time, and it involves replacing the current generator of economic scenarios (GOES) that is used for both reserves and capital. He stated that he would not go into all the details; this is being done, but the work is proceeding with substantial progress, and new charges are being requested to establish some governance and related structure around the GOEA once it is developed. He noted that this was adopted by the Life Insurance and Annuities (A) Committee. He stated that Iowa has agreed to chair the Subgroup,

and Ohio has agreed to vice chair the Subgroup. He also stated that while a good membership has already volunteered, anyone interested can contact NAIC staff or himself.

Finston made a motion, seconded by Kaumann, to form the new subgroup named the Generator of Economic Scenarios (E/A) Subgroup of the Life Risk-Based Capital (E) Working Group with the proposed charges as presented (Attachment One-B). The motion passed unanimously.

3. Adopted Model #630

Obusek stated that the Mortgage Guaranty Insurance (E) Working Group was charged with updating the *Mortgage Guaranty Insurance Model Act* (#630) to strengthen and modernize the model in response to the 2008 financial crisis. The last time the model was substantially updated was 1976. Obusek noted that the Executive (EX) Committee approved the Request for NAIC Model Law Development in July 2013. At that time, the development of a capital model to accompany Model #630 was the key focus of the Financial Condition (E) Committee's attention. The Working Group worked with two different consulting firms over several years to attempt to build a capital model, which was met with several challenges. In April 2021, the Working Group referred a draft mortgage guaranty exhibit to the Blanks (E) Working Group, and the exhibit was finalized and integrated into the blank, effective year-end 2021. In May 2022, the Mortgage Guaranty Insurance (E) Working Group decided to pause the development of the capital model and continue collecting data for further analysis in the future. As a result, the Working Group focused on finalizing the amendments to Model #630. Obusek noted that the Model #630 Drafting Group consisted of all of the members of the Working Group represented by herself as the chair; Kurt Regner (AZ); Monica Macaluso and Joyce Zeng (CA); Robert Ballard (FL); Rehagen (MO); Margot Small (NY); Diana Sherman (PA); Amy Garcia (TX); and Amy Malm and Levi Olson (WI). Obusek stated that over the next 14 months, the drafting group met 12 times, and Model #630 was exposed for public comment on Oct. 7, 2022; Feb. 27, 2023; and May 11, 2023. During those exposures, various comments were received from the mortgage guaranty consortium and the consumer representatives and discussed both by the drafting group and during open meetings of the Working Group. She noted that many of the comments received were addressed through changes integrated into the draft model included in the proposed changes. Some of the more significant amendments dealt with the reserving requirements related to contingency reserves and waivers with respect to risk in-force. The Working Group adopted the amended Model #630 during its July 13 conference call. Superintendent Dwyer reminded the Committee that in order to advance Model #630 to the Executive (EX) Committee and Plenary for consideration, a two-thirds majority vote is needed by the Financial Condition (E) Committee members in total; therefore 10 members would need to vote yes.

Commissioner Houdek made a motion, seconded by Rehagen, to adopt Model #630 (Attachment One-C). The motion passed unanimously.

Having no further business, the Financial Condition (E) Committee adjourned.

[https://naiconline.sharepoint.com/sites/NAICSupportStaffHub/Member Meetings/E CMTE/2023-2-Summer/071923 E Minutes.docx](https://naiconline.sharepoint.com/sites/NAICSupportStaffHub/Member%20Meetings/E%20CMTE/2023-2-Summer/071923%20E%20Minutes.docx)

Capital Adequacy (E) Task Force RBC Proposal Form

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|---|--|--|
| <input type="checkbox"/> Capital Adequacy (E) Task Force | <input type="checkbox"/> Health RBC (E) Working Group | <input type="checkbox"/> Life RBC (E) Working Group |
| <input type="checkbox"/> Catastrophe Risk (E) Subgroup | <input type="checkbox"/> P/C RBC (E) Working Group | <input type="checkbox"/> Longevity Risk (A/E) Subgroup |
| <input type="checkbox"/> Variable Annuities Capital. & Reserve (E/A) Subgroup | <input type="checkbox"/> Economic Scenarios (E/A) Subgroup | <input checked="" type="checkbox"/> RBC Investment Risk & Evaluation (E) Working Group |

<p style="text-align: right;">DATE: <u>4/20/23</u></p> <p>CONTACT PERSON: <u>Dave Fleming</u></p> <p>TELEPHONE: <u>816-783-8121</u></p> <p>EMAIL ADDRESS: <u>dfleming@naic.org</u></p> <p>ON BEHALF OF: <u>RBC Inv. Risk & Eval. (E) Working Group</u></p> <p>NAME: <u>Philip Barlow</u></p> <p>TITLE: <u>Associate Commissioner for Insurance</u></p> <p>AFFILIATION: <u>District of Columbia</u></p> <p>ADDRESS: <u>1050 First Street, NE Suite 801</u> <u>Washington, DC 20002</u></p>	<p style="text-align: center;">FOR NAIC USE ONLY</p> <p>Agenda Item # <u>2023-09-IRE</u> Year <u>2023</u></p> <p style="text-align: center;">DISPOSITION</p> <p>ADOPTED:</p> <p><input checked="" type="checkbox"/> TASK FORCE (TF) <u>6/30</u></p> <p><input checked="" type="checkbox"/> WORKING GROUP (WG) <u>6/14</u></p> <p><input type="checkbox"/> SUBGROUP (SG) _____</p> <p>EXPOSED:</p> <p><input type="checkbox"/> TASK FORCE (TF) _____</p> <p><input checked="" type="checkbox"/> WORKING GROUP (WG) _____</p> <p><input type="checkbox"/> SUBGROUP (SG) _____</p> <p>REJECTED:</p> <p><input type="checkbox"/> TF <input type="checkbox"/> WG <input type="checkbox"/> SG _____</p> <p>OTHER:</p> <p><input type="checkbox"/> DEFERRED TO _____</p> <p><input type="checkbox"/> REFERRED TO OTHER NAIC GROUP _____</p> <p><input type="checkbox"/> (SPECIFY) _____</p>
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IDENTIFICATION OF SOURCE AND FORM(S)/INSTRUCTIONS TO BE CHANGED

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| <input type="checkbox"/> Health RBC Blanks | <input type="checkbox"/> Property/Casualty RBC Blanks | <input checked="" type="checkbox"/> Life and Fraternal RBC Blanks |
| <input type="checkbox"/> Health RBC Instructions | <input type="checkbox"/> Property/Casualty RBC Instructions | <input type="checkbox"/> Life and Fraternal RBC Instructions |
| <input type="checkbox"/> Health RBC Formula | <input type="checkbox"/> Property/Casualty RBC Formula | <input type="checkbox"/> Life and Fraternal RBC Formula |
| <input type="checkbox"/> OTHER _____ | | |

DESCRIPTION/REASON OR JUSTIFICATION OF CHANGE(S)

This proposal applies a .45 base RBC factor in the life RBC formula for residual tranches.

Additional Staff Comments:

DF – The Working Group adopted a factor of .30 for yearend 2023 to be replaced by .45 beginning with yearend 2024 with consideration of positive or negative adjustment based on additional information.
EY- The Task Force adopted this proposal and 2023-10-IRE together during June 30 meeting.

**** This section must be completed on all forms.**

Revised 2-2023

	(1) Book / Adjusted Carrying Value	(2) Unrated Items †	(3) RBC Subtotal †	(4) Factor	(5) RBC Requirement
OTHER LONG-TERM ASSETS (CONTINUED)					
	<u>Annual Statement Source</u>				
(42) Schedule BA - Unaffiliated Common Stock	AVR Equity Component Column 1 Line 65		X	\$	=
(43) Schedule BA Unaffiliated Common Stock-Public	AVR Equity Component Column 1 Line 66		X	0.3000	=
(44) Total Schedule BA Unaffiliated Common Stock (pre-MODCO/Funds Withheld)	Line (42) + (43)				
(45) Reduction in RBC for MODCO/Funds Withheld Reinsurance Ceded Agreements	Company Records (enter a pre-tax amount)				
(46) Increase in RBC for MODCO/Funds Withheld Reinsurance Assumed Agreements	Company Records (enter a pre-tax amount)				
(47) Total Schedule BA Unaffiliated Common Stock (including MODCO/Funds Withheld.)	Lines (44) - (45) + (46)				
Schedule BA - All Other					
(48.1) BA Affiliated Common Stock - Life with AVR	AVR Equity Component Column 1 Line 67				
(48.2) BA Affiliated Common Stock - Certain Other	AVR Equity Component Column 1 Line 68		X	0.3000	=
(48.3) Total Schedule BA Affiliated Common Stock - C-1o	Line (48.1) + (48.2)				
(49.1) BA Affiliated Common Stock - All Other	AVR Equity Component Column 1 Line 69		X	0.3000	=
(49.2) Total Sch. BA Affiliated Common Stock - C-1cs	Line (49.1) + AVR Equity Component Column 1 Line 93		X	0.0680	=
(50) Schedule BA Collateral Loans	Schedule BA Part 1 Column 12 Line 29999999 + Line 30999999				
(51) Total Residual Tranches or Interests	AVR Equity Component Column 1 Line 93		X	0.3000	=
(52.1) NAIC 01 Working Capital Finance Notes	AVR Equity Component Column 1 Line 94		X	0.0050	=
(52.2) NAIC 02 Working Capital Finance Notes	AVR Equity Component Column 1 Line 95		X	0.0163	=
(52.3) Total Admitted Working Capital Finance Notes	Line (52.1) + (52.2)				
(53.1) Other Schedule BA Assets	AVR Equity Component Column 1 Line 96				
(53.2) Less NAIC 2 thru 6 Rated/Designated Surplus Notes and Capital Notes	Column (1) Lines (23) through (27) + Column (1) Lines (33) through (37)				
(53.3) Net Other Schedule BA Assets	Line (53.1) less (53.2)		X	0.3000	=
(54) Total Schedule BA Assets C-1o (pre-MODCO/Funds Withheld)	Lines (11) + (21) + (31) + (41) + (48.3) + (50) + (52.3) + (53.3)				
(55) Reduction in RBC for MODCO/Funds Withheld Reinsurance Ceded Agreements	Company Records (enter a pre-tax amount)				
(56) Increase in RBC for MODCO/Funds Withheld Reinsurance Assumed Agreements	Company Records (enter a pre-tax amount)				
(57) Total Schedule BA Assets C-1o (including MODCO/Funds Withheld.)	Lines (54) - (55) + (56)				
(58) Total Schedule BA Assets Excluding Mortgages and Real Estate	Line (47) + (49.2) + (51) + (57)				

† Fixed income instruments and surplus notes designated by the NAIC Capital Markets and Investment Analysis Office or considered exempt from filing as specified in the *Purposes and Procedures Manual of the NAIC Investment Analysis Office* should be reported in Column (3).

‡ Column (2) is calculated as Column (1) less Column (3) for Lines (1) through (17). Column (2) equals Column (3) - Column (1) for Line (53.3).

§ The factor for Schedule BA publicly traded common stock should equal 30 percent adjusted up or down by the weighted average beta for the Schedule BA publicly traded common stock portfolio subject to a minimum of 22.5 percent and a maximum of 45 percent in the same manner that the similar 15.8 percent factor for Schedule BA publicly traded common stock in the Asset Valuation Reserve (AVR) calculation is adjusted up or down. The rules for calculating the beta adjustment are set forth in the AVR section of the annual statement instructions.

Denotes items that must be manually entered on the filing software.

Capital Adequacy (E) Task Force RBC Proposal Form

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|---|--|--|
| <input type="checkbox"/> Capital Adequacy (E) Task Force | <input type="checkbox"/> Health RBC (E) Working Group | <input type="checkbox"/> Life RBC (E) Working Group |
| <input type="checkbox"/> Catastrophe Risk (E) Subgroup | <input type="checkbox"/> P/C RBC (E) Working Group | <input type="checkbox"/> Longevity Risk (A/E) Subgroup |
| <input type="checkbox"/> Variable Annuities Capital. & Reserve (E/A) Subgroup | <input type="checkbox"/> Economic Scenarios (E/A) Subgroup | <input checked="" type="checkbox"/> RBC Investment Risk & Evaluation (E) Working Group |

<p style="text-align: right;">DATE: <u>4/20/23</u></p> <p>CONTACT PERSON: <u>Steve Clayburn</u></p> <p>TELEPHONE: <u>(202)624-2197</u></p> <p>EMAIL ADDRESS: <u>steveclayburn@acli.com</u></p> <p>ON BEHALF OF: <u>American Council of Life Insurers (ACLI)</u></p> <p>NAME: <u>Steve Clayburn</u></p> <p>TITLE: _____</p> <p>AFFILIATION: _____</p> <p>ADDRESS: _____</p>	<p style="text-align: center;">FOR NAIC USE ONLY</p> <p>Agenda Item # <u>2023-10-IRE</u></p> <p>Year <u>2023</u></p> <p style="text-align: center;">DISPOSITION</p> <p>ADOPTED:</p> <p><input checked="" type="checkbox"/> TASK FORCE (TF) <u>6/30</u></p> <p><input checked="" type="checkbox"/> WORKING GROUP (WG) <u>6/14</u></p> <p><input type="checkbox"/> SUBGROUP (SG) _____</p> <p>EXPOSED:</p> <p><input type="checkbox"/> TASK FORCE (TF) _____</p> <p><input checked="" type="checkbox"/> WORKING GROUP (WG) _____</p> <p><input type="checkbox"/> SUBGROUP (SG) _____</p> <p>REJECTED:</p> <p><input type="checkbox"/> TF <input type="checkbox"/> WG <input type="checkbox"/> SG _____</p> <p>OTHER:</p> <p><input type="checkbox"/> DEFERRED TO _____</p> <p><input type="checkbox"/> REFERRED TO OTHER NAIC GROUP _____</p> <p><input type="checkbox"/> (SPECIFY) _____</p>
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IDENTIFICATION OF SOURCE AND FORM(S)/INSTRUCTIONS TO BE CHANGED

- | | | |
|--|---|---|
| <input type="checkbox"/> Health RBC Blanks | <input type="checkbox"/> Property/Casualty RBC Blanks | <input checked="" type="checkbox"/> Life and Fraternal RBC Blanks |
| <input type="checkbox"/> Health RBC Instructions | <input type="checkbox"/> Property/Casualty RBC Instructions | <input type="checkbox"/> Life and Fraternal RBC Instructions |
| <input type="checkbox"/> Health RBC Formula | <input type="checkbox"/> Property/Casualty RBC Formula | <input type="checkbox"/> Life and Fraternal RBC Formula |
| <input type="checkbox"/> OTHER _____ | | |

DESCRIPTION/REASON OR JUSTIFICATION OF CHANGE(S)

The adoption by the Working Group of proposal 2023-04-IRE provides the structure for this sensitivity test. This proposal is to address the factor to be applied in that test.

Additional Staff Comments:

DF – The Working Group adopted a factor of .15 for yearend 2023.
EY- The Task Force adopted this proposal and 2023-09-IRE together during June 30 meeting.

**** This section must be completed on all forms.**

Revised 2-2023

SENSITIVITY TESTS - AUTHORIZED CONTROL LEVEL

Sensitivity Tests Affecting Authorized Control Level Risk-Based Capital	Source	(1) Statement Value	Additional Sensitivity Factor	(2) Additional RBC	(3) Authorized Control Level Before Test	(4) Authorized Control Level After Test
(1.1) Other Affiliates: Company	LR042 Summary for Affiliated Investments Column (1) Line (13)		0.700			
(1.2) Other Affiliates: Subsidiaries	LR038 Additional Information Required Column (1) Line (1.2)		0.700			
(1.99) Total Other Affiliates			0.700			
(2.1) Noncontrolled Assets - Company	LR017 Off-Balance Sheet and Other Items Column (1) Line (15)		0.020			
(2.2) Noncontrolled Assets - Subsidiaries	LR038 Additional Information Required Column (1) Line (2.2)		0.020			
(2.99) Total Noncontrolled Assets			0.020			
(3.1) Guarantees for Affiliates: Company	LR017 Off-Balance Sheet and Other Items Column (1) Line (24)		0.020			
(3.2) Guarantees for Affiliates: Subsidiaries	LR038 Additional Information Required Column (1) Line (3.2)		0.020			
(3.99) Total Guarantees for Affiliates			0.020			
(4.1) Contingent Liabilities: Company	LR017 Off-Balance Sheet and Other Items Column (1) Line (25)		0.020			
(4.2) Contingent Liabilities: Subsidiaries	LR038 Additional Information Required Column (1) Line (4.2)		0.020			
(4.99) Total Contingent Liabilities			0.020			
(5.1) Long-Term Leases: Company	LR017 Off-Balance Sheet and Other Items Column (1) Line (26)		0.030			
(5.2) Long-Term Leases: Subsidiaries	LR038 Additional Information Required Column (1) Line (5.2)		0.030			
(5.99) Total Long-Term Leases			0.030			
(7.1) Affiliated Investments†: Company	LR038 Additional Information Required Column (1) Line (7.14)		0.100			
(7.2) Affiliated Investments†: Subsidiaries	LR038 Additional Information Required Column (1) Line (7.2)		0.100			
(7.99) Total Affiliated Investments			0.100			
(8.1) Total Residual Tranches or Interests	LR038 Additional Information Required Column (1) Line (11.1)		0.150			

† Excluding affiliated preferred and common stock

Denotes items that must be manually entered on the filing software.

1. The **Generator of Economic Scenarios (GOES) (E/A) Subgroup** of the Life Risk-Based Capital (E) Working Group and the Life Actuarial (A) Task Force will:
 - A. Monitor that the economic scenario governance framework is being appropriately followed by all relevant stakeholders involved in scenario delivery.
 - B. Review material economic scenario generator updates, either driven by periodic model maintenance or changes to the economic environment and provide recommendations.
 - C. Regularly review key economic conditions and metrics to evaluate the need for off-cycle or significant economic scenario generator updates and maintain a public timeline for economic scenario generator updates.
 - D. Support the implementation of an economic scenario generator for use in statutory reserve and capital calculations.
 - E. Develop and maintain acceptance criteria that reflect history as well as plausibly more extreme scenarios.

NAIC Model Laws, Regulations, Guidelines and Other Resources—July 2023

Draft: [May 11, 2023]*Adopted by Mortgage Guaranty Insurance (E) Working Group*—[July 13, 2023]*Adopted by [insert parent committee]*—[insert date]**MORTGAGE GUARANTY INSURANCE MODEL ACT****Table of Contents**

Section 1.	Title
Section 2.	Definitions
Section 3.	Insurer’s Authority to Transact Business
Section 4.	Mortgage Guaranty Insurance as Monoline
Section 5.	Risk Concentration
Section 6.	Capital and Surplus
Section 7.	Geographic Concentration
Section 8.	Advertising
Section 9.	Investment Limitation
Section 10.	Reserve Requirements
Section 11.	Reinsurance
Section 12.	Sound Underwriting Practices
Section 13.	Quality Assurance
Section 14.	Policy Forms and Premium Rates Filed
Section 15.	Risk in Force and Waivers
Section 16.	Conflict of Interest
Section 17.	Compensating Balances Prohibited
Section 18.	Limitations on Rebates, Commissions, Charges and Contractual Preferences
Section 19.	Rescission
Section 20.	Records Retention
Section 21.	Regulations

Section 1. Title

This Act may be cited as the Mortgage Guaranty Insurance Act.

Section 2. Definitions

The definitions set forth in this Act shall govern the construction of the terms used in this Act but shall not affect any other provisions of the code.

A. “Authorized Real Estate Security” means:

- (1) An amortized note, bond or other instrument of indebtedness, except for reverse mortgage loans made pursuant to [insert citation of state law that authorizes reverse mortgages] of the real property law, evidencing a loan, not exceeding one hundred three percent (103%) of the fair market value of the real estate, secured by a mortgage, deed of trust, or other instrument that constitutes, or is equivalent to, a first lien or junior lien or charge on real estate, with any percentage in excess of one hundred percent (100%) being used to finance the fees and closing costs on such indebtedness; provided:
 - (a) The real estate loan secured in this manner is one of a type that a creditor, which is supervised and regulated by a department of any state or territory of the U.S or an agency of the federal government, is authorized to make, or would be authorized to make, disregarding any requirement applicable to such an institution that the amount of the loan not exceed a certain percentage of the value of the real estate;
 - (b) The loan is to finance the acquisition, initial construction or refinancing of real estate that is a:

MO-630-1

Mortgage Guaranty Insurance Model Act

- (i) Residential building designed for occupancy by not more than four families, a one-family residential condominium or unit in a planned unit development, or any other one-family residential unit as to which title may be conveyed freely; or
 - (ii) Mixed-use building with only one non-residential use and one one-family dwelling unit; or
 - (iii) Building or buildings designed for occupancy by five (5) or more families or designed to be occupied for industrial or commercial purposes.
- (c) The lien on the real estate may be subject to and subordinate to other liens, leases, rights, restrictions, easements, covenants, conditions or regulations of use that do not impair the use of the real estate for its intended purpose.
- (2) Notwithstanding the foregoing, a loan referenced in Section 2A(1) of this Act may exceed 103% of the fair market value of the real estate in the event that the mortgage guaranty insurance company has approved for loss mitigation purposes a request to refinance a loan that constitutes an existing risk in force for the company.
- (3) An amortized note, bond or other instrument of indebtedness evidencing a loan secured by an ownership interest in, and a proprietary lease from, a corporation or partnership formed for the purpose of the cooperative ownership of real estate and at the time the loan does not exceed one hundred three percent (103%) of the fair market value of the ownership interest and proprietary lease, if the loan is one of a type that meets the requirements of Section 2A(1)(a), unless the context clearly requires otherwise, any reference to a mortgagor shall include an owner of such an ownership interest as described in this paragraph and any reference to a lien or mortgage shall include the security interest held by a lender in such an ownership interest.
- B. “Bulk Mortgage Guaranty Insurance” means mortgage guaranty insurance that provides coverage under a single transaction on each mortgage loan included in a defined portfolio of loans that have already been originated.
- C. “Certificate of Insurance” means a document issued by a mortgage guaranty insurance company to the initial insured to evidence that it has insured a particular authorized real estate security under a master policy, identifying the terms, conditions and representations, in addition to those contained in the master policy and endorsements, applicable to such coverage.
- D. “Commissioner.” The term “commissioner” shall mean the insurance commissioner, the commissioner’s deputies, or the Insurance Department, as appropriate.

Drafting Note: Insert the title of the chief insurance regulatory official wherever the word “commissioner” appears.

- E. “Contingency Reserve” means an additional premium reserve established to protect policyholders against the effect of adverse economic cycles.
- F. “Domiciliary Commissioner” means the principal insurance supervisory official of the jurisdiction in which a mortgage guaranty insurance company is domiciled.
- G. “Effective Guaranty” refers to the assumed backing of existing or future holders of securities by virtue of their issuer’s conservatorship or perceived access to credit from the U.S. Treasury, as opposed to the direct full faith and credit guarantee provided by the U.S. government.
- H. “Loss” refers to losses and loss adjustment expenses.
- I. “Master Policy” means a document issued by a mortgage guaranty insurance company that establishes the terms and conditions of mortgage guaranty insurance coverage provided thereunder, including any endorsements thereto.
- J. “Mortgage Guaranty Insurance” is insurance against financial loss by reason of nonpayment of principal,

MO-630-2

NAIC Model Laws, Regulations, Guidelines and Other Resources—July 2023

interest or other sums agreed to be paid under the terms of any authorized real estate security.

- K. “Mortgage Guaranty Quality Assurance Program” means an early detection warning system for potential underwriting compliance issues which could potentially impact solvency or operational risk within a mortgage guaranty insurance company.
- L. “NAIC” means the National Association of Insurance Commissioners.
- M. “Pool Mortgage Guaranty Insurance” means mortgage guaranty insurance that provides coverage under a single transaction or a defined series of transactions on a defined portfolio of loans for losses up to an aggregate limit.
- N. “Right of Rescission” represents a remedy available to a mortgage guaranty insurance company to void a certificate and restore parties to their original position, based on inaccurate, incomplete or misleading information provided to, or information omitted or concealed from, the mortgage guaranty insurance company in connection with the insurance application, resulting in an insured loan that did not meet the mortgage guaranty insurance company’s eligibility requirements in effect on the date of submission of the insurance application.
- O. “Risk in Force” means the mortgage guaranty insurance coverage percentage applied to the unpaid principal balance.

Section 3. Insurer’s Authority to Transact Business

A company may not transact the business of mortgage guaranty insurance until it has obtained a certificate of authority from the commissioner.

Section 4. Mortgage Guaranty Insurance as Monoline

A mortgage guaranty insurance company that anywhere transacts any class of insurance other than mortgage guaranty insurance is not eligible for the issuance of a certificate of authority to transact mortgage guaranty insurance in this state nor for the renewal thereof.

Section 5. Risk Concentration

A mortgage guaranty insurance company shall not expose itself to any loss on any one authorized real estate security risk in an amount exceeding ten percent (10%) of its surplus to policyholders. Any risk or portion of risk which has been reinsured shall be deducted in determining the limitation of risk.

Section 6. Capital and Surplus

- A. **Initial and Minimum Capital and Surplus Requirements.** A mortgage guaranty insurance company shall not transact the business of mortgage guaranty insurance unless, if a stock insurance company, it has paid-in capital of at least \$10,000,000 and paid-in surplus of at least \$15,000,000, or if a mutual insurance company, a minimum initial surplus of \$25,000,000. A stock insurance company or a mutual insurance company shall at all times thereafter maintain a minimum policyholders’ surplus of at least \$20,000,000.
- B. **Minimum Capital Requirements Applicability.** A mortgage guaranty insurance company formed prior to the passage of this Act may maintain the amount of capital and surplus or minimum policyholders’ surplus previously required by statute or administrative order for a period not to exceed twelve months following the effective date of the adoption of this Act.
- C. **Minimum Capital Requirements Adjustments.** The domiciliary commissioner may by order reduce the minimum amount of capital and surplus or minimum policyholders’ surplus required under Section 6A under the following circumstances:
 - (1) For an affiliated reinsurer that is a mortgage guaranty insurance company and that is or will be engaged solely in the assumption of risks from affiliated mortgage guaranty insurance companies, provided that the affiliated reinsurer is in run-off and, in the domiciliary commissioner’s opinion,

MO-630-3

Mortgage Guaranty Insurance Model Act

the business plan and other relevant circumstances of the affiliated reinsurer justify the proposed reduction in requirements.

- (2) For mortgage guaranty insurance companies that are in run-off and not writing new business that is justified in a business plan, in the domiciliary commissioner's opinion.

Section 7. Geographic Concentration

- A. A mortgage guaranty insurance company shall not insure loans secured by a single risk in excess of ten percent (10%) of the company's aggregate capital, surplus and contingency reserve.
- B. No mortgage guaranty insurance company shall have more than twenty percent (20%) of its total insurance in force in any one Standard Metropolitan Statistical Area (SMSA), as defined by the U.S Department of Commerce.
- C. The provisions of this section shall not apply to a mortgage guaranty insurance company until it has possessed a certificate of authority in this state for three (3) years.

Section 8. Advertising

No mortgage guaranty insurance company or an agent or representative of a mortgage guaranty insurance company shall prepare or distribute or assist in preparing or distributing any advertising media or communication to the effect that the real estate investments of any financial institution are "insured investments," unless the advertising media or communication clearly states that the loans are insured by mortgage guaranty insurance companies possessing a certificate of authority to transact mortgage guaranty insurance in this state or are insured by an agency of the federal government.

Section 9. Investment Limitation

Investments in notes or other evidence of indebtedness secured by a mortgage or other liens upon residential real property shall not be allowed as assets in any determination of the financial condition of a mortgage guaranty insurer. This section shall not apply to obligations secured by real property, or contracts for the sale of real property, which obligations or contract of sale are acquired in the course of good faith settlement of claims under policies of insurance issued by the mortgage guaranty insurance company, or in the good faith disposition of real property so acquired. This section shall not apply to investments backed by the full faith and credit of the U.S. Government or investments with the effective guaranty of the U.S. Government. This section shall not apply to investments held by a mortgage guaranty insurance company prior to the passage of this Act.

Section 10. Reserve Requirements

- A. **Unearned premium Reserves, Loss Reserves, and Premium Deficiency Reserves.** Financial reporting will be prepared in accordance with the Accounting Practices and Procedures Manual and Annual Financial Statement Instructions of the NAIC.
- B. **Contingency Reserve.** Each mortgage guaranty insurance company shall establish a contingency reserve subject to the following provisions:
- (1) The mortgage guaranty insurance company shall make an annual contribution to the contingency reserve which in the aggregate shall be equal to fifty percent (50%) of the direct earned premiums reported in the annual statement or net earned premiums reported if the reinsurer maintains the contingency reserve.
- (2) Except as provided within this Act, a mortgage guaranty insurance company's contributions to the contingency reserve made during each calendar year shall be maintained for a period of 120 months, to provide for reserve buildup. The portion of the contingency reserve established and maintained for more than 120 months shall be released and shall no longer constitute part of the contingency reserve.
- (3) Withdrawals may be made from the contingency reserve on a first-in, first-out basis or such other basis, with the prior written approval of the domiciliary commissioner, based on the amount by which:

MO-630-4

NAIC Model Laws, Regulations, Guidelines and Other Resources—July 2023

- (a) Incurred losses and loss adjustment expenses exceed 35% of the direct earned premium in any year. Provisional withdrawals may be made from the contingency reserve on a quarterly basis in an amount not to exceed 75% of the withdrawal as adjusted for the quarterly nature of the withdrawal; or
- (b) Upon the approval of the domiciliary commissioner and 30-day prior notification to non-domiciliary commissioners, a mortgage guaranty insurer may withdraw from the contingency reserve any amounts which are in excess of the requirements of Section 15 as required in [insert section of the mortgage guaranty Insurance model law requiring minimum policyholder's position] as filed with the most recently filed annual statement.
 - (i) The mortgage guaranty insurance company's domiciliary commissioner may consider loss developments and trends in reviewing a request for withdrawal. If any portion of the contingency reserve for which withdrawal is requested is maintained by a reinsurer or in a segregated account or trust of a reinsurer, the domiciliary commissioner may also consider the financial condition of the reinsurer.

- C. **Miscellaneous.** Unearned premium reserves and contingency reserves on risks insured before the effective date of this Act may be computed and maintained as required previously.

Section 11. Reinsurance

- A. **Prohibition of Captive Reinsurance.** A mortgage guaranty insurance company shall not enter into captive reinsurance arrangements which involve the direct or indirect ceding of any portion of its insurance risks or obligations to a reinsurer owned or controlled by an insured; any subsidiary or affiliate of an insured; an officer, director or employee of an insured or any member of their immediate family; a corporation, partnership, trust, trade association in which an insured is a member, or other entity owned or controlled by an insured or an insured's officer, director or employee or any member of their immediate family that has a financial interest; or any designee, trustee, nominee or other agent or representative of any of the foregoing.
- B. **Reinsurance Cessions.** A mortgage guaranty insurer may, by written contract, reinsure any insurance that it transacts, except that no mortgage guaranty insurer may enter into reinsurance arrangements designed to circumvent the compensating control provisions of Section 17 or the contingency reserve requirement of Section 10. The unearned premium reserve and the loss reserves required by Section 10 shall be established and maintained by the direct insurer or by the assuming reinsurer so that the aggregate reserves shall be equal to or greater than the reserves required by direct writer. The cession shall be accounted for as provided in the accounting practices and procedures prescribed or permitted by the applicable Accounting Practices and Procedures Manual of the NAIC.

Section 12. Sound Underwriting Practices

- A. **Underwriting Review and Approval Required.** All certificates of mortgage guaranty insurance, excluding policies of reinsurance, shall be written based on an assessment of evidence that prudent underwriting standards have been met by the originator of the mortgage. Delegated underwriting decisions shall be reviewed based on a reasonable method of sampling of post-closing loan documentation to ensure compliance with the mortgage guaranty insurance company's underwriting standards.
- B. **Quality Control Reviews.** Quality control reviews for bulk mortgage guaranty insurance and pool mortgage guaranty insurance shall be based on a reasonable method of sampling of post-closing loan documentation for delegated underwriting decisions to ensure compliance with the representations and warranties of the creditors or creditors originating the loans and with the mortgage guaranty insurance company's underwriting standards.
- C. **Minimum Underwriting Standards.** Mortgage guaranty insurance companies shall establish formal underwriting standards which set forth the basis for concluding that prudent underwriting standards have been met.

MO-630-5

Mortgage Guaranty Insurance Model Act

- D. **Underwriting Review and Approval.** A mortgage guaranty insurance company's underwriting standards shall be:
- (1) Reviewed and approved by executive management, including, but not limited to the highest-ranking executive officer and financial officer; and
 - (2) Communicated across the organization to promote consistent business practices with respect to underwriting.
- E. **Notification of Changes in Underwriting Standards.** On or before March 1 of each year, a mortgage guaranty insurance company shall file with the domiciliary commissioner changes to its underwriting standards and an analysis of the changes implemented during the course of the immediately preceding year. The annual summary of material underwriting standards changes should include any change associated with loan to value ratios, debt to income ratios, borrower credit standing or maximum loan amount which has resulted in a material impact on net premium written of +/- 5% from prior year to date.
- F. **Nondiscrimination.** In extending or issuing mortgage guaranty insurance, a mortgage guaranty insurance company may not discriminate on the basis of the applicant's sex, marital status, race, color, creed, national origin, disability, or age or solely on the basis of the geographic location of the property to be insured unless the discrimination related to geographic location is for a business purpose that is not a mere pretext for unfair discrimination; or the refusal, cancellation, or limitation of the insurance is required by law or regulatory mandate.

Drafting Note: States and jurisdictions should consult their constitution or comparable governance documents and applicable civil rights legislation to determine if broader protections against unacceptable forms of discrimination should be included in Section 12F.

Section 13. Quality Assurance

- A. **Quality Assurance Program.** A mortgage guaranty insurance company shall establish a formal internal mortgage guaranty quality assurance program, which provides an early detection warning system as it relates to potential underwriting compliance issues which could potentially impact solvency or operational risk. This mortgage guaranty quality assurance program shall provide for the documentation, monitoring, evaluation and reporting on the integrity of the ongoing loan origination process based on indicators of potential underwriting inadequacies or non-compliance. This shall include, but not limited to:
- (1) **Segregation of Duties.** Administration of the quality assurance program shall be delegated to designated risk management, quality assurance or internal audit personnel, who are technically trained and independent from underwriting activities that they audit.
 - (2) **Senior Management Oversight.** Quality assurance personnel shall provide periodic quality assurance reports to an enterprise risk management committee or other equivalent senior management level oversight body.
 - (3) **Board of Director Oversight.** Quality assurance personnel shall provide periodic quality assurance reports to the board of directors or a designated committee of directors established to facilitate board of director oversight.
 - (4) **Policy and Procedures Documentation.** Mortgage guaranty quality assurance program, excluding policies and procedures of reinsurance, shall be formally established and documented to define scope, roles and responsibilities.
 - (5) **Underwriting Risk Review.** Quality assurance review shall include an examination of underwriting risks including classification of risk and compliance with risk tolerance levels.
 - (6) **Lender Performance Reviews.** Quality assurance monitoring provisions shall include an assessment of lender performance.

MO-630-6

NAIC Model Laws, Regulations, Guidelines and Other Resources—July 2023

- (7) **Underwriting Performance Reviews.** Quality assurance monitoring provisions shall assess compliance with underwriting standard.
 - (8) **Problem Loan Trend Reviews.** Quality assurance monitoring provisions shall assess prospective risks associated with timely loan payment including delinquency, default inventory, foreclosure and persistency trends.
 - (9) **Underwriting System Change Oversight.** Underwriting system program changes shall be monitored to ensure the integrity of underwriting and pricing programs, which impact automated underwriting system decision making.
 - (10) **Pricing and Performance Oversight.** Pricing controls shall be monitored to ensure that business segment pricing supports applicable performance goals.
 - (11) **Internal Audit Validation.** Periodic internal audits shall be conducted to validate compliance with the mortgage guaranty quality assurance program.
- B. **Regulator Access and Review of Quality Assurance Program.** The commissioner shall be provided access to an insurer's mortgage guaranty quality assurance program for review at any reasonable time upon request and during any financial regulatory examination. Nothing herein shall be construed to limit a regulator's right to access any and all of the records of an insurer in an examination or as otherwise necessary to meet regulatory responsibilities.

Section 14. Policy Forms and Premium Rates Filed

- A. **Policy Forms.** Policy forms, endorsements, and modifications (excluding bulk mortgage guaranty insurance and pool mortgage guaranty insurance) shall be filed with and be subject to the approval of the commissioner. With respect to owner-occupied, single-family dwellings or a mixed-use building described in Section 2A(1)(b), which is owner-occupied at the time of loan origination and for at least 50% of the days within the twelve (12) consecutive months prior to borrower default, the borrower shall not be liable to the insurance company for any deficiency arising from a foreclosure sale.
- B. **Premium Rates.** Each mortgage guaranty insurance company (excluding bulk mortgage guaranty insurance and pool mortgage guaranty insurance) shall file with the commissioner the rate to be charged including all modifications.
- C. **Premium Charges.** Every mortgage guaranty insurance company shall make available to insureds the premium charges for mortgage guaranty insurance policies via a company website or an integration with a third-party system. The premium rate provided shall show the entire amount of premium charge for the type of mortgage guaranty insurance policy to be issued by the insurance company.

Drafting Note: Open rating states may delete a portion or all of Section 14 and insert their own rating law.

Section 15. Risk in Force and Waivers

- A. **Risk in Force.** A mortgage guaranty insurance company shall not at any time have outstanding risk in force, net of reinsurance, under its aggregate mortgage guaranty insurance policies exceeding twenty-five (25) times its capital, surplus and contingency reserve. In the event that any mortgage guaranty insurance company has outstanding total risk in force exceeding twenty-five (25) times its capital, surplus and contingency reserve, it shall cease transacting new mortgage guaranty business until such time as its total risk in force no longer exceeds twenty-five (25) times its capital, surplus and contingency reserve. Total risk in force shall be calculated on an individual entity basis.
- B. **Waiver.** The commissioner may waive the requirement found in Section 15A at the written request of a mortgage guaranty insurer upon a finding that the mortgage guaranty insurer's policyholders position is reasonable in relationship to the mortgage guaranty insurer's aggregate insured risk in force and adequate to its financial needs. The request must be made in writing at least 90 days in advance of the date that the mortgage guaranty insurer expects to exceed the requirement of Section 15A and shall, at a minimum, address the factors specified in Section 15C.

MO-630-7

Mortgage Guaranty Insurance Model Act

- C. **Waiver Criteria.** In determining whether a mortgage guaranty insurer's policyholders position is reasonable in relation to the mortgage guaranty insurer's aggregate insured risk in force and adequate to its financial needs, all of the following factors, among others, may be considered:
- (1) The size of the mortgage guaranty insurer as measured by its assets, capital and surplus, reserves, premium writings, insurance in force, and other appropriate criteria.
 - (2) The extent to which the mortgage guaranty insurer's business is diversified across time, geography, credit quality, origination, and distribution channels.
 - (3) The nature and extent of the mortgage guaranty insurer's reinsurance program.
 - (4) The quality, diversification, and liquidity of the mortgage guaranty insurer's assets and its investment portfolio.
 - (5) The historical and forecasted trend in the size of the mortgage guaranty insurer's policyholders position.
 - (6) The policyholders position maintained by other comparable mortgage guaranty insurers in relation to the nature of their respective insured risks.
 - (7) The adequacy of the mortgage guaranty insurer's reserves.
 - (8) The quality and liquidity of investments in affiliates. The commissioner may treat any such investment as a nonadmitted asset for purposes of determining the adequacy of surplus as regards policyholders.
 - (9) The quality of the mortgage guaranty insurer's earnings and the extent to which the reported earnings of the mortgage guaranty insurer include extraordinary items.
 - (10) An independent actuary's opinion as to the reasonableness and adequacy of the mortgage guaranty insurer's historical and projected policyholders position.
 - (11) The capital contributions which have been infused or are available for future infusion into the mortgage guaranty insurer.
 - (12) The historical and projected trends in the components of the mortgage guaranty insurer's aggregate insured risk, including, but not limited to, the quality and type of the risks included in the aggregate insured risk.
- D. **Authority to Retain Experts.** The commissioner may retain accountants, actuaries, or other experts to assist in the review of the mortgage guaranty insurer's request submitted pursuant to Section 15B. The mortgage guaranty insurer shall bear the commissioner's cost of retaining those persons.
- E. **Specified Duration.** Any waiver shall be:
- (1) For a specified period of time not to exceed two years; and
 - (2) Subject to any terms and conditions that the commissioner shall deem best suited to restoring the mortgage guaranty insurer's minimum policyholders position required by Section 15A.

Section 16. Conflict of Interest

A mortgage guaranty insurer may underwrite mortgage guaranty insurance on mortgages originated by the holding company system or affiliate or on mortgages originated by any mortgage lender to which credit is extended, directly or indirectly by the holding company system or affiliate only if the insurance is underwritten on the same basis, for the same consideration and subject to the same insurability requirements as insurance provided to nonaffiliated lenders. Mortgage guaranty insurance

MO-630-8

underwritten on mortgages originated by the holding company system or affiliate or on mortgages originated by any mortgage lender to which credit is extended, directly or indirectly by the holding company system or affiliate shall be limited to 50% of the insurer's direct premium written in any calendar year, or such higher percentage established in writing for the insurer in the domiciliary commissioner's discretion, based on the domiciliary commissioner's determination that a higher percentage is not likely to adversely affect the financial condition of the insurer.

Section 17. Compensating Balances Prohibited

Except for commercial checking accounts and normal deposits in support of an active bank line of credit, a mortgage guaranty insurance company, holding company or any affiliate thereof is prohibited from maintaining funds on deposit with the lender for which the mortgage guaranty insurance company has insured loans. Any deposit account bearing interest at rates less than what is currently being paid other depositors on similar deposits or any deposit in excess of amounts insured by an agency of the federal government shall be presumed to be an account in violation of this section. Furthermore, a mortgage guaranty insurance company shall not use compensating balances, special deposit accounts or engage in any practice that unduly delays its receipt of monies due or that involves the use of its financial resources for the benefit of any owner, mortgagee of the real property or any interest therein or any person who is acting as agent, representative, attorney or employee of the owner, purchaser or mortgagee as a means of circumventing any part of this section.

Section 18. Limitations on Rebates, Commissions, Charges and Contractual Preferences

- A. **Inducements.** A mortgage guaranty insurance company shall not pay or cause to be paid either directly or indirectly, to any owner, purchaser, lessor, lessee, mortgagee or prospective mortgagee of the real property that secures the authorized real estate security or that is the fee of an insured lease, or any interest therein, or to any person who is acting as an agent, representative, attorney or employee of such owner, purchaser, lessor, lessee or mortgagee, any commission, or any part of its premium charges or any other consideration as an inducement for or as compensation on any mortgage guaranty insurance business.
- B. **Compensation for Placement.** In connection with the placement of any mortgage guaranty insurance, a mortgage guaranty insurance company shall not cause or permit the conveyance of anything of value, including but not limited to any commission, fee, premium adjustment, remuneration or other form of compensation of any kind whatsoever to be paid to, or received by an insured lender or lessor; any subsidiary or affiliate of an insured; an officer, director or employee of an insured or any member of their immediate family; a corporation, partnership, trust, trade association in which an insured is a member, or other entity in which an insured or an officer, director or employee or any member of their immediate family has a financial interest; or any designee, trustee, nominee or other agent or representative of any of the foregoing, except for the value of the insurance itself or claim payments thereon as provided by contract or settlement.
- C. **Rebates.** A mortgage guaranty insurance company shall not make a rebate of any portion of the premium charge, as shown by the schedule required by Section 14C. No mortgage guaranty insurance company shall not quote any rate or premium charge to a person that is different than that currently available to others for the same type of coverage. The amount by which a premium charge is less than that called for by the current schedule of premium charges is an unlawful rebate.
- D. **Undue Contractual Preferences.**
 - (1) Any contract, letter agreement, or other arrangement used to clarify any terms, conditions, or interpretations of a master policy or certificate shall be documented in writing.
 - (2) Any contractual or letter agreements used to modify or clarify general business practices and administrative, underwriting, claim submission or other information exchange processes shall not contain provisions which override or significantly undermine the intent of key provisions of the mortgage guaranty insurance model act, including mortgage insurer discretion, rights and responsibilities related to:
 - (a) Underwriting standards.
 - (b) Quality assurance.
 - (c) Rescission.

Mortgage Guaranty Insurance Model Act

- E. **Sanctions.** The commissioner may, after notice and hearing, suspend or revoke the certificate of authority of a mortgage guaranty insurance company, or in his or her discretion, issue a cease and desist order to a mortgage guaranty insurance company that pays a commission, rebate, or makes any unlawful conveyance of value under this section in willful violation of the provisions of this Act. In the event of the issuance of a cease and desist order, the commissioner may, after notice and hearing, suspend or revoke the certificate of authority of a mortgage guaranty insurance company that does not comply with the terms thereof.
- F. **Educational Efforts and Promotional Materials Permitted.** A mortgage guaranty insurance company may engage in any educational effort with borrowers, members of the general public, and officers, directors, employees, contractors and agents of insured lenders that may reasonably be expected to reduce its risk of Loss or promote its operational efficiency and may distribute promotional materials of minor value.

Section 19. Rescission

All mortgage guaranty insurance company master policies shall include a detailed description of provisions governing rescissions, re-pricing, and cancellations, which specify the insurer's and insured's rights, obligations and eligibility terms under which those actions may occur to ensure transparency.

Section 20. Records Retention

- A. **Record Files.** A licensed mortgage guaranty insurance company shall maintain its records in a manner which allows the commissioner to readily ascertain the insurer's compliance with state insurance laws and rules during an examination including, but not limited to, records regarding the insurer's management, operations, policy issuance and servicing, marketing, underwriting, rating and claims practices.
- B. **Retention Period.** Policy and claim records shall be retained for the period during which the certificate or claim is active plus five (5) years, unless otherwise specified by the insurance commissioner. Recordkeeping requirements shall relate to:
 - (1) Records to clearly document the application, underwriting, and issuance of each master policy and certificate of insurance; and
 - (2) Claim records to clearly document the inception, handling, and disposition.
- C. **Record Format.** Any record required to be maintained by a mortgage insurer may be created and stored in the form of paper, photograph, magnetic, mechanical or electronic medium.
- D. **Record Maintenance.** Record maintenance under this Act shall comply with the following requirements:
 - (1) Insurer maintenance responsibilities shall provide for record storage in a location that will allow the records to be reasonably produced for examination within the time period required.
 - (2) Third-Party maintenance related responsibilities shall be set forth in a written agreement, a copy of which shall be maintained by the insurer and available for purposes of examination.

Section 21. Regulations

The commissioner shall have the authority to promulgate rules and regulations deemed necessary to effectively implement the requirements of this Act.

Chronological Summary of Actions (all references are to the Proceedings of the NAIC).

1976 Proc. II 15, 17, 647, 686, 747-753 (adopted).

1979 Proc. I 44, 47-48, 49, 719, 968-969 (corrected).

MO-630-10

PROJECT HISTORY – 2023**MORTGAGE GUARANTY INSURANCE MODEL ACT (#630)****1. Description of the Project, Issues Addressed, etc.**

The current NAIC *Mortgage Guaranty Insurance Model Act* (#630) was first adopted in 1976 and amended in 1979. Model #630 was created to provide effective regulation and supervision of mortgage guaranty insurers. Model #630 defines mortgage guaranty insurance as insurance against financial loss by reason of nonpayment of principal, interest, or other sums agreed to be paid on any note secured by a mortgage, deed of trust, or other instrument constituting a lien or charge on real estate. Mortgage guaranty insurance may also cover against financial loss by reason of nonpayment of rent under the terms of a written lease. As of April 2012, eight states had adopted the most recent version of the model in a substantially similar manner. An additional 12 states have adopted an older version of the model, legislation, or regulation derived from other sources such as bulletins and administrative rulings.

The Mortgage Guaranty Insurance (E) Working Group was formed in November 2012. By early 2013, the Working Group developed a list of potential regulatory changes to Model #630 to address changes in mortgage lending and mortgage finance since the model's original approval in the 1970s and to respond to the lessons learned during the 2008 national recession and housing market downturn. As a result, a Request for NAIC Model Law Development was made and approved by the Executive (EX) Committee at the 2013 Summer National Meeting.

Development of the modernized model has a long history dating back to the fall of 2012. At that time, development of a capital model to accompany Model #630 was the key focus of attention. During 2013, mortgage guaranty insurers engaged Oliver Wyman to begin working on a Mortgage Guaranty Capital Model. Over the next several years, the Mortgage Guaranty Capital Model was developed. It was determined in December 2016 that a secondary contractor would need to be hired to further assess the reliability of the Mortgage Guaranty Capital Model. In September 2017, Milliman began its work to review and validate the Mortgage Guaranty Capital Model.

In March 2018, Milliman provided its assessment of the capital model to the Working Group. It indicated that inconsistencies and errors were found in the data preparation steps used to: 1) estimate the capital model coefficients and the application of the same capital model coefficients; and 2) forecast future loan performance. Milliman stated that these inconsistencies and errors were material to the capital model and would need to be addressed before the Mortgage Guaranty Capital Model could be implemented.

As a result, Milliman continued its work on the Mortgage Guaranty Capital Model, and in December 2019, it was exposed for public comment. The comments regarding the exposure were expected to be discussed during the 2020 Spring National Meeting. However, due to the COVID-19 pandemic, this meeting was cancelled. The Working Group also began working on an annual statement exhibit to begin collecting data for the capital model. In April 2021, the Mortgage Guaranty Insurance (E) Working Group referred the exhibit proposal to the Blanks (E) Working Group. The exhibit was finalized and implemented into the blank effective year-end 2021. In May 2022, the Mortgage Guaranty Insurance (E) Working Group decided to pause the development of the capital model and continue collecting data for further analysis in the future. As a result, the Working Group focused on finalizing the model.

Mortgage Guaranty Insurance Model Act (#630)Project History

2. Name of Group Responsible for Drafting the Model and States Participating

The Mortgage Guaranty Insurance (E) Working Group comprised the drafting Group and consisted of the following states during 2023: North Carolina (chair); Arizona; California; Florida, Missouri, New York, Pennsylvania; Texas; and Wisconsin.

3. Project Authorized by What Charge and Date First Given to the Group

The Executive (EX) Committee approved the Request for NAIC Model Law Development during the 2013 Summer National Meeting. Throughout the course of model development, the Financial Condition (E) Committee chair approved extensions due to extenuating circumstances.

4. A General Description of the Drafting Process (e.g., drafted by a subgroup, interested parties, the full group, etc). Include any parties outside the members that participated.

The Working Group formed a drafting group, which consisted of: Jackie Obusek (NC–Chair); Kurt Regner (AZ); Monica Macaluso (CA); Robert Ballard (FL); John Rehagen (MO); Margot Small (NY); Melissa Greiner (PA); Amy Garcia (TX); and Amy Malm (WI). Following the lengthy hiatus from the development of the model, due to work being completed on the Mortgage Guaranty Capital Model, the drafting group began finalization of model in May 2022 without consideration of the capital model. During its May meeting, the drafting group discussed the overall approach to finalizing the model and a rather aggressive timeline for completion.

5. A General Description of the Due Process (e.g., exposure periods, public hearings, or any other means by which widespread input from industry, consumers and legislators was solicited)

The Working Group met in open session on Oct. 6 and Dec. 13, 2022, and March 22, 2023. During these sessions, interested regulators and parties submitted comment letters to the Working Group. The drafting group held nine regulator-only discussion and planning calls between May 2022 and March 2023. The Working Group exposed the model for public comment on Oct. 7, 2022, and again on Feb. 27, 2023, and May 11, 2023. Comments were received from: the California Department of Insurance (DOI); the Center for Economic Justice (CEJ); and the Mortgage Guaranty Consortium (Arch Mortgage Insurance Company, Enact Mortgage Insurance Corporation, Essent Guaranty Inc., Mortgage Guaranty Insurance Corporation, National Mortgage Insurance Corporation, and Radian Guaranty Inc).

6. A Discussion of the Significant Issues (items of some controversy raised during the due process and the group’s response)**Section 10, Reserve Requirements – Contingency Reserve**

The most significant issue raised during development was related to the recording of the contingency reserves when reinsurance is used. The specific provision is: “The Mortgage Guaranty Insurance company shall make an annual contribution to the Contingency Reserve which in the aggregate shall be equal to fifty percent (50%) of the direct earned premiums reported in the annual statement or net earned premiums reported if the reinsurer maintains the contingency reserve.” The mortgage insurers indicated that many reinsurers do not complete a statutory financial statement and would not have the ability to record the contingency reserve. The drafting group members discussed the topic and agreed to leave the provision as stated.

Mortgage Guaranty Insurance Model Act (#630)Project History

Section 21, No Private Right of Action Provision

The mortgage guaranty insurers proposed the following provision for inclusion in the model: “No Private Right of Action. Nothing in this Act is intended to, or does, create a private right of action based upon compliance or noncompliance with any of the Act’s provisions. Authority to enforce compliance with this Act is vested exclusively in the Commissioner.” Following discussion by the drafting group, the provision was added to the model and included in the Feb. 27, 2023, exposure. The drafting group received several comments on the provision. Following discussion, Section 21 was removed from the model.

7. List the Key Provisions of the Model (sections considered most essential to state adoption)**Section 10. Reserve Requirements**

- A. **Unearned Premium Reserves, Loss Reserves, and Premium Deficiency Reserves.** Financial reporting will be prepared in accordance with the *Accounting Practices and Procedures Manual* (AP&P Manual) and Annual Financial Statement Instructions of the NAIC.
- B. **Contingency Reserve.** Each mortgage guaranty insurance company shall establish a contingency reserve subject to the following provisions:
- (1) The mortgage guaranty insurance company shall make an annual contribution to the contingency reserve, which, in the aggregate, shall be equal to 50% of the direct earned premiums reported in the annual statement or net earned premiums reported if the reinsurer maintains the contingency reserve.
 - (2) Except as provided within this act, a mortgage guaranty insurance company’s contributions to the contingency reserve made during each calendar year shall be maintained for a period of 120 months to provide for reserve buildup. The portion of the contingency reserve established and maintained for more than 120 months shall be released and shall no longer constitute part of the contingency reserve.
 - (3) Withdrawals may be made from the contingency reserve on a first-in, first-out basis or such other basis, with the prior written approval of the domiciliary commissioner, based on the amount by which:
 - (a) Incurred losses and loss adjustment expenses exceed 35% of the direct earned premium in any year. Provisional withdrawals may be made from the contingency reserve on a quarterly basis in an amount not to exceed 75% of the withdrawal as adjusted for the quarterly nature of the withdrawal; or
 - (b) Upon the approval of the domiciliary commissioner and 30-day prior notification to non-domiciliary commissioners, a mortgage guaranty insurer may withdraw from the contingency reserve any amounts that are in excess of the requirements of Section 15 as required in (insert section of the mortgage guaranty insurance model law requiring minimum policyholder’s position) as filed with the most recently filed annual statement.
 - (i.) The mortgage guaranty insurance company’s domiciliary commissioner may consider loss developments and trends in reviewing a request for withdrawal. If any portion of the contingency reserve for which withdrawal is requested is maintained by a reinsurer or in a segregated

Mortgage Guaranty Insurance Model Act (#630)Project History

account or trust of a reinsurer, the domiciliary commissioner may also consider the financial condition of the reinsurer.

C. **Miscellaneous.**

- (1) Unearned premium reserves and contingency reserves on risks insured before the effective date of this act may be computed and maintained as required previously.

Section 15. Risk in Force and Waivers

- A. **Risk in Force.** A mortgage guaranty insurance company shall not at any time have outstanding risk in force, net of reinsurance, under its aggregate mortgage guaranty insurance policies exceeding 25 times its capital, surplus, and contingency reserve. In the event that any mortgage guaranty insurance company has outstanding total risk in force exceeding 25 times its capital, surplus, and contingency reserve, it shall cease transacting new mortgage guaranty business until such time as its total risk in force no longer exceeds 25 times its capital, surplus, and contingency reserve. Total risk in force shall be calculated on an individual entity basis.
- B. **Waiver.** The commissioner may waive the requirement found in subsection (a) of this section at the written request of a mortgage guaranty insurer upon a finding that the mortgage guaranty insurer's policyholders position is reasonable in relationship to the mortgage guaranty insurer's aggregate insured risk in force and adequate to its financial needs. The request must be made in writing at least 90 days in advance of the date that the mortgage guaranty insurer expects to exceed the requirement of subsection (a) of this section and shall, at a minimum, address the factors specified in subsection (j) of this section.
- C. **Waiver Criteria.** In determining whether a mortgage guaranty insurer's policyholders position is reasonable in relation to the mortgage guaranty insurer's aggregate insured risk in force and adequate to its financial needs, all of the following factors, among others, may be considered:
 - (1) The size of the mortgage guaranty insurer as measured by its assets, capital and surplus, reserves, premium writings, insurance in force, and other appropriate criteria.
 - (2) The extent to which the mortgage guaranty insurer's business is diversified across time, geography, credit quality, origination, and distribution channels.
 - (3) The nature and extent of the mortgage guaranty insurer's reinsurance program.
 - (4) The quality, diversification, and liquidity of the mortgage guaranty insurer's assets and its investment portfolio.
 - (5) The historical and forecasted trend in the size of the mortgage guaranty insurer's policyholders position.
 - (6) The policyholders position maintained by other comparable mortgage guaranty insurers in relation to the nature of their respective insured risks.

Mortgage Guaranty Insurance Model Act (#630)Project History

- (7) The adequacy of the mortgage guaranty insurer's reserves.
 - (8) The quality and liquidity of investments in affiliates. The commissioner may treat any such investment as a nonadmitted asset for purposes of determining the adequacy of surplus as regards policyholders.
 - (9) The quality of the mortgage guaranty insurer's earnings and the extent to which the reported earnings of the mortgage guaranty insurer include extraordinary items.
 - (10) An independent actuary's opinion as to the reasonableness and adequacy of the mortgage guaranty insurer's historical and projected policyholders position.
 - (11) The capital contributions that have been infused or are available for future infusion into the mortgage guaranty insurer.
 - (12) The historical and projected trends in the components of the mortgage guaranty insurer's aggregate insured risk, including the quality and type of the risks included in the aggregate insured risk.
- D. **Authority to Retain Experts.** The commissioner may retain accountants, actuaries, or other experts to assist the commissioner in the review of the mortgage guaranty insurer's request submitted pursuant to subsection (i) of this section. The mortgage guaranty insurer shall bear the commissioner's cost of retaining those persons.
- E. **Specified Duration.** Any waiver shall be (i) for a specified period of time not to exceed two years and (ii) subject to any terms and conditions that the commissioner shall deem best suited to restoring the mortgage guaranty insurer's minimum policyholders position required by subsection (a) of this section.

8. Any Other Important Information (e.g., amending an accreditation standard)

None. It is not an accreditation standard, and the Working Group is not making a recommendation that it be considered as an accreditation standard.

NAIC Model Laws, Regulations, Guidelines and Other Resources—July 2000/2023

Draft: [May 11, 2023]
Adopted by Mortgage Guaranty Insurance (E) Working Group—[July 13, 2023]
Adopted by [insert parent committee]—[insert date]

MORTGAGE GUARANTY INSURANCE MODEL ACT

Table of Contents

Section 1. Title
 Section 2. Definitions
 Section 3. ~~Capital and Surplus~~ Insurer’s Authority to Transact Business
 Section 4. ~~Insurer’s Authority to Transact Business~~ Mortgage Guaranty Insurance as Monoline
 Section 5. Risk Concentration
 Section 6. Capital and Surplus
 Section 7. ~~Geographic Concentration~~
 Section 8. ~~Section 6.~~ Advertising
 Section 9. ~~Section 7.~~ Investment Limitation
 Section 8. ~~Coverage Limitation~~
 Section 9. ~~Mortgage Guaranty Insurance as Monoline~~
 Section 10. Reserve Requirements
 Section 11. Reinsurance
 Section 12. Sound Underwriting ~~Discrimination~~ Practices
 Section 13. Quality Assurance
 Section 14. ~~Section 11.~~ Policy Forms and Premium Rates Filed
 Section 15. Risk in Force and Waivers
 Section 16. Conflict of Interest
 Section 17. ~~Section 12.~~ Outstanding Total Liability
 Section 13. ~~Rebates, Commissions and Charges~~
 Section 14. ~~Compensating Balances Prohibited~~
 Section 18. Limitations on Rebates, Commissions, Charges and Contractual Preferences
 Section 19. Rescission
 Section 20. Records Retention
 Section 21. ~~Section 15.~~ Conflict of Interest
 Section 16. ~~Reserves~~
 Section 17. Regulations

Section 1. Title

This Act may be cited as the Mortgage Guaranty Insurance Act.

Section 2. Definitions

The definitions set forth in this Act shall govern the construction of the terms used in this Act but shall not affect any other provisions of the code.

- A. ~~“Authorized real estate security,” for the purpose of this Act,~~ Real Estate Security” means an:
 - (1) An amortized note, bond or other evidence instrument of indebtedness, except for reverse mortgage loans made pursuant to [insert citation of state law that authorizes reverse mortgages] of the real property law, evidencing a loan, not exceeding ninety-five one hundred three percent (95103%) of the fair market value of the real estate, secured by a mortgage, deed of trust, or other instrument that constitutes, or is equivalent to, a first lien or charge on real estate junior lien or charge on real estate, with any percentage in excess of one hundred percent (100%) being used to finance the fees and closing costs on such indebtedness; provided:
 - (a) ~~(1)~~ The real estate loan secured in this manner is one of a type that a bank, savings and loan association, or an insurance company creditor, which is supervised and regulated by a department of this any state or territory of the U.S or an agency of the federal government, is authorized to make, or would be authorized to make, disregarding any requirement applicable

MO-630-1

Mortgage Guaranty Insurance Model Act

to such an institution that the amount of the loan not exceed a certain percentage of the value of the real estate;

~~(2b) The improvement on loan is to finance the acquisition, initial construction or refinancing of real estate that is a:~~

~~(i) Residential building designed for occupancy by not more than four families, a one-family residential condominium or unit in a planned unit development, or any other one-family residential unit as to which title may be conveyed freely; or~~

~~(ii) Mixed-use building with only one non-residential use and one one-family dwelling unit; or~~

~~(iii) Building or buildings designed for occupancy as specified by Subsections A(1) and A(2) of this section; and by five (5) or more families or designed to be occupied for industrial or commercial purposes.~~

~~(3c) The lien on the real estate may be subject to and subordinate to the following:~~

~~(a) The lien of any public bond, assessment or tax, when no installment, call or payment of or under the bond, assessment or tax is delinquent; and~~

~~(b) Outstanding mineral, oil, water or timber other liens, leases, rights, rights-of-way, easements or rights-of-way of support, sewer rights, building restrictions or other restrictions or easements, covenants, conditions or regulations of use, or outstanding leases upon the real property under which rents or profits are reserved to the owner thereof that do not impair the use of the real estate for its intended purpose.~~

~~(2) Notwithstanding the foregoing, a loan referenced in Section 2A(1) of this Act may exceed 103% of the fair market value of the real estate in the event that the mortgage guaranty insurance company has approved for loss mitigation purposes a request to refinance a loan that constitutes an existing risk in force for the company.~~

~~(3) An amortized note, bond or other instrument of indebtedness evidencing a loan secured by an ownership interest in, and a proprietary lease from, a corporation or partnership formed for the purpose of the cooperative ownership of real estate and at the time the loan does not exceed one hundred three percent (103%) of the fair market value of the ownership interest and proprietary lease, if the loan is one of a type that meets the requirements of Section 2A(1)(a), unless the context clearly requires otherwise, any reference to a mortgagor shall include an owner of such an ownership interest as described in this paragraph and any reference to a lien or mortgage shall include the security interest held by a lender in such an ownership interest.~~

~~B. "Bulk Mortgage Guaranty Insurance" means mortgage guaranty insurance that provides coverage under a single transaction on each mortgage loan included in a defined portfolio of loans that have already been originated.~~

~~C. "Certificate of Insurance" means a document issued by a mortgage guaranty insurance company to the initial insured to evidence that it has insured a particular authorized real estate security under a master policy, identifying the terms, conditions and representations, in addition to those contained in the master policy and endorsements, applicable to such coverage.~~

~~D. "Commissioner" means [insert the title of the principal insurance supervisory official] of this state, or the [insert the title of the principal insurance supervisory official]'s deputies or assistants, or any employee of the [insert name of the principal insurance regulatory agency] of this state acting in the [insert the title of the principal insurance supervisory official]'s name and by the [insert the title of the principal insurance supervisory official]'s delegated authority. "Commissioner." The term "commissioner" shall mean the insurance commissioner, the commissioner's deputies, or the Insurance Department, as appropriate.~~

~~**Drafting Note:** Insert the title of the chief insurance regulatory official wherever the word "commissioner" appears.~~

NAIC Model Laws, Regulations, Guidelines and Other Resources—July 2000/2023

- E.
- ~~B.~~ “Contingency reserve”Contingency Reserve means an additional premium reserve established to protect policyholders against the effect of adverse economic cycles.
- ~~C.~~ “Mortgage guaranty insurance” is ~~F.~~ “Domiciliary Commissioner” means the principal insurance supervisory official of the jurisdiction in which a mortgage guaranty insurance company is domiciled, ~~or that principal insurance supervisory official’s deputies or assistants, or any employee of the regulatory agency of which that principal insurance supervisory official is the head acting in that principal insurance supervisory official’s name and by that principal insurance supervisory official’s delegated authority.~~
- G. “Effective Guaranty” refers to the assumed backing of existing or future holders of securities by virtue of their issuer’s conservatorship or perceived access to credit from the U.S. Treasury, as opposed to the direct full faith and credit guarantee provided by the U.S. government.
- H. “Loss” refers to losses and loss adjustment expenses.
- I. “Master Policy” means a document issued by a mortgage guaranty insurance company that establishes the terms and conditions of mortgage guaranty insurance coverage provided thereunder, including any endorsements thereto.
- J. “Mortgage Guaranty *
- ~~(1)~~ Insurance” is insurance against financial loss by reason of nonpayment of principal, interest or other sums agreed to be paid under the terms of any ~~note or bond or other evidence of indebtedness secured by a mortgage, deed of trust, or other instrument constituting a lien or charge on real estate, provided the improvement on the real estate is a residential building or a condominium unit or buildings designed for occupancy by not more than four families;~~authorized real estate security.
- ~~(2)~~ Insurance against financial loss by reason of nonpayment of principal, interest or other sums agreed to be paid under the terms of any ~~note or bond or other evidence of indebtedness secured by a mortgage, deed of trust, or other instrument constituting a lien or charge on real estate, provided the improvement on the real estate is a building or buildings designed for occupancy by five (5) or more families or designed to be occupied for industrial or commercial purposes; and~~
- ~~(3)~~ Insurance against financial loss by reason of nonpayment of rent or other sums agreed to be paid under the terms of a written lease for the possession, use or occupancy of real estate, ~~provided the improvement on the real estate is a building or buildings designed to be occupied for industrial or commercial purposes.~~
- ~~K.~~ “Mortgage Guaranty Quality Assurance Program” means ~~an early detection warning system for potential underwriting compliance issues which could potentially impact solvency or operational risk within a mortgage guaranty insurance company.~~
- ~~L.~~ “NAIC” means the National Association of Insurance Commissioners.
- ~~M.~~ “Pool Mortgage Guaranty Insurance” means ~~mortgage guaranty insurance that provides coverage under a single transaction or a defined series of transactions on a defined portfolio of loans for losses up to an aggregate limit.~~
- ~~N.~~ “Right of Rescission” represents ~~a remedy available to a mortgage guaranty insurance company to void a certificate and restore parties to their original position, based on inaccurate, incomplete or misleading information provided to, or information omitted or concealed from, the mortgage guaranty insurance company in connection with the insurance application, resulting in an insured loan that did not meet the mortgage guaranty insurance company’s eligibility requirements in effect on the date of submission of the insurance application.~~
- ~~O.~~ “Risk in Force” means ~~the mortgage guaranty insurance coverage percentage applied to the unpaid principal balance.~~

Section 3. Insurer’s Authority to Transact Business

MO-630-3

Mortgage Guaranty Insurance Model Act

A company may not transact the business of mortgage guaranty insurance until it has obtained a certificate of authority from the commissioner.

Section 4. Mortgage Guaranty Insurance as Monoline

A mortgage guaranty insurance company that anywhere transacts any class of insurance other than mortgage guaranty insurance is not eligible for the issuance of a certificate of authority to transact mortgage guaranty insurance in this state nor for the renewal thereof.

Section 5. Risk Concentration

A mortgage guaranty insurance company shall not expose itself to any loss on any one authorized real estate security risk in an amount exceeding ten percent (10%) of its surplus to policyholders. Any risk or portion of risk which has been reinsured shall be deducted in determining the limitation of risk.

Section 6. Capital and Surplus

- A. Initial and Minimum Capital and Surplus Requirements. A mortgage guaranty insurance company shall not transact the business of mortgage guaranty insurance unless, if a stock insurance company, it has paid-in capital of at least ~~\$410,000,000~~ and paid-in surplus of at least ~~\$415,000,000~~, or if a mutual insurance company, a minimum initial surplus of ~~\$225,000,000~~. A stock insurance company or a mutual insurance company shall at all times thereafter maintain a minimum policyholders' surplus of at least ~~\$1,500,000,000~~.

~~**Section 4. Insurer's Authority to Transact Business**~~

~~No mortgage guaranty insurance company may issue policies until it has obtained from the commissioner of insurance a certificate setting forth that fact and authorizing it to issue policies.~~

- B. Section 5. Minimum Capital Requirements Applicability. A mortgage guaranty insurance company formed prior to the passage of this Act may maintain the amount of capital and surplus or minimum policyholders' surplus previously required by statute or administrative order for a period not to exceed twelve months following the effective date of the adoption of this Act.
- C. Minimum Capital Requirements Adjustments. The domiciliary commissioner may by order reduce the minimum amount of capital and surplus or minimum policyholders' surplus required under Section 6A under the following circumstances:
- (1) For an affiliated reinsurer that is a mortgage guaranty insurance company and that is or will be engaged solely in the assumption of risks from affiliated mortgage guaranty insurance companies, provided that the affiliated reinsurer is in run-off and, in the domiciliary commissioner's opinion, the business plan and other relevant circumstances of the affiliated reinsurer justify the proposed reduction in requirements.
 - (2) For mortgage guaranty insurance companies that are in run-off and not writing new business that is justified in a business plan, in the domiciliary commissioner's opinion.

Section 7. Geographic Concentration

- A. A mortgage guaranty insurance company shall not insure loans secured by a single risk in excess of ten percent (10%) of the company's aggregate capital, surplus and contingency reserve.
- B. No mortgage guaranty insurance company shall have more than twenty percent (20%) of its total insurance in force in any one Standard Metropolitan Statistical Area (SMSA), as defined by the ~~United States~~ U.S. Department of Commerce.
- C. The provisions of this section shall not apply to a mortgage guaranty insurance company until it has possessed a certificate of authority in this state for three (3) years.

MO-630-4

NAIC Model Laws, Regulations, Guidelines and Other Resources—July 2000/2023

Section 68. Advertising

No mortgage guaranty insurance company or an agent or representative of a mortgage guaranty insurance company shall prepare or distribute or assist in preparing or distributing any ~~brochure, pamphlet, report or any form of~~ advertising media or communication to the effect that the real estate investments of any financial institution are “insured investments,” unless the ~~brochure, pamphlet, report or~~ advertising media or communication clearly states that the loans are insured by mortgage guaranty insurance companies possessing a certificate of authority to transact mortgage guaranty insurance in this state or are insured by an agency of the federal government, ~~as the case may be.~~

Section 79. Investment Limitation

~~A mortgage guaranty insurance company shall not invest~~ Investments in notes or other evidences of indebtedness secured by a mortgage or other liens upon residential real property shall not be allowed as assets in any determination of the financial condition of a mortgage guaranty insurer. This section shall not apply to obligations secured by real property, or contracts for the sale of real property, which obligations or contracts of sale are acquired in the course of ~~the~~ good faith settlement of claims under policies of insurance issued by the mortgage guaranty insurance company, or in the good faith disposition of real property so acquired. ~~This section shall not apply to investments backed by the full faith and credit of the U.S. Government or investments with the effective guaranty of the U.S. Government. This section shall not apply to investments held by a mortgage guaranty insurance company prior to the passage of this Act.~~

Section 8. ~~Coverage Limitation~~ 10. Reserve Requirements

~~A. Unearned premium Reserves, Loss Reserves, and Premium Deficiency Reserves. Financial reporting will be prepared in accordance with the Accounting Practices and Procedures Manual and Annual Financial Statement Instructions of the NAIC.~~

~~B. Contingency Reserve. Each mortgage guaranty insurance company shall establish a contingency reserve subject to the following provisions:~~

~~(1) The mortgage guaranty insurance company shall make an annual contribution to the contingency reserve which in the aggregate shall be equal to fifty percent (50%) of the direct earned premiums reported in the annual statement or net earned premiums reported if the reinsurer maintains the contingency reserve.~~

~~(2) Except as provided within this Act, a mortgage guaranty insurance company’s contributions to the contingency reserve made during each calendar year shall be maintained for a period of 120 months, to provide for reserve buildup. The portion of the contingency reserve established and maintained for more than 120 months shall be released and shall no longer constitute part of the contingency reserve.~~

~~(3) Withdrawals may be made from the contingency reserve on a first-in, first-out basis or such other basis, with the prior written approval of the domiciliary commissioner, based on the amount by which:~~

~~(a) Incurred losses and loss adjustment expenses exceed 35% of the direct earned premium in any year. Provisional withdrawals may be made from the contingency reserve on a quarterly basis in an amount not to exceed 75% of the withdrawal as adjusted for the quarterly nature of the withdrawal; or~~

~~(b) Upon the approval of the domiciliary commissioner and 30-day prior notification to non-domiciliary commissioners, a mortgage guaranty insurer may withdraw from the contingency reserve any amounts which are in excess of the requirements of Section 15 as required in [insert section of the mortgage guaranty Insurance model law requiring minimum policyholder’s position] as filed with the most recently filed annual statement.~~

~~(i) The mortgage guaranty insurance company’s domiciliary commissioner may consider loss developments and trends in reviewing a request for withdrawal. If any portion of the contingency reserve for which withdrawal is requested is maintained by a reinsurer or in a~~

MO-630-5

Mortgage Guaranty Insurance Model Act

segregated account or trust of a reinsurer, the domiciliary commissioner may also consider the financial condition of the reinsurer.

C. **Miscellaneous.** Unearned premium reserves and contingency reserves on risks insured before the effective date of this Act may be computed and maintained as required previously.

Section 11. Reinsurance

- A. **Prohibition of Captive Reinsurance.** A mortgage guaranty insurance company shall not enter into captive reinsurance arrangements which involve the direct or indirect ceding of any portion of its insurance risks or obligations to a reinsurer owned or controlled by an insured; any subsidiary or affiliate of an insured; an officer, director or employee of an insured or any member of their immediate family; a corporation, partnership, trust, trade association in which an insured is a member, or other entity owned or controlled by an insured or an insured's officer, director or employee or any member of their immediate family that has a financial interest; or any designee, trustee, nominee or other agent or representative of any of the foregoing.
- B. **Reinsurance Cessions.** A mortgage guaranty insurer may, by written contract, reinsure any insurance that it transacts, except that no mortgage guaranty insurer may enter into reinsurance arrangements designed to circumvent the compensating control provisions of Section 17 or the contingency reserve requirement of Section 10. The unearned premium reserve and the loss reserves required by Section 10 shall be established and maintained by the direct insurer or by the assuming reinsurer so that the aggregate reserves shall be equal to or greater than the reserves required by direct writer. The cession shall be accounted for as provided in the accounting practices and procedures prescribed or permitted by the applicable Accounting Practices and Procedures Manual of the NAIC.

Section 12. Sound Underwriting Practices

- A. **Underwriting Review and Approval Required.** All certificates of mortgage guaranty insurance, excluding policies of reinsurance, shall be written based on an assessment of evidence that prudent underwriting standards have been met by the originator of the mortgage. Delegated underwriting decisions shall be reviewed based on a reasonable method of sampling of post-closing loan documentation to ensure compliance with the mortgage guaranty insurance company's underwriting standards.
- B. **Quality Control Reviews.** Quality control reviews for bulk mortgage guaranty insurance and pool mortgage guaranty insurance shall be based on a reasonable method of sampling of post-closing loan documentation for delegated underwriting decisions to ensure compliance with the representations and warranties of the creditors or creditors originating the loans and with the mortgage guaranty insurance company's underwriting standards.
- C. **Minimum Underwriting Standards.** Mortgage guaranty insurance companies shall establish formal underwriting standards which set forth the basis for concluding that prudent underwriting standards have been met.
- D. **Underwriting Review and Approval.** A mortgage guaranty insurance company's underwriting standards shall be:
- (1) A mortgage guaranty insurance company shall limit its coverage net of reinsurance ceded to a reinsurer in which the company has no interest to a maximum of twenty five percent (25%) of the entire indebtedness to the insured or in lieu thereof, a mortgage guaranty insurance company may elect to pay the entire indebtedness to the insured and acquire title to the authorized real estate security.

Section 9. Reviewed and approved by executive management, including, but not limited to the highest-ranking executive officer and financial officer; and

(2) Communicated across the organization to promote consistent business practices with respect to underwriting.

- E. **Notification of Changes in Underwriting Standards.** On or before March 1 of each year, a mortgage guaranty insurance company shall file with the domiciliary commissioner changes to its underwriting

MO-630-6

NAIC Model Laws, Regulations, Guidelines and Other Resources—July 2000/2023

standards and an analysis of the changes implemented during the course of the immediately preceding year. The annual summary of material underwriting standards changes should include any change associated with loan to value ratios, debt to income ratios, borrower credit standing or maximum loan amount which has resulted in a material impact on net premium written of +/- 5% from prior year to date.

Nondiscrimination. In extending or issuing mortgage guaranty insurance, a mortgage guaranty insurance company

- ~~A. A mortgage guaranty insurance company that anywhere transacts any class of insurance other than mortgage guaranty insurance is not eligible for the issuance of a certificate of authority to transact mortgage guaranty insurance in this state nor for the renewal thereof.~~
- ~~B. A mortgage guaranty insurance that anywhere transacts the classes of insurance defined in Section 2A(2) or 2A(3) is not eligible for a certificate of authority to transact in this state the class of mortgage guaranty insurance defined in Section 2A(1). However, a mortgage guarantee insurance company that transacts a class of insurance defined in Section 2A may write up to five percent (5%) of its insurance in force on residential property designed for occupancy by five (5) or more families.~~

~~**Section 10. Underwriting Discrimination**~~

- ~~A. Nothing in this chapter shall be construed as limiting the right of a mortgage guaranty insurance company to impose reasonable requirements upon the lender with regard to the terms of a note or bond or other evidence of indebtedness secured by a mortgage or deed of trust, such as requiring a stipulated down payment by the borrower may not =~~
- ~~F. ~~B.~~ No mortgage guaranty insurance company may discriminate in the issuance or extension of mortgage guaranty insurance on the on the basis of the applicant's sex, marital status, race, color, creed ~~or national origin, national origin, disability, or age~~ or solely on the basis of the geographic location of the property to be insured unless the discrimination related to geographic location is for a business purpose that is not a mere pretext for unfair discrimination; or the refusal, cancellation, or limitation of the insurance is required by law or regulatory mandate.~~
- ~~C. No policy **Drafting Note:** States and jurisdictions should consult their constitution or comparable governance documents and applicable civil rights legislation to determine if broader protections against unacceptable forms of discrimination should be included in Section 12F.~~

~~**Section 13. mortgage guaranty insurance Quality Assurance**~~

- ~~A. **Quality Assurance Program.** A mortgage guaranty insurance company shall establish a formal internal mortgage guaranty quality assurance program, which provides an early detection warning system as it relates to potential underwriting compliance issues which could potentially impact solvency or operational risk. This mortgage guaranty quality assurance program shall provide for the documentation, monitoring, evaluation and reporting on the integrity of the ongoing loan origination process based on indicators of potential underwriting inadequacies or non-compliance. This shall include, but not limited to:~~
- ~~(1) **Segregation of Duties.** Administration of the quality assurance program shall be delegated to designated risk management, quality assurance or internal audit personnel, who are technically trained and independent from underwriting activities that they audit.~~
 - ~~(2) **Senior Management Oversight.** Quality assurance personnel shall provide periodic quality assurance reports to an enterprise risk management committee or other equivalent senior management level oversight body.~~
 - ~~(3) **Board of Director Oversight.** Quality assurance personnel shall provide periodic quality assurance reports to the board of directors or a designated committee of directors established to facilitate board of director oversight.~~
 - ~~(4) **Policy and Procedures Documentation.** Mortgage guaranty quality assurance program, excluding policies and procedures of reinsurance, shall be formally established and documented to define scope, roles and responsibilities.~~

MO-630-7

Mortgage Guaranty Insurance Model Act

- (5) **Underwriting Risk Review.** Quality assurance review shall include an examination of underwriting risks including classification of risk and compliance with risk tolerance levels.
- (6) **Lender Performance Reviews.** Quality assurance monitoring provisions shall include an assessment of lender performance.
- (7) **Underwriting Performance Reviews.** Quality assurance monitoring provisions shall assess compliance with underwriting standard.
- (8) **Problem Loan Trend Reviews.** Quality assurance monitoring provisions shall assess prospective risks associated with timely loan payment including delinquency, default inventory, foreclosure and persistency trends.
- (9) **Underwriting System Change Oversight.** Underwriting system program changes shall be monitored to ensure the integrity of underwriting and pricing programs, which impact automated underwriting system decision making.
- (10) **Pricing and Performance Oversight.** Pricing controls shall be monitored to ensure that business segment pricing supports applicable performance goals.
- (11) **Internal Audit Validation.** Periodic internal audits shall be conducted to validate compliance with the mortgage guaranty quality assurance program.

- B. **Regulator Access and Review of Quality Assurance Program.** The commissioner shall be provided access to an insurer's mortgage guaranty quality assurance program for review at any reasonable and thorough examination of the evidence supporting credit worthiness of the borrower and the appraisal report reflecting market evaluation of the property and has determined that prudent underwriting standards have been met time upon request and during any financial regulatory examination. Nothing herein shall be construed to limit a regulator's right to access any and all of the records of an insurer in an examination or as otherwise necessary to meet regulatory responsibilities.

Section 1414. Policy Forms and Premium Rates Filed

- A. **Policy Forms.** All policy forms and endorsements, and modifications (excluding bulk mortgage guaranty insurance and pool mortgage guaranty insurance) shall be filed with and be subject to the approval of the commissioner. With respect to owner-occupied, single-family dwellings, the mortgage guaranty insurance policy shall provide that a mixed-use building described in Section 2A(1)(b), which is owner-occupied at the time of loan origination and for at least 50% of the days within the twelve (12) consecutive months prior to borrower default, the borrower shall not be liable to the insurance company for any deficiency arising from a foreclosure sale.
- B. **Premium Rates.** Each mortgage guaranty insurance company (excluding bulk mortgage guaranty insurance and pool mortgage guaranty insurance) shall file with the department commissioner the rate to be charged and the premium including all modifications of rates and premiums to be paid by the policyholder.
- C. **Premium Charges.** Every mortgage guaranty insurance company shall adopt, print and make available a schedule of insureds the premium charges for mortgage guaranty insurance policies. Premium charges made in conformity via a company website or an integration with the provisions of this Act shall not be deemed to be interest or other charges under any other provision of law limiting interest or other charges in connection with mortgage loans, a third-party system. The schedule premium rate provided shall show the entire amount of premium charge for each type of mortgage guaranty insurance policy to be issued by the

MO-630-8

NAIC Model Laws, Regulations, Guidelines and Other Resources—July 2000~~2023~~

insurance company.

Drafting Note: Open rating states may delete a portion or all of ~~this provision~~Section 14 and insert their own rating law.

Section 12. ~~Outstanding Total Liability~~15. Risk in Force and Waivers

- ~~A. A mortgage guaranty insurance~~**Risk in Force.** A mortgage guaranty insurance company shall not at any time have outstanding ~~a total liability~~**risk in force**, net of reinsurance, under its aggregate mortgage guaranty insurance policies exceeding twenty-five (25) times its capital, surplus and contingency reserve. In the event that any mortgage guaranty insurance company has outstanding total ~~liability~~**risk in force** exceeding twenty-five (25) times its capital, surplus and contingency reserve, it shall cease transacting new mortgage guaranty business until such time as its total ~~liability~~**risk in force** no longer exceeds twenty-five (25) times its capital, surplus and contingency reserve. Total ~~outstanding liability~~**risk in force** shall be calculated on a ~~consolidated an individual entity~~ basis ~~for all mortgage guarantee insurance companies.~~
- ~~B. Waiver.~~ The commissioner may waive the requirement found in Section 15A at the written request of a mortgage guaranty insurer upon a finding that ~~are part of a holding company system~~**the mortgage guaranty insurer's policyholders position is reasonable in relationship to the mortgage guaranty insurer's aggregate insured risk in force and adequate to its financial needs. The request must be made in writing at least 90 days in advance of the date that the mortgage guaranty insurer expects to exceed the requirement of Section 15A and shall, at a minimum, address the factors specified in Section 15C.**
- ~~C. Waiver Criteria.~~ In determining whether a mortgage guaranty insurer's policyholders position is reasonable in relation to the mortgage guaranty insurer's aggregate insured risk in force and adequate to its financial needs, ~~all of the following factors, among others, may be considered:~~
- ~~(1) The size of the mortgage guaranty insurer as measured by its assets, capital and surplus, reserves, premium writings, insurance in force, and other appropriate criteria.~~
 - ~~(2) The extent to which the mortgage guaranty insurer's business is diversified across time, geography, credit quality, origination, and distribution channels.~~
 - ~~(3) The nature and extent of the mortgage guaranty insurer's reinsurance program.~~
The quality, diversification, and liquidity of the
 - ~~(4) mortgage guaranty insurer's assets and its investment portfolio.~~
 - ~~(5) The historical and forecasted trend in the size of the mortgage guaranty insurer's policyholders position.~~
 - ~~(6) The policyholders position maintained by other comparable mortgage guaranty insurers in relation to the nature of their respective insured risks.~~
 - ~~(7) The adequacy of the mortgage guaranty insurer's reserves.~~
 - ~~(8) The quality and liquidity of investments in affiliates. The commissioner may treat any such investment as a nonadmitted asset for purposes of determining the adequacy of surplus as regards policyholders.~~
 - ~~(9) The quality of the mortgage guaranty insurer's earnings and the extent to which the reported earnings of the mortgage guaranty insurer include extraordinary items.~~
 - ~~(10) An independent actuary's opinion as to the reasonableness and adequacy of the mortgage guaranty insurer's historical and projected policyholders position.~~
 - ~~(11) The capital contributions which have been infused or are available for future infusion into the mortgage guaranty insurer.~~

MO-630-9

Mortgage Guaranty Insurance Model Act

(12) The historical and projected trends in the components of the mortgage guaranty insurer's aggregate insured risk, including, but not limited to, the quality and type of the risks included in the aggregate insured risk.

D. **Authority to Retain Experts.** The commissioner may retain accountants, actuaries, or other experts to assist in the review of the mortgage guaranty insurer's request submitted pursuant to Section 15B. The mortgage guaranty insurer shall bear the commissioner's cost of retaining those persons.

E. **Specified Duration.** Any waiver shall be:

(1) For a specified period of time not to exceed two years; and

(2) Subject to any terms and conditions that the commissioner shall deem best suited to restoring the mortgage guaranty insurer's minimum policyholders position required by Section 15A.

Section 16. Conflict of Interest

A mortgage guaranty insurer may underwrite mortgage guaranty insurance on mortgages originated by the holding company system or affiliate or on mortgages originated by any mortgage lender to which credit is extended, directly or indirectly by the holding company system or affiliate only if the insurance is underwritten on the same basis, for the same consideration and subject to the same insurability requirements as insurance provided to nonaffiliated lenders. Mortgage guaranty insurance underwritten on mortgages originated by the holding company system or affiliate or on mortgages originated by any mortgage lender to which credit is extended, directly or indirectly by the holding company system or affiliate shall be limited to 50% of the insurer's direct premium written in any calendar year, or such higher percentage established in writing for the insurer in the domiciliary commissioner's discretion, based on the domiciliary commissioner's determination that a higher percentage is not likely to adversely affect the financial condition of the insurer.

Section 17. Compensating Balances Prohibited

Except for commercial checking accounts and normal deposits in support of an active bank line of credit, a mortgage guaranty insurance company, holding company or any affiliate thereof is prohibited from maintaining funds on deposit with the lender for which the mortgage guaranty insurance company has insured loans. Any deposit account bearing interest at rates less than what is currently being paid other depositors on similar deposits or any deposit in excess of amounts insured by an agency of the federal government shall be presumed to be an account in violation of this section. Furthermore, a mortgage guaranty insurance company shall not use compensating balances, special deposit accounts or engage in any practice that unduly delays its receipt of monies due or that involves the use of its financial resources for the benefit of any owner, mortgagee of the real property or any interest therein or any person who is acting as agent, representative, attorney or employee of the owner, purchaser or mortgagee as a means of circumventing any part of this section.

Section 18. Limitations on Rebates, Commissions, Charges and Contractual Preferences

A. **insuraneInducements.** A mortgage guaranty insurance company shall not pay or cause to be paid either directly or indirectly, to any owner, purchaser, lessor, lessee, mortgagee or prospective mortgagee of the real property that secures the authorized real estate security or that is the fee of an insured lease, or any interest therein, or to any person who is acting as an agent, representative, attorney or employee of such owner, purchaser, lessor, lessee or mortgagee, any commission, or any part of its premium charges or any other consideration as an inducement for or as compensation on any mortgage guaranty insurance business.

B. **Compensation for Placement.** In connection with the placement of any mortgage guaranty insurance, a mortgage guaranty insurance company shall not cause or permit the conveyance of anything of value, including but not limited to any commission, fee, premium adjustment, remuneration or other form of compensation of any kind whatsoever to be paid to, or received by an insured lender or lessor; any subsidiary or affiliate of an insured; an officer, director or employee of an insured or any member of their immediate family; a corporation, partnership, trust, trade association in which an insured is a member, or other entity in which an insured or an officer, director or employee or any member of their immediate family has a financial interest; or any designee, trustee, nominee or other agent or representative of any of the foregoing, except for

MO-630-10

NAIC Model Laws, Regulations, Guidelines and Other Resources—July 2000/2023

the value of the insurance itself or claim payments thereon as provided by contract or settlement.

~~C. C. No mortgage guaranty insurance~~**Rebates.** A mortgage guaranty insurance company shall not make a rebate of any portion of the premium charge, as shown by the schedule required by Section ~~14C. No mortgage guaranty insurance~~**14C.** No mortgage guaranty insurance company shall not quote any rate or premium charge to a person that is different than that currently available to others for the same type of coverage. The amount by which a premium charge is less than that called for by the current schedule of premium charges is an unlawful rebate.

D. Undue Contractual Preferences.

(1) Any contract, letter agreement, or other arrangement used to clarify any terms, conditions, or interpretations of a master policy or certificate shall be documented in writing.

(2) Any contractual or letter agreements used to modify or clarify general business practices and administrative, underwriting, claim submission or other information exchange processes shall not contain provisions which override or significantly undermine the intent of key provisions of the mortgage guaranty insurance model act, including mortgage insurer discretion, rights and responsibilities related to:

(a) Underwriting standards.

(b) Quality assurance.

(c) Rescission.

E. Sanctions. The commissioner may, after notice and hearing, suspend or revoke the certificate of authority of a mortgage guaranty insurance company, or in his or her discretion, issue a cease and desist order to a mortgage guaranty insurance company that pays a commission, rebate, or makes any unlawful ~~rebate~~conveyance of value under this section in willful violation of the provisions of this Act. In the event of the issuance of a cease and desist order, the commissioner may, after notice and hearing, suspend or revoke the certificate of authority of a mortgage guaranty insurance company that does not comply with the terms thereof.

Section 14. Compensating Balances Prohibited

~~F. Except for commercial checking accounts and normal deposits in support of an active bank line of credit, a mortgage guaranty insurance company, holding company or any affiliate thereof is prohibited from maintaining funds on deposit with the lender for which the mortgage guaranty insurance company has insured loans. Any deposit account bearing interest at rates less than what is currently being paid other depositors on similar deposits or any deposit in excess of amounts insured by an agency of the federal government shall be presumed to be an account in violation of this section.~~**Educational Efforts and Promotional Materials Permitted.** A mortgage guaranty insurance company may engage in any educational effort with borrowers, members of the general public, and officers, directors, employees, contractors and agents of insured lenders that may reasonably be expected to reduce its risk of Loss or promote its operational efficiency and may distribute promotional materials of minor value.

Section 19. Rescission

All mortgage guaranty insurance company master policies shall include a detailed description of provisions governing rescissions, re-pricing, and cancellations, which specify the insurer's and insured's rights, obligations and eligibility terms under which those actions may occur to ensure transparency.

Section 20. Records Retention

A. Record Files. A licensed mortgage guaranty insurance company shall maintain its records in a manner which allows the commissioner to readily ascertain the insurer's compliance with state insurance laws and rules during an examination including, but not limited to, records regarding the insurer's management, operations, policy issuance and servicing, marketing, underwriting, rating and claims practices.

MO-630-11

Mortgage Guaranty Insurance Model Act

~~B. Furthermore, a mortgage guaranty insurance company shall not use compensating balances, special deposit accounts or engage in any practice that unduly delays its receipt of monies due or that involves the use of its financial resources for the benefit of any owner, mortgagee of the real property or any interest therein or any person who is acting as agent, representative, attorney or employee of the owner, purchaser or mortgagee as a means of circumventing any part of this section.~~

~~Section 15. — Retention Period. Policy and claim records shall be retained for the period during which the certificate or claim is active plus five (5) years, unless otherwise specified by the insurance commissioner. Recordkeeping requirements shall relate to:~~

~~(1) Records to clearly document the application, underwriting, and issuance of each master policy and certificate of insurance; and~~

~~(2) Claim records to clearly document the inception, handling, and disposition.~~

~~C. Record Format. Any record required to be maintained by a mortgage insurer may be created and stored in the form of paper, photograph, magnetic, mechanical or electronic medium.~~

~~D. Record Maintenance. Record maintenance under this Act shall comply with the following requirements:~~

~~(1) Insurer maintenance responsibilities shall provide for record storage in a location that will allow the records to be reasonably produced for examination within the time period required.~~

~~(2) Third-Party maintenance related responsibilities shall be set forth in a written agreement, a copy of which shall be maintained by the insurer and available for purposes of examination.~~

Conflict of Interest

~~A. — If a member of a holding company system, a mortgage guaranty insurance company licensed to transact business in this state shall not, as a condition of its certificate of authority, knowingly underwrite mortgage guaranty insurance on mortgages originated by the holding company system or an affiliate or on mortgages originated by any mortgage lender to which credit is extended, directly or indirectly, by the holding company system or an affiliate.~~

~~A. — B. — A mortgage guaranty insurance company, the holding company system of which it is a part, or any affiliate shall not as a condition of the mortgage guaranty insurance company's certificate of authority, pay any commissions, remuneration, rebates or engage in activities proscribed in Sections 13 and 14.~~

Section 16. — Reserves~~A. — Unearned Premium Reserves~~

~~A mortgage guaranty insurance company shall compute and maintain an unearned premium reserve as set forth by regulation adopted by the commissioner of insurance.~~

~~B. — Loss Reserve~~

~~A mortgage guaranty insurance company shall compute and maintain adequate case basis and other loss reserves that accurately reflect loss frequency and loss severity and shall include components for claims reported and for claims incurred but not reported, including estimated losses on:~~

~~(1) Insured loans that have resulted in the conveyance of property that remains unsold;~~

~~(2) Insured loans in the process of foreclosure;~~

~~(3) Insured loans in default for four (4) months or for any lesser period that is defined as default for such purposes in the policy provisions; and~~

~~(4) Insured leases in default for four (4) months or for any lesser period that is defined as default for such purposes in policy provisions.~~

~~C. — Contingency Reserve~~

MO-630-12

NAIC Model Laws, Regulations, Guidelines and Other Resources—July 2000~~2023~~

~~Each mortgage guaranty insurance company shall establish a contingency reserve out of net premium remaining (gross premiums less premiums returned to policyholders net of reinsurance) after establishment of the unearned premium reserve. The mortgage guaranty insurance company shall contribute to the contingency reserve an amount equal to fifty percent (50%) of the remaining unearned premiums. Contributions to the contingency reserve made during each calendar year shall be maintained for a period of 120 months, except that withdrawals may be made by the company in any year in which the actual incurred losses exceed thirty-five percent (35%) of the corresponding earned premiums, and no releases shall be made without prior approval by the commissioner of insurance of the insurance company's state of domicile.~~

~~If the coverage provided in this Act exceeds the limitations set forth herein, the commissioner of insurance shall establish a rate formula factor that will produce a contingency reserve adequate for the added risk assumed. The face amount of an insured mortgage shall be computed before any reduction by the mortgage guaranty insurance company's election to limit its coverage to a portion of the entire indebtedness.~~

~~D. Reinsurance~~

~~Whenever a mortgage guaranty insurance company obtains reinsurance from an insurance company that is properly licensed to provide reinsurance or from an appropriate governmental agency, the mortgage guaranty insurer and the reinsurer shall establish and maintain the reserves required in this Act in appropriate proportions in relation to the risk retained by the original insurer and ceded to the assuming reinsurer so that the total reserves established shall not be less than the reserves required by this Act.~~

~~E. Miscellaneous~~

- ~~(1) Whenever the laws of any other jurisdiction in which a mortgage guaranty insurance company subject to the requirement of this Act is also licensed to transact mortgage guaranty insurance require a larger unearned premium reserve or contingency reserve in the aggregate than that set forth herein, the establishment of the larger unearned premium reserve or contingency reserve in the aggregate shall be deemed to be in compliance with this Act.~~
- ~~(2) Unearned premium reserves and contingency reserves shall be computed and maintained on risks insured after the effective date of this Act as required by Subsections A and C. Unearned premium reserves and contingency reserves on risks insured before the effective date of this Act may be computed and maintained as required previously.~~

Section 1721. Regulations

The commissioner shall have the authority to promulgate rules and regulations deemed necessary to effectively implement the requirements of this Act.

Chronological Summary of Actions (all references are to the Proceedings of the NAIC).

1976 Proc. II 15, 17, 647, 686, 747-753 (adopted).

1979 Proc. I 44, 47-48, 49, 719, 968-969 (corrected).

Draft: 8/8/23

Group Capital Calculation (E) Working Group
Virtual Meeting
July 27, 2023

The Group Capital Calculation (E) Working Group of the Financial Condition (E) Committee met July 27, 2023. The following Working Group members participated: John Rehagen, Chair (MO); Susan Berry, Vice Chair (IL); William Arfanis (CT); Philip Barlow (DC); Ray Spudeck (FL); Kevin Clark (IA); Roy Eft (IN); John Turchi and Christopher Joyce (MA); Judy Weaver (MI); Ben Slutsker (MN); Lindsay Crawford and Anthony Quandt (NE); David Wolf (NJ); Dale Bruggeman (OH); Diana Sherman (PA); Trey Hancock (TN); Mike Arendall (TX); and Connie Duong (VA). Also participating was: Kim Hudson (CA).

1. Discussed the Comment Letter Received from the ACLI

Jennifer McAdam (American Council of Life Insurers—ACLI) presented the ACLI's comment letter regarding the group capital calculation (GCC) scalar methodology proposal. She said the ACLI fully supports this proposal, and it believes excess relative risk (ERR) scalars are the most appropriate methodology for the GCC, specifically because ERR scalars recognize differences in reserve methodologies across jurisdictions. They can also adjust to significant changes in jurisdictional solvency regimes. Many global insurers are already using the ERR methodology to allocate group capital. In adopting ERR scalars, the ACLI wants to be sure to design methodological solutions to limit volatility in GCC results and have resources available for maintaining and updating ERR scalar calculations going forward. Therefore, the ACLI and several of its members have agreed to engage a team of consultants to help the NAIC address these issues for selected life and health scalars. The project aims to be completed by the end of the year.

The ACLI will identify sources of data in each jurisdiction, including a list of insurers making up each industry average and solvency ratios for each insurer included in the average and the first point of regulatory intervention. The project will also result in a recommendation of methodological solutions to address changes to scalars over time, including the length of the historical data series needed to provide accurate scalar estimates with limited volatility over time and methodologies for adjusting scalars to account for significant changes in jurisdictional solvency regimes. For example, Bermuda is having a solvency regime change in 2023, and Japan is in 2025. Additionally, McAdam made another point that was not included in the ACLI's comment letter. She said ERR scalars would work for the aggregation method (AM). This is why it is so urgent that the NAIC approve the ERR scalars. The GCC is supposed to be the U.S. AM, and the AM probably needs them for the comparability assessment, which starts very soon. Because the ACLI wants the GCC to be the AM in the U.S., approving ERR scalars for the GCC will help keep the process parallel and moving forward. The ACLI has put a lot of time and effort into planning for this project, and it plans to expend significant resources to get this work accomplished, which will benefit its members and all U.S. insurers.

Martin Mair (MetLife), chair of the ACLI's GCC Working Group, presented a side-by-side suitability comparison of the ACLI's and UnitedHealth Group's (UHG's) proposals for scalars. There are seven points.

The first point is the breadth of the industry support behind these two alternative proposals. The ACLI's proposal is supported by a broad group of life insurance companies, as well as the life trade ACLI, while the UHG's proposal is supported by a single company. While both scalar methodologies were proposed as early as 2017, there has been considerable development over time in the ERR scalars as opposed to the UHG's scalars.

The second point is that between 2020 and 2021, the American Academy of Actuaries (Academy) did an exhaustive vetting of the major scalar types that were around at the time to debate whether they were legitimate and what the pros and cons of each approach were. The ERR scalars were included as one of the scalar methodologies vetted by the Academy. The UHG's relative total asset requirement (TAR) approach was not vetted by the Academy; therefore, it bypassed that review from the Academy.

The third point is that the relative TAR scalars have not been calculated in the GCC field testing, which would not have a history leading up to the adoption if the NAIC were to adopt this approach. In contrast, the ERR scalars have been included in the GCC field testing, and the companies have been generating those results for quite some time, and they have a relatively long history of what those calculations look like.

The fourth point is that the relative TAR methodology requires additional collection of reserve data by each jurisdiction, which can be quite onerous to do. The ACLI does not have that type of additional reporting requirement.

The fifth point is that the NAIC would need some support in terms of how to collect the data to make a transition from a placeholder scalar to a more sophisticated scalar. This is why the ACLI has arranged for a team of consultants to help with this transition, which includes Oliver Wyman, the company that did the original consulting work back in 2015. The UHG's proposal has no such support for the transition.

The sixth point is that the UHG's proposal prefers to maintain the placeholder scalars, to which there are two major drawbacks. It is almost universally known that it is wrong to convert overseas capital to a risk-based capital (RBC) equivalent on a one-for-one basis from a theoretical perspective. So, the first major drawback is that it is an inaccurate calculation to begin with. The other major drawback is that the proposal does not have a mechanism for adjusting for a jurisdictional regime change. At the end of the year, Bermuda is enacting a significant change in its solvency regime. A placeholder scalar will not adjust for it. So, volatility will be seen in the GCC figures based on changing ratios in Bermuda. At the end of 2025, Japan is going to be implementing a major regime change, moving from its current solvency margin ratio (SMR) basis to the insurance capital standard (ICS) solvency II basis. Mair said a very significant change in Japan's solvency ratios is expected to be seen. They are expected to change from 700% to 800% on average and eventually to around 300% post-2025, which is a major downward shift in ratios. A major drop in the GCC ratios will be seen using placeholder scalars for those companies that have operations in Japan. The ACLI's proposal for switching to the ERR adjusts for these changes, whereas the UHG's proposal does not. This is one of the selling points for getting funding from six companies in addition to the ACLI, particularly given the Bermuda change, which is happening at the end of the year. If the transition cannot be done by then, Mair is not sure whether that funding is going to be available in a future year to make it happen. So, it is now or never to make this scalar change.

The seventh point is that the ACLI's proposal of ERR scalars appropriately reflects the first point of regulatory intervention. The ERR scalars reflect the action of a prudent insurance company in multiple jurisdictions. A prudent insurer does not want to get to a point where they must submit a capital plan to a state insurance regulator and signal to the marketplace on the potential difficulty. ERR scalars use the first point of regulatory intervention as one of its primary benchmarks. Prudent insurers should try to stay out of that territory. The ERR scalars do not reflect the regulatory takeover but rather the first point of regulatory intervention. Therefore, the ACLI believes it aligns with what a prudent insurer would do in each major jurisdiction. Altogether, there are seven excellent reasons the ACLI believes its proposal is superior to the UHG's proposal.

In addition, Mariana Gomez-Vock (ACLI) provided some background. The ACLI has been highly engaged in every GCC exposure from 2017 to the present. It can attest that the process has robust stakeholder participation and opportunities to comment, particularly in 2020, when state insurance regulators met once a week to finalize the

GCC instructions, including the scalar methodology. There were at least 10 meetings of the ACLI's GCC Working Group during which scalar methodology was discussed. The Working Group settled on two final scalar options among multiple approaches. Initially, there were the pure relative ratio approach and the ERR approach. Both were included in the Academy's study, along with two other methods that the Academy proposed. The pure relative ratio approach is very similar to the ERR. The difference is how it treats available capital. Ultimately, the state insurance regulators decided that ERR was used as a placeholder for the sensitivity test of the GCC. Gomez-Vock said the Working Group and NAIC staff have three to four years' worth of data on the ERR. Lastly, she said she has a lot of respect for the state insurance regulators' commitment and the time they spent to really evaluate and consider views from all stakeholders with respect to the process.

Clark had a follow-up question related to a comment Mair made. He asked why it is now or never to decide on a methodology change. Mair said the NAIC needs some help from the industry in terms of making the transition. The ACLI and six volunteer companies agreed to provide the funding to make the transition happen. A major incentive for the companies to provide funding is that they do not want their own GCC figures to be volatile when there is a jurisdictional regime change. One of those regime changes coming up at the end of the year is in Bermuda. Therefore, companies want to have some type of mechanism to adjust for those changes. If the scalar methodology change does not happen this year, about one-third of the companies that provide funding are primarily involved in the Bermuda regime change and might fall off the list of providing funding. He is not sure whether the ACLI will be able to pull the funding together if this is not approved for this year.

Berry expressed her concerns regarding different methodologies between property/casualty (P/C), health, and life insurance companies. Gomez-Vock responded by pointing out that the ERR works for P/C and health insurance companies. She said the only reason these two lines of insurance companies were not included in the funding plan is that they did not have as much of a vested interest in participating. Scalars tend to be a much bigger deal for life insurers, which have long-term liabilities and liquid assets.

Rehagen asked how it would work in terms of ERR scalar percentages if the relative difference for health insurers is a lot different than the relative difference for life insurers. Gomez-Vock said it is designed to make the average operating ratios relative. Therefore, it is an average operating ratio for the life insurers, an average operating ratio for P/C insurers, and an average operating ratio for the health insurers. Mair agreed with what Gomez-Vock said. He said there will be different industry averages for each segment, and they may have different regulatory intervention rates as well. Each of them is going to vary by jurisdiction, but the methodology should be consistent.

Clark asked whether no comments on the exposure from the P/C trade should be taken as an agreement with the methodology and whether there are any past discussions that shed light on the level of consensus across the trades. Gomez-Vock said the ACLI aligned relatively closely with the American Property Casualty Insurance Association (APCIA) on the group capital type of issues. Based on her recent conversations with them, the scalar is not as big of a deal to them because they have short-term liabilities and assets.

Stephen Broadie (APCIA) said the APCIA does not disagree with the methodology. When it was presented to its members, they did not have a tremendous amount of interest in it. They are not opposed to the ERR methodology.

Rey Villarreal (Genworth) made a comment and expressed concern about the application, specifically. He said Genworth is a life and mortgage insurer. The lack of scaling applied to different lines of business to calibrate continues to be a concern. Genworth has brought it up in the past, and it pointed this out in its GCC filing.

Berry asked Broadie whether the P/C industry will be concerned with the ERR methodology at a later point. Broadie said they have looked at the ERR approach, and they do not have concerns with it.

Tom Finnell (America's Health Insurance Plans—AHIP) said he is going to ask AHIP's members with significant international business whether they can support the ERR proposal or not.

Gomez-Vock said current scalars are different for different lines of insurance companies. In addition, she said people have had many opportunities to object if they had serious concerns because companies with international business have already been calculating the scalar when completing the sensitivity test of the GCC.

James Braue (UHG) made a clarification on the last two points for their relative TAR approach, which was presented by Mair in the suitability comparison. He said this approach basically takes exactly what was done for the ERR approach and adds in the reserves. Therefore, there was no intention to use a different benchmark to speak for the capital, and it only reflects the reserves directly. Therefore, the last two points for the relative TAR approach should have been shown as "Yes" instead.

2. Discussed the Comment Letter Received from the UHG

Braue presented the UHG's comment letter, and he said the only theoretical assumption that it is making is the one that is stated to underlie the ERR, which is that insurers will tend to hold the same level of conservatism across all jurisdictions. Everything the UHG is doing from here out is just arithmetic. In addition, Braue pointed out a mistake in the arithmetic of the UHG's mathematical demonstration, which was used to show that the ERR approach can produce very incorrect results under certain circumstances. The UHG believes it is its responsibility to point out that the ERR approach has this mathematical flaw in it. Braue continued to point out that there is a relatively easy methodological fix to this problem, as the ACLI noted, that would require additional information about the different jurisdictions. He said he could not comment on how easy or difficult it would be to obtain that information. Based on the information the UHG has, it cannot say anything about how large this potential error is in any given jurisdiction. It is up to the Group Capital Calculation (E) Working Group to decide how much of a concern this potential for error is.

Mair made a comment and said the ERR methodology accounts for reserve differences across jurisdictions. MetLife does not believe there is a significant error in the calculation, which was not pointed out in the Academy's study. Mair said the ERR scalars are the best option for the current time, given all the vetting and calculations that have happened. Any better option can be adopted in the future.

Kevin Mackay (MetLife) said he does not believe the UHG's example works because it does not calculate the ERR properly. Braue said a company in any jurisdiction can deviate from the average, while the premise of the ERR approach is that the average company will maintain the same level of conservatism regardless of jurisdiction.

Rehagen asked Mair about the outlier identification. Mair explained how the ERR approach works. For example, if a company's solvency ratio in a jurisdiction is significantly above the average, which is considered an outlier, when the ratio gets mapped into the GCC, it will be above the average capital that is reflected in the GCC.

3. Discussed the Scalar Methodology Proposal

Berry said she has reservations about moving forward when the Working Group has not heard from health insurers. In addition, she is curious whether any of the P/C companies with a large amount of international business have any different thoughts on this.

Joyce said he agreed with Berry's concerns, but he wondered whether it will be easily resolved by giving the P/C and health industry a short window to provide any concerns. If they do not provide any concerns by then, the Working Group can consider moving forward with the proposal. In addition, he asked whether any of the NAIC

staff have any concerns about the proposal. Ned Tyrrell (NAIC) asked whether the proposal, which was driven by life insurers, includes P/C and health insurers. Gomez-Vock said the Working Group could consider adopting it for the life industry at least and then give the health and P/C industry two additional weeks to inform the Working Group of their views. Tyrrell asked whether consultants could produce scalars for all industries or for the life industry only. Gomez-Vock said the ACLI could not bear the significantly incremental cost of producing scalars for the P/C and health industries.

Joseph B. Sieverling (Reinsurance Association of America—RAA) said there is no perfect way to estimate scalars. The ERR is the best approach based on the RAA's evaluation in 2019 and 2020.

Rehagen said he had some concerns that the procedure for updating should include all types of companies.

Weaver said she believes there was enough time for everybody to weigh in, and she was fine moving forward with the ACLI's proposal. Berry said she did not take issue with moving forward with life scalars and then developing P/C and health scalars later. She said she took issue with the possibility that there is a different methodology, which is her only concern. Clark said he had some concerns about how this might affect the scalar methodology for the AM. Barlow asked whether any information is expected to be received in the short term to help address this question. Tyrrell said the assessment is starting soon, but it is not going to be completed until late 2024.

4. Adopted the Scalar Methodology Proposal for Life Insurance Companies

Rehagen said it is important to get a methodology to maintain the scalar.

Weaver made a motion, seconded by Crawford, to move forward with the ACLI's proposal.

Bruggeman asked whether the ACLI's proposal is for all types of companies or just for life insurers. Weaver said she is willing to limit it to life insurers and then give P/C and health insurers two more weeks if this is the will of the Working Group.

Rehagen took a vote. All were in favor of adopting the ERR scalar proposal (Attachment Two-A) except for Berry. Berry was opposed to this motion because it leaves open the possibility for different methodologies. She said she would prefer to wait an additional two weeks to see if there are any methodology recommendations from the other two lines of insurance companies and then move forward altogether.

Having no further business, the Group Capital Calculation (E) Working Group adjourned.

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Draft: 6/21/23

Group Capital Calculation (E) Working Group
Virtual Meeting
June 13, 2023

The Group Capital Calculation (E) Working Group of the Group Capital Calculation (E) Working Group met June 13, 2023. The following Working Group members participated: John Rehagen, Chair (MO); Susan Berry, Vice Chair (IL); Susan Bernard and Michelle Lo (CA); John Loughran (CT); Philip Barlow (DC); Ray Spudeck (FL); Roy Eft (IN); Kevin Clark (IA); John Turchi and Christopher Joyce (MA); Judy Weaver (MI); Ben Slutsker (MN); Lindsay Crawford and Anthony Quandt (NE); David Wolf (NJ); Bob Kasinow (NY); Dale Bruggeman and Tim Biler (OH); Doug Hartz (OR); Diana Sherman (PA); Trey Hancock (TN); Amy Garcia (TX); David Smith (VA); and Amy Malm (WI).

1. Exposed the Proposed Scalar for the 2023 GCC

Rehagen announced that Susan Berry (IL) had agreed to serve as the Working Group's vice chair. He then provided background on the topic for the day. He said there were several conversations over the past year about moving forward with the scalar proposal and also discussions around making sure any scalar that is considered for adoption has a good process for updating, as well as not having the scalars move things around too much from one period to the next.

Martin Mair (MetLife), representing the American Council of Life Insurers (ACLI), presented the group capital calculation (GCC) scalar proposal for the 2023 GCC. He said that currently the GCC includes multiple scalar methodologies in the calculation and is set up with a placeholder scalar as the primary calculation, which is an unscaled approach, and all the other scalar methodologies are set up to be sensitivities within the calculation. The ACLI proposal is to adopt the excess relative ratio (ERR) approach as the primary scalar methodology, and all the other scalar methodologies will continue to be viewed as sensitivities to the primary approach. He said these scalar methodologies need to be maintained and updated as Rehagen mentioned and so always reflect current conditions without too much volatility into the system. He said different scalar approaches do not give dramatically different answers in terms of converting overseas capital ratios into a risk-based capital (RBC) ratio equivalent.

Mair pointed out some advantages of the ERR approach. The first one is that the scalar methodology best recognizes differences in required reserves across different jurisdictions. He used the Japanese solvency regime as an example, which sees a typical solvency ratio of 800% for a life insurance company compared to 400% in the U.S. He said the difference in reserving requirements accounts for most of the differences in the capital ratios across different jurisdictions. He said the Solvency II-like jurisdictions tend to have relatively low reserve requirements relative to the U.S., which is balanced by a higher required capital. As a result, solvency ratios generally end up lower. In addition, he said the second advantage is that the ERR approach preserves insurer excess capital and aligns with the prudent insurer solvency management.

Mair said this approach uses two benchmarks to establish the scalar. The first one is the average insurer solvency ratio in each jurisdiction because companies generally want to keep somewhere around the industry average to maintain competitiveness in the marketplace. The second one is the point of first regulatory intervention where there is a capital plan required of the insurer by the regulator. He said the capital level is managed to be around the industry average not only under normal circumstances, but also under a stress situation such as the great financial crisis or severe increases in the interest rates that the local operation in the jurisdiction can continue to operate without a regulatory intervention to maintain independence under stress. The ERR approach incorporates

both of these elements as benchmarks. He said this is how many insurers manage their capital, and MetLife is one of them.

Rehagen asked whether this is for life insurance only. Mair said this proposal is going to cover both life and health insurance. He said this approach should be the primary approach for all insurance companies, and the ACLI thinks this is the best approach across different lines.

Mair continued to explain why it is important to make this change now. He said the consistency in the solvency regime around the world is about to change, and there will be significant changes to the solvency regime in the next few years. Bermuda is going to make some significant changes to its solvency regime at the end of the year, which is expected to have a significant change to its ratios. Additionally, Japan is expected to adopt the insurance capital standard (ICS) at the end of 2025. The current placeholder scalars are unresponsive to these changes, which would cause significant volatilities in the GCC ratio, and this is caused by nothing other than a regulatory regime change. He said the reason to set up a responsive scalar mechanism/methodology is to get prepared for regulatory regime changes and to be able to make proper adjustments to the scalar so that the GCC ratio remains relatively stable.

In addition, Mair talked about how to support this approach and make the change robust over time. He said last time the ACLI took a deeper dive into this was in 2015 and 2016. There is a need for ongoing work both from identifying data sources for the average solvency ratio in 14 jurisdictions and what the point of first regulatory intervention is in each jurisdiction, as well as a number of outstanding methodological issues such as representative insurers and their jurisdictions. So, a consultant will work through these with the industry and the NAIC. The ACLI put out bids for this work and has identified a dream team of consultants to work on this project. One of them is Oliver Wyman, which did in-depth work back in 2015 and 2016, and it has agreed to work on this project to support the transition. The other one is Lou Felice, who was with the NAIC in 2015 and was a central figure in pulling this together with health scalars as one of his specialties. The total cost is estimated to be \$300,000 for 2023. The ACLI and six individual insurers have agreed to share the cost. It is up to the Working Group to decide whether all these are acceptable. He said if acceptable, they will start to engage the consultants and work on the project. He said they hope to have 2023 year-end data for the GCC be based on the scalar methodology.

Tom Finnell (America's Health Insurance Plans—AHIP) asked whether the proposed scalars are for life and health business combined or are separate scalars for the health business. Mair said the ACLI is thinking of separate health scalars for selected jurisdictions, and Japan is one of them.

Rehagen asked Mair whether he had any reaction to the June 1 meeting of the Federal Reserve Board's (FRB's) Insurance Policy Advisory Council (IPAC), which is a group of volunteers in the industry advising on insurance matters. During the meeting, the group provided an update to its project on scalars, which is going to be combined into a paper later this summer. Mair said the ACLI had discussions with the FRB on whether there would be any issue if the NAIC adopts the ERR approach in light of the IPAC scalar review, and the answer they received was that there is no perceived conflict between the two. IPAC's scalar review is an educational tool. Because the ICS methodology does not include anything like scalars and everything is based on a mark-to-market basis, there is no need to convert from one jurisdiction to another since they are all treated equally. The FRB did not feel that the selection of one scalar methodology over another would have any impact on the comparability assessment.

Rehagen said he is interested in seeing if there is any inconsistency between what they come up with and the NAIC approach. Mair said the answer he got was that this would neither improve the chances for comparability nor degrade the chances for favorable comparability assessments.

Rehagen asked whether any Working Group members, other insurance regulators, and interested parties have any questions. Ned Tyrrell (NAIC) asked about where the data is coming from and the scope of the data. He wondered whether there are any jurisdictions where it would be as easy to get scalars for property/casualty (P/C) insurance without too much extra effort beyond what would be needed to get the life or health scalars.


Mair said the industry and consultants would work together and make recommendations to the NAIC. He said it is up to the NAIC to be comfortable with and approve them. He said the focus of this project is to find the data and develop those methodologies for the life and selected health jurisdictions. He said he does not know the answer to Tyrrell's question. However, he speculated that it may be easier for P/C once data sources are identified for the other sectors. Tyrrell said various online databases are available for free for European P/C insurance companies and Canadian companies. Mair said Lou Felice might be able to help identify the data sources not only for life and health, but also for P/C along the way.

Quandt asked whether it would be more lenient than risk-based capital (RBC) if insurers move their risks to a jurisdiction with lighter reserve requirements to release capital. Mair said there is a rough equivalence across the major jurisdictions in terms of the overall level of conservatism in the combination of the reserves, capital requirements, and capital ratios. In the major jurisdictions, there are a lot of entities that operate across different jurisdictions, which run to relatively similar levels of conservatism overall even though their capital ratios look different. Tyrrell asked whether a similar level of conservatism would be RBC at 200% or 300%. Mair said RBC at 200%. Tyrrell asked what the equivalent for a European entity would be. Mair said it would typically be about 250% for life, which is a similar level of conservatism on a holistic basis of reserves, capital, and capital ratio.

Without further questions, the Working Group agreed to expose the GCC scalar proposal for a 30-day public comment period ending July 13.

Having no further business, the Group Capital Calculation (E) Working Group adjourned.

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ACL GCC Scalar Proposal

June 2023

ACL Proposal and Projected Support

The primary GCC calculation currently relies on placeholder scalars, which convert non-US available and required capital figures into an RBC equivalent on a 1:1 basis. Other scalar methodologies are reported on a sensitivity basis.

ACL has pointed out significant shortcomings of placeholder scalars and has proposed that Excess Relative Ratio (ERR) scalars would generate superior GCC figures for regulators and industry.

ACL has solicited consultant bids to facilitate a potential transition from placeholder scalars to ERR scalars during 2023 for the Life and Health sectors. This project has two major components:

1. Identify data sources for solvency ratios and regulatory intervention levels by jurisdiction
2. Work with NAIC to develop appropriate methodologies for generating ERR scalars over time (use of moving averages, dealing with jurisdictional solvency regime change, identifying representative insurers, etc.)

ACL and six individual insurers have agreed to fund the total \$300,000 consultant cost to engage Oliver Wyman and Lou Felice to help NAIC transition to ERR scalars during 2023.

2

Executive Summary

Replacing placeholder scalars with ERR will appropriately recognize non-U.S. business in the GCC formula

Credible approaches – Prob. of Negative Outcomes (PNO), Pure & Excess Ratio - produce directionally similar scalars

Excess Ratio approach has two critical advantages relative to other ratio-based approaches:

1. Excess Ratio best recognizes *cross-jurisdictional differences in required reserves*
2. Excess Ratio best reflects *capital management practices of prudent global insurers*

3

ERR Scalar Benefits for US Insurers

Replacing placeholder scalars with ERR scalars provides multiple benefits for US insurers:

1. Unlike placeholder scalars, ERR scalars can be designed to adjust immediately to solvency regime changes, avoiding uneconomic GCC volatility through time
2. Since ERR scalars recognize cross-jurisdictional differences in required reserves, ERR scalars produce GCC figures most accurately aligned with RBC – facilitating insurers’ most efficient allocation of capital
3. By helping select representative insurers in each jurisdiction, industry can improve the accuracy of each jurisdictional scalar
4. By providing input into scalar update methodologies, insurers can align future GCC figures with their internal forecasts
5. ERR scalars can also be leveraged for IAIS comparability purposes – to convert GCC into ICS-equivalent figures

4

Improving GCC Accuracy

Replacing the existing approach with ERR scalars will improve GCC accuracy and avoid the following potential criticisms of current placeholder:

- No justification for assuming available & required capital is equivalent globally
- Placeholder scalar penalizes insurers in the many jurisdictions with Solvency II-like regimes

Credible scalars are **directionally consistent** converting overseas capital to RBC

- Japan SMR is discounted heavily when converted to RBC equivalent
- Conversely, Solvency II-like ratios are increased upon conversion to RBC

Different scalar approaches use similar underlying data (regulatory intervention points, industry average ratios) across risk-sensitive jurisdictions, resulting in roughly similar scalar estimates

5

Unique Advantages of Excess Ratio Approach

Excess Ratio methodology best recognizes differences in required reserves across jurisdictions

- JGAAP reserves are very stringent, balanced by lower required capital
- Jurisdictions with Solvency II-like regimes often have relatively low reserve requirements, balanced by higher required capital

Excess Ratio preserves insurers' excess capital and aligns with prudent insurers' solvency management:

- Ongoing Competitiveness:** Manage local solvency ratio within range of industry average to ensure ability to sell new products
- Independence Under Stress:** Manage local solvency to remain independent of regulatory intervention during the inevitable periods of market stress

6

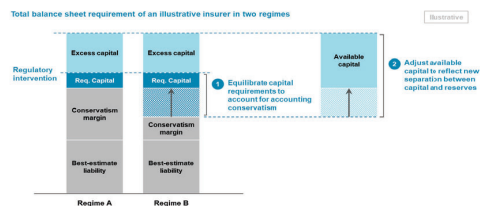
Appendix 1: Excess Ratio Scalars in GCC Template

	Life	Non-Life	Health
Canada	15%	28%	
Bermuda	44%	44%	
Japan	101%	121%	72%
Solvency II (EU)	31%	47%	
Solvency II (UK)	31%	47%	
Australia	30%	30%	30%
Switzerland	16%	56%	
Hong Kong	100%	100%	
Singapore	100%	100%	100%
Chinese Taipei	100%	100%	100%
South Africa	100%	100%	100%
Mexico	100%	100%	
China	100%	100%	
South Korea	100%	100%	

7

Appendix 2: How does the Excess Relative Ratio Adjust for Key Differences?

The Excess Relative Ratio scalar is a total balance sheet-based approach that recognizes different accounting conservatism levels to equilibrate capital requirements:



* Also accounts for differences in asset valuation and admissibility rules (e.g., for eligible assets). For reference, assets admitted under Regime B but not Regime A may be considered a "coste-savings" in Regime B that is subsequently removed when raising Regime B's conservatism margin to equate Regime B and Regime A.

8

Appendix 3: Distinguishing Between Alternative Scalar Approaches

1. Shareholder Approach – 1.0
Scalar = 1.0x

Resultant capital ratios
100% → 100%

- Restating the entity's balance sheet to US creates net increase in total assets, as available capital rises the same.
- Scaled capital ratio unrealistically low.

2. The Pure Relative Ratio Approach (aka "Operating Ratio" approach)
Scalar = 0.7x

Resultant capital ratios
100% → 64%

- Restating the entity's balance sheet to US creates net increase in total assets, as available capital stays the same.
- Scaled capital ratio in-line with US insurers, but with larger cushion of "excess capital".

3. The Excess Relative Ratio Approach (aka "total balance sheet approach")
Scalar = 0.2x

Resultant capital ratios
100% → 66%

- No net increase in assets from restating the entity's balance sheet to US.
- Scaled capital ratio in-line with US insurers, with comparable level of "excess capital".

1. Scalar = 100% of SCR / 100% NEC C/L (applied to required capital)
2. Scalar = 100% of SCR / 150% NEC C/L (scaled to required capital)
3. See previous slide for scalar calculation and application notes

Appendix 4: Sample Demonstration of Excess Scalar

A US-based life insurer has significant operations in both Europe (Solvency II) and Japan. In each jurisdiction, the insurer has an industry-average solvency ratio.

How are excess scalars developed, and what is the insurer's GCC ratio?

Assumptions	US	SII	Japan
(a) Industry Avg Ratio (%)	400%	200%	800%
(b) First Regulatory Intervention (%)	100%	100%	200%
(c) Current Available Capital (\$)	\$400	\$200	\$400
(d) Available Capital at Intervention (\$)	\$100	\$100	\$100
(e) Required Capital (\$)	\$100	\$100	\$50
(a)-(b) (c)	300%	100%	300%
(f) Excess Ratio	N/A	0.333	1.00
(f) Country (f) US = (f) Excess Scalar ¹			

¹Actual excess scalars listed on GCC Template (slide 6) are 0.31 (SII) and 1.01 (Japan)

Appendix 5: Applying Excess Scalars to SII and Japan

Country scaled capital example

Excess scalars are first applied to required capital

	SII	Japan
Available Capital at Intervention	\$100	\$100
Scalar	0.333	1.00
X (b) = (c)	\$33	\$100
– (a) = (d)	Required Capital Difference (\$67)	50

Available Capital is adjusted by the change in required capital

	SII	Japan	
Current Available Capital	\$200	\$400	
Required Capital Difference	(\$67)	50	
– (d)	Scaled Available Capital	\$133	\$400

Group capital aggregation example

	US	SII	Japan	GROUP
Scaled Available Capital	\$400	\$133	\$400	\$933
Scaled Required Capital	\$100	\$33	\$100	\$233
Solvency Ratio	400%	400%	400%	400%

Appendix 6: Sample Methodological Issues in Generating Scalars

A robust framework for generating scalars should address issues including:

- How long of an historical time series is required (e.g., 5-year rolling average)?
- What minimum percentage of the industry should be included in the average?
- What circumstances justify excluding certain companies from the calculation (e.g., outlier ratios or ratings, very different business model, not representative of IAIG's)?
- How should jurisdictional scalars adjust when there is a regulatory regime change?
- Should there be a minimum trigger for year-over-year changes in scalars? Excluding a change in solvency regime, should scalars generally be static for a period of time and revised every few years?
- What outcomes suggest that a particular scalar is not appropriate?

Date: 8/11/23

Mortgage Guaranty Insurance (E) Working Group
Virtual Meeting
July 13, 2023

The Mortgage Guaranty Insurance (E) Working Group of the Financial Condition (E) Committee met July 13, 2023. The following Working Group members participated: Jackie Obusek, Chair (NC); Kurt Regner (AZ); Monica Macaluso (CA); Bradley Trim (FL); John Rehagen (MO); Margot Small (NY); Diana Sherman (PA); Chris Miller (TX); and Amy Malm and Levi Olson (WI).

1. Adopted its Spring National Meeting Minutes

Rehagen made a motion, seconded by Macaluso, to adopt the Working Group's March 22 minutes (*see NAIC Proceedings – Spring 2023, Financial Condition (E) Committee, Attachment One*). The motion passed unanimously.

2. Adopted Amendments to Model #630

Obusek commented that during the Spring National Meeting, the Working Group discussed draft revisions to the *Mortgage Guaranty Insurance Model Act (#630)* (Attachment Three-A). Following this discussion, the drafting group met and integrated revisions to the draft and re-exposed Model #630 for a 15-day public comment period that ended May 26. As a result of the exposure, a letter was received from the Center for Economic Justice (CEJ) and the mortgage guaranty consortium (MGC) (Attachment Three-B). Obusek asked to hear from those who submitted comments.

Birny Birnbaum (CEJ) indicated that the CEJ requested three changes to the draft revised model. The first change is that Section 21—No Private Right of Action be stricken and replaced with an explicit private right of action for violations of those provisions of the model for which consumer harm can be directly demonstrated and which avoid any provision that interferes with solvency regulation. Birnbaum noted that there is no other personal lines model law that has a provision barring a private right of action, and the inclusion in the model law would be unprecedented. He further commented that a private right of action is warranted based on the history of private mortgage insurers' actions leading up to the 2008 financial crisis. He said the proposed ban on private litigation is unfair by limiting consumer access to courts while leaving insurers free to sue consumers.

Birnbaum indicated that the next two amendment requests relate to Section 18A—Inducements and Section 18C—Rebates. He proposed that both be stricken, as they water down critical consumer protections by allowing room for insurers to engage in anti-competitive and unsound business practices. He stated that the recent revisions to the *Unfair Trade Practices Act (#880)* focus on a declaration that insurer risk mitigation efforts are not illegal rebates; however, there is no loss mitigation associated with an inducement. He reasoned that Section 18C should be removed because there is no way for a rebate, as set out in the proposed model, to comply with the remaining portion of the paragraph because if the rebate is set forth in the filed rates, it is not a rebate but a rate discount. He further indicated that referencing Model #880 is inapplicable because rebates are not policy form provisions approved by the state insurance regulator.

Birnbaum stated that the MGC requested the deletion of the anti-deficiency judgment protection in Section 14A—Policy Forms, and the CEJ opposed the change and urged retention of the anti-deficiency protection for several reasons: 1) permitting deficiency judgments penalizes consumers who are victims of economic conditions that depress home prices; 2) deficiency collection is often limited; and 3) the CEJ found no anomaly in prohibiting a

mortgage insurer from pursuing a deficiency judgment while permitting a lender to do so. Therefore, the industry proposal would potentially subject a consumer to two deficiency lawsuits for the same deficiency.

Benjamin Schmidt (Radian Guaranty Inc.) commented on behalf of the MGC. He stated that Radian Guaranty Inc.'s comment letter included the same stance that the MGC had already provided regarding Section 10B(1). He stated that the language in the exposure would discourage the use of reinsurance, as reinsurers may not file statutory financial statements and in those instances would not have a way to report contingency reserves. He indicated that the suggested language from the MGC would clarify that the Contingency Reserve requirement is achieved based on the maintenance by the reinsurer of equivalent collateralized or segregated assets supporting the reinsurance obligations even if the reinsurer does not file a statutory financial statement. He also commented on Section 14A, stating that the second sentence should be removed entirely based on the comments from the MGC's prior letter. He indicated that the sentence was partially deleted following its November 2022 comment letter; however, it may have inadvertently been restored to the current draft after the MGC flagged a fragment of the sentence that remained in the February exposure draft.

Obusek indicated that the comments heard were not new topics, and they have already been discussed. She stated that after materials for the meeting were posted, there was additional communication with the CEJ on the issues raised in its comment letter. As a result of those discussions, she proposed an amendment to Section 18A and Section 18C to remove the first sentence and Section 21 entirely from the model.

Hearing no further discussion, Malm made a motion, seconded by Rehagen, to adopt the proposed amendments to Model #630 with an amendment to Section 18A and Section 18C to strike, "Unless set forth in the policy and subject to the [state equivalent of the Unfair Trade Practices Act #880]" and strike in its entirety Section 21. The motion passed with New York opposing.

Having no further business, the Mortgage Guaranty Insurance (E) Working Group adjourned.

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NAIC Model Laws, Regulations, Guidelines and Other Resources—July 2000/2023

Draft: [May 11, 2023]
~~Adopted by Mortgage Guaranty Insurance (E) Working Group—[insert date]~~
~~Adopted by [insert parent committee]—[insert date]~~

MORTGAGE GUARANTY INSURANCE MODEL ACT

Table of Contents

Section 1. Title
 Section 2. Definitions
 Section 3. ~~Capital and Surplus~~ Insurer’s Authority to Transact Business
 Section 4. ~~Insurer’s Authority to Transact Business~~ Mortgage Guaranty Insurance as Monoline
 Section 5. Risk Concentration
 Section 6. Capital and Surplus
 Section 7. ~~Geographic Concentration~~
 Section 8. ~~Section 6.~~ Advertising
 Section 9. ~~Section 7.~~ Investment Limitation
 Section 8. ~~Coverage Limitation~~
 Section 9. ~~Mortgage Guaranty Insurance as Monoline~~
 Section 10. Reserve Requirements
 Section 11. Reinsurance
 Section 12. Sound Underwriting ~~Discrimination~~ Practices
 Section 13. Quality Assurance
 Section 14. ~~Section 11.~~ Policy Forms and Premium Rates Filed
 Section 15. Risk in Force and Waivers
 Section 16. Conflict of Interest
 Section 17. ~~Section 12.~~ Outstanding Total Liability
 Section 13. ~~Rebates, Commissions and Charges~~
 Section 14. ~~Compensating Balances Prohibited~~
 Section 18. Limitations on Rebates, Commissions, Charges and Contractual Preferences
 Section 19. Rescission
 Section 20. Records Retention
 Section 21. No Private Right of Action
 Section 22. ~~Section 15.~~ Conflict of Interest
 Section 16. ~~Reserves~~
 Section 17. Regulations

Section 1. Title

This Act may be cited as the Mortgage Guaranty Insurance Act.

Section 2. Definitions

The definitions set forth in this Act shall govern the construction of the terms used in this Act but shall not affect any other provisions of the code.

- ~~A.~~ A. —“Authorized ~~real estate security,~~” for the purpose of this Act, Real Estate Security” means ~~an:~~
- (1) An amortized note, bond or other evidence instrument of indebtedness, except for reverse mortgage loans made pursuant to [insert citation of state law that authorizes reverse mortgages] of the real property law, evidencing a loan, not exceeding ninety-five one hundred three percent (95103%) of the fair market value of the real estate, secured by a mortgage, deed of trust, or other instrument that constitutes, or is equivalent to, a first lien or charge on real estate junior lien or charge on real estate, with any percentage in excess of one hundred percent (100%) being used to finance the fees and closing costs on such indebtedness; provided:
- (a) ~~(1)~~—The real estate loan secured in this manner is one of a type that a ~~bank, savings and loan association, or an insurance company~~ creditor, which is supervised and regulated by a department of ~~this~~ any state or territory of the U.S or an agency of the federal government, is

MO-630-1

Mortgage Guaranty Insurance Model Act

authorized to make, or would be authorized to make, disregarding any requirement applicable to such an institution that the amount of the loan not exceed a certain percentage of the value of the real estate;

~~(2b)~~ The improvement on loan is to finance the acquisition, initial construction or refinancing of real estate that is a:

~~(i)~~ Residential building designed for occupancy by not more than four families, a one-family residential condominium or unit in a planned unit development, or any other one-family residential unit as to which title may be conveyed freely; or

~~(ii)~~ Mixed-use building with only one non-residential use and one one-family dwelling unit; or

~~(iii)~~ Building or buildings designed for occupancy as specified by Subsections A(1) and A(2) of this section; and by five (5) or more families or designed to be occupied for industrial or commercial purposes.

~~(3c)~~ The lien on the real estate may be subject to and subordinate to the following:

~~(a)~~ The lien of any public bond, assessment or tax, when no installment, call or payment of or under the bond, assessment or tax is delinquent; and

~~(b)~~ Outstanding mineral, oil, water or timber other liens, leases, rights, rights of way, easements or rights of way of support, sewer rights, building restrictions or other restrictions or, easements, covenants, conditions or regulations of use, or outstanding leases upon the real property under which rents or profits are reserved to the owner thereof that do not impair the use of the real estate for its intended purpose.

~~(2)~~ Notwithstanding the foregoing, a loan referenced in Section 2A(1) of this Act may exceed 103% of the fair market value of the real estate in the event that the mortgage guaranty insurance company has approved for loss mitigation purposes a request to refinance a loan that constitutes an existing risk in force for the company.

~~(3)~~ An amortized note, bond or other instrument of indebtedness evidencing a loan secured by an ownership interest in, and a proprietary lease from, a corporation or partnership formed for the purpose of the cooperative ownership of real estate and at the time the loan does not exceed one hundred three percent (103%) of the fair market value of the ownership interest and proprietary lease, if the loan is one of a type that meets the requirements of Section 2A(1)(a), unless the context clearly requires otherwise, any reference to a mortgagor shall include an owner of such an ownership interest as described in this paragraph and any reference to a lien or mortgage shall include the security interest held by a lender in such an ownership interest.

~~B.~~ “Bulk Mortgage Guaranty Insurance” means mortgage guaranty insurance that provides coverage under a single transaction on each mortgage loan included in a defined portfolio of loans that have already been originated.

~~C.~~ “Certificate of Insurance” means a document issued by a mortgage guaranty insurance company to the initial insured to evidence that it has insured a particular authorized real estate security under a master policy, identifying the terms, conditions and representations, in addition to those contained in the master policy and endorsements, applicable to such coverage.

~~D.~~ “Commissioner” means [insert the title of the principal insurance supervisory official] of this state, or the [insert the title of the principal insurance supervisory official]’s deputies or assistants, or any employee of the [insert name of the principal insurance regulatory agency] of this state acting in the [insert the title of the principal insurance supervisory official]’s name and by the [insert the title of the principal insurance supervisory official]’s delegated authority.” Commissioner.” The term “commissioner” shall mean the insurance commissioner, the commissioner’s deputies, or the Insurance Department, as appropriate.

Drafting Note: Insert the title of the chief insurance regulatory official wherever the word “commissioner” appears.

NAIC Model Laws, Regulations, Guidelines and Other Resources—July 2000/2023

- E.
- ~~B.~~ “~~Contingency reserve~~“Contingency Reserve” means an additional premium reserve established to protect policyholders against the effect of adverse economic cycles.
- ~~C.~~ “~~Mortgage guaranty insurance~~” is F. “Domiciliary Commissioner” means the principal insurance supervisory official of the jurisdiction in which a mortgage guaranty insurance company is domiciled, ~~or that principal insurance supervisory official’s deputies or assistants, or any employee of the regulatory agency of which that principal insurance supervisory official is the head acting in that principal insurance supervisory official’s name and by that principal insurance supervisory official’s delegated authority.~~
- G. “Effective Guaranty” refers to the assumed backing of existing or future holders of securities by virtue of their issuer’s conservatorship or perceived access to credit from the U.S. Treasury, as opposed to the direct full faith and credit guarantee provided by the U.S. government.
- H. “Loss” refers to losses and loss adjustment expenses.
- I. “Master Policy” means a document issued by a mortgage guaranty insurance company that establishes the terms and conditions of mortgage guaranty insurance coverage provided thereunder, including any endorsements thereto.
- J. “Mortgage Guaranty *
- ~~(1)~~ Insurance” is insurance against financial loss by reason of nonpayment of principal, interest or other sums agreed to be paid under the terms of any ~~note or bond or other evidence of indebtedness secured by a mortgage, deed of trust, or other instrument constituting a lien or charge on real estate, provided the improvement on the real estate is a residential building or a condominium unit or buildings designed for occupancy by not more than four families;~~authorized real estate security.
- ~~(2)~~ Insurance against financial loss by reason of nonpayment of principal, interest or other sums agreed to be paid under the terms of any note or bond or other evidence of indebtedness secured by a mortgage, deed of trust, or other instrument constituting a lien or charge on real estate, provided the improvement on the real estate is a building or buildings designed for occupancy by five (5) or more families or designed to be occupied for industrial or commercial purposes; and
- ~~(3)~~ Insurance against financial loss by reason of nonpayment of rent or other sums agreed to be paid under the terms of a written lease for the possession, use or occupancy of real estate, provided the improvement on the real estate is a building or buildings designed to be occupied for industrial or commercial purposes.
- K. “Mortgage Guaranty Quality Assurance Program” means an early detection warning system for potential underwriting compliance issues which could potentially impact solvency or operational risk within a mortgage guaranty insurance company.
- L. “NAIC” means the National Association of Insurance Commissioners.
- M. “Pool Mortgage Guaranty Insurance” means mortgage guaranty insurance that provides coverage under a single transaction or a defined series of transactions on a defined portfolio of loans for losses up to an aggregate limit.
- N. “Right of Rescission” represents a remedy available to a mortgage guaranty insurance company to void a certificate and restore parties to their original position, based on inaccurate, incomplete or misleading information provided to, or information omitted or concealed from, the mortgage guaranty insurance company in connection with the insurance application, resulting in an insured loan that did not meet the mortgage guaranty insurance company’s eligibility requirements in effect on the date of submission of the insurance application.
- O. “Risk in Force” means the mortgage guaranty insurance coverage percentage applied to the unpaid principal balance.

MO-630-3

Mortgage Guaranty Insurance Model Act

Section 3. Insurer's Authority to Transact Business

A company may not transact the business of mortgage guaranty insurance until it has obtained a certificate of authority from the commissioner.

Section 4. Mortgage Guaranty Insurance as Monoline

A mortgage guaranty insurance company that anywhere transacts any class of insurance other than mortgage guaranty insurance is not eligible for the issuance of a certificate of authority to transact mortgage guaranty insurance in this state nor for the renewal thereof.

Section 5. Risk Concentration

A mortgage guaranty insurance company shall not expose itself to any loss on any one authorized real estate security risk in an amount exceeding ten percent (10%) of its surplus to policyholders. Any risk or portion of risk which has been reinsured shall be deducted in determining the limitation of risk.

Section 6. Capital and Surplus

- A. **Initial and Minimum Capital and Surplus Requirements.** A mortgage guaranty insurance company shall not transact the business of mortgage guaranty insurance unless, if a stock insurance company, it has paid-in capital of at least \$~~10~~10,000,000 and paid-in surplus of at least \$~~15~~15,000,000, or if a mutual insurance company, a minimum initial surplus of \$~~25~~25,000,000. A stock insurance company or a mutual insurance company shall at all times thereafter maintain a minimum policyholders' surplus of at least \$~~1,500~~20,000,000.

Section 4. Insurer's Authority to Transact Business

No mortgage guaranty insurance company may issue policies until it has obtained from the commissioner of insurance a certificate setting forth that fact and authorizing it to issue policies.

- B. **Section 5. Minimum Capital Requirements Applicability.** A mortgage guaranty insurance company formed prior to the passage of this Act may maintain the amount of capital and surplus or minimum policyholders' surplus previously required by statute or administrative order for a period not to exceed twelve months following the effective date of the adoption of this Act.
- C. **Minimum Capital Requirements Adjustments.** The domiciliary commissioner may by order reduce the minimum amount of capital and surplus or minimum policyholders' surplus required under Section 6A under the following circumstances:
- (1) For an affiliated reinsurer that is a mortgage guaranty insurance company and that is or will be engaged solely in the assumption of risks from affiliated mortgage guaranty insurance companies, provided that the affiliated reinsurer is in run-off and, in the domiciliary commissioner's opinion, the business plan and other relevant circumstances of the affiliated reinsurer justify the proposed reduction in requirements.
 - (2) For mortgage guaranty insurance companies that are in run-off and not writing new business that is justified in a business plan, in the domiciliary commissioner's opinion.

Section 7. Geographic Concentration

- A. A mortgage guaranty insurance company shall not insure loans secured by a single risk in excess of ten percent (10%) of the company's aggregate capital, surplus and contingency reserve.
- B. No mortgage guaranty insurance company shall have more than twenty percent (20%) of its total insurance in force in any one Standard Metropolitan Statistical Area (SMSA), as defined by the ~~United States~~U.S Department of Commerce.
- C. The provisions of this section shall not apply to a mortgage guaranty insurance company until it has possessed

MO-630-4

NAIC Model Laws, Regulations, Guidelines and Other Resources—July ~~2000~~2023

a certificate of authority in this state for three (3) years.

Section 68. Advertising

No mortgage guaranty insurance company or an agent or representative of a mortgage guaranty insurance company shall prepare or distribute or assist in preparing or distributing any ~~brochure, pamphlet, report or any form of~~ advertising media or communication to the effect that the real estate investments of any financial institution are “insured investments,” unless the ~~brochure, pamphlet, report or~~ advertising media or communication clearly states that the loans are insured by mortgage guaranty insurance companies possessing a certificate of authority to transact mortgage guaranty insurance in this state or are insured by an agency of the federal government, ~~as the case may be.~~

Section 79. Investment Limitation

~~A mortgage guaranty insurance company shall not invest~~Investments in notes or other evidences of indebtedness secured by a mortgage or other liens upon residential real property ~~shall not be allowed as assets in any determination of the financial condition of a mortgage guaranty insurer.~~ This section shall not apply to obligations secured by real property, or contracts for the sale of real property, which obligations or contracts of sale are acquired in the course of ~~the~~ good faith settlement of claims under policies of insurance issued by the mortgage guaranty insurance company, or in the good faith disposition of real property so acquired. ~~This section shall not apply to investments backed by the full faith and credit of the U.S. Government or investments with the effective guaranty of the U.S. Government. This section shall not apply to investments held by a mortgage guaranty insurance company prior to the passage of this Act.~~

~~Section 8. Coverage Limitation~~**10. Reserve Requirements**

~~A. Unearned premium Reserves, Loss Reserves, and Premium Deficiency Reserves.~~ Financial reporting will be prepared in accordance with the Accounting Practices and Procedures Manual and Annual Financial Statement Instructions of the NAIC.

~~B. Contingency Reserve.~~ Each mortgage guaranty insurance company shall establish a contingency reserve subject to the following provisions:

(1) ~~The mortgage guaranty insurance company shall make an annual contribution to the contingency reserve which in the aggregate shall be equal to fifty percent (50%) of the direct earned premiums reported in the annual statement or net earned premiums reported if the reinsurer maintains the contingency reserve.~~

(2) ~~Except as provided within this Act, a mortgage guaranty insurance company’s contributions to the contingency reserve made during each calendar year shall be maintained for a period of 120 months, to provide for reserve buildup. The portion of the contingency reserve established and maintained for more than 120 months shall be released and shall no longer constitute part of the contingency reserve.~~

(3) ~~Withdrawals may be made from the contingency reserve on a first-in, first-out basis or such other basis, with the prior written approval of the domiciliary commissioner, based on the amount by which:~~

(a) ~~Incurred losses and loss adjustment expenses exceed 35% of the direct earned premium in any year. Provisional withdrawals may be made from the contingency reserve on a quarterly basis in an amount not to exceed 75% of the withdrawal as adjusted for the quarterly nature of the withdrawal; or~~

(b) ~~Upon the approval of the domiciliary commissioner and 30-day prior notification to non-domiciliary commissioners, a mortgage guaranty insurer may withdraw from the contingency reserve any amounts which are in excess of the requirements of Section 15 as required in [insert section of the mortgage guaranty Insurance model law requiring minimum policyholder’s position] as filed with the most recently filed annual statement.~~

(i) ~~The mortgage guaranty insurance company’s domiciliary commissioner may consider loss developments and trends in reviewing a request for withdrawal. If any portion of the~~

MO-630-5

Mortgage Guaranty Insurance Model Act

contingency reserve for which withdrawal is requested is maintained by a reinsurer or in a segregated account or trust of a reinsurer, the domiciliary commissioner may also consider the financial condition of the reinsurer.

C. **Miscellaneous.** Unearned premium reserves and contingency reserves on risks insured before the effective date of this Act may be computed and maintained as required previously.

Section 11. Reinsurance

A. **Prohibition of Captive Reinsurance.** A mortgage guaranty insurance company shall not enter into captive reinsurance arrangements which involve the direct or indirect ceding of any portion of its insurance risks or obligations to a reinsurer owned or controlled by an insured; any subsidiary or affiliate of an insured; an officer, director or employee of an insured or any member of their immediate family; a corporation, partnership, trust, trade association in which an insured is a member, or other entity owned or controlled by an insured or an insured's officer, director or employee or any member of their immediate family that has a financial interest; or any designee, trustee, nominee or other agent or representative of any of the foregoing.

B. **Reinsurance Cessions.** A mortgage guaranty insurer may, by written contract, reinsure any insurance that it transacts, except that no mortgage guaranty insurer may enter into reinsurance arrangements designed to circumvent the compensating control provisions of Section 17 or the contingency reserve requirement of Section 10. The unearned premium reserve and the loss reserves required by Section 10 shall be established and maintained by the direct insurer or by the assuming reinsurer so that the aggregate reserves shall be equal to or greater than the reserves required by direct writer. The cession shall be accounted for as provided in the accounting practices and procedures prescribed or permitted by the applicable Accounting Practices and Procedures Manual of the NAIC.

Section 12. Sound Underwriting Practices

A. **Underwriting Review and Approval Required.** All certificates of mortgage guaranty insurance, excluding policies of reinsurance, shall be written based on an assessment of evidence that prudent underwriting standards have been met by the originator of the mortgage. Delegated underwriting decisions shall be reviewed based on a reasonable method of sampling of post-closing loan documentation to ensure compliance with the mortgage guaranty insurance company's underwriting standards.

B. **Quality Control Reviews.** Quality control reviews for bulk mortgage guaranty insurance and pool mortgage guaranty insurance shall be based on a reasonable method of sampling of post-closing loan documentation for delegated underwriting decisions to ensure compliance with the representations and warranties of the creditors or creditors originating the loans and with the mortgage guaranty insurance company's underwriting standards.

C. **Minimum Underwriting Standards.** Mortgage guaranty insurance companies shall establish formal underwriting standards which set forth the basis for concluding that prudent underwriting standards have been met.

D. **Underwriting Review and Approval.** A mortgage guaranty insurance company's underwriting standards shall be:

(1) A mortgage guaranty insurance company shall limit its coverage net of reinsurance ceded to a reinsurer in which the company has no interest to a maximum of twenty five percent (25%) of the entire indebtedness to the insured or in lieu thereof, a mortgage guaranty insurance company may elect to pay the entire indebtedness to the insured and acquire title to the authorized real estate security.

Section 9. Reviewed and approved by executive management, including, but not limited to the highest-ranking executive officer and financial officer; and

(2) Communicated across the organization to promote consistent business practices with respect to underwriting.

NAIC Model Laws, Regulations, Guidelines and Other Resources—July 2000~~2023~~

~~E. **Notification of Changes in Underwriting Standards.** On or before March 1 of each year, a mortgage guaranty insurance company shall file with the domiciliary commissioner changes to its underwriting standards and an analysis of the changes implemented during the course of the immediately preceding year. The annual summary of material underwriting standards changes should include any change associated with loan to value ratios, debt to income ratios, borrower credit standing or maximum loan amount which has resulted in a material impact on net premium written of +/- 5% from prior year to date.~~

~~**Nondiscrimination.** In extending or issuing mortgage guaranty insurance, a mortgage guaranty insurance company~~

~~A. A mortgage guaranty insurance company that anywhere transacts any class of insurance other than mortgage guaranty insurance is not eligible for the issuance of a certificate of authority to transact mortgage guaranty insurance in this state nor for the renewal thereof.~~

~~B. A mortgage guaranty insurance that anywhere transacts the classes of insurance defined in Section 2A(2) or 2A(3) is not eligible for a certificate of authority to transact in this state the class of mortgage guaranty insurance defined in Section 2A(1). However, a mortgage guarantee insurance company that transacts a class of insurance defined in Section 2A may write up to five percent (5%) of its insurance in force on residential property designed for occupancy by five (5) or more families.~~

~~**Section 10. Underwriting Discrimination**~~

~~A. Nothing in this chapter shall be construed as limiting the right of a mortgage guaranty insurance company to impose reasonable requirements upon the lender with regard to the terms of a note or bond or other evidence of indebtedness secured by a mortgage or deed of trust, such as requiring a stipulated down payment by the borrower may not.~~

~~B. No mortgage guaranty insurance company may discriminate in the issuance or extension of mortgage guaranty insurance on the on the basis of the applicant's sex, marital status, race, color, creed or national origin, national origin, disability, or age or solely on the basis of the geographic location of the property to be insured unless the discrimination related to geographic location is for a business purpose that is not a mere pretext for unfair discrimination; or the refusal, cancellation, or limitation of the insurance is required by law or regulatory mandate.~~

~~C. **No policy.** Drafting Note: States and jurisdictions should consult their constitution or comparable governance documents and applicable civil rights legislation to determine if broader protections against unacceptable forms of discrimination should be included in Section 12F.~~

~~**Section 13. mortgage guaranty insurance Quality Assurance**~~

~~A. **Quality Assurance Program.** A mortgage guaranty insurance company shall establish a formal internal mortgage guaranty quality assurance program, which provides an early detection warning system as it relates to potential underwriting compliance issues which could potentially impact solvency or operational risk. This mortgage guaranty quality assurance program shall provide for the documentation, monitoring, evaluation and reporting on the integrity of the ongoing loan origination process based on indicators of potential underwriting inadequacies or non-compliance. This shall include, but not limited to:~~

~~(1) **Segregation of Duties.** Administration of the quality assurance program shall be delegated to designated risk management, quality assurance or internal audit personnel, who are technically trained and independent from underwriting activities that they audit.~~

~~(2) **Senior Management Oversight.** Quality assurance personnel shall provide periodic quality assurance reports to an enterprise risk management committee or other equivalent senior management level oversight body.~~

~~(3) **Board of Director Oversight.** Quality assurance personnel shall provide periodic quality assurance reports to the board of directors or a designated committee of directors established to facilitate board of director oversight.~~

MO-630-7

Mortgage Guaranty Insurance Model Act

- (4) **Policy and Procedures Documentation.** Mortgage guaranty quality assurance program, excluding policies and procedures of reinsurance, shall be formally established and documented to define scope, roles and responsibilities.
- (5) **Underwriting Risk Review.** Quality assurance review shall include an examination of underwriting risks including classification of risk and compliance with risk tolerance levels.
- (6) **Lender Performance Reviews.** Quality assurance monitoring provisions shall include an assessment of lender performance.
- (7) **Underwriting Performance Reviews.** Quality assurance monitoring provisions shall assess compliance with underwriting standard.
- (8) **Problem Loan Trend Reviews.** Quality assurance monitoring provisions shall assess prospective risks associated with timely loan payment including delinquency, default inventory, foreclosure and persistency trends.
- (9) **Underwriting System Change Oversight.** Underwriting system program changes shall be monitored to ensure the integrity of underwriting and pricing programs, which impact automated underwriting system decision making.
- (10) **Pricing and Performance Oversight.** Pricing controls shall be monitored to ensure that business segment pricing supports applicable performance goals.
- (11) **Internal Audit Validation.** Periodic internal audits shall be conducted to validate compliance with the mortgage guaranty quality assurance program.

- B. Regulator Access and Review of Quality Assurance Program.** The commissioner shall be provided access to an insurer's mortgage guaranty quality assurance program for review at any reasonable and thorough examination of the evidence supporting credit worthiness of the borrower and the appraisal report reflecting market evaluation of the property and has determined that prudent underwriting standards have been met upon request and during any financial regulatory examination. Nothing herein shall be construed to limit a regulator's right to access any and all of the records of an insurer in an examination or as otherwise necessary to meet regulatory responsibilities.

Section 1414. Policy Forms and Premium Rates Filed

- A. **Policy Forms.** All policy forms and endorsements, and modifications (excluding bulk mortgage guaranty insurance and pool mortgage guaranty insurance) shall be filed with and be subject to the approval of the commissioner. With respect to owner-occupied, single-family dwellings, the mortgage guaranty insurance policy shall provide that or a mixed-use building described in Section 2A(1)(b), which is owner-occupied at the time of loan origination and for at least 50% of the days within the twelve (12) consecutive months prior to borrower default, the borrower shall not be liable to the insurance company for any deficiency arising from a foreclosure sale.
- B. **Premium Rates.** Each mortgage guaranty insurance company (excluding bulk mortgage guaranty insurance and pool mortgage guaranty insurance) shall file with the department commissioner the rate to be charged and the premium including all modifications of rates and premiums to be paid by the policyholder.
- C. **Premium Charges.** Every mortgage guaranty insurance company shall adopt, print and make available a schedule of insureds the premium charges for mortgage guaranty insurance policies. Premium charges

MO-630-8

NAIC Model Laws, Regulations, Guidelines and Other Resources—July 2000/2023

~~made in conformity via a company website or an integration with the provisions of this Act shall not be deemed to be interest or other charges under any other provision of law limiting interest or other charges in connection with mortgage loans—a third-party system. The schedule premium rate provided shall show the entire amount of premium charge for each the type of mortgage guaranty insurance policy to be issued by the insurance company.~~

Drafting Note: Open rating states may delete a portion or all of ~~this provision~~ Section 14 and insert their own rating law.

Section 12. ~~Outstanding Total Liability~~ 15. Risk in Force and Waivers

- ~~A. A mortgage guaranty insurance~~ **Risk in Force.** ~~A mortgage guaranty insurance~~ company shall not at any time have outstanding ~~a total liability~~ **risk in force**, net of reinsurance, under its aggregate mortgage guaranty insurance policies exceeding twenty-five (25) times its capital, surplus and contingency reserve. In the event that any mortgage guaranty insurance company has outstanding total ~~liability~~ **risk in force** exceeding twenty-five (25) times its capital, surplus and contingency reserve, it shall cease transacting new mortgage guaranty business until such time as its total ~~liability~~ **risk in force** no longer exceeds twenty-five (25) times its capital, surplus and contingency reserve. Total ~~outstanding liability~~ **risk in force** shall be calculated on ~~a consolidated an individual entity~~ basis ~~for all mortgage guarantee insurance companies.~~
- ~~B. Waiver.~~ The commissioner may waive the requirement found in Section 15A at the written request of a mortgage guaranty insurer upon a finding that ~~are part of a holding company system~~ the mortgage guaranty insurer's policyholders position is reasonable in relationship to the mortgage guaranty insurer's aggregate insured risk in force and adequate to its financial needs. The request must be made in writing at least 90 days in advance of the date that the mortgage guaranty insurer expects to exceed the requirement of Section 15A and shall, at a minimum, address the factors specified in Section 15C.
- ~~C. Waiver Criteria.~~ In determining whether a mortgage guaranty insurer's policyholders position is reasonable in relation to the mortgage guaranty insurer's aggregate insured risk in force and adequate to its financial needs, all of the following factors, among others, may be considered:
- ~~(1) The size of the mortgage guaranty insurer as measured by its assets, capital and surplus, reserves, premium writings, insurance in force, and other appropriate criteria.~~
 - ~~(2) The extent to which the mortgage guaranty insurer's business is diversified across time, geography, credit quality, origination, and distribution channels.~~
 - ~~(3) The nature and extent of the mortgage guaranty insurer's reinsurance program.~~
~~The quality, diversification, and liquidity of the~~
 - ~~(4) mortgage guaranty insurer's assets and its investment portfolio.~~
 - ~~(5) The historical and forecasted trend in the size of the mortgage guaranty insurer's policyholders position.~~
 - ~~(6) The policyholders position maintained by other comparable mortgage guaranty insurers in relation to the nature of their respective insured risks.~~
 - ~~(7) The adequacy of the mortgage guaranty insurer's reserves.~~
 - ~~(8) The quality and liquidity of investments in affiliates. The commissioner may treat any such investment as a nonadmitted asset for purposes of determining the adequacy of surplus as regards policyholders.~~
 - ~~(9) The quality of the mortgage guaranty insurer's earnings and the extent to which the reported earnings of the mortgage guaranty insurer include extraordinary items.~~
 - ~~(10) An independent actuary's opinion as to the reasonableness and adequacy of the mortgage guaranty insurer's historical and projected policyholders position.~~

MO-630-9

Mortgage Guaranty Insurance Model Act

(11) The capital contributions which have been infused or are available for future infusion into the mortgage guaranty insurer.

(12) The historical and projected trends in the components of the mortgage guaranty insurer's aggregate insured risk, including, but not limited to, the quality and type of the risks included in the aggregate insured risk.

D. **Authority to Retain Experts.** The commissioner may retain accountants, actuaries, or other experts to assist in the review of the mortgage guaranty insurer's request submitted pursuant to Section 15B. The mortgage guaranty insurer shall bear the commissioner's cost of retaining those persons.

E. **Specified Duration.** Any waiver shall be:

(1) For a specified period of time not to exceed two years; and

(2) Subject to any terms and conditions that the commissioner shall deem best suited to restoring the mortgage guaranty insurer's minimum policyholders position required by Section 15A.

Section 16. Conflict of Interest

A mortgage guaranty insurer may underwrite mortgage guaranty insurance on mortgages originated by the holding company system or affiliate or on mortgages originated by any mortgage lender to which credit is extended, directly or indirectly by the holding company system or affiliate only if the insurance is underwritten on the same basis, for the same consideration and subject to the same insurability requirements as insurance provided to nonaffiliated lenders. Mortgage guaranty insurance underwritten on mortgages originated by the holding company system or affiliate or on mortgages originated by any mortgage lender to which credit is extended, directly or indirectly by the holding company system or affiliate shall be limited to 50% of the insurer's direct premium written in any calendar year, or such higher percentage established in writing for the insurer in the domiciliary commissioner's discretion, based on the domiciliary commissioner's determination that a higher percentage is not likely to adversely affect the financial condition of the insurer.

Section 17. Compensating Balances Prohibited

Except for commercial checking accounts and normal deposits in support of an active bank line of credit, a mortgage guaranty insurance company, holding company or any affiliate thereof is prohibited from maintaining funds on deposit with the lender for which the mortgage guaranty insurance company has insured loans. Any deposit account bearing interest at rates less than what is currently being paid other depositors on similar deposits or any deposit in excess of amounts insured by an agency of the federal government shall be presumed to be an account in violation of this section. Furthermore, a mortgage guaranty insurance company shall not use compensating balances, special deposit accounts or engage in any practice that unduly delays its receipt of monies due or that involves the use of its financial resources for the benefit of any owner, mortgagee of the real property or any interest therein or any person who is acting as agent, representative, attorney or employee of the owner, purchaser or mortgagee as a means of circumventing any part of this section.

Section 18. Limitations on Rebates, Commissions, Charges and Contractual Preferences

A. **Insurance Inducements.** Unless set forth in the policy and subject to the [state equivalent of the Unfair Trade Practices Act #880], a mortgage guaranty insurance company shall not pay or cause to be paid either directly or indirectly, to any owner, purchaser, lessor, lessee, mortgagee or prospective mortgagee of the real property that secures the authorized real estate security or that is the fee of an insured lease, or any interest therein, or to any person who is acting as an agent, representative, attorney or employee of such owner, purchaser, lessor, lessee or mortgagee, any commission, or any part of its premium charges or any other consideration as an inducement for or as compensation on any mortgage guaranty insurance business.

B. **Compensation for Placement.** In connection with the placement of any mortgage guaranty insurance, a mortgage guaranty insurance company shall not cause or permit the conveyance of anything of value, including but not limited to any commission, fee, premium adjustment, remuneration or other form of compensation of any kind whatsoever to be paid to, or received by an insured lender or lessor; any subsidiary

MO-630-10

NAIC Model Laws, Regulations, Guidelines and Other Resources—July 2000/2023

or affiliate of an insured; an officer, director or employee of an insured or any member of their immediate family; a corporation, partnership, trust, trade association in which an insured is a member, or other entity in which an insured or an officer, director or employee or any member of their immediate family has a financial interest; or any designee, trustee, nominee or other agent or representative of any of the foregoing, except for the value of the insurance itself or claim payments thereon as provided by contract or settlement.

~~C. C. — No mortgage guaranty insurance~~Rebates. Unless set forth in the policy and subject to the [state equivalent of the Unfair Trade Practices Act #880], a mortgage guaranty insurance company shall not make a rebate of any portion of the premium charge, as shown by the schedule required by Section 11C. No mortgage guaranty insurance~~14C. No mortgage guaranty insurance~~ company shall not quote any rate or premium charge to a person that is different than that currently available to others for the same type of coverage. The amount by which a premium charge is less than that called for by the current schedule of premium charges is an unlawful rebate.

D. Undue Contractual Preferences.

~~(1) Any contract, letter agreement, or other arrangement used to clarify any terms, conditions, or interpretations of a master policy or certificate shall be documented in writing.~~

~~(2) Any contractual or letter agreements used to modify or clarify general business practices and administrative, underwriting, claim submission or other information exchange processes shall not contain provisions which override or significantly undermine the intent of key provisions of the mortgage guaranty insurance model act, including mortgage insurer discretion, rights and responsibilities related to:~~

~~(a) Underwriting standards.~~

~~(b) Quality assurance.~~

~~(c) Rescission.~~

~~E. Sanctions.~~ The commissioner may, after notice and hearing, suspend or revoke the certificate of authority of a mortgage guaranty insurance company, or in his or her discretion, issue a cease and desist order to a mortgage guaranty insurance company that pays a commission, rebate, or makes any unlawful ~~rebate~~conveyance of value under this section in willful violation of the provisions of this Act. In the event of the issuance of a cease and desist order, the commissioner may, after notice and hearing, suspend or revoke the certificate of authority of a mortgage guaranty insurance company that does not comply with the terms thereof.

~~Section 14. Compensating Balances Prohibited~~

~~F. Except for commercial checking accounts and normal deposits in support of an active bank line of credit, a mortgage guaranty insurance company, holding company or any affiliate thereof is prohibited from maintaining funds on deposit with the lender for which the mortgage guaranty insurance company has insured loans. Any deposit account bearing interest at rates less than what is currently being paid other depositors on similar deposits or any deposit in excess of amounts insured by an agency of the federal government shall be presumed to be an account in violation of this section.~~ Educational Efforts and Promotional Materials Permitted. A mortgage guaranty insurance company may engage in any educational effort with borrowers, members of the general public, and officers, directors, employees, contractors and agents of insured lenders that may reasonably be expected to reduce its risk of Loss or promote its operational efficiency and may distribute promotional materials of minor value.

~~Section 19. Rescission~~

All mortgage guaranty insurance company master policies shall include a detailed description of provisions governing rescissions, re-pricing, and cancellations, which specify the insurer's and insured's rights, obligations and eligibility terms under which those actions may occur to ensure transparency.

~~Section 20. Records Retention~~

MO-630-11

Mortgage Guaranty Insurance Model Act

~~A. **Record Files.** A licensed mortgage guaranty insurance company shall maintain its records in a manner which allows the commissioner to readily ascertain the insurer's compliance with state insurance laws and rules during an examination including, but not limited to, records regarding the insurer's management, operations, policy issuance and servicing, marketing, underwriting, rating and claims practices.~~

~~B. Furthermore, a mortgage guaranty insurance company shall not use compensating balances, special deposit accounts or engage in any practice that unduly delays its receipt of monies due or that involves the use of its financial resources for the benefit of any owner, mortgagee of the real property or any interest therein or any person who is acting as agent, representative, attorney or employee of the owner, purchaser or mortgagee as a means of circumventing any part of this section.~~

~~**Section 15. — Retention Period.** Policy and claim records shall be retained for the period during which the certificate or claim is active plus five (5) years, unless otherwise specified by the insurance commissioner. Recordkeeping requirements shall relate to:~~

~~(1) Records to clearly document the application, underwriting, and issuance of each master policy and certificate of insurance; and~~

~~(2) Claim records to clearly document the inception, handling, and disposition.~~

~~C. **Record Format.** Any record required to be maintained by a mortgage insurer may be created and stored in the form of paper, photograph, magnetic, mechanical or electronic medium.~~

~~D. **Record Maintenance.** Record maintenance under this Act shall comply with the following requirements:~~

~~(1) Insurer maintenance responsibilities shall provide for record storage in a location that will allow the records to be reasonably produced for examination within the time period required.~~

~~(2) Third-Party maintenance related responsibilities shall be set forth in a written agreement, a copy of which shall be maintained by the insurer and available for purposes of examination.~~

~~**Section 21. — No Private Right of Action**~~

~~This Act may not be construed to create or imply a private cause of action for violation of its provisions nor may it be construed to curtail a private cause of action which would otherwise exist in the absence of this Act.~~

~~**Conflict of Interest**~~

~~A. — If a member of a holding company system, a mortgage guaranty insurance company licensed to transact business in this state shall not, as a condition of its certificate of authority, knowingly underwrite mortgage guaranty insurance on mortgages originated by the holding company system or an affiliate or on mortgages originated by any mortgage lender to which credit is extended, directly or indirectly, by the holding company system or an affiliate.~~

~~A. — B. — A mortgage guaranty insurance company, the holding company system of which it is a part, or any affiliate shall not as a condition of the mortgage guaranty insurance company's certificate of authority, pay any commissions, remuneration, rebates or engage in activities proscribed in Sections 13 and 14.~~

~~**Section 16. — Reserves**~~

~~A. — Unearned Premium Reserves~~

~~— A mortgage guaranty insurance company shall compute and maintain an unearned premium reserve as set forth by regulation adopted by the commissioner of insurance.~~

~~B. — Loss Reserve~~

~~— A mortgage guaranty insurance company shall compute and maintain adequate case basis and other loss reserves that accurately reflect loss frequency and loss severity and shall include components for claims reported and for claims incurred but not reported, including estimated losses on:~~

~~(1) — Insured loans that have resulted in the conveyance of property that remains unsold;~~

MO-630-12

NAIC Model Laws, Regulations, Guidelines and Other Resources—July 2000~~2023~~

- ~~(2) Insured loans in the process of foreclosure;~~
- ~~(3) Insured loans in default for four (4) months or for any lesser period that is defined as default for such purposes in the policy provisions; and~~
- ~~(4) Insured leases in default for four (4) months or for any lesser period that is defined as default for such purposes in policy provisions.~~

~~C. Contingency Reserve~~

~~Each mortgage guaranty insurance company shall establish a contingency reserve out of net premium remaining (gross premiums less premiums returned to policyholders net of reinsurance) after establishment of the unearned premium reserve. The mortgage guaranty insurance company shall contribute to the contingency reserve an amount equal to fifty percent (50%) of the remaining unearned premiums. Contributions to the contingency reserve made during each calendar year shall be maintained for a period of 120 months, except that withdrawals may be made by the company in any year in which the actual incurred losses exceed thirty five percent (35%) of the corresponding earned premiums, and no releases shall be made without prior approval by the commissioner of insurance of the insurance company's state of domicile.~~

~~If the coverage provided in this Act exceeds the limitations set forth herein, the commissioner of insurance shall establish a rate formula factor that will produce a contingency reserve adequate for the added risk assumed. The face amount of an insured mortgage shall be computed before any reduction by the mortgage guaranty insurance company's election to limit its coverage to a portion of the entire indebtedness.~~

~~D. Reinsurance~~

~~Whenever a mortgage guaranty insurance company obtains reinsurance from an insurance company that is properly licensed to provide reinsurance or from an appropriate governmental agency, the mortgage guaranty insurer and the reinsurer shall establish and maintain the reserves required in this Act in appropriate proportions in relation to the risk retained by the original insurer and ceded to the assuming reinsurer so that the total reserves established shall not be less than the reserves required by this Act.~~

~~E. Miscellaneous~~

- ~~(1) Whenever the laws of any other jurisdiction in which a mortgage guaranty insurance company subject to the requirement of this Act is also licensed to transact mortgage guaranty insurance require a larger unearned premium reserve or contingency reserve in the aggregate than that set forth herein, the establishment of the larger unearned premium reserve or contingency reserve in the aggregate shall be deemed to be in compliance with this Act.~~
- ~~(2) Unearned premium reserves and contingency reserves shall be computed and maintained on risks insured after the effective date of this Act as required by Subsections A and C. Unearned premium reserves and contingency reserves on risks insured before the effective date of this Act may be computed and maintained as required previously.~~

Section ~~1722~~. Regulations

The commissioner shall have the authority to promulgate rules and regulations deemed necessary to effectively implement the requirements of this Act.

Chronological Summary of Actions (all references are to the Proceedings of the NAIC).

1976 Proc. II 15, 17, 647, 686, 747-753 (adopted).

1979 Proc. I 44, 47-48, 49, 719, 968-969 (corrected).

MO-630-13

**Consumer Organizations’ and NAIC Consumer Representatives’ Comments to the
NAIC Mortgage Guaranty Insurance (E) Working Group
On the May 11, 2023 Exposure Draft of the Mortgage Guaranty Insurance Model Act
May 26, 2023**

The undersigned NAIC consumer representatives and consumer organizations strenuously oppose the new provision eliminating a private right of action for violations of the act. While different from the “no private right of action” provision in the prior draft of the model law, the latest version of “no private right of action” in the May 11, 2023 exposure draft remains unwarranted and profoundly anti-consumer.

We also object to the watering-down of essential consumer protections.

A Private Right of Action is Necessary and Justified for Violations of Sections 8 (Advertising), 11A (Prohibition of Captive Reinsurance), 12 F (Nondiscrimination), 16 (Conflict of Interest), 18A (Inducements), 18B (Compensation for Placement), 18C (Rebates), 18F (Educational Materials) and 19 (Rescission)

The current NAIC mortgage guaranty insurance model act – adopted many years prior to the 2008 financial crisis – contains no provision limiting any consumer’s right of action against the insurance company for violations of the act. It is unclear what rationale or basis or changes in the market exist to support the new “no private right of action” provision.

The current model includes, in Section 13, anti-rebating and anti-kickback provisions to protect consumers from collusion among mortgage insurers and lenders – practices that harm consumers. Despite these anti-kickback provisions in the model law, some insurance regulators not only failed to stop kickback schemes, such as captive reinsurance, but approved these anti-consumer schemes. Private rights of action garnered some relief for consumers who suffered losses because of the prohibited kickback schemes.

Historical experience demonstrates that regulatory oversight alone failed to protect mortgage guaranty insurance consumers and private rights of action helped address regulatory and market failures to provide some redress for harmed consumers. It is illogical that regulators would now insert a provision eliminating a private right of action for consumer redress in the revised model.

Industry’s sole argument for the “no private right of action” is the ephemeral chestnut of “potential frivolous litigation.” While we have pointed to justified litigation, industry has offered no examples of “frivolous litigation.” We have previously pointed out that while industry wants to prevent consumers from going to court for protection against and redress from

Consumer Organizations' and NAIC Consumer Representatives' Comments to the
NAIC Mortgage Guaranty Insurance (E) Working Group
May 26, 2023
Page 2

abusive mortgage guaranty insurer practices, the insurers themselves have no qualms about going to court against consumers. It would be an unfair double standard for regulators to endorse a “no private right of action” by consumers while leaving insurers’ access to the courts untouched.

The addition of the “no private right of action” provision is unprecedented. There is no other personal line of insurance with such an anti-consumer provision. There is certainly no such provision in any of the NAIC model laws for lines of insurance that, like mortgage guaranty insurance, are subject to reverse competition – not for consumer credit insurance and not for title insurance.¹ Lines of insurance subject to reverse competition demand greater consumer protection tools, not fewer.

It would not be objectionable to limit the private right of action to only those provisions of the model for which consumer harm can be directly demonstrated and which avoid any provisions that would interfere with regulatory oversight of mortgage guaranty insurer solvency. A private right of action for violations of Sections 8, 11A, 12F, 16, 18A, 18B, 18C, 18F and 19 will not interfere with regulatory oversight of mortgage guaranty financial condition or market conduct – just as private rights of action for any other personal line of insurance complement regulatory oversight of insurers’ market conduct in those other lines of insurance.

The revised “no private right of action” language – “neither creates a private right of action for violation of its provisions nor may it be construed to curtail a private right of action which would otherwise exist in the absence of the Act” – is very broad and could be interpreted to have the same effect as simply stating no private right of action. For example, the revised model now includes “limitations” on rebates, commissions and inducements instead of outright prohibitions. It is unclear what or how any other state laws specifically reference any of these prohibited practices and, consequently, how a private right of action would otherwise exist in the absence of the law. If a private right of action otherwise exists, it is likely because there is a federal law governing the behavior of mortgage insurers and state law will not usurp those private rights of action regardless of whether the new mortgage guaranty insurance model mentions “otherwise existing” private rights of action.

¹ “Reverse competition means competition among insurers that regularly takes the form of insurers vying with each other for the favor of persons who control, or may control, the placement of the insurance with insurers. Reverse competition tends to increase insurance premiums or prevent the lowering of premiums in order that greater compensation may be paid to persons for such business as a means of obtaining the placement of business. In these situations, the competitive pressure to obtain business by paying higher compensation to these persons overwhelms any downward pressures consumers may exert on the price of insurance, thus causing prices to rise or remain higher than they would otherwise.” NAIC Credit Personal Property Model Act, 3X.

Consumer Organizations' and NAIC Consumer Representatives' Comments to the
NAIC Mortgage Guaranty Insurance (E) Working Group
May 26, 2023
Page 3

Watering Down of Important Consumer Protections

Section 18A is significantly weakened from a consumer protection standpoint. The model upends a fundamental anti-competitive practice – no inducements by insurers for the steering of business to the insurer – and makes such inducements permissible if included in the policy and subject to the Unfair Trade Practices Act. This is precisely the wrong way to regulate a line of business subject to reverse competition in which the insurers compete not for individual consumers, but for the lenders who select the mortgage guaranty insurer and steer the borrowers to those insurers. It was reverse competition in mortgage guaranty insurance markets that motivated a variety of inducement mechanisms to secure business from lenders leading up to the financial crisis of 2008. It was reverse competition that compromised mortgage guaranty insurers' risk management practices.

The recent revisions to the UFTA model act attempt to encourage risk mitigation efforts by insurers without conflicting with anti-rebate concerns. There is no risk mitigation associated with an inducement. Section 18A should be revised to delete the proposed addition at the beginning of the paragraph to clearly prohibit inducements.

The change to Section 18C – permitting rebates if set forth in the policy and subject to the UTPA – is also bewildering. The draft section states:

Rebates: Unless set force (sic) in the policy and subject to the [state equivalent of the Unfair Trade Practice Act (Model #880)], a Mortgage Guaranty Insurance company shall not quote any rate or premium charge to a person that is different than that currently available to others for the same type of coverage. The amount by which a premium charge is less than that called for by the current schedule of premium charges is an unlawful rebate.

There is simply no way for a “rebate” as set out in the first phrase (set forth in the policy and subject the UTPA) to comply with the remaining portion of the paragraph. If the “rebate” is set forth in the filed rates, it is not a “rebate,” but a rate discount. If the “rebate” is available to all for the same type of coverage, it is not a “rebate,” but a rate discount. Further, reaching to the recent revisions of the NAIC UTPA model does not help; those recent revisions were intend to promote loss prevention and loss mitigation efforts without conflicting with anti-rebating prohibitions. If the “rebate” is set out in the policy form, then the UTPA is inapplicable because rebates are not policy form provisions approved by the regulator.

Consumer Organizations' and NAIC Consumer Representatives' Comments to the
NAIC Mortgage Guaranty Insurance (E) Working Group
May 26, 2023
Page 4

Private mortgage insurers do not engage in risk mitigation with borrowers – lenders and mortgage services are the entities that do such activities. While private mortgage insurers may engage in risk mitigation with lenders and servicers – because the mortgage insurance is for the benefit of the mortgage owner – there is no rationale for providing a “rebate” to lenders or services and such activity would clearly be a prohibited inducement or rebate.

Please contact Birny Birnbaum at birny@cej-online.org if you have any questions or would like additional information.

Center for Economic Justice
Consumer Federation of America
National Consumer Law Center (on behalf of its low-income clients)
United Policyholders
Amy Bach, NAIC Consumer Representative
Birny Birnbaum, NAIC Consumer Representative
Brendan Bridgeland, NAIC Consumer Representative
Bonnie Burns, NAIC Consumer Representative
Brenda Cude, NAIC Consumer Representative
Deborah Darcy, NAIC Consumer Representative
Yosha Dotson, NAIC Consumer Representative
Erica Eversman, NAIC Consumer Representative
Kara Hinkley, NAIC Consumer Representative
C. P. Hoffman, NAIC Consumer Representative
Karroll Kitt, NAIC Consumer Representative
Ken Klein, NAIC Consumer Representative
Peter Kochenburger, NAIC Consumer Representative
Matthew J. Smith, NAIC Consumer Representative
Harry Ting, NAIC Consumer Representative
Richard M. Weber, NAIC Consumer Representative
Jackson Williams, NAIC Consumer Representative
Silvia Yee, NAIC Consumer Representative

June 2, 2023

Ms. Jackie Obusek, Chair
Mortgage Guaranty Insurance (E) Working Group
National Association of Insurance Commissioners
1100 Walnut Street
Kansas City, MO 64106-2197
c/o Andy Daleo,
Senior Manager – Financial Regulatory Services

RE: MI Industry Group Comment Letter – May 2023 Model Act Exposure Draft

Dear Ms. Obusek:

The Private Mortgage Guaranty Insurance Industry Group (“Industry Group”) submits the following comments with regard to Sections 10(B)(1) and 14(A) of the *Mortgage Guaranty Insurance Model Act* exposed on May 11, 2023 (“May 2023 Model Act”).

Section 10(B)(1) – Contingency Reserve

The Industry Group recommends the following revision to draft Section 10(b)(1) and accompanying drafting notes for the Working Group’s consideration. This proposal is meant to avoid adoption of a Model Act that would discourage the use of reinsurance by requiring the same amount of annual contribution to the Contingency Reserve irrespective of whether premiums are being ceded pursuant to a reinsurance agreement or treaty. Both a Contingency Reserve requirement and collateralized or otherwise specifically segregated assets required to be maintained pursuant to a reinsurance agreement or treaty serve the same function of providing assurance of claims paying ability. Form should not be elevated over function by granting credit towards the Contingency Reserve requirement only where the dedicated funding is able to be formally accounted for as a Contingency Reserve on a statutory financial statement, particularly since collateral held in a segregated trust could be considered to provide even more certain access to such funds for the cedent than assets commingled within a reinsurer’s general investment portfolio to support a recorded Contingency Reserve entry.

The current exposure draft requires an annual contribution to the Contingency Reserve “*which in the aggregate shall be equal to fifty percent (50%) of the direct earned premiums reported in the annual statement or net earned premiums reported if the reinsurer maintains the contingency reserve.*” The Working Group addressed the interaction of reinsurance with the Contingency Reserve by adding the language “*or net earned premiums reported if the reinsurer maintains the contingency reserve.*” However, except in the case where the reinsurer is another mortgage guaranty insurance company, the impact of this language would unfortunately be illusory because reinsurers that are not mortgage guaranty insurance companies do not file a statutory financial statement that shows a contingency reserve entry.

The suggested drafting approach below would clarify that the Contingency Reserve requirement is deemed to be achieved based on the maintenance by the reinsurer of equivalent collateralized or otherwise specifically segregated assets supporting the reinsurance obligations, in trust or

otherwise, even if the reinsurer does not file a statutory financial statement that shows a contingency reserve entry.

B. Contingency Reserve. *Each Mortgage Guaranty Insurance company shall establish a Contingency Reserve subject to the following provisions:*

- (1) The Mortgage Guaranty Insurance company shall make an annual contribution to the Contingency Reserve which in the aggregate shall be equal to fifty percent (50%) of (a) the direct earned premiums reported in the annual statement or (b) earned premiums net of reinsurance reported if the reinsurer maintains the Contingency Reserve or equivalent assets that support its reinsurance obligation. Credit for maintenance of the Contingency Reserve or equivalent assets in connection with reinsurance shall apply to the extent of and during the period that such amounts are maintained. In the event of a release of such amounts before the 120 month period in subpart (B)(2) of this Section for any reason other than as approved under subpart (B)(3) of this Section, the Mortgage Guaranty Insurance company shall reestablish such amounts in its Contingency Reserve effective as of the date of the next annual contribution to the Contingency Reserve.*

In conjunction with this version of Section 10(B)(1), we also propose adding the following drafting note:

Drafting Note: *As used in this section, the term “reinsurance” includes traditional forms of insurance as well as other similar mechanisms or constructs, such as insurance linked notes with a reinsurance feature, that permit the primary direct insurer to transfer risk in a manner that allows that insurer to record such risk transfer and any capital support attendant thereto either as an asset or a reduction from liability on its statutory financial statements in accordance with statutory accounting principles. As used in this section, the phrase “equivalent assets” includes the maintenance by the reinsurer of collateral in a trust or segregated account to support the reinsurer’s obligation, or the direct insurer recording a liability for funds held under the reinsurance treaty.*

Finally, we also offer an optional drafting note that may accompany Section 10 to the extent that the Working Group deems it to be helpful. While the Industry Group does not view it to be essential, the optional drafting note is intended to memorialize, for the avoidance of any doubt, that the contingency reserve provision in this model law that is unique to the mortgage guaranty insurance line should not be construed as being in conflict with the provisions of either the Covered Agreement or the NAIC’s separate model law relating to credit for reinsurance.

Drafting Note: *In accordance with The Bilateral Agreement Between the United States of America and the European Union on Prudential Measures Regarding Insurance and Reinsurance (“Covered Agreement”), states should not interpret this section in a manner that would violate or contravene the Covered Agreement. Nothing in this section is intended to be in conflict with NAIC Model 785 Credit for Reinsurance Law or NAIC Model 786 Credit for Reinsurance Regulation.*

Section 14(A) – Policy Forms

The Industry Group continues to recommend the deletion in its entirety of the second sentence in Section 14(A) relating to deficiencies arising from a foreclosure sale.

Citing experiences from the great financial crisis involving moral hazards such as the temptation of a borrower to strategically default on a mortgage loan notwithstanding having the financial wherewithal to repay amounts due, the Industry Group previously commented that the ability to evaluate loans for pursuit of deficiency actions on a case by case basis supports the overall solvency of the mortgage guaranty insurance industry.¹ There is a divergence among states with regard to the pursuit of deficiency judgments -- many states permit such actions while some states have passed an anti-deficiency judgment law of general effect that applies to both loan servicers and mortgage guaranty insurers alike. We commented that it would be an anomalous result if scenarios were to arise in certain states where the loan servicer is allowed to pursue the borrower for a deficiency arising from a foreclosure sale while the mortgage insurer is restricted from doing so.² Finally, we offered reassurance to the Working Group that in those states that do have anti-deficiency judgment acts, the Master Policy form already acknowledges the limitations on the mortgage guaranty insurer to pursue deficiencies arising from a foreclosure sale in those particular jurisdictions.³ Therefore, we requested to remove this sentence from the Model Act draft exposed in October 2022.

Following the submission of the November 18, 2022 Comment Letter, the Working Group did, in fact, remove the language referring to deficiency actions from the February 2023 Model Act exposure draft, but appeared to have inadvertently retained a fragment of the sentence. Believing this to be a typographical error in need of correction, we flagged this sentence fragment in the attachment to our March 14, 2023 Comment Letter. However, the May 2023 Model Act corrected the typographical error by restoring the original draft prohibition on pursuit of deficiency actions, rather than by deleting the sentence fragment. Therefore, we again raise this matter to the Working Group's attention and request to remove the second sentence of Section 14(A) in its entirety for the reasons in our prior comment letter and summarized above.

Conclusion

The Industry Group supports the Working Group's efforts to update the Model Act, and we would be pleased to make representatives of each company available for a telephonic conference to discuss the comments in this letter if that would be of assistance to you.

Respectfully submitted on behalf of the Industry Group companies below,

**Arch Mortgage Insurance Company,
Enact Mortgage Insurance Corporation,
Essent Guaranty, Inc.,
Mortgage Guaranty Insurance Corporation,
National Mortgage Insurance Corporation, and
Radian Guaranty Inc.**

¹ See Industry Group Comment Letter dated November 18, 2022, at 11.

² See *id.* at 12.

³ See *id.*

Draft: 5/8/23

Restructuring Mechanisms (E) Working Group
Virtual Meeting
May 4, 2023

The Restructuring Mechanisms (E) Working Group of the Financial Condition (E) Committee met May 4, 2023. The following Working Group members participated: Elizabeth Kelleher Dwyer, Co-Chair, and Matt Gendron (RI); Glen Mulready Co-Chair, and Andrew Schallhorn (OK); Leo Liu (AR); Rolf Kaumann (CO); Jared Kosky and Jack Broccoli (CT); Judy Mottar and Vincent Tsang (IL); Robert Wake (ME); Judy Weaver (MI); Fred Andersen (MN); John Rehagen (MO); Lindsay Crawford (NE); John Sirovetz (NJ); Bob Kasinow (NY); Dale Bruggeman (OH); Diana Sherman (PA); Amy Garcia (TX); Doug Stolte and David Smith (VA); Steve Drutz (WA); and Amy Malm (WI).

1. Received and Considered Comments on Exposed Draft Guidance and New Language to Address Previous Comments

Superintendent Dwyer announced that during the April 4 meeting, the Working Group exposed draft Best Practices guidance and requested wording to address issues discussed during the meeting. Superintendent Dwyer noted the Working Group received twelve comments (Attachment Four-A) and the discussion will focus on the comments received related to the exposed redline changes, as well as the new language to address previous comments, that later of which will be exposed sometime after this call.

A. Accreditation Requirements

Superintendent Dwyer explained that with respect to the question of making the Best Practices document currently being developed and debated and accreditation requirement, the product would proceed to the Financial Condition (E) Committee. They would decide whether to refer the Best Practices to the Financial Regulation Standards and Accreditation (F) Committee, who would decide what portions, if any, of the Best Practices document would become an accreditation standard.

B. Guaranty Fund Coverage

Robin Marcotte (NAIC) summarized the comments on the next issue dealing with retaining guaranty fund coverage. Superintendent Dwyer asked for comments from individuals that did not support the existing language in the draft Best Practices document on the topic of guaranty fund coverage. Wayne Mehlman (American Council of Life Insurers—ACLI) stated they support the existing language on guaranty fund coverage in the Best Practices document. Kristen DiCarmine (New York Life) stated they had no objections and that they would follow the document as it is considered at various stages for accreditation. Rehagen stated appreciation for the language included but noted that he was struck that the legal opinion requirement was removed. Superintendent Dwyer explained that as an attorney, she would prefer the company tell her as a regulator whether their attorney opines on the guaranty fund protection being retained. She explained that within the departments of insurance, she believes they understand the issue well enough and if they do not, she is not sure they could seek a legal opinion but that would be a reason for not requiring a formal legal opinion.

Bill O'Sullivan (National organization of Life and Health Guaranty Associations—NOLHGA) stated he agreed with Superintendent Dwyer on the reason for removing the legal opinion language because guaranty fund coverage, both on the life and property casualty side, will be determined at the time the company is placed into liquidation. He stated there could be all sorts of factors in making the determination regarding potential limitation and exclusions of coverage that would be difficult to estimate at the time of the transaction. He stated he believes it

was more important is that certain factors are met and as included in the previously exposed revised language. Superintendent Dwyer stated that as an attorney, she preferred that to a representation at a point in time from some outside law firm. Rehagen stated that he was concerned that all states would not adopt the language but since the language has specific factors that must be addressed and assessed, he found the reason for taking that certification requirement out of the draft Best Practices document. Robert Romano (Norton Rose Fulbright and on behalf of Protucket Insurance Company) stated their comment is focused on the distinction between how guaranty fund coverage for life and health and property and casualty are managed and that at least in theory, they should be the same in the end. O'Sullivan responded that for life and health coverage, for there to be guaranty fund coverage, the insurer must be a member of the state guaranty fund association, which means they must be licensed or have been licensed in the state. Barbara Cox (National Conference of Insurance Guaranty Funds—NCIGF) stated that for property casualty business, the insolvency company must issue the covered business. She stated that NCIGF supports state regulation and that it would be good if the successor insurer was also a licensed insurer under the supervision of the state regulator, but current that does not ensure coverage on the property casualty side. The Receivership and Insolvency (E) Task Force is currently modifying the language that will address this issue. Cox noted the hope was for the language to be adopted by the Summer National Meeting. Romano suggested that once the language Ms. Cox is referring to is adopted by all the states, the Best Practices document will need to be updated. Peter L. Hartt (Randall and Quilter) stated they defer to the expertise of others, but they were simply looking for clarification on the purpose of licensure is. Superintendent Dwyer responded that she believes the guaranty fund representatives were correct that while licensure is especially important in life and annuity, not as important you sometimes could have coverage and guaranties in property and casualty in a separate way. Superintendent Dwyer asked one final time for objections to the previously exposed language for this item, as well as editorial changes for the remainder of the section and there were none.

C. Independent Expert

Marcotte summarized the comments on the next issue dealing with the use of an independent expert. Mehlman stated that the ACLI principles on this topic require an independent expert on both an insurance business transfer (IBT) and a corporate division (CD), and the development of such principles was after months of negotiations between members. Superintendent Dwyer noted that this issue had been discussed extensively and noted she believed most everyone believes that most transactions there is a need for such an expert, but that the Department's staff knows the company and the Department would on occasion find that and independent expert was not necessary. Superintendent Dwyer added that as drafted, this would require the Department to set that out and make a very explicit statement on why. Mehlman responded that they appreciate that but that he can only restate what is in the ACLI principles that require an independent expert regardless. Birny Birnbaum (Center for Economic Justice—CEJ) stated his company takes no issue with the language, but noted it demonstrates a greater need for a policyholder advocate. He noted it is unclear where there would be any kind of public report assessing the impact on policyholders and if there is no independent expert then there is really an even greater need for policyholder advocates to be part of the process. Superintendent Dwyer asked one final time for objections to the previously exposed language for this item, as well as editorial changes for the remainder of the section and there were none.

D. Other Redline Changes Edits to Previously Exposed Draft Best Practices

Superintendent Dwyer asked for objections to the remaining redline changes in the previously exposed document, as well as editorial changes noted by NAIC staff and the chair, and there were none.

E. New Language on Proforma Financials

Marcotte summarized the comments on the next issue dealing with proforma financial statements noting that both comments support the position of the Working Group on this issue. Birnbaum stated that while three years of proforma financial statements may be adequate for some types of analysis associated with these proposed transactions, it is certainly not enough time to consider the treatment of policyholders. This would include for example fees, expenses, and changes thereon that gets at servicing issues. An example would be a transaction dealing with variable annuities where the transferee has a history of increased expense provisions on those types of products. There were no additional comments, but the revised language will be included for additional comments in the next exposure.

F. New Language on Evaluating Policyholder Impacts & Not Creating Monoline Insurers

DiCarmine discussed their previous comments discussed during the last call on no worse off and how to evaluate that and how their proposed language submitted attempts to address this concern of theirs. Malm asked for clarification of the use of the term monoline insurers since that has a connotation among regulators to include things such as mortgage guaranty insurance and financial guaranty insurance. Superintendent Dwyer suggested something like “the domestic regulator should consider whether the transfer or the transferee will become a monoline company following the transaction. Birnbaum suggested the idea of the concern is good and for whatever that means for a life insurer but questioned the language fix. He set forth a number of related issues that he thinks should be addressed in the financial analysis of the receiving company. Superintendent Dwyer suggested perhaps “consider or evaluate” is better than “ensure” to leave room for those lines of business. DiCarmine described how supplemental benefits could be an example of a life insurer monoline of business where perhaps the transferor previously sold life and annuities as well. Marcotte suggested the better term might be diversification. Superintendent Dwyer agreed with Marcotte and suggested this language be modified in the next version of the draft Best Practices.

G. New Language on Policyholder Advocate

Superintendent Dwyer stated that she understood the concerns raised in the comment letter by the Center for Economic Justice but that personally having worked at an insurance department for 25 years, she believes that the states are the policyholder advocate. Superintendent Dwyer noted that while the commentor believes there is a conflict, she respectfully disagreed with that view. Superintendent Dwyer asked if there were others that shared similar views. Bonnie Burns (California Health Advocate) stated she supported the comments from the Center for Economic Justice. Burns stated that while departments can help consumers with these issues, those consumers may not get to a department of insurance for a variety of reasons. Burns noted she has a lot of experience with people who have questions beyond what the department of insurance can manage.

Superintendent Dwyer asked for an example. Burns noted that if a consumer was considering taking legal action and has indicated such to the department of insurance who is unable to help with information. Or sometimes there are provider issues that come up outside of the department’s expertise. Birnbaum stated that the way the draft Best Practices was currently structured, there is a communication plan that alerts policyholders to the business transfer and gives the consumer an opportunity to participate in any kind of public forum. So, the problem is if the consumer calls in and makes a comment its not framed in a way that is helpful to the regulator because the consumer does not really understand the process and does not understand the requirements placed upon the regulator to decide. If there were a policyholder advocate, they could not only take the information provided to them for serving in that capacity, and they could also sort of supplement that information with additional information from the consumer and other consumers and put into the context that is relevant for the regulator to consider. He described how in a long-term care rate filing, many regulators hold a hearing on those types of issues, where the consumer calls in, makes comments, but they are not comments that a regulator can use in terms of the requirements. As previously noted, a policyholder advocate could assist in the situation. Burns

noted how she was a consumer, and this was not her area of expertise and would be relying on Birnbaum. Burns noted that consumers come to her for information about how things affect them and what if anything they can do to assist and people in the insurance department are unable to talk to them in that way. Superintendent Dwyer responded that she wanted to be clear, but that she was not saying that policyholder advocates and things that consumer advocates do have no value. She noted that long-term care rate filings and provider issues are not what is at issue, rather the issue is whether a book of business should be transferred from one company to another without any change in the policy. Birnbaum agreed this was different than a proceeding to approve a policy form or a rate but there is a similarity and while he understands that its regulators responsibility to make sure there are no adverse or materially adverse impact on those policyholders, but any type of situation in which there an impact on policyholders and the benefits of having a policyholder advocate. Superintendent Dwyer asked the members of the Working Group if any of them wanted to change their view on this issue and the addition of such language and no one responded.

H. Hong Kong Legislation

Marcotte noted that Dave Wolf (NJ) had provided some language on the Hong Kong legislation that he had some previous experience with and had questioned on the April 4 call if it included “material” in its requirement of an adverse effects. The Working Group deferred discussion on the topic until NAIC staff could review the legislation more closely and Mr. Wolf could be on to discuss more specifically his view.

I. No Material Adverse Effects

Superintendent Dwyer noted this issue was discussed on the last call and the Working Group expressed a preference for using “material” specifically in addition to “no adverse effect.” Robert Woody (American Property Casualty Insurers Association—APCIA) noted how this standard had been used in other places and how he thought there are some circumstances where material might even be defined. Without such a standard, the door could be opened to very minor issues becoming an obstacle to a transaction. Stephen DiCenso (Milliman) noted that he thought the comments he submitted stand on their own and if there needs to be further elaboration, there is some documentation in the minutes of an example that he provided. Romano stated his agreement and that there needed to be changes made throughout the document for consistency. Hartt agreed with the other comments and too also emphasized the need for consistency throughout the document. Birnbaum noted that industry seems to favor the no material adverse effect language which seems to imply there can be some assessment of all policyholder with one assessment when in fact if you look at the corporate division narrative, it refers to evidence demonstrating that the interests of all classes of policyholders and stakeholders will be protected. There could be a variety of positive and negative effects and part of this has to do with material, which is who gets to decide what is material. The question is how you determine what a material adverse effect is and how do you ensure consistency or uniformity across the states. Stolte stated he agreed with Birnbaum and more specifically that he does not think a policyholder should have any adverse impact from one of these transactions; something he finds problematic. Superintendent Dwyer noted she would ask NAIC staff to draft up something that will be included in the next exposure.

J. Other Comments

Marcotte noted that comments were received on the topic of runoff, and as has been noted in the past, the inclusion of that topic in the current Best Practices was related to the fact that the group was charged to address the issue but that ultimately that topic may need to be placed elsewhere in a different document. Carolyn Fahey (AIRROC) expressed AIRROCs willingness to work with the Working Group to further examine some of the questions related to runoff and the distinct differences between runoff and restructuring. Mehlman asked about the status of the White Paper. Superintendent Dwyer responded that the White Paper was waiting on these Best

Practices and that once these are finished, they will be incorporated into the White Paper, by reference. Superintendent Dwyer stated they are trying to get both done by the end of the year.

Having no further business, the Restructuring Mechanisms (E) Working Group adjourned.

[https://naiconline.sharepoint.com/sites/NAICSupportStaffHub/Member Meetings/E CMTE/2023-2-Summer/Restructuring Mech WG/5-4-23/5-4-23 Restructure WG.docx](https://naiconline.sharepoint.com/sites/NAICSupportStaffHub/Member%20Meetings/E%20CMTE/2023-2-Summer/Restructuring%20Mech%20WG/5-4-23/5-4-23%20Restructure%20WG.docx)

Draft: 4/20/23

Restructuring Mechanisms (E) Working Group
Virtual Meeting
April 4, 2023

The Restructuring Mechanisms (E) Working Group of the Financial Condition (E) Committee met April 4, 2023. The following Working Group members participated: Elizabeth Kelleher Dwyer, Co-Chair, and Matt Gendron (RI); Glen Mulready Co-Chair, and Andrew Schallhorn (OK); Leo Liu (AR); Rolf Kaumann (CO); Jared Kosky and Jack Broccoli (CT); Fred Moore, Judy Mottar, and Vincent Tsang (IL); Robert Wake (ME); Judy Weaver (MI); Fred Andersen (MN); John Rehagen and James Le (MO); Lindsay Crawford (NE); David Wolf (NJ); Bob Kasinow (NY); Dale Bruggeman (OH); Diana Sherman (PA); Amy Garcia (TX); Doug Stolte and David Smith (VA); Dan Petterson (VT); Tim Hays (WA); and Amy Malm (WI).

1. Discussed the Merger of the Restructuring Mechanisms (E) Subgroup into the Restructuring Mechanisms (E) Working Group

Superintendent Dwyer said at the Spring National Meeting, the merger of the Restructuring Mechanisms (E) Subgroup into the Restructuring Mechanisms (E) Working Group was announced during the Financial Condition (E) Committee meeting. It was also noted that the membership and charges would be merged into the Working Group, with Ohio added as one new member. Members were asked to contact NAIC staff if they would like to make any changes to their listed representative; although, it was noted that a merger of the two groups is appropriate given that many of the representatives are the same. Superintendent Dwyer noted that the Subgroup developed a first draft of regulatory principles and best practices for insurance business transfers (IBTs) and corporate divisions (CDs), but the merged Working Group would now complete that work. Commissioner Mulready stated that the goal is to have all products of the Working Group, including the best practices, finalized by the Fall National Meeting.

2. Adopted the Restructuring Mechanisms (E) Subgroup's Nov. 9, 2022, Minutes

Malm made a motion, seconded by Commissioner Mulready, to adopt the Restructuring Mechanisms (E) Subgroup's Nov. 9, 2022, minutes (*see NAIC Proceedings – Fall 2022, Financial Condition (E) Committee, Attachment Seven*). The motion passed unanimously.

3. Exposed Proposed Revisions to Best Practices

Superintendent Dwyer announced that included in the materials were proposed revisions to the best practices that address: 1) the use of an independent expert for CDs; and 2) language to address comments from the National Organization of Life and Health Insurance Guaranty Associations (NOLHGA) and the National Conference of Insurance Guaranty Funds (NCIGF). The concept of the changes was previously authorized by the Restructuring Mechanisms (E) Subgroup, and NAIC staff developed language to address both concepts. Superintendent Dwyer indicated that there was a desire to expose the proposed revisions for a 21-day public comment period ending April 26 so the comments could be discussed during the Working Group's next meeting, which is scheduled for May 4. Rehagen stated that the exposure period is shorter than normal, but he appreciates the reason and is therefore not opposed to it. Superintendent Dwyer indicated that the changes appear to be non-controversial and therefore proposed a shorter proposed exposure period, but comments may suggest otherwise which would cause another exposure period. William O'Sullivan (NOLHGA) stated his appreciation for NAIC staff working with him on the changes that are intended to preserve guaranty fund coverage by requiring the successor entity to continue to be licensed in the appropriate jurisdictions. Superintendent Dwyer noted that the Receivership and

Insolvency (E) Task Force is developing changes to the *Property and Casualty Insurance Guaranty Association Model Act* (#540) that would provide similar assurances for property/casualty (P/C) contracts.

Kaumann made a motion, seconded by Commissioner Mulready, to expose the revisions to the best practices until April 26. The motion passed unanimously.

4. Heard an Update on RBC Runoff Referrals

Bruggeman stated that the referral from the Working Group to the Property and Casualty Risk-Based Capital (E) Working Group had been discussed, and after that, the Capital Adequacy (E) Task Force requested that the Health Risk-Based Capital (E) Working Group and the Life Risk-Based Capital (E) Working Group also review and discuss it. He noted that the Life Risk-Based Capital (E) Working Group reviewed and discussed the issue of runoffs for its formula, and it concluded that no changes were needed. He also noted that the Health Risk-Based Capital (E) Working Group came to the same conclusion as the Property and Casualty Risk-Based Capital (E) Working Group, which is that resulting insurers should be monitored through the state analysis and examination functions. They also concluded that if a change is ultimately made to the health risk-based capital (RBC) formula, they would recommend that it be defined as a voluntary or involuntary, and includes the characteristics of: 1) non-renewing of policies for at least 12 months; 2) no plan or intention to write new business or assume new business; and 3) no additional runoff blocks of business. Additionally, if the remaining reserves are zero, the runoff is probably complete or almost complete.

5. Continued Discussion of the Review of Previously Submitted Comments

A. No Worse Off

Superintendent Dwyer noted that the first topic that has been discussed by the Restructuring Mechanisms (E) Subgroup but for which the Restructuring Mechanisms (E) Working Group would need to conclude is the issue of “no worse off” language. Superintendent Dwyer stated that standards such as “best interest of the policyholder” or “no material adverse effect,” was the United Kingdom (UK) standard and standards previously interpreted by Courts provide a clearer standard. Commissioner Mulready noted that Oklahoma modeled the language in its law after the Part VII UK standard, and he suggested the same for these NAIC best practices. He noted that the “no material adverse effect” language has worked for over 20 years and over 300 transactions. Stolte stated that Virginia prefers “no worse off” since it does not believe a policyholder should experience any type of adverse impact, and materiality is in the eye of the beholder. Commissioner Mulready responded that he appreciates the comment on materiality, but he noted that the process is so robust, and the materiality in the process would be in the eyes of the independent expert, as well as the state insurance regulator and the judge.

Superintendent Dwyer stated that while the standards are financial, language that has previously been used and for which case law exists would be preferred. She noted that it was not clear where “no worse off” language was derived from. Stolte noted that they were not lawyers, but they were just trying to protect the policyholders in the transaction. He noted that this would have no impact on Virginia policyholders because of the Virginia anti-innovation law, and the company would be required to come to the Virginia state insurance regulator for approval. Smith added that the “no worse off” language was a compromise between the best interests of the policyholders and the “no material adverse effect.” Kosky noted that Connecticut law uses a best interest rule, and its CD law uses similar language.

Luann Petrellis (Catalina Re) voiced support for the “no material adverse impact” standard. It has been widely used through the UK Part VII Transfers for many years without any subsequent financial difficulties in any transaction. She also emphasized that materiality is a universally accepted standard of review, and there is a

wealth of legal precedent interpreting what that means. There is an aspect of subjectivity in any of these standards, but there are tried and true tested procedures with material adverse impact, and there have been successfully completed transactions in the U.S. that utilized that standard. Petrellis noted that during legislative processes on this topic, everyone in the industry from all points of view agreed with this language, and using any other standard would likely result in inconsistency. Stephen DiCenso (Milliman) provided an example of the issue, noting that if an insurer had an RBC of 500, and then after the transaction it was 400, some might argue that the policyholder was worse off, but in either of those two cases, judgment would indicate that there is no material impact. That example supports the “no material adverse effect” standard. Peter L. Hartt (Randall and Quilter) stated that he concurs with the comments from DiCenso and Petrellis, and he stated that Randall and Quilter’s concerns would be the unintended consequences of experimenting with new terminology that has not been well tested. Kristen DiCarmine (New York Life) noted that the points raised in its joint letter are different than those others have made, and she emphasized that there are some financial and administrative elements that would help to define “no worse off” or not materially adverse. She suggested adding language that would address this comment. Superintendent Dwyer asked DiCarmine to send in such language.

James Mills (Enstar) stated that “no material adverse effects” goes beyond just UK Part VII Transfers, and more precisely, it is a term of art used broadly in contract evaluation. He noted that there was a comprehensive framework that would be used, and it is important to recognize what exists in statutes that legislatures have enacted. He agreed with the point made by DiCenso, and he argued that any dividend payment by an insurer would be detracting from the financial stability of its policy, but state insurance regulators evaluate capital adequacy, not capital maximization, within insurers, and there are difficulties in the insurance industry. Stolte responded that these are best practices, and in Virginia, its law is to consider the best interests of the policyholder, and nothing done by the Working Group will change that. Superintendent Dwyer agreed with Stolte regarding nothing within the Working Group changing Virginia law, and the same goes for other state laws. She stated the Working Group’s product will be to set high financial standards for these transactions. She asked if there were states besides Virginia and Connecticut that were against the use of the “no material adverse effect.”

Broccoli responded that Connecticut is fine with that standard for IBTs, and its position previously described was with respect to CDs. No other states responded. Superintendent Dwyer summarized that the Working Group would utilize “no material adverse effect.” She added that the Working Group will work on this further regarding how to measure the standard. It will also look at whether the standard would be different for reinsurers. Wolf asked if it would be possible to remove material from the standard. He believes that the standard in Hong Kong was “no adverse effect on policyholders.” Superintendent Dwyer stated that in addition to the concepts mentioned by New York Life, the Working Group would ask Wolf to provide information on the Hong Kong standard.

B. Due Process

Rehagen noted that in Missouri, it is illegal to transfer policies without policyholder consent, as it pertains to assumption reinsurance. Superintendent Dwyer stated in such a situation, it would be up to the court to decide. She asked if there was specific language in the standards as far as the coordination of other states or access to the filings. Rehagen said years ago, there were some transactions for which effected states were not notified, however, communication between the states has greatly improved. He suggested a requirement that states be notified ahead of time. Superintendent Dwyer stated that requiring the state to notify and coordinate might be fine but advised against specifics regarding the format of communication deferring to the most efficient method of delivery. Robin Marcotte (NAIC) discussed how the current best practices draft suggests requiring a communication plan from the company, which then needs to be approved by the state insurance regulator. The current draft requires that this plan coordinate with other affected state insurance regulators and allowing them to have adequate time to assess the impact and the opportunity to submit written comments or attend public

hearings. Gendron stated that clarification is needed as to when notification is required and who is responsible for that notification.

Birny Birnbaum (Center for Economic Justice—CEJ) discussed how the parties receiving notice other than the policyholders have the resources and expertise to meaningfully engage the process. He stated that consequently, there is a need for a policyholder advocate as part of the process. This position would receive and interpret comments from policyholders or simply answer questions when they do not understand the notice they receive. Birnbaum also stated that with respect to the independent expert, this person would likely focus on those things that can be easily quantified, such as material impact and administration capacity. He stated that this would be necessary for personal policies and commercial policies that are more similar to personal policies, such as small business policies. Superintendent Dwyer asked Birnbaum how that person would be defined and what language he would propose to address this issue. Birnbaum responded that the establishment of the policyholder advocate would be part of the process, as well as part of the communication plan, but it would also need to have access to the same kind of confidential information as the state insurance regulator. Commissioner Mulready responded that he believed that was part of the process already, as the current three-step process includes ensuring that there is no material adverse impact on the policyholders by the independent expert. He noted that the state insurance regulator is also already meant to protect the consumer, and the judge is reviewing the information to conclude that it is for that purpose.

DiCarmine noted the need to ensure opportunities for policyholders to meaningfully participate, both in person and remotely. Superintendent Dwyer stated that current statutes make provisions for this and there might be additional participation through Court order. Birnbaum questioned what the policyholder would do without a policyholder advocate that could more easily consider the complexity of the transaction and multiple moving parts. Thus, he asserted that participation would likely not be meaningful because the policyholder does not have the resources or skill set to evaluate the transaction. This advocate would not diminish the commissioner's role. Superintendent Dwyer explained that in this situation, the insurance department would sit down with the policyholder to explain the transaction to them. Wayne Mehlman (American Council of Life Insurers—ACLI) stated that for IBTs and CDs, while the ACLI does not suggest the need for policyholder consent, it suggests the need to require notice, a public hearing, and an independent expert for a review.

C. Do Not Create Monoline Companies

DiCarmine stated a comment on not allowing IBT and CD to create monoline companies was included in comments that were made by New York Life and two other insurers. She stated that New York Life could work on some language for the Working Group to consider.

D. Pro Forma Financial Statements

Superintendent Dwyer stated that the next issue deals with financial strength and how many years of pro forma financial statements are needed. Weaver stated that the Restructuring Mechanisms (E) Subgroup discussed the question of three or five years, but noted that Michigan requires five years. Consequently, five years was recommended by Weaver, but she also suggesting that the domestic regulator would have the ability to require more than five years in the appropriate circumstances. Malm stated support for five years with the potential for more depending upon the line of business. Commissioner Mulready stated that the Oklahoma statute requires three years, but more can be requested. He suggested that five years seemed like too many. Kosky agreed with Commissioner Mulready, and he noted that Connecticut requires three years, with more in the appropriate situation. Broccoli agreed with Kosky and Commissioner Mulready, but he noted that if the company has no access to capital, a state insurance regulator would probably want a longer period of time, even more than five years.

E. CD Procedures Similar to Form A Procedures

Kosky stated that Connecticut made comments at a past Restructuring Mechanisms (E) Subgroup meeting that it views the process for reviewing a CD similarly to a Form A Change in Control. Kosky noted that it has always been Connecticut's plan to review CDs under the same lens as a Form A. He also noted that under Connecticut law, the commissioner shall approve the division unless the commissioner finds that the interest of any policyholder will not be adequately protected or constitutes fraud. Marcotte noted that Locke Lord LLP made similar comments on the Subgroup's exposure. Superintendent Dwyer suggested language that indicated that for a CD or anything that an actual court of record does not approve, there must be a robust process within the department. Kosky suggested that there be six or seven standards would be appropriate for a CD that the commissioner review regarding approval. Superintendent Dwyer asked about a hearing. Kosky stated that the law was a "may" standard for the commissioner in holding a hearing as deemed appropriate. Marcotte described how in the current proposed best practices, there was an intent to avoid duplication between listing the same standards for IBTs and CDs, and many of the financial review requirements are combined unless there is a specific statement about something being different between the two.

F. Retention of Licenses

O'Sullivan noted that comments have been made to the Working Group and the Restructuring Mechanisms (E) Subgroup since their inception regarding a need for an insurance company to retain its licenses in states after an IBT or CD to retain guaranty fund coverage. He noted that for life insurers, any successor company needs to retain its licenses in its states to be considered a member of the guaranty fund association and, therefore, provide guarantee fund coverage. He noted that there were some regulatory discussions that some sort of streamlined licensing may be needed to address this issue. Wake indicated concern about the unintended consequences of requiring states to automatically license all surviving companies. Superintendent Dwyer asked about the status of the #540 model language at the Receivership and Insolvency (E) Task Force. O'Sullivan indicated that such changes were meant to address issues related to P/C. Wake noted that there was a consensus of the Task Force to use a surgical approach with limited changes. He noted that if licenses were not retained, there was concern about straining the orphan clause and existing coverage in the domestic state. He noted that that was perhaps not a bad consideration because it forces the domestic state to think through the transaction, given the ramifications if things do not go well.

Peter Gallanis (NOLHGA) discussed the decision at the Task Force to not address the life issues with an IBT and CD because of the fundamental differences between the P/C and life and health. For instance, there are differences in the types of contracts that are covered in P/C and life and health. Gallanis noted his concern that tugging on a thread in this sweater could have unintended consequences. Therefore, the recommendation for life and other long-term contracts issued by life insurers is to have the same licensure in the same states post-transaction and pre-transaction. If that cannot be met, perhaps the transaction should not be approved.

Weaver noted that the Financial Analysis (E) Working Group has made some reference or referrals to the National Treatment and Coordination (E) Working Group that states have seen issues in which other states are not ensuring that companies are licensed in the states when there is a merger. This step is needed to ensure states can properly regulate and oversee that business.

Having no further business, the Restructuring Mechanisms (E) Working Group adjourned.

[https://naiconline.sharepoint.com/sites/NAICSupportStaffHub/Member Meetings/E CMTE/2023-2-Summer/Restructuring Mech WG/4-4-23/4-4-23 Restructure WG.docx](https://naiconline.sharepoint.com/sites/NAICSupportStaffHub/Member%20Meetings/E%20CMTE/2023-2-Summer/Restructuring%20Mech%20WG/4-4-23/4-4-23%20Restructure%20WG.docx)

Restructuring Mechanisms (E) Subgroup
4-26-23 CommentsTABLE OF CONTENTS

COMMENTER / DOCUMENT	PAGE REFERENCE
1. Missouri Department of Commerce and Insurance/John Rehagen	○ 1
2. American Council of Life Insurers (ACLI)	○ 2
3. American Property Casualty Insurance Association (APCIA)	○ 4
4. AIRROC	○ 6
5. Center for Economic Justice – (CEJ)	○ 9
6. Enstar (US) Inc.	○ 15
7. Milliman	○ 17
8. Joint Letter a. New York Life Insurance Company b. Western & Southern Financial Group c. The Northwestern Mutual Life Insurance Company	○ 19
9. Joint letter (NOLHGA) and (NCIGF) a. National Organization of Life & Health Insurance Guaranty Associations b. National Conference of Insurance Guaranty Funds	22
10. NOLHGA	23
11. ProTucket Insurance Company	28
12. R&Q Investment Holdings Ltd.	33

To: Restructuring Mechanisms (E) Working Group
Re: Best Practices Redline Exposure April 2023
Date: April 26, 2023

To start, I will say that I think adding the licensing requirement for life was a positive change.

My main concern is removing the requirement for a legal opinion in Section VII of the Best Practices Procedures for IBT/Corporate Divisions.

The language contained in the Best Practices Procedures for IBT/Corporate Divisions related to guaranty association coverage involving property and casualty insurance assumes that each U.S. jurisdiction has laws that address the issue that we are concerned about....guaranty fund coverage not being reduced, eliminated, or otherwise changed as a result of the transaction.

The Drafting Note contained on page 5 acknowledges that the Receivership Law (E) Working Group is still working on this very issue. Assuming that the Working Group obtains consensus and recommends changes to the Property and Casualty Insurance Guaranty Association Model Act (#540), there are no assurances that states will actually adopt the changes. For this reason, it does not seem unreasonable to me in a best practices scenario, to suggest that interested parties obtain a legal opinion regarding guaranty fund protection for policyholders of restructured entities.

John F. Rehagen, CFE, ACI
Division Director
Missouri Department of Commerce & Insurance



Wayne Mehlman
Senior Counsel
(202) 624-2135
waynemehlman@acli.com

April 26, 2023

Elizabeth Kelleher Dwyer, Co-Chair
 Glen Mulready, Co-Chair
 Restructuring Mechanisms (E) Working Group
 National Association of Insurance Commissioners
 1100 Walnut Street, Suite 1500
 Kansas City, MO 64106

RE: Revised Draft of its *Best Practices Procedures for IBTs and Corporate Divisions*

Dear Superintendent Dwyer and Commissioner Mulready:

The American Council of Life Insurers (ACLI) appreciates this opportunity to comment on the Restructuring Mechanisms Working Group's revised draft of its *Best Practices Procedures for IBTs and Corporate Divisions*.

We would first like to thank the Working Group for developing this document since it will help regulators better understand the various procedures that need be followed as they review proposed IBT and corporate division transactions.

There are, however, several items that we'd like to bring to your attention.

- (1) The page numbers in the Table of Contents will need to be renumbered due to language that was added to the revised draft.
- (2) *Section V, Subsection 1 – Use of an Independent Expert* allows for an in-house Department expert to review a proposed corporate division transaction instead of an independent expert, though an independent expert is preferred. As we previously mentioned to this Working Group in our letter dated June 21, 2022, our *Principles on IBT and Corporate Division Legislation* state that independent experts must be utilized during the reviews of both IBT and corporate division transactions.
- (3) In *Section VII – Analysis of Issues Affecting Policyholders, Claimant and other Stakeholders*, we suggest that Subsection 2.a. be deleted since policyholder consent is not required for IBT or corporate division transactions. Other requirements, including those for notice, public hearing, independent expert review (or in-house expert review for corporate divisions), robust regulatory review and court

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The American Council of Life Insurers (ACLI) is the leading trade association driving public policy and advocacy on behalf of the life insurance industry. 90 million American families rely on the life insurance industry for financial protection and retirement security. ACLI's member companies are dedicated to protecting consumers' financial wellbeing through life insurance, annuities, retirement plans, long-term care insurance, disability income insurance, reinsurance, and dental, vision and other supplemental benefits. ACLI's 280 member companies represent 95 percent of industry assets in the United States.

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approval (for IBTs) are designed to protect policyholders who are not otherwise able to consent to, or opt-out of, a proposed transaction.

(4) *Section IX, Subsection 1.a. – Guaranty Association Coverage* states:

Prior to approving a proposed restructuring transaction, a commissioner should make a factual determination regarding guaranty association coverage issues based on the criteria outlined below.

a. For restructuring transactions involving life, annuity or health insurance, the assuming or resulting insurer(s) should be licensed so that policyholders maintain eligibility for guaranty association coverage from the same guaranty association that would have provided coverage immediately prior to the restructuring transaction. This means that the assuming insurer or resulting insurer(s) must be licensed in all U.S. jurisdictions where the transferring or dividing insurer was licensed or had ever been licensed with respect to the policies being transferred or allocated in the transaction.

We strongly support this section of the revised draft and urge that it not be modified. It is very important from a life and health insurance guaranty association (G/A) coverage standpoint that a successor entity be licensed in the same state(s) where the original entity was licensed (or had ever been licensed) with respect to the policies being transferred or allocated, since each state requires an insurer to be licensed in its state in order for it to be a “member insurer” of its state’s G/A.

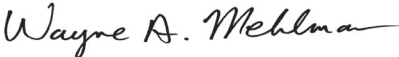
If a successor entity is placed into liquidation and its policyholders are not covered by the same state G/As as they were prior to a restructuring transaction, and instead receive “orphan” coverage through the successor entity’s domiciliary state G/A, it is possible that the domiciliary state G/A: (1) may not provide the same level of G/A coverage as the policyholders’ state G/As and/or (2) may not have enough assessment capacity to pay policyholders’ claims on a timely basis, either of which would harm policyowners.

It should be noted that the NAIC updated its *Life and Health Insurance Guaranty Association Model Act* many years ago to state that G/A coverage should generally be provided to policyholders by their resident state G/As, rather than by an insolvent insurer’s domiciliary state G/A. One reason for this was to prevent assessment capacity issues.

Given these concerns, and the importance of having a strong life and health insurance G/A safety net, we urge the Working Group to maintain the licensing requirement language that is in the revised draft.

Thanks again for this opportunity to provide comments. If you have any questions, feel free to contact me at waynemehlman@acli.com or 202-624-2135.

Sincerely,



Wayne Mehlman
Senior Counsel, Insurance Regulation

April 26, 2023

Superintendent Elizabeth Kelleher Dwyer
Chair, Restructuring Mechanisms Working Group
National Association of Insurance Commissioners

RE: Principles for Insurance Business Transfers (IBT) and Division Statutes

Dear Superintendent Dwyer:

The American Property Casualty Insurance Association (APCIA) appreciates the opportunity to provide comments on the draft *Principles for Insurance Business Transfer (IBT) and Division Statutes*.

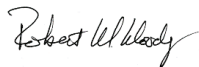
As the Working Group is aware, there is a broad diversity of views on IBTs and division statutes within APCIA's membership, and APCIA has therefore generally refrained from either supporting or opposing such legislation when it is proposed in state legislatures. However, APCIA members have reached consensus on a set of guiding principles that should be reflected in any IBT, or division legislation considered. APCIA has previously shared those principles with the Working Group (and they are attached hereto for your reference). We are pleased that, with only one exception noted below, the Working Group's draft Principles document generally reflects APCIA's consensus principles, and in some cases has adopted language directly from those principles. We are grateful to the Working Group for the careful consideration it has given to our members' views.

One of our principles requires that any regulatory review of proposed IBT or division statutes must establish that the terms and impact of the transaction "do not have a *material* adverse impact on policyholders, reinsurers, or guaranty associations"(emphasis added). We note that the draft Principles document makes numerous references to regulatory consideration of potential adverse impacts but omits the word "material." A "no material adverse impact" standard is utilized in the UK's Part VII regime (on which existing U.S. IBT laws generally are based), as well as in various state laws, including for example, in Oklahoma where IBTs are successfully occurring. Omission of the word "material" could open the door to minor and relatively insignificant issues becoming an obstacle to an otherwise sound transaction. We therefore urge the Working Group to consider using the "material adverse impact" standard in the Principles document.

One of our members has also expressed concern that some of the language in the draft referring to parental guarantees might be used to require such guarantees where they are not needed and are unobtainable, thus preventing an otherwise sound transaction from even being reviewed. Not all insurers will necessarily have a parent company at all or may not have one that is capable of providing a financial guarantee. Many successful IBT transactions have occurred without a parental guarantee. While a parental guarantee might be useful in some circumstances, the lack of one need not necessarily be an insurmountable roadblock to *any* transaction that is otherwise fully reserved, conservative, and prudent. We urge the Working Group to ensure that the language of the draft provides regulators with clear and adequate flexibility on this point.

We appreciate the Working Group's past and continuing consideration of our views.

Sincerely,



Robert W. Woody
Vice President & Counsel
APCIA

Principles for Insurance Business Transfers (IBT) and Division Statutes

Due Process

- Robust due process must be afforded to stakeholders impacted by a transaction (policyholders, reinsurers, guaranty associations). This should include:
 - Notice to stakeholders as determined by the regulator
 - Public hearing
 - Opportunity to submit written comments

Guaranty Fund Coverage

- No impacted policyholder should lose or gain guaranty fund protection as a result of a transaction.

Robust Regulatory Review Process

- The regulatory review must be robust and should, at a minimum, include the following findings:
 - The assets to be allocated to insurers involved in the transaction are adequate to cover the insurer's liabilities.
 - The impact and terms of the transaction do not have a material adverse impact on policyholders, reinsurers, or guaranty associations.
 - The review should consider the plans of any insurer involved in the transaction to liquidate another involved insurer, sell its assets, consolidate, merge, or make other changes, and the resulting impact on policyholders, reinsurers, and guaranty associations.

Independent Expert

- The regulatory review process for insurance business transfers will utilize an independent expert to advise and assist the regulator in reviewing proposed transactions (including advising on any material adverse impact on policyholders, reinsurers, or guaranty associations) and to provide any other assistance or advice the regulator may require.

Court Approval

- Court approval must be required for insurance business transfer transactions but not for divisions.



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April 26, 2023

Superintendent Elizabeth Kelleher Dwyer,
Chair of the Restructuring Mechanisms (E) Working Group

Re: Best Practices Procedures for IBT/Corporate Divisions
Exposure Draft 4-4-23

Superintendent Dwyer and Members of the Restructuring Mechanisms (E) Working Group,

AIRROC is pleased to offer comments in response to the draft “Best Practices Procedures for IBT/Corporate Divisions”. As a non-profit association AIRROC and its Board do not advocate for any specific position but provide resources and information. For that reason, AIRROC is not commenting on any specific aspects of the proposed best practices.

AIRROC is the only US based non-profit association focusing on the legacy sector of the insurance and reinsurance industries. Membership is on a corporate level and given the impact and importance of legacy business to the entire industry, AIRROC has attracted many talented and experienced participants that all have legacy or runoff business in their portfolio. The members include major US and international insurance and reinsurance companies, legacy acquirers, well-known rehabilitations, receiverships and liquidations, brokers, run-off managers and state insurance departments.

Because of our belief in the importance of clarity and discussion on the topic of runoff, AIRROC is requesting that the working group remove “Section X – Run-off Procedures” from the Best Practices Procedures for IBT/Corporate Divisions. We believe that the subject is distinct from the issues that this document is being developed to address, and that its inclusion confuses the distinct topics of restructuring and runoff. We would support the further discussion of runoff for inclusion in the white paper the committee is developing or in independent guidance as appropriate. We look forward to working with the members on identifying best practices around this important subject.

As referenced in the PwC Global Runoff Survey from 2022, the size of the global runoff market is \$960 bn with \$464 bn of those liabilities in North America. This is an increasingly important segment of the insurance market, and its management encompasses a broad range of insurers and activities. While this is an important indicator of the demand for more restructuring mechanisms within the insurance industry in recent years, it is important to note that these are distinct and separate issues.

Over the past two or more decades, the term “runoff” has been expanded to refer not only to the runoff of a particular contract, but also to entire books of business, to the insurance or reinsurance company itself and finally, to the entire sector of the market in which such business is administered. There have been many changes since the development of the 1997 Restructure White Paper, and before duplicating its analysis in a modern document it would be prudent to undertake a thorough discussion as to whether it remains relevant to today’s insurance industry.

How can runoff be defined? Runoff business is most widely defined as lines of business that are no longer written. The definition can vary widely by individual companies so this should be considered carefully. The definition of runoff can have different meanings based on situations.

Insurance and reinsurance companies voluntarily place lines of business into runoff for varying reasons: to discontinue a line of business for which they no longer have expertise or profitable experience, to re-focus their business strategy, to improve claims handling by transfer to those better equipped, and consequently improve their capital deployment. Also, as you are all aware, a state regulator can also put a company into receivership, insolvency or liquidation to protect the rights of policyholders, so the state appointed receiver administers the runoff. It is worth making the point that this “involuntary runoff” is very different from a “voluntary runoff” where there is a conscious decision by management to cease underwriting or dispose of a certain line of business as a strategic step. A “voluntary runoff” in these situations is in essence strategic portfolio management.

As the NAIC looks at the options and new states continue to adopt laws that create tools for restructuring, this is an opportunity to create a structure that can underpin the insurers in your state. Restructuring mechanisms provide the opportunity for insurers to grow and serve policyholders by giving them a way to change their operations to improve efficiency and let those that are experts in runoff take the helm.

In conclusion, AIRROC is asking that the Restructuring Mechanisms (E) Working Group consider three main points:

- 1) Remove Section X from the draft “Best Practices Procedures for IBT/Corporate Divisions”.
- 2) Work with AIRROC and our member companies to conduct an updated analysis of the runoff sector in lieu of relying on a 1997 White Paper.
- 3) Consider adding this analysis to the in progress White Paper or in separate guidance.

AIRROC looks forward to a continued dialogue with the NAIC and more specifically the Restructuring Mechanisms (E) Working Group.

Respectfully Submitted,



Carolyn W. Fahey
Executive Director, AIRROC

cc: Robin Marcotte and Dave Daveline, NAIC



Comments of the Center for Economic Justice

To the NAIC Restructuring Mechanisms (E) Working Group

Regarding Draft “Best Practices for IBT/Insurer Divisions”

April 26, 2023

The Center for Economic Justice offers the following comments on April 4, 2023 exposure draft of “Best Practices for IBT/Insurer Divisions.” Our comments focus on the need for a policyholder advocate in any IBT and Division transaction.

Overview and Rationale

The purpose of a policyholder advocate – or consumer advocate, generally – in regulatory proceedings is to ensure that consumer interests have an advocate with sufficient resources and expertise to engage substantively in the regulatory proceeding on behalf of consumers as a necessary counterweight to essentially unlimited resources available to the industry entities seeking a particular regulatory outcome.

The meetings of this working group provide a good example. Each meeting is well attended by numerous industry participants and their advocates and lobbyists. While CEJ has participated in a number of the working group’s calls, there is clearly a massive disparity in resources between industry’s and the sole consumer advocate’s participation.

Now consider this experience at the state level where – with rare exceptions – there is no consumer advocate participating in any regulatory proceeding, let alone an IBT or division proceeding.

A few arguments have been offered in opposition to formalizing the designation and participation of a policyholder advocate in IBT or division proceedings. One argument is that affected policyholders can participate in the process through mechanisms set out in the communication plan. Assuming such participation even occurs, it is unclear how a consumer can meaningfully participate in proceeding marked by highly technical and legal issues with many key documents marked as confidential and unavailable to the consumer.

CEJ Comments to NAIC Restructuring Mechanisms WG
April 26, 2023
Page 2

Such proposed individual consumer participation is analogous – but even less understandable to a consumer – than asking a consumer to participate in a review of an auto or long-term care insurance rate filing or a policy form filing. Absent the technical and legal expertise to address the criteria imposed on the regulator, consumer participation will almost certainly be limited to generalized concern or complaints which have little impact in an IBT or division proceeding.

In contrast, if the IBT or division proceeding required the appointment and participation of a policyholder advocate with adequate funding for such participation, policyholders would have a true advocate with the skills and resources to gather and understand consumer concerns as well as evaluate the proposed transaction from the viewpoint of the consumer.

CEJ knows firsthand the impact of the involvement of a consumer advocate in regulatory proceedings. CEJ routinely weighed on rate and form filings in Texas for various lines of insurance and, in most cases, the preliminary decision by the regulator or the proposal by the insurer was modified – changes that would not have occurred in the absence of a consumer advocate.

Another argument is that the Commissioner is charged with protecting consumers and, consequently, is the consumer's advocate. While insurance regulators are charged with consumer protection, that responsibility is not the same as serving as a consumer advocate in a proceeding in which the Commissioner must make a regulatory decision. If insurance commissioners were consumer advocates, there'd be no need for a consumer participation program at the NAIC or for public participation in regulatory proceedings. The fact that public participation is required for most regulatory proceedings – particularly those that directly impact certain consumers – is recognition that the regulator is not consumer advocate.

Another argument is the there is an expert hired by the Commissioner to evaluate the impact on consumers. In every IBT transaction, we've learned about, the independent expert is an actuary whose primary responsibility is to ensure the receiving entity is as financially strong and administratively competent as the insurer transferring the business. While actuaries have great expertise in certain areas, they don't have expertise in all areas related to consumer protection. Nor is the independent expert a consumer advocate. In all these proceedings the insurance entities are able to provide as much information and explanation and rationale as they want to the Commissioner and to the independent expert – there is no policyholder advocate to do the same for consumers or rebut industry assertions when so warranted.

CEJ Comments to NAIC Restructuring Mechanisms WG
April 26, 2023
Page 3

For these reasons, CEJ urges the working group to include the appointment and funding of a policyholder advocate for both IBTs and divisions. A policyholder advocate is necessary for both types of transactions. With IBTs, the consumer is forced without consent to do business with an insurance company the consumer did not select. Consequently, there are policyholder issues that go beyond technical financial analysis or some assessment of administrative capability.

As with IBTs, an insurer engaging in a division is doing so because it provides significant financial benefits to the insurer. In any situation in which the proposed transaction is based on financial gain for the proposing insurer, there is a need for a policyholder advocate to ensure consumer concerns are identified and given consideration. In the case of divisions, it is vitally important that policyholders are not moved to a new entity with less financial strength. We recognize that regulators' main task is evaluating these transactions is just that type of financial analysis, but regulators sometimes miss things – in part due to representations made by the proposing insurer. One example would be some regulators' approval of lender-affiliated reinsurance transactions by private mortgage insurers leading up to the financial crisis. Some regulators saw these transactions as legitimate risk-spreading when, in fact, they represented the absence of risk management because they were kickbacks from the insurer to the lender to convince the lender to select the particular private mortgage insurer.

Specific Recommendations for the Document

Section II (1)(d)

Section II (1) sets out procedures for IBTs and divisions. The procedures are a list of information required of the applicants for the transaction. Section II(1)(d) states:

The effect of the IBT on the **transferring company's and assuming company's** policyholders, **(including with respect to guaranty association coverage)**, claimants and other stakeholders.

With the exception of this Section II (1)(d) and new language related to guaranty fund coverage impacts, all the information requested in this section about the IBT is financial information spelled in great detail. The fact that 12 of the information items are for financial information with only 1 item for non-financial information raises our concern that non-financial impacts and impacts not easily quantifiable will not be deemed important and reinforces the need and our proposal for a policyholder advocate in the proceeding.

We suggest Section II(1)(d) be expanded to itemize certain information that should be provided by changing the period at the end of the section to a comma and adding the following:

CEJ Comments to NAIC Restructuring Mechanisms WG
April 26, 2023
Page 4

. . . including

- the assuming company’s historical performance relative to the transferring company’s performance serving policyholders and claimants, including
 - percentage of claims denied;
 - time to settle claims;
 - number of consumer-disputed claim settlements;
 - number and type of consumer complaints;
 - number of type of regulatory investigations and enforcement actions;
 - nature and effectiveness of routine policyholder communications
 - ability of policyholders to access information about the policies and company procedures; and
 - any other comparison of non-financial performance between the transferring assuming companies’ historical performance relevant for assessing policyholder impact of the proposed transaction.
- the capability and performance of the assuming company’s infrastructure and systems for communications with policyholders;
- the capability and performance of the assuming company’s infrastructure and systems for claims settlement, including dispute resolution related track record of assuming company;
- the capability and performance of the assuming company’s infrastructure and systems to assist policyholders to understand and use their policies;
- any changes in the nature of regulatory oversight of the assuming company from the transferring company and regulatory oversight of the transferred policies following the transaction;
- the quality and readability of the assuming company’s templates for consumer notices and disclosures; and
- any other aspect of company non-financial performance potentially impacted by the transaction.

Section II (2) (e)

Section II (2) provides a list of information required of the insurer proposing a corporate division and item II (2)(e) is the sole item requiring information about policyholder impact. Item II (2) (k) adds a set of questions about the future marketing and products which is important information, but does not address impact on current policyholders. We suggest expanding item II(2)(e) along the lines of our proposed expansion of item II(1)(d), above.

CEJ Comments to NAIC Restructuring Mechanisms WG
April 26, 2023
Page 5

Provisions for adding a policyholder advocate

In section III (1), add “Appointment and Report of Policyholder Advocate.”

In section III (2) add “Appointment and Report of Policyholder Advocate.”

In section IV (2) High Level of Confidence, add a paragraph (c):

- (c) Appoint and provide sufficient funding for a policyholder advocate to
- i. represent and advocate on behalf of policyholders in the proceeding;
 - ii. review all documents, whether deemed confidential or not, submitted or prepared in connection with the proposed transaction;
 - iii. submit requests for information to the proposing companies to the extent the requested information is relevant for assessing the consumer impacts of the proposed transaction;
 - iv. offer recommendations for effective communication with affected policyholders and other stakeholders;
 - v. obtain comments and feedback from affected policyholders regarding the proposed transaction;
 - vi. provide a report with a recommendation for the Commissioner to approve or disapprove the proposed transaction with the rationale for the recommendation and communicate that report to the Commissioner, proposing insurers, affected policyholders and other stakeholders. The full report provided to the Commissioner and proposing insurers may contain confidential information if necessary for supporting the recommendation. A report provided to any other persons, including affected policyholders, must redact confidential information; and
 - vii. participate in regulatory and legal proceedings and meetings regarding the proposed transaction

Add a new section: Appointment of the Policyholder Advocate

- a. The appointment and funding of a policyholder advocate to provide substantive representation and advocacy in the proceeding is essential to ensure consumer interests are adequately represented.
- b. The Commissioner will appoint a policyholder advocate with demonstrated experience and skills to:
 - i. Effectively represent consumers;
 - ii. Provide the necessary technical and non-technical analysis;
 - iii. Effectively communicate with parties to the transaction;
 - iv. Coordinate and utilize experts as needed; and
 - v. Contribute value to the proceeding.

CEJ Comments to NAIC Restructuring Mechanisms WG
April 26, 2023
Page 6

- c. In appointing the policyholder advocate, the Commissioner shall not appoint a person with a material conflict of interest that might compromise the advocate's ability or willingness to adequately represent consumers. In considering persons for appointment as policyholder advocate, the Commissioner shall solicit recommendations from consumer organizations within and outside the state.
- d. The Commissioner shall appoint the policyholder advocate as soon as practical following receipt of the transaction application, but no later than 21 days after receipt of the transaction application.
- e. The Commissioner shall direct the proposing companies to provide funding for the policyholder advocate within 7 days of the Commissioner's appointment of the policy advocate in amount of the greater of \$50,000 or 0.01% of the total value of the liabilities in the transaction. The \$50,000 minimum should be increased annually by the annual change in the Consumer Price Index starting in 2024.
- f. The Commissioner shall audit the expenditures of the policyholder advocate and the appointment of the policyholder advocate shall be conditioned upon the advocate taking personal responsibility for any misuse of funds.
- g. (See earlier comments for specific tasks and responsibilities of the policyholder advocate)

Please see our comments above regarding the policyholder advocate's role in the communication plan with stakeholders.

Thank you for your consideration of our comments.



ENSTAR (US) Inc.

Comments to Restructuring Mechanisms (E) Working Group – April 26, 2023

Dear Superintendent Elizabeth Kelleher Dwyer:

Thank you to the working group members and NAIC staff for the continued work and discussion relating to the *Best Practices Procedures for IBT/Corporate Divisions* (“Best Practices”). Enstar provided comments on the Best Practices during its last exposure period, and we continue to believe that regulatory best practices should be founded in the legislation that states are enacting to enable insurance business transfers (“IBT”) and corporate divisions. The Best Practices diverge from statutory requirements and purposes in several notable areas, including the development of pro-forma financial statements, the creation of new policyholder rights, and the necessity and method of obtaining policyholder consent, which we addressed in our prior letter and reaffirm without repeating here.

With the increasing interest in restructuring mechanisms and the few states that have passed enabling legislation at this time, it is likely that regulators will be asked to review or even participate in the oversight of restructuring transactions without similar legislation in their own states, which is especially applicable to IBT. We believe that it is important for regulators in this position who may seek out the work of this working group to provide guidance for their review have a clear understanding of why elements of the Best Practices differ from existing state law and similar NAIC frameworks. For example, the NAIC Form A model regulation requires three-year financial projections, and the NCOIL IBT Model Act requires three years of pro-forma financials, with all states with similar acts requiring the same or an unspecified amount. However, the Best Practices recommend five years of pro-formas, without addressing a reason for the difference from existing laws and models. For this and other similar changes to already established review standards, we would appreciate that the working group provide context for the differences. In doing so, the working group can help insurers and states with existing laws from being placed into a position of trying to explain why their standards and this document are not in alignment, when those standards are what came first and are the basis of the creation of the Best Practices.

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Page 2 of 2
26 April 2023

We also would encourage the reconsideration of *Section X – Run-off Procedures* in this document. IBT and division transactions may or may not result in runoff, and runoff can be created and exist without a restructuring transfer occurring. Runoff is frequently managed voluntarily, without negative solvency implications. Court-authorized transfers for insolvent companies (similar to the IBT framework) have occurred in states without IBT legislation under the authority of the receivership court. However, these types of transfers are not addressed by the Best Practices, and as such this section on involuntary runoff seems out of place in a discussion of voluntary, solvent restructuring transactions. We believe this section would be best suited for a separate document, and we would appreciate additional discussion of the purpose and objectives of this section should it remain a part of the Best Practices.

Sincerely,



Robert Redpath
Senior Vice President
Regulatory & Technical Director



James Mills
Vice President
Legal Counsel



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April 26, 2023

Superintendent Elizabeth Kelleher Dwyer
Chair of the Restructuring Mechanisms (E) Working Group

RE: Best Practices Procedures for IBT/Corporate Divisions

Dear Ms. Dwyer:

Below are comments that I have for Best Practices Procedures for IBT/Corporate Divisions. I appreciate the opportunity to submit these to the Restructuring Mechanisms (E) Working Group.

Page 5 – n. ii. 2nd line - delete duplicate **that**

Page 9 – 2. High Level of Confidence – **Per comments below, I would recommend deleting this section and incorporating relevant areas into the prior section.**

Page 9 – 2. 1st line - establish, at a high level of confidence -

Part VII guidance, for example, does not say anything about levels of confidence and it does not ask the IE to “establish” anything, rather give their opinion. Rather, the guidance says that the IE should give their “opinion of the likely effects of the scheme...” and “analyse and conclude on how groups of policyholders are affected differently by the scheme, and whether such effects are material in the independent expert’s opinion. Where the independent expert considers such effects to be material, they should explain how this affects their overall opinion.”

Page 9 –2. 2nd line – no adverse effects - suggest adding **"material"**

Page 10 – b. iii 1st line – adverse impact – suggest **“material adverse effect”**

Page 10 – 3. a. 1st line - Prescribed conservative assumptions - **These should be defined, and as to why they need to be conservative.**

Page 11 – 4. 1st line - Assessment of risk capital - **It seems unclear as to the situations where no additional capital can be accessed.**

Page 11 – 4. a. 1st line - before some add **“, under”**

Page 11 – 4. b. iv. 1st line - after capital **remove comma**

Page 12 – 5. a. 2nd line - add space after **the**

Page 12 – Section V 1st line – after an add **Independent**

Page 12 – d. 2nd line - to establish at a high level of confidence that policyholders and other key stakeholders experience no adverse effects – **same comments as earlier**

Page 12 – e. 4th line - a neutral or better condition – suggest replacing with **not materially adverse impacted**

Page 12 – e. 9th line - **remove space after change**

Page 13 – f. 2nd line - **add space after to**

Page 14 – 3rd line - put the policyholders and other key stakeholders in the same or better position - **create no material adverse effect on**

Page 14 – 1. a. 1st line - “ground up” - **What is this intended to mean? I think it should be clarified that independent actuarial tests are not required but could be performed if needed.**

Page 14 – 1. a. iii. 1st line - “insurer’s – **clarify which insurer(s)**

Page 14 – 2. a. 2nd line - in the same or better condition – suggest replacing with **not materially adverse effected by**

Page 20 – Drafting Note: 2nd line - delete **to**

Page 23 – Independent Consultant – 4th line - within the past twenty-four (24) months - **This time frame seems onerous. You could also ensure that the expert has the time and capacity to undertake the work.**

Page 23 – Independent Consultant – 6th line - **add space after this**

Regards,



Stephen R. DiCenso, FCAS, MAAA

cc: Robin Marcotte, NAIC
Wendy Jacks, NAIC
Dan Daveline, NAIC

I:\Best Practices ED 4-4-23_SRD Comments

Milliman

BY E-MAIL

April 26, 2023

Director Dwyer
Commissioner Mulready
Co-Chairs, NAIC Restructuring Mechanisms (E) Working Group (“Working Group”)

Attention: Robin Marcotte (rmarcotte@naic.org)

Re: Comments on Working Group’s Re-Exposure of Best Practices

The undersigned companies welcome the opportunity to comment on the revised Best Practices document re-exposed by the Working Group. We appreciate the thought and time that the Working Group members have devoted to refining the exposure, and, overall, **believe that the Best Practices document provides a strong foundation for ensuring appropriate solvency and consumer protections will apply to Insurance Business Transfer (“IBT”) and Corporate Division (“CD”) (collectively, “IBT/CD”) transactions.**

Use of Independent Expert

In prior comment letters, the undersigned companies have maintained that we strongly believe that every IBT/CD should require an independent expert (“IE”) report, and that the IE report should be publicly available. We note that the Best Practices require IE reports for IBTs; we welcome and appreciate this position. After working with the Working Group, we believe that the Best Practices document strikes an appropriate balance in the use of IEs for CD transactions. We further believe it would be appropriate for any report generated by an in-house department of insurance also be made public in order to allow interested policyholders and stakeholders to participate in a public hearing on the CD.

Guaranty Associations

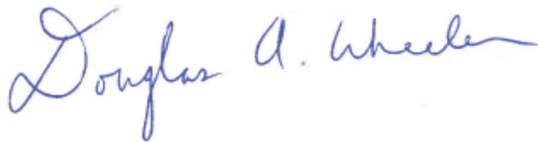
We reiterate our support for Section IX(1)(a) of the NAIC Best Practices Procedures for IBT/Corporate Divisions. This section requires that for restructuring transactions involving life, annuity or health insurance, the assuming or resulting insurer(s) should be licensed in each state where the transferor or predecessor insurer(s) are licensed so that policyholders maintain eligibility for guaranty association coverage from the same guaranty association that would have provided coverage immediately prior to the restructuring transaction. It is important from a Life and Health Guaranty Association coverage standpoint that the successor entity be licensed and regulated in a similar fashion. The NAIC Life & Health GA Model Act requires that an insurer be licensed (or formerly licensed) in a state to be considered a member of that state’s guaranty association.

If the policyowners are not covered by the same guaranty association as they were prior to the restructuring transaction (and instead receive coverage via the insurer’s domestic guaranty association), the domestic guaranty association may not have the necessary assessment capacity to pay claims on a timely basis, nor offer the same level of guaranty association coverage as the previous guaranty association, further harming policyowners. Given these concerns, and the importance of maintaining a strong guaranty association safety net, we urge the Working Group

to include the licensing requirement in its Best Practices document. In addition, we recommend an accreditation requirement that policyowners must have coverage under the same guaranty association both before and after the transaction, which will require licensing of the acquiring insurer in each of the jurisdictions where customers of the existing insurer reside.

We appreciate the efforts of the Working Group in getting to this point. Once the Best Practices document has been finalized, we urge the Working Group to take the appropriate steps so that its requirements become accreditation standards. A robust accreditation system has proven over time as the most effective tool to promote consistent and strong solvency regulation. We believe establishing the Best Practices as an accreditation standard is the best way to protect against the potentially significant adverse consequences from these transactions.

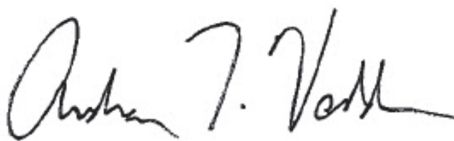
Sincerely,



Douglas A. Wheeler
Senior Vice President, Office of Governmental Affairs
New York Life Insurance Company



Kevin L. Howard
Vice President, Deputy General Counsel & Head of Government Affairs
Western & Southern Financial Group



Andrew T. Vedder
Vice President – Enterprise Risk Management
The Northwestern Mutual Life Insurance Company

Northwestern Mutual , New York Life and Western and Southern Joint response to requested Wording

No Monolines

In Section IV.2, we would propose to insert the following language:

- c. The Domestic Regulator should ensure that neither the transferor nor transferee will be a monoline company following the transaction. In making this determination, the Domestic Regulator or Independent Expert, as appropriate, should determine that, following the transaction:
 - i. Neither the transferor nor transferee will have 90% or more of its reserves in the same line of business; and
 - ii. Both the transferor and transferee will have diversification across lines of business. In making this determination, the Domestic Regulator or Independent Expert should consider whether company is operating in a single industry segment, is offering differentiated types of insurance products, or is otherwise exposed to increased risk because of its insurable risk profile.

No Worse Off

In Section II.1 and II.2, we would propose to insert the following language as items (o)-(p) and (m)-(n) respectively:

- o./m.: Update to the Own Risk and Solvency Assessment reports (“ORSA”) demonstrating how the proposed transaction would impact the ORSA analysis for the dividing or transferring insurer as well as for any insurer that will be assuming policy liabilities if the proposed transaction is approved.
- p./n.: Documentation of how the administration of policies by the dividing or transferring insurer following the transaction will provide a continuing level and quality of service.

In Section IV.3, we would propose to insert the following language:

- e. The financial ratings for all companies involved in the transaction should have at least the same financial rating as the company transferring the policy liabilities. This should apply for all new companies as well as the ongoing rating for the transferring or dividing company.

In Section IV.4.b, we would propose the following language to address how to assess from an actuarial perspective whether insureds are “no worse off”, regardless of whether it is an IBT or a CD:

- b. ~~For IBTs or other transactions which will not have access to additional capital,~~ An actuarial report of the adequacy of ~~run-off~~ reserves (gross and net) being transferred should include an analysis of . . .



**JOINT SUBMISSION OF NOLHGA AND NCIGF
TO NAIC'S RESTRUCTURING MECHANISMS WORKING GROUP
REGARDING THE RESTRUCTURING MECHANISMS BEST PRACTICES EXPOSURE DRAFT**

April 26, 2023

The National Organization of Life & Health Insurance Guaranty Associations ("NOLHGA") and the National Conference of Insurance Guaranty Funds ("NCIGF") are writing to comment on the Restructuring Mechanisms Working Group's (the "Working Group") April 4, 2023 draft of its Best Practices Procedures for IBT/Corporate Divisions (the "Current Exposure").¹ NOLHGA and NCIGF appreciate the Working Group and NAIC staff's efforts to incorporate technical changes related to guaranty association/fund coverage. Representatives of both organizations worked closely with NAIC staff on the Current Exposure and are in full support of the Working Group's adoption of the language related to guaranty association/fund coverage.

As has been the case throughout the NAIC's drafting process of the Best Practices and the White Paper, our comments generally focus on the concept (recognized by the Restructuring Mechanisms Working Group in both documents) that the policyholder protection of guaranty system coverage should not be reduced, eliminated or otherwise changed as a result of a restructuring transaction. The changes in the Current Exposure set forth the specific standards that must be satisfied to ensure that guaranty association/fund protection a policyholder would have had prior to a restructuring transaction is preserved when a restructuring transaction is consummated. Those standards differ depending on the lines of insurance involved in a proposed insurance business transfer or corporate division, and those differences are reflected in the Current Exposure. The Current Exposure contemplates that an applicant will present evidence of how those standards are satisfied in a proposed restructuring transaction, and the commissioner reviewing a proposed restructuring transaction will make the factual determination regarding whether those standards have been satisfied.

NOLHGA and NCIGF are prepared to continue this dialogue and to work closely with the Working Group as the Current Exposure is finalized. Thank you for the opportunity to share our perspective on the Current Exposure, and we look forward to working with you as this project moves forward.

Contact Information

**National Organization of Life and
Health Insurance Guaranty Associations**
13873 Park Center Road, Suite 505
Herndon, VA 20171
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Peter G. Gallanis
President
E-Mail: pgallanis@nolhga.com

**National Conference of Insurance
Guaranty Funds**
300 North Meridian, Suite 1020
Indianapolis, IN 46204
Phone: 317.464.8176

Roger H. Schmelzer
President
E-Mail: rschmelzer@ncigf.org

¹ In response to questions and discussion at the end of the last meeting of the Working Group, NOLHGA will be submitting a separate comment letter to clarify and confirm its position on preserving guaranty association coverage in restructuring transactions involving life, annuity and health insurance lines of business.



April 26, 2023

Superintendent Elizabeth Kelleher Dwyer, Co-Chair
Commissioner Glen Mulready, Co-Chair
Restructuring Mechanisms (E) Working Group
National Association of Insurance Commissioners
1100 Walnut Street, Suite 1500
Kansas City, MO 64106

Re: Exposure of Best Practices Procedures for IBT/Corporate Divisions (“Best Practices Document”)

Dear Co-Chairs Dwyer and Mulready:

This letter is being submitted on behalf of the National Organization of Life and Health Insurance Guaranty Associations (“NOLHGA”) to express its support for the portions of the Best Practices Document seeking to ensure the preservation of life and health guaranty association (“L&H GA”) coverage for policyholders whose company is involved in an IBT or corporate division transaction (“Restructuring Transaction”).

For the reasons stated in NOLHGA’s comment letter of May 27, 2022 to the Receivership and Insolvency Task Force (copy enclosed), we believe the only effective way to preserve L&H GA Coverage in Restructuring Transactions is to require the successor entity in the transaction to be licensed in all states where the predecessor entity was ever licensed with respect to life, annuity and health policies being transferred in the transaction.

This approach will not only ensure that a successor entity’s inherited life, annuity and health policies remain eligible for coverage by the L&H GAs in those states, but also will ensure that the successor entity is subject to regulatory oversight in each of those states for the benefit of the policyholders in those states. This continuing regulatory oversight is particularly important for life, annuity and health personal lines of business since most of these products (e.g., life insurance, annuities, LTC and disability insurance) represent long term obligations by an insurer to provide essential financial security protection to individual consumers.

We want to express our appreciation to the Working Group for its efforts on the Best Practices Document, and for allowing us the opportunity to provide input and comments on the document. We look forward to discussing these matters with you on the next call of the Working Group.

Very truly yours,

A handwritten signature in black ink that reads "Peter G. Gallanis".

Peter G. Gallanis
President



National Organization of Life and Health Insurance Guaranty Associations

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May 27, 2022

Jane M. Koenigsman, FLMI
Sr. Manager II, L&H Financial Analysis
National Association of Insurance Commissioners
1100 Walnut Street, Suite 1500
Kansas City, MO 64106

Re: Request for NAIC Model Law Development for the P&C Insurance Guaranty Association Model Act

Dear Ms. Koenigsman:

This letter is submitted with respect to the Receivership and Insolvency Task Force’s recent exposure of a “Request for NAIC Model Law Development” (“MLD”) relating to the Property & Casualty Insurance Guaranty Association Model Act (the “P&C Model Act”). We understand that the MLD’s sole purpose is to propose changes to the P&C Model Act tailored to ensure that P&C guaranty fund coverage is not lost, expanded, or otherwise affected by corporate division (“CD”) or insurance business transfer (“IBT”) transactions (collectively, “Restructuring Transactions”). Given that the MLD is solely focused on P&C GA coverage, NOLHGA has no position on the MLD but rather will defer to the views of those with expertise in P&C guaranty funds (e.g., the NCIGF and its members).¹

NOLHGA, however, would like to address comments submitted in response to the MLD that suggested consideration also should be given to amending the Life and Health Insurance Guaranty Association Model Act (“L&H GA Model Act”). In particular, one of the comments suggested that the L&H GA Model Act should be amended to deem successor entities in Restructuring Transactions, irrespective of their licensing status, to be member insurers of the life and health guaranty associations (L&H GA).

For the reasons that will be discussed further below, NOLHGA would reiterate its view that successor entities in Restructuring Transactions involving life and health policies should be licensed in all states where the predecessor entity was ever licensed with respect to the policies being transferred. This not only will ensure that the successor entity’s inherited life and health policies will remain eligible for coverage by the L&H GAs in those states, but it also will ensure that the successor entity is subject to regulatory oversight in each of those states for the benefit of each state’s insurance consumers. As reflected in the draft Restructuring Mechanisms White Paper², requiring licensing of a successor entity where it inherits business could be important to ensuring ongoing regulatory control over the entity and avoiding potential harm to insurance consumers.

¹ As previously noted, NOLHGA also does not have a position on whether states should adopt laws authorizing Restructuring Transactions. That is, NOLHGA neither supports nor opposes such laws but rather is focused on the potential implications of Restructuring Transactions to its member life and health insurance guaranty associations, and the protection its members provide to insurance consumers when their insurance company is placed in liquidation.

² The above reference, and similar references to “White Paper” in this letter, refer to the draft Restructuring Mechanisms White Paper, dated March 28, 2022, that was created by the Restructuring Mechanisms (E) Working Group of Financial Condition (E) Committee.

Most Life and Health Products Evidence Long-Term Policyholder Obligations

Virtually all life and annuity products, and many health products, represent long-term obligations by an insurer to provide essential financial security protection to its policyholders.³ Consumers who buy these products have an expectation that their insurer will provide this protection for decades into the future, or even for a lifetime (or longer, in the case of some annuities). This long-term commitment of life and health insurers is extremely important to policyholders since, as they age and/or experience health problems, they will find it increasingly difficult, if not impossible, to obtain similar coverage on comparable terms.

The nature of life and health products is quite different from most property and casualty products. Property and casualty products typically provide coverage on an annually renewable basis. This permits property and casualty policyholders to go back into the marketplace to seek replacement coverage if they become dissatisfied with their insurer's performance or the terms of their policy, or if their insurance company fails. In addition, property and casualty coverage typically does not become prohibitively expensive or completely unavailable to consumers because of advancing age or developing health conditions. As a result, property and casualty policyholders should have the ability to non-renew their coverage and obtain comparable replacement coverage if they became dissatisfied with the insurer that takes over their policy in a Restructuring Transaction. Importantly, many life and health insurance policyholders would not have that option, for the reasons stated above.

L&H GAs have Long-Term Obligations to Continue Coverage for Policyholders

Given the long-term nature of many life, annuity, and health insurance policy obligations, and the difficulty consumers may experience in replacing this coverage, L&H GAs have explicit statutory obligations to continue coverage for policyholders of insolvent insurers. This statutory duty to continue coverage often results in L&H GAs having obligations that continue for many years into the future. As an example, L&H GAs affected by the Penn Treaty/ANIC insolvencies have obligations for covering long term care policies that are projected to continue for the next 30 years or more.

There are Important Policy Reasons Member Insurers of L&H GAs Should be Licensed

Given the long-term nature of L&H GA Coverage obligations, and concerns about the risks to L&H GAs of backstopping the obligations of insurers that are not subject to regulation, the L&H Model Act has provided from its inception that insurers must be licensed to be members of a state's L&H GA.⁴ In effect, the licensing requirement ensures a level, regulatory playing field among insurers that will be eligible to have their products covered by the L&H GA. In this way, the L&H GA Model Act is designed

³ Certain forms of health insurance, which are renewed on an annual basis, are exceptions to this statement (e.g., most forms of conventional medical insurance issued today). However, other forms of health insurance (e.g., individual long term care insurance and disability income insurance) are guaranteed renewable for the life of the policyholder and therefore do represent long-term obligations to policyholders.

⁴ "Member Insurer" was defined in § 5(7) of the 1970 Model to include any person authorized to transact in this state any kind of insurance to which this Act applies under Section 3. **1971-4 NAIC Proc. 157, 162 (Dec. 14, 1970)**. "Authorized" was changed to "licensed" in this definition as part of the 1975 revisions. **1976-4 NAIC Proc. 296, 300 (Dec. 9, 1975)**. The commentary notes that this change was intended to ensure that all unauthorized insurers are excluded from the Act. **1976-4 NAIC Proc. 296, 299 (Dec. 9, 1975)**. The 1975 version of the Model also included a comment at the end of section entitled Scope, which included the following language: "Furthermore, it [this Model Act] applies only to direct insurance issued by persons licensed to transact insurance in this state at any time. Coverage issued by insurers which have not submitted to the application of a state's regulatory safeguards is excluded from protection by this act".

to protect L&H GAs (and their member insurers) from being generally responsible for the insurance obligations of entities that are not subject to state licensing and regulatory requirements.

In 1985, the L&H Model Act was amended to provide that the definition of “member insurer” includes insurers whose license or certificate of authority in this State may have been suspended, revoked, not renewed, or voluntarily withdrawn. This language was not intended to create a general exception to the requirement that insurers should be licensed to be members of the L&H GA, but rather was intended to avoid having policyholders become ineligible for GA coverage due to a state regulatory action.⁵ In many cases, financially troubled insurers will have their licenses suspended or revoked even before they are placed in receivership. The 1985 revision to the definition of member insurer was intended to avoid policyholders losing eligibility for GA coverage in those kinds of circumstances.

Concerns with Deeming Non-Licensed Successor Entities to be Member Insurers

As noted in the draft Restructuring Mechanisms White Paper, there is a fundamental regulatory interest in ensuring the licensing status of successor entities in Restructuring Transactions. If a successor entity to a Restructuring Transaction operates without a license in a state, it could result in a lack of regulatory knowledge and control regarding the company’s ongoing operations in that state, which in turn could make harm to consumers more likely. This harm potentially could encompass all aspects of state insurance regulation.

These potential harms also could expose L&H GAs to increased risks if successor entities in Restructuring Transactions are deemed member insurers of the GAs without being licensed and subject to regulation in the GAs’ home states. These risks could increase, based on the structure and the nature of the business that is the subject of the Restructuring Transaction. As an example, if the successor company is a newly formed or limited purpose entity running off risky forms of business (e.g., long term care policies), there could be substantial increased risk to a GA from such an entity not being licensed and regulated in the GA’s home state. This is exactly the type of situation that the drafters of the L&H Model Act sought to prevent by generally requiring member insurers to be licensed entities.

There is an additional concern with unlicensed, successor companies being deemed member insurers of the L&H GAs. This concern relates to Section 11.B of the L&H GA Model Act, which empowers the Commissioner to suspend or revoke the license of a member insurer that fails to timely pay its guaranty association assessments. This provision is commonly viewed as a practical and effective way to ensure that member insurers timely pay their L&H GA assessments. In the event successor companies are deemed to be member insurers without being licensed, the power of a commissioner to enforce the payment of assessments by those insurers by revoking their licenses would not be available.

In addition to the above concerns, NOLHGA believes that obtaining amendments to all 51 L&H GA Acts to include unlicensed entities as member insurers may not be a practical or realistic solution. While the Life and Health GA System has been quite successful over the years working with regulators and legislators to update state GA Acts to be consistent with the Model Act, those results have only been

⁵ As reflected in the NAIC Proceedings, the industry proponents of the 1985 amendments to the definition of “member insurer” provided the following explanation for those changes: “To emphasize the importance of what should be the clear dependence of coverage under the act on adequate regulation for solvency and competitive equality, the term “member insurer” has been modified and used to link more clearly the sections of the act relating to purpose, coverage, powers and duties, and assessments. Thus, the definition of member insurer has been expanded to include entities whose license may have been suspended or revoked. Insureds should not lose guaranty association coverage because of enforcement actions against an insurer under the laws and regulations designed to assure solvency, proper market conduct and competitive equality that all member insurers must adhere to. Equally, insurers should not be expected to extend coverage to entities that are not required to adhere to the same laws and regulations.” **1984-2 NAIC Proc. 440, 462 (June 3, 1984).**

possible because of the widespread support of state regulators and industry members for various Model Act improvements. Given the fundamental change and potential increased risks of deeming unlicensed insurers to be L&H GA members, amendments to achieve that purpose could be considered controversial and difficult to accomplish in many states.

The Draft White Paper's Recommendation for a Possible Solution to Licensing Issues

NOLHGA sees some promise in the draft White Paper's recommendation for a possible solution to addressing licensing issues in Restructuring Transactions. That recommendation, which appears on the last page of the draft White Paper, is to have the appropriate NAIC working group consider whether changes should be made to the licensing process for companies resulting from Restructuring Transactions of runoff blocks. In that regard, the draft White Paper notes, "A streamlined process that still ensures appropriate regulatory oversight (and any licensure necessary to preserve guaranty association coverage) may be appropriate in limited circumstances."

As noted above, the draft White Paper recognizes that the failure of a successor entity to be licensed in relevant states could result not only in the loss of L&H GA coverage, but also in a lack of regulatory knowledge and control regarding the company's ongoing operations, which in turn could result in harm to insurance consumers. This risk to consumers, by itself, would seem to be of sufficient concern to justify the NAIC's consideration of an alternative licensing process for successor entities in Restructuring Transactions.

Very truly yours,



Peter G. Gallanis
President



April 26, 2023

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**Superintendent Elizabeth Kelleher Dwyer,
Chair of the Restructuring Mechanisms
(E) Working Group,
National Association of Insurance Commissioners**

Re: Comments to Best Practices Procedures for IBT/Corporate Divisions,
Exposure draft 4-4-23

Dear Superintendent Dwyer:

We thank the NAIC Restructuring Mechanisms Working Group (the "Working Group") for the opportunity to comment upon the draft Best Practices Procedures for IBT/Corporate Divisions, exposure draft 4-4-23 (the "Draft"). Our comments below should be considered in the context of our prior comments (the "ProTucket Letter"), copy attached, to the draft White Paper, then dated October 22, 2021 (the "White Paper"), relating to Insurance Business Transfers ("IBTs") and Corporate Divisions ("CDs") which we submitted on behalf of our client, ProTucket Insurance Company ("ProTucket"). We and ProTucket also submitted comments to a prior version of the Draft. We once again submit comments on behalf of that client.

Our comments are organized as follows: I. General Comments to the form and scope of the Draft; II. Comments of Substance addressing specific issues of substance raised in the Draft; and III. Miscellaneous Comments addressing organizational and other miscellaneous drafting issues.

I. General Comments.

The Draft appears to be a combination of text from varied source documents, including the 1997 White Paper on restructurings, the Illinois Corporate Division statute, the Rhode Island IBT law, United Kingdom Part VII practices and commentary from some market participants. These documents in many cases contain similar guidance expressed in different terms and sometimes contradict one another. It appears that the Draft was not intended to be a fully integrated, internally consistent, document, and we cannot tell whether commentators should be reviewing the Draft as a "concept piece" to raise issues for further discussion or as guidance to be published for the use of examining regulators as implied in its title, "Best Practices Procedures for IBT/Corporate Divisions."

If the Draft is intended as guidance for use by regulators, we fear that the duplication and excessive prescriptive provisions in the Draft, sometimes set forth in exacting detail, will place an onerous and excessively time-consuming burden on examiners and applicants. Even if the Draft is intended to merely suggest standards for review, examiners will be tempted to follow its guidance with rigor, especially in light of the novelty of the subject matter. If it is intended as

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April 26, 2023
Page 2

guidance to regulators, we recommend that the Working Group seriously consider a different format and an approach that reduces duplications and moderates some of the more onerous provisions of the Draft. Some of the provisions that we suggest be reworked or deleted are set forth in Sections II and III below.

As an over-all general comment, we recommend that the Draft be revised to speak in one voice and to reconcile the similar points made in different sections. Without such a re-draft it is difficult to provide definitive comments, and we would suggest that commentators be given opportunities to comment further once the Working Group clarifies how it proposes to use the Draft.

The Working Group may have its own preferences, but we recommend that it consider drafting guidance that would use a pre-existing format already familiar to regulators -- to which the IBT and CD issues can be added -- rather than creating an altogether new format. Specifically, we suggest that the Working Group use the Form A format as a framework into which IBT and CD issues can be added.

II. Comments of Substance.

Beyond these general comments, we note the points of substance set forth below.

1. Definition of IBTs. (Page 1.) Just as in the case of CD's, IBT's will almost always involve a transfer of obligations and assets. The first sentence of the Draft should be amended accordingly.
2. Scope and Timing of Guidance. (Page 1.) The Draft indicates that it is not intended to provide guidance as a model law or regulation. We recommend that the Working Group consider the scope of guidance to be provided – and whether it should be issued, for example, as optional or mandatory addition to the Financial Analysis Handbook
3. Projections. (Page 5 et seq.) The Draft would request 5 years of financial pro-formas or projections (for example, Section II (1)(i).) Although some states may at times request 5, instead of 3, years, the term for projections in Form A and license applications is usually 3 years. We recommend that 3 years be used as the standard.
4. Guaranty Funds. (Page 5 et seq.) The Draft addresses guaranty fund issues for life and non-life separately (for example, Section II (1)(n)(i) and (ii)). It appears that the intention behind the different text for these lines is the same, yet the provisions are worded differently. As these issues are still under consideration by the relevant NAIC committees and interested parties, we suggest that the language describing the due diligence needed to assure post-transfer guaranty fund coverage be general to accommodate changing legislation.
5. Parental Guarantee. (Page 8.) The Draft (Section II (4)(b)) implies that an IBT or CD “should provide for a commitment of parental and other... support”. Requiring such support can effectively subvert the purpose of IBTs and CDs. Although there may be circumstances under which regulators may seek some level of external support for an IBT or CD, we recommend that this should not be generally required for such plans.

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April 26, 2023
Page 3

6. Licenses. (Page 8.) The Draft (Section II (5)(a)) implies that the resulting insurer in an IBT or CD should have licenses “in all jurisdictions in which it [the predecessor insurer] wrote business.” We recommend that that text be deleted. It should be sufficient that the insurer “will be licensed in all jurisdictions where required to take on business as a result of the restructuring.” This text should also be understood to include circumstances where the transaction is structured to carve out those jurisdictions where the license, surplus line eligibility or other similar status is unnecessary to effect the transfer. For example, it should be sufficient to post collateral to support reinsurance credit as a substitute for a license.
7. Adverse Impact Standard. (Page 10 et seq.) The Draft refers to a number of standards to evaluate the impact of IBTs or CDs on stakeholders. Section IV (2)(b)(iii) requires that the transaction not have “any adverse impact”. Section VI (preamble) requires that “policyholders and key stakeholders” be “in the same or better position” after the transfer. Section V (1)(d) calls for “no adverse effects”. Section V (1)(e) requires that such participants be in “a neutral or better condition after” the transfer.

Such standards could be onerous and impractical for a number of reasons. In a transfer between two highly creditworthy parties, it would make little sense to object to a transfer from a \$12 Billion company equity to a company with \$10 Billion, both with the same high credit rating. When evaluating the impact on both the transferor and transferee, it would very difficult to maintain that both parties would be in precisely the same position before and after a transfer. Furthermore, it would depart from normal practice to require regulators to regulate to a zero level of risk.

Accordingly, we recommend that the Draft adopt a standard of “material adverse effect”. This standard is very frequently used in commercial contracts and indeed in NAIC guidance and insurance laws.

8. RBC. (Page 10 et seq.) The Draft refers to Risk Based Capital (RBC) on numerous occasions. As discussed in the ProTucket Letter, RBC can often be an imprecise and misleading measure of solvency for insurers in run-off. As the evaluation of IBT and CD transactions may often involve insurers in run-off or books of business in run-off, we urge the Working Group to continue its dialogue with other NAIC committees in consideration of this issue and to make some allowance in the Draft for the distortions resulting from the application of RBC when evaluating IBTs and CDs involving insurers or books of business in run-off. Adding a footnote in the Draft to this effect would help sustain interest in this issue.
9. Role of Non-Domiciliary Regulators. (Page 18.) The Draft (Section VIII (3)) requires that all affected US jurisdictions approve or non-object to an IBT or CD. Such a provision is inconsistent with the laws of states which have adopted IBT and CD statutes and pre-judges the deliberations of the Working Group. Furthermore, it would be inappropriate for the regulators of one non-domiciliary state to make their evaluations dependent upon whether another non-domiciliary state would require approval of the transfer. We recommend that this requirement be deleted.

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April 26, 2023
Page 4

10. Run Off Procedures. (Page 20.) The Draft (Section X) appears to focus attention on run-offs resulting from an IBT or CD, possibly implicating insolvency. The Draft does not appear to discuss the broader issues arising from the business of running off solvent legacy books or the proper financial and regulatory aspects of this market, including the unique management, RBC, accounting and disclosure standards for prudent run-off administration. We believe that the current text can be misleading and confusing and would therefore recommend that this Section be deleted and the subject instead be treated to a separate more fulsome discussion elsewhere.

III. Miscellaneous Comments.

The following comments address organizational and other miscellaneous drafting issues.

1. Re-Ordering of Introductory Text. It may be useful to introduce the guidance by starting with a brief introduction/summary narrative of the regulatory approvals and expected timing before detailing the Company Information and Transactional Design in what is currently Sections I and II.
2. Consistency and Lack of Clarity. As indicated in our introductory comments, the Draft is derived from multiple sources that are sometimes inconsistent, duplicative and contradictory and some lack clarity. We recommend that these defects be corrected. For example:
 - a. Page 4 et seq., Section II (1) and (2). IBT's and CD's have many common characteristics, but are treated separately and inconsistently. It is preferable to treat them together under the same provisions, followed by a subsection to address those issues which are unique to one or the other.
 - b. Page 6, Section II (2)(f). This provision states that: "Nothing in this shall expand or reduce the allocation and assignment of reinsurance as stated in the reinsurance contract". We suggest it be re-worded for clarity.
 - c. Page 7 et seq., Section II (3), (4) and (5). These provisions at times indicate that they apply to both IBTs and CDs and at other times do not so indicate. We suggest this text be re-worded for clarity.
 - d. Page 8 et seq., Sections III and IV. We believe that these provisions are better read together. We suggest they be combined into one Section.
 - e. Pages 9 et seq., Sections IV and V. These provisions derive from multiple sources and at times appear to be unnecessarily burdensome. We suggest that these provisions be reviewed carefully to assure that they are consistent and sufficient for the purpose without imposing excessive burdens. For example, on a number of occasions, As stated in our general comments above, we suggest that the Draft be reformulated to more closely follow existing NAIC and state approval formats, in particular the format used for Form A reviews, with appropriate modifications to accommodate issues arising from IBTs and CDs.
 - f. Page 11, Section IV (4)(a). This text is confusing. We suggest it be re-worded for clarity.

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April 26, 2023
Page 5

3. Protected Cell Insurers. The ProTucket Letter (page 7, item 11) observed that the Working Group had been charged with identifying and addressing the legal issues associated with restructuring insurers using protected cells. Although those issues may have been set aside for future review, we ask that they not be forgotten. We recommend that the Draft, by way of footnote or otherwise, acknowledge that these issues will be considered at some future time when appropriate.

Because of the number and importance of the issues raised in the Draft, we urge the Working Group to remain open to further comments from interested parties.

We appreciate the opportunity to comment upon the Draft and are available to follow-up with further comments and further assistance that the Working Group.

Sincerely,

A handwritten signature in blue ink, appearing to read "RAR", written over a horizontal line.

Robert A. Romano

RAR

cc: Albert Miller, Esq., ProTucket Insurance Company
Jonathan Bank, Esq., Norton Rose Fulbright
Al Bottalico, Norton Rose Fulbright

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R&Q Insurance Holdings Ltd

VIA EMAIL

April 26, 2023

Superintendent Elizabeth Kelleher Dwyer
Commissioner Glen Mulready
Co-Chairs, NAIC Restructuring Mechanisms (E) Working Group

Attention: Robin Marcotte rmarcotte@naic.org
Dan Daveline ddaveline@naic.org

Re: Request for Comments – Best Practices Procedures for IBT/Corporate Divisions

Dear Superintendent Dwyer and Commissioner Mulready:

Thank you for the opportunity to comment on the most recent Best Practices exposure. R&Q Insurance Holdings Ltd. (RQIH) continues to support the mission of the Restructuring Mechanisms (E) Working Group and shares the view that state insurance markets would benefit from greater uniformity and robust regulatory standards for Insurance Business Transfers (IBTs) and similar mechanisms.

Properly structured and regulated IBTs can benefit state insurance markets and consumers by strengthening the management of complex risks while promoting capital and operational efficiencies for transferring insurers, leaving them sounder and enabling them to redeploy resources to meet other marketplace needs. But in our view some additional clarity in portions of the recent Best Practices exposure may be helpful in assuring these positive outcomes should the Working Group's proposal become a common standard amongst the states.

Our comments fall into five main categories: the standard of review; licensure requirements; parental guarantees; reinsurance transfers; and the expected end state of this NAIC process. These comments and some suggested clarifications to the exposure are detailed in the following.

Standard of Review

We support the “no material adverse impact” standard and appreciate that this appears to have become the consensus view of the Working Group and interested parties. We raise it here simply to reaffirm our view on the issue since it has been a topic of some ongoing discussions.

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As has been well articulated by numerous regulators and interested parties, this is a well-tested and well-understood standard in successful use in the Part VII regime in the UK (which regime forms the basis of existing IBT laws in the US), in Oklahoma where IBTs are successfully occurring, in the US courts, and in contract law.

We believe that the other standards that have been discussed from time to time are less tested and could create unintended consequences, increasing the amount of subjectivity that could be applied in practice. These alternate standards could, for example, result in the denial of a proposed IBT transaction simply because of non-material differences in the RBCs of the transferor and transferee. If such a standard of review were to take hold, proposed transactions may not get to the point of being evaluated for their holistic benefit to consumers and a state's insurance marketplace. Additionally, transactions of essentially identical parameters might be approved in one jurisdiction but not another, decreasing instead of increasing uniformity in the state system of insurance regulation.

We therefore encourage that “no material adverse impact” remain the standard as the Best Practices undergoes further development.

Licensure Requirements

In our understanding, the Working Group has historically discussed the need for licensure of IBT transferees as necessary to assure the continuation of guaranty fund eligibility for insureds who would have been eligible for that coverage prior to the IBT transaction. We wholeheartedly support this, and thus appreciate that the most recent exposure draft contains language from the guaranty associations appearing to make clear that the need for licensure of a P&C IBT transferee in a given state or states is related to the impact such licensure would have on guaranty fund coverage. We raise the issue here just to encourage additional clarity around this intent, perhaps through added language such as the following: *“The licensure of transferees in non-domiciliary states should be required if necessary to preserve eligibility for guaranty fund coverage.”* We would suggest this be appended to Section II, 1. n. ii (page 5 of the exposure) and in subsequent references.

Parental Guarantees

A key premise of the Best Practices is that conditions post-transaction should not be materially different from conditions pre-transaction. But the exposure includes parental guarantee language that could be interpreted as creating material differences by placing requirements on a transferred book of business that did not exist prior to the transfer. Especially in cases where no parental guaranty has been in place, we wonder why it would be required after the transfer. Further, some transferees may not be part of a holding company system with a parent positioned to make such a guaranty. Thus, requiring guarantees may prevent IBTs from occurring in the future.

Accordingly, we respectfully suggest that the current references to parental guarantees be amended to specify that consideration may be given to guarantees if they were in place at the transferring insurer at the time of the IBT and the transferee is part of a holding company system in which such a guarantee is feasible. For example, Section II, 4. b. (page 8) might be revised to read: *“Where the transferring insurer provided such commitment and the transferee is part of a holding company system enabling such parental commitments, the plan may provide for a commitment of parental and other legally enforceable plans for financial support to run off operations in the event of:...”*

We note that these proposed guarantees appear to emanate from recommendations in a 1997 NAIC whitepaper, which was an initial look at the issue of restructurings some 26 years ago and which thus predated the successful completion of a large number of such transfers in the UK and elsewhere without such requirements.

Reinsurance Transfers

The Best Practices document and the discussions to date have understandably focused on the potential impact of IBTs on individual consumers. But in practice these transactions sometimes involve only books of reinsurance, where the policyholder is not an individual but another insurance company. We suggest that this be recognized in the NAIC proposal with a statement indicating that a transfer solely involving reinsurance, where the transferred policyholder is another insurer, may be considered by regulators as a positive factor in their evaluation of the potential for any material adverse impact on consumers.

Expected End State of this NAIC Process

We believe that additional clarity may be helpful regarding the NAIC process on these Best Practices going forward. We understand that the current goal is to present a finalized document for approval at the NAIC Fall National Meeting, but are unsure of the thinking beyond that point, for example with respect to measures that would further encourage broad adoption amongst the states. Any guidance on this matter would be appreciated.

Thank you for your attention to our comments and proposed refinements to this important exposure. We are available at your convenience should you have any questions in this regard.

Sincerely,



Peter L. Hartt
US Head of Compliance and Regulatory Affairs
R&Q Insurance Holdings Ltd.

R&Q Insurance Holdings Ltd. ('RQIH'), headquartered and operating in Bermuda with extensive operations in the US and Europe, is a leading provider of finality solutions for run-off portfolios and global program capacity for MGAs and their reinsurers. R&Q has a proven track record over three decades of acquiring discontinued books of non-life business and non-life (re)insurance companies and captives in run-off. We have access to capital and the experience of managing run-off which enables us to free management and investors from the cost and constraints of handling discontinued business. We can do this on both sides of the Atlantic with our licensed platforms in the US, Bermuda and Europe.

Draft: 8/17/23

Risk-Focused Surveillance (E) Working Group
Seattle, Washington
August 14, 2023

The Risk-Focused Surveillance (E) Working Group of the Financial Condition (E) Committee met in Seattle, WA, Aug. 14, 2023. The following Working Group members participated: Amy Malm, Chair (WI); Lindsay Crawford, Vice Chair (NE); Blase Abreo (AL); Laura Clements and Michelle Lo (CA); William Arfanis and Jack Broccoli (CT); Ainsley Hurley and Bradley Trim (FL); Daniel Mathis (IA); Cindy Andersen (IL); Roy Eft (IN); Stewart Guerin (LA); Dmitriy Valekha (MD); Vanessa Sullivan (ME); Steve Mayhew and Judy Weaver (MI); Debbie Doggett, John Rehagen, and Shannon Schmoeger (MO); Angela Hatchell (NC); Pat Gosselin (NH); David Wolf (NJ); Mark McLeod (NY); Dwight Radel (OH); Diane Carter, Andrew Schallhorn, and Eli Snowbarger (OK); Diana Sherman (PA); Ted Hurley and John Tudino (RI); Johanna Nickelson (SD); Amy Garcia (TX); Jake Garn (UT); Greg Chew and David Smith (VA); Dan Petterson (VT); and Steve Drutz and Tarik Subbagh (WA).

1. Discussed Updated Guidance for Reviewing Affiliated Service Agreements

Malm stated that the first agenda item is to discuss an updated draft of proposed edits to NAIC handbooks to provide additional guidance for state insurance regulators in reviewing and monitoring transactions and service agreements between insurers and their affiliates. An updated draft of proposed revisions to both the NAIC's *Financial Analysis Handbook* and the *Financial Condition Examiners Handbook* was included in the meeting materials. The updated draft was revised in response to comments received during a recent exposure period, which ended May 8.

Comments were received from UnitedHealthcare and a joint group of interested parties, which primarily focused on placing guidance in the handbooks related to cost-plus reimbursement contracts. The comments were considered by members of the Affiliated Services Drafting Group in developing the updated draft, which included state insurance regulators from Connecticut, Idaho, Maine, North Carolina, Pennsylvania, Texas, Virginia, and Wisconsin.

Bruce Jenson (NAIC) provided an overview of the updated guidance, which included additional language on cost-plus reimbursement contracts whereby the rate charged under the agreement is based upon the cost to perform the service plus a negotiated fee/profit margin to recognize the risk of providing the service. He stated that the guidance indicates that these types of agreements should only be entered into as a method of last resort and may not be acceptable in all jurisdictions.

Chew stated that state insurance regulators recognize that the "method of last resort" language is not viewed favorably by the industry. He proposed the removal of that language from the draft and replacement with language indicating that the state insurance regulator should determine if the company has provided documentation sufficient to support the cost-plus methodology or if another methodology should be suggested. Malm and Broccoli expressed their support for this proposal.

Tom Finnell (America's Health Insurance Plans—AHIP) stated that interested parties object to the "method of last resort" language, as cost-plus methodology is widely used across the industry and is even required by some international jurisdictions for service agreements that involve international affiliates. He agreed that the change proposed by Chew would adequately address the industry concerns.

Malm stated that the guidance has been exposed multiple times over a period of almost two years and has gone through various iterations in response to the comments received. She stated although the guidance is not perfect, it is an improvement over what currently exists in NAIC handbooks, and it will be important in assisting states to review the increased number and complexity of affiliated service agreements being filed with state insurance departments.

Chew made a motion, seconded by Mathis, to refer the proposed guidance to the Financial Analysis Solvency Tools (E) Working Group and the Financial Condition Examiners Handbook (E) Technical Group for consideration of adoption. The motion passed unanimously.

2. Discussed Next Steps in Addressing the 2022 Macroprudential (E) Working Group Referral

Malm stated that the next agenda item is to discuss the Working Group's next steps in responding to the 2022 referral from the Macroprudential (E) Working Group. This referral relates to issues in affiliated service agreements that are being recognized more frequently in private equity (PE)-owned insurers. While the guidance just discussed does not yet address these issues, state insurance regulators wanted to finalize general affiliated services guidance before moving into the more specific topics raised in the referral.

The referral covers two different topics that the Risk-Focused Surveillance (E) Working Group was asked to consider related to affiliated investment management agreements (IMAs) and capital maintenance plans. Regarding the first topic, the referral recommends that the Working Group consider:

The material terms of the IMA and whether they are arm's length, address conflicts of interest — including the amount and types of investment management fees paid by the insurer, the termination provisions (how difficult or costly it would be for the insurer to terminate the IMA) and the degree of discretion or control of the investment manager over investment guidelines, allocation, and decisions.

The referral also includes some notes from state insurance regulator discussions on this topic, as well as comments received from Risk & Regulatory Consulting LLC (RRC). Malm asked Ed Toy (RRC) to provide an overview of the topic and issues the Working Group should consider in addressing the referral.

Toy stated that the review of IMAs should focus on several key areas to assess whether the agreements were fair and reasonable to the company and policyholders, including the following:

- Is the investment manager registered under the Investment Advisers Act of 1940 (40 Act), and does it acknowledge the fiduciary standard of care?
- Are investment guidelines included and sufficiently detailed to guide the investment managers' activities and allow the company to assess compliance and performance?
- Are the management fees fair and appropriate, reflecting the type of assets managed, the total assets under management, and the investment strategy in the context of the current market?
- Are there appropriate termination provisions?
- Are the investment managers allowed to engage sub-advisers? Does the company have control over such engagements? Who is responsible for the management fees of the sub-advisers?
- Are there adequate reporting requirements that include sufficient information for the company to monitor the investment manager and meet its reporting and regulatory needs?
- Is there language to address the potential for conflicts of interest?

Arfanis asked whether in Toy's experience most affiliated investment managers being utilized by insurers are registered under the 40 Act. Toy stated that his experience has been that 85–90% of affiliated investment managers are registered under the act. However, he stated that newer or less experienced insurance groups are more likely to utilize affiliated investment managers that are not registered under the act.

Jenson asked whether an IMA with broad investment guidelines could result in control of the insurer being ceded to a related party investment manager, as the investment manager could be placed in a position to make most investment decisions on behalf of the insurer. Toy indicated that it is important to ensure that IMAs provide sufficient guidance on the types of investments acceptable to the insurer to provide effective oversight and avoid granting control of the insurer through the agreement. All IMAs grant some discretionary authority to investment managers, but it is important to ensure that there are appropriate bounds to the discretion granted through the agreement.

Malm thanked Toy for his overview of the topic and recommended that a drafting group be formed to develop guidance to assist state insurance regulators in reviewing affiliated IMAs. She encouraged anyone interested in participating in the drafting group to contact NAIC staff to participate in the project.

Malm stated that the other topic addressed in the referral asks the Working Group to consider the following:

Owners of insurers, regardless of type and structure, may be focused on short-term results which may not be in alignment with the long-term nature of liabilities in life products. For example, investment management fees, when not fair and reasonable, paid to an affiliate of the owner of an insurer may effectively act as a form of unauthorized dividend in addition to reducing the insurer's overall investment returns. Similarly, owners of insurers may not be willing to transfer capital to a troubled insurer.

The referral encourages the Working Group to consider the development of additional guidance on how to require or strengthen capital maintenance agreements between an insurer and its parent company to address these concerns. Malm asked NAIC staff to develop some additional guidance on this topic for the Working Group to consider in a future meeting.

3. Discussed the Financial Analyst/Examiner Salary Survey

Malm stated that a survey of all the states to collect information on pay rates for common financial analysis and examination positions was closed on June 30. Responses to the survey were received from 40+ states and three different contact examination firms. NAIC staff are working to clean the data, adjust it for localized cost of living rates, and then aggregate it to calculate national and regional averages for the various positions.

After the current pay rates are analyzed and aggregated, NAIC staff plan to pull together external market data for comparison, including industry information and salary rates for federal and state banking regulators. The results will then be compared against the existing pay ranges in NAIC handbooks, which will likely result in proposed adjustments to the ranges. The proposed adjustments will be presented to the Working Group for review and adoption ahead of the Fall National Meeting.

4. Received an Update on 2023 Peer Review Sessions

Crawford stated that the NAIC Peer Review Program provides an opportunity for a group of experienced financial analysts and examiners to participate in reviewing each other's recently completed analysis and examination files.

The peer review discussions provide an opportunity to identify both best practices and opportunities for improvement within individual files and on an aggregate level across the country.

Crawford reported that three different peer review sessions have been held in 2023, all of which received excellent participation and feedback from all participants. A financial analysis session was held in February, with a total of 10 states participating in that session. In May, a financial exam session was held with a contractor-led examination theme. Six different states participated in that session, along with contract firm representatives, with a focus on identifying best practices in effectively utilizing contractors to conduct examinations. This session led to several new sound practices being identified and resulted in a referral being sent to the Financial Analysis Solvency Tools (E) Working Group and the Financial Condition Examiners Handbook (E) Technical Group on coordination between analysts and examiners during the fieldwork stages of an exam.

In July, a special Own Risk and Solvency Assessment (ORSA) financial analysis session was held with six states participating. The focus of this session was to identify sound practices in reviewing ORSA filings and incorporating them into financial analysis. Several new sound practices were identified through this session, which NAIC staff are still working to accumulate and finalize.

Crawford stated that due to other ongoing projects and construction at the NAIC central office, the Risk-Focused Surveillance (E) Working Group has decided not to hold any more peer review sessions in 2023. Instead, the Working Group plans to put together a comprehensive webinar for department chiefs and supervisors on the sound practices identified through NAIC peer review sessions to date. The goal of this webinar will be to encourage department leadership to support staff in their implementation of sound practices identified through peer review.

Crawford stated that plans for 2024 include holding another financial analysis session in the first quarter of the year, as well as scheduling two to three additional peer review sessions to meet demand once the NAIC central office is reconfigured.

Having no further business, the Risk-Focused Surveillance (E) Working Group adjourned.

[https://naiconline.sharepoint.com/sites/NAICSupportStaffHub/Member Meetings/E CMTE/2023-2-Summer/RFSWG/Surveillance WG 8-14-23 Minutes.docx](https://naiconline.sharepoint.com/sites/NAICSupportStaffHub/Member%20Meetings/E%20CMTE/2023-2-Summer/RFSWG/Surveillance%20WG%208-14-23%20Minutes.docx)

Clarifications for the MWG Reinsurance Worksheet

**Summary Response to Comments Received
 Joint FSTF/MWG Call
 June 20, 2023**

<p>1. OPTIONAL TOOL: This worksheet is designed as an OPTIONAL tool to assist lead state/domiciliary regulators when reviewing reinsurance transactions to allow them to obtain the information necessary to understand the economic impacts, typically upon initial review of the proposed transaction but also potentially when the lead state/domiciliary regulator is performing a historical review of the transaction for some specific purpose.</p>
<p>2. NOT AN ONGOING FILING: This worksheet is NOT for use as an ongoing filing with the NAIC and/or the lead/domiciliary state. It is an EDUCATIONAL tool for lead state/domiciliary regulators to use on an ad hoc basis as needed.</p>
<p>3. ONLY USED IF NEEDED: The worksheet is NOT designed to be used with EVERY reinsurance transaction. It is designed as a consistent tool for lead state/domiciliary regulators to use when reviewing reinsurance transactions for which they need to determine the economic impacts of said reinsurance transactions. If a reinsurance transaction is easily understood without the use of this worksheet, then a worksheet would not be used by the lead state/domiciliary regulator.</p>
<p>4. NOT A FIXED TEMPLATE: The worksheet is NOT a fixed template which MUST be used to answer the lead state/domiciliary regulators’ information needs. If an insurer has materials used in its own assessment of the reinsurance transaction which answer the information needs of the lead state/domiciliary regulator expressed in the worksheet, then those materials may be accepted by the lead state/domiciliary regulator rather than requiring the insurer to use the worksheet format. Every effort should be made to avoid duplicate requests for information.</p>
<p>5. OPEN TO REINSURANCE TYPE: The worksheet was designed with life reinsurance transactions as the initial focus, but there is no reason to limit this tool to life reinsurance transactions. If the lead state/domiciliary regulator has a P/C reinsurance transaction for which they are struggling to understand the economic impact (despite any existing notes, interrogatories, and Schedule F disclosures for already approved transactions), the lead state/domiciliary regulator would be able to use the worksheet to request the needed information, with appropriate edits. Again, this worksheet should not be used if the lead state/domiciliary regulator has a clear understanding of the transaction from data already provided.</p>
<p>a. Similarly, the worksheet was designed with affiliated transactions as the initial focus, but a lead state/domiciliary regulator should use the template for unaffiliated transactions if existing information does not provide a clear understanding of the transaction.</p>
<p>6. NOT REINSURANCE POLICY: The Macroprudential (E) Working Group is working in coordination with the Reinsurance (E) Task Force. This optional, informational tool is not intended to impact any of its reinsurance policies or procedures, such as the qualified/reciprocal jurisdiction evaluation process or the U.S. Covered Agreement.</p>
<p>7. ONLY REFERENCED IN HANDBOOKS: The worksheet is not included in the Financial Analysis Handbook or the Examination Handbook, although it may be referenced there as an optional tool. The worksheet will be available on StateNet.</p>
<p>8. CONFIDENTIALITY: The worksheet would be confidential under a states existing confidentiality laws and regulations in place to assess such transactions.</p>

Cross-border Affiliated Reinsurance Comparison Worksheet - by Treaty					
	Date:				
Category	US Stat. Pre-Transaction	Impacts of Transaction (Col's B-D)	US Stat. Post-Transaction	Other Jurisdiction	(Alternate Method) - Other Jurisdiction
Other Jurisdiction Name					
BALANCE SHEET COMPARISON:					
Asset Grouping 1 (e.g., Cash/Investments)					
Asset Grouping 2 (e.g., Policy Loans)					
Asset Grouping 3 (e.g., Separate Accounts)					
Other Assets					
TOTAL ASSETS *					
Liab. Grouping 1 (e.g., Gen. Acct. Reserves)					
Liab. Grouping 2 (e.g., Gen. Acct. Policy Loan Reserves)					
Liab. Grouping 3 (e.g., Separate Accounts)					
Unauthorized Reinsurance Liability					
Other Liabilities (See NOTES SECTION)					
TOTAL LIABILITIES					
TOTAL ASSET REQUIREMENT COMPARISON:					
Reserve Grouping 1 (e.g., Separate Account Reserves)					
Reserve Grouping 2 (e.g., GA Policy Loan Reserves)					
Reserve Grouping 3 (e.g., GA Policy Reserves)					
TOTAL RESERVES					
Capital Grouping 1 (e.g., Required Capital)					
Capital Grouping 2 (e.g., Add'l Capital for Rating Agency)					
Capital Grouping 3 (e.g., in Excess of Rating Agency Cap.)					
TOTAL CAPITAL					
TOTAL ASSET REQUIREMENT					
CHANGE IN CAPITAL AND SURPLUS:					
Capital and Surplus					
Net Income					
Change in Liability for Unauthorized Reinsurance					
Aggregate Write Ins for gains and losses in surplus					
Capital Contribution/(Dividends)					
Other Changes in surplus					
TOTAL LIABILITIES & CAPITAL					
SOLVENCY RATIO					
* Supported by listings of asset categories and amounts to highlight differences in supporting assets after the transaction.					
NOTES SECTION:					
(e.g., explain product line, describe transaction and any unique aspects)					
(If Asset Adequacy Testing is included in "Other Liabilities," additional regulatory guidance may be needed, e.g., on counterparty asset assumptions where access is limited.)					

Transaction Details				
Please identify the following transaction details if applicable:				
Which party of the contract are you (assuming or retro)ceding?	Contract 1 (if needed)	Contract 2 (if needed)	Contract 3 (if needed)	Contract 4 (if needed)
Description risk category covered (mortality, longevity, Cat Risk, etc.)				
Start date				
End date				
Currency				
Sum Insured / Gross Notional amount / PML				
Capital at risk				
Line of Business (e.g. annuities, term, participating guarantee, etc.)				
Risks covered (e.g. longevity, mortality, etc.)				
Type of reinsurance treaty (XOL, Quota share – proportionate, etc.)				
Collateral value				
Value of guarantee				
Name(s) of the reinsurer(s) (please only include top 3 by premium share if more than one)				
Rating of reinsurer(s)				
Countries of reinsurer(s)				
Assets pledged by reinsurer				
Initial premium				
Initial fees				
Value of reserves				
Ceding commission structure				If yes, please provide a brief description
Any experience refund or loss carryforward features				If yes, please provide a brief description
Do you use or plan to use any form of derivatives for reinsurance purposes (e.g. longevity or mortality swaps)?				If yes, provide description of these derivatives
Was any debt or surplus note issued in connection with the transaction? Ex. Such as in an embedded value securitization				If yes, please provide a brief description
Please identify and describe if any of the following types of arrangements are associated with this transaction:	Description			
Trust	Please describe Exit mechanism if known			
Funds Withheld				
Coinsurance				
Modified Coinsurance				
Sidecars				
Any other Joint Venture or SPV				
Third-party capital				
Ceded and Retroceded Details	Reinsurer Name	Jurisdiction		
If ceding to an offshore affiliate please identify the assuming affiliated reinsurer(s) and their regulatory jurisdiction				
If ceding to an offshore affiliate and that affiliate is going to retrocede to another reinsurer, please identify the ultimate assuming reinsurer(s) and their regulatory jurisdiction				
Key Definitions				
PML -Probable Maximum Loss				
Capital at risk -required capital or capital charge				
Collateral value -the market value of securities pledged as collateral if a trust is set up in connection with the transaction.				
Value of the guarantee - For example, third party guarantees in non-standard types of reinsurance, e.g. an MGA owns affiliated insurers, an unaffiliated reinsurer reinsures with the MGA affiliate with a guarantee from the MGA.				

Interpretation of the Statutory Accounting Principles (E) Working Group

Net Negative (Disallowed) Interest Maintenance Reserve

INT 23-01 Dates Discussed

April 10, 2023, June 28, 2023, August 13, 2023

INT 23-01 References

Current:

*SSAP No. 7—Asset Valuation Reserve and Interest Maintenance Reserve
Annual Statement Instructions*

INT 23-01 Issue

1. The statutory accounting guidance for interest maintenance reserve (IMR) and the asset valuation reserve (AVR) is within *SSAP No. 7—Asset Valuation Reserve and Interest Maintenance Reserve*, but the guidance within *SSAP No. 7* is very limited. It provides a general description, identifies that IMR/AVR shall be calculated and reported per the guidance in the applicable SSAP, and if not explicit in the SSAP, in accordance with the annual statement instructions. The SSAPs most often simply direct allocation to (or between) IMR and AVR, with the bulk of the guidance residing within the annual statement instructions.

2. As detailed in *SSAP No. 7*, paragraph 2, the guidance for IMR and AVR applies to life and accident and health insurance companies and focuses on IMR and AVR liability recognition and distinguishing between IMR and AVR:

2. Life and accident and health insurance companies shall recognize liabilities for an AVR and an IMR. The AVR is intended to establish a reserve to offset potential credit-related investment losses on all invested asset categories excluding cash, policy loans, premium notes, collateral notes and income receivable. The IMR defers recognition of the realized capital gains and losses resulting from changes in the general level of interest rates. These gains and losses shall be amortized into investment income over the expected remaining life of the investments sold. The IMR also applies to certain liability gains/losses related to changes in interest rates. These gains and losses shall be amortized into investment income over the expected remaining life of the liability released.

3. The IMR guidance in the annual statement instructions provides information on the net balance. A positive IMR represents net interest rate realized gains and is reported as a liability on a dedicated reporting line. A negative disallowed IMR represents net interest rate realized losses and is reported as a miscellaneous other-than-invested write-in asset in the general account and nonadmitted.

4. IMR balances between the general account and separate accounts are separate and distinct. Meaning, a net negative IMR in the general account only represents activity that occurred in the general account that was allocated to IMR. However, the net positive or negative balance of the general account influences how the net positive or negative balances are reported in separate account statements (and vice versa). (A net negative IMR balance in the general account may not be disallowed if there is a covering net positive IMR in the separate account. Negative IMR that is not disallowed is reported as a contra-liability.) The instructions for reporting the net negative and positive balances are detailed in the annual statement instructions:

Line 6 – Reserve as of December 31, Current Year

23-01T-1

INT 23-01

Appendix B

Record any positive or allowable negative balance in the liability line captioned "Interest Maintenance Reserve" on Page 3, Line 9.4 of the General Account Statement and Line 3 of the Separate Accounts Statement. A negative IMR balance may be recorded as a negative liability in either the General Account or the Separate Accounts Statement of a company only to the extent that it is covered or offset by a positive IMR liability in the other statement.

If there is any disallowed negative IMR balance in the General Account Statement, include the change in the disallowed portion in Page 4, Line 41 so that the change will be appropriately charged or credited to the Capital and Surplus Account on Page 4. If there is any disallowed negative IMR balance in the Separate Accounts Statement, determine the change in the disallowed portion (prior year less current year disallowed portions), and make a direct charge or credit to the surplus account for the "Change in Disallowed Interest Maintenance Reserve" in the write-in line, in the Surplus Account on Page 4 of the Separate Accounts Statement. The following information is presented to assist in determining the proper accounting:

General Account IMR Balance	Separate Account IMR Balance	Net IMR Balance
Positive	Positive	Positive (See rule a)
Negative	Negative	Negative (See rule b)
Positive	Negative	Positive (See rule c)
Positive	Negative	Negative (See rule d)
Negative	Positive	Positive (See rule e)
Negative	Positive	Negative (See rule f)

Rules:

- a. If both balances are positive, then report each as a liability in its respective statement.
 - b. If both balances are negative, then no portion of the negative balances is allowable as a negative liability in either statement. Report a zero for the IMR liability in each statement and follow the above instructions for handling disallowed negative IMR balances in each statement.
 - c. If the general account balance is positive, the separate accounts balance is negative and the combined net balance is positive, then all of the negative IMR balance is allowable as a negative liability in the Separate Accounts Statement.
 - d. If the general account balance is positive, the separate account balance is negative, and the combined net balance is negative, then the negative amount not covered by the positive amount is not allowable. Report only the allowable portion as a negative liability in the Separate Accounts Statement and follow the above instructions for handling the disallowed portion of negative IMR balances in the Separate Accounts Statement.
 - e. If the general account balance is negative, the separate account balance is positive, and the combined net balance is positive, then all of the negative IMR balance is allowable as a negative liability in the General Account Statement.
 - f. If the general account balance is negative, the separate account balance is positive, and the combined net balance is negative, then the negative amount not covered by the positive amount is not allowable. Report only the allowable portion as a negative liability in the General Account Statement and follow the above instructions for handling the disallowed portion of negative IMR balances in the General Account Statement.
5. In October 2022, the ACLI requested the Statutory Accounting Principles (E) Working Group to reassess the guidance for net negative (disallowed) IMR, with a request to consider admittance of those amounts. The ACLI noted that the nonadmittance of disallowed negative IMR can have adverse negative ramifications for insurers with two key themes:

23-01-2

Net Negative (Disallowed) IMR

INT 23-01

- a. In general, rising interest rates are favorable to the financial health of the insurance industry and policyholders. However, with negative IMR, there is an inappropriate perception of decreased financial strength through lower surplus and risk-based capital.
- b. Negative IMR could impact the rating agency view of the industry or incentivize companies to avoid prudent investment transactions that are necessary to avoid mismatches between assets and liabilities. In either scenario, negative IMR encourages short-term non-economic activity that is not in the best long-term interest of a reporting entity's financial health or its policyholders.

6. In considering the request, the Working Group concluded that, for year-end 2022, there would be no change to statutory accounting guidance and deviations from statutory accounting principles would need to be approved via a permitted or prescribed practice. The Working Group then held company-specific educational sessions in January 2023 to receive detailed information regarding negative IMR and received a subsequent comment letter from the ACLI.

7. During the 2023 Spring National Meeting, the Working Group further discussed the topic of negative IMR and directed NAIC staff to proceed with drafting guidance for a 2023 solution and to begin work towards a long-term solution.

INT 23-01 Discussion

8. This interpretation prescribes limited-time, optional, statutory accounting guidance, as an exception to the existing guidance detailed in SSAP No. 7 and the annual statement instructions that requires nonadmittance of net negative (disallowed) IMR as a short-term solution. Specifically, this interpretation impacts the annual statement instruction rules regarding disallowed negative IMR detailed in rules 'b,' 'd' and 'f' shown in paragraph 4. As this interpretation overrides existing guidance, it will require a 2/3rd vote.

9. Reporting entities are permitted to admit net negative (disallowed) IMR with the following restrictions:

- a. Reporting entities that qualify pursuant to paragraph 9b, are permitted to admit net negative (disallowed) IMR up to 10% of the reporting entity's adjusted general account¹ capital and surplus as required to be shown on the statutory balance sheet of the reporting entity for its most recently filed statement with the domiciliary state commissioner. The capital and surplus shall be adjusted to exclude any net positive goodwill, EDP equipment and operating system software, net deferred tax assets and admitted² net negative (disallowed) IMR.
- b. Reporting entities applying this interpretation are required to have a risk-based capital (RBC) greater than 300% after an adjustment to total adjusted capital (TAC) that reflects a reduction to remove any net positive goodwill, EDP equipment and operating system software, net deferred tax assets and admitted net negative (disallowed) IMR. Compliance with this adjusted RBC calculation shall be affirmed for all quarterly and annual financial statements for which net negative (disallowed) IMR is reported as an admitted asset in the

¹ The general account capital and surplus includes surplus reflected in the separate account; therefore, an aggregation of general account and separate account surplus is not necessary.

² As the separate account does not have "admitted" assets, broad reference to "admitted net negative (disallowed) IMR" throughout this interpretation includes what is admitted in the general account and what is recognized as an asset in the separate accounts.

INT 23-01

Appendix B

general account or recognized as an asset in the separate accounts. Reporting entities shall provide documentation to illustrate compliance with this requirement upon state regulator request. Reporting entities with an adjusted RBC calculation of 300% or lower are not permitted to admit net negative (disallowed) IMR in the general account or recognize IMR assets in the separate accounts.

- c. The net negative (disallowed) IMR permitted for admittance shall not include losses from derivatives that were reported at fair value prior to derivative termination³ unless the reporting entity has historically followed the same process for interest-rate hedging derivatives that were terminated in a gain position. In other words, there is a requirement for documented, historical evidence illustrating that unrealized gains from derivatives reported at fair value were reversed to IMR (as a liability) and amortized as part of IMR. Reporting entities that do not have evidence of this past application are required to remove realized losses from derivatives held at fair value from the net negative (disallowed) IMR balance to determine the amount permitted to be admitted. Reporting entities that begin a new process for the use of hedging derivatives, perhaps with a theoretical process to treat derivative losses and derivative gains similarly, but do not have evidence illustrating the historical treatment of derivative gains through IMR are not permitted to include derivative losses in the net negative (disallowed) IMR permitted to be admitted. This evidence is required separately for the general account, insulated separate account and non-insulated separate account if losses from derivatives previously reported at fair value are currently being allocated to IMR in those accounts.
10. Reporting entities that admit net negative (disallowed) IMR shall follow the following process:
 - a. All net negative (disallowed) IMR in the general account shall first be admitted until the capital and surplus percentage limit, as detailed in paragraph 9.a, is reached.
 - b. If all general account net negative (disallowed) IMR has been fully admitted, and the reporting entity is still below the paragraph 9.a capital and surplus limit, then the reporting entity can report net negative (disallowed) IMR as an asset in the separate accounts. Reporting entities that have both insulated and non-insulated separate accounts shall recognize IMR assets proportionately between the insulated and non-insulated statements until the aggregated amount recognized as an admitted asset in the general account and as an asset in the insulated and non-insulated statements reaches the percentage limit of capital and surplus detailed in paragraph 9a.
 11. Reporting entities that admit net negative (disallowed) IMR in the general account shall report the admittance in the balance sheet as follows:
 - a. Reporting entities shall report the net negative (disallowed) IMR as an aggregate write-in to miscellaneous other-than-invested assets (line 25) (named as “Admitted Disallowed IMR”) on the asset page. The net negative (disallowed) IMR shall be admitted to the extent permitted per paragraph 9a, with the remaining net negative (disallowed) IMR balance nonadmitted.
 - b. Reporting entities shall allocate an amount equal to the general account admitted net negative (disallowed) IMR from unassigned funds to an aggregate write-in for special surplus funds (line 34) (named as “Admitted Disallowed IMR”). Although dividends are

³ Reference to derivative termination throughout this interpretation includes all actions that close out a derivative, including, but not limited to, termination, expiration, settlement, or sale.

Net Negative (Disallowed) IMR

INT 23-01

contingent on state specific statutes and laws, the intent of this reporting is to provide transparency and preclude the ability for admitted negative IMR to be reported as funds available to dividend.

12. Reporting entities that record net negative (disallowed) IMR as an asset in the separate account shall report the recognition in the balance sheet as follows:

- a. Reporting entities shall report the permitted net negative (disallowed) IMR as an aggregate write-in to miscellaneous other-than-invested assets (line 15) (named as “Recognized Disallowed IMR”) on the asset page.
- b. Reporting entities shall allocate an amount from surplus equal to the asset recognized as disallowed IMR as an aggregate write-in for special surplus funds (line 19) (named as “Recognized Disallowed IMR) on the liabilities and surplus page.

13. Reporting entities admitting net negative (disallowed) IMR are required to complete the following disclosures in the annual and quarterly financial statements for IMR:

- a. Reporting entities that have allocated gains/losses to IMR from derivatives that were reported at fair value prior to the termination of the derivative shall disclose the unamortized balances in IMR from these allocations separately between gains and losses.
- b. Reporting entities shall complete a note disclosure that details the following:
 - i. Net negative (disallowed) IMR in aggregate and allocated between the general account, insulated separate account and non-insulated account,
 - ii. Amounts of negative IMR admitted in the general account and reported as an asset in the separate account insulated and non-insulated blank,
 - iii. The calculated adjusted capital and surplus per paragraph 9a, and
 - iv. Percentage of adjusted capital and surplus for which the admitted net negative (disallowed) IMR represents (including what is admitted in the general account and what is recognized as an asset in the separate account).
- c. Reporting entities shall include a note disclosure that attests to the following statements:
 - i. Fixed income investments generating IMR losses comply with the reporting entity’s documented investment or liability management policies,
 - ii. IMR losses for fixed income related derivatives are all in accordance with prudent and documented risk management procedures, in accordance with a reporting entity’s derivative use plans and reflect symmetry with historical treatment in which unrealized derivative gains were reversed to IMR and amortized in lieu of being recognized as realized gains upon derivative termination.
 - iii. Any deviation to 13.c.i was either because of a temporary and transitory timing issue or related to a specific event, such as a reinsurance transaction, that mechanically made the cause of IMR losses not reflective of reinvestment activities.

INT 23-01**Appendix B**

- iv. Asset sales were not compelled by liquidity pressures (e.g., to fund significant cash outflows including, but not limited to excess withdrawals and collateral calls).

INT 23-01 Status

14. The consensuses in this interpretation were adopted on August 13, 2023, to provide limited-time exception guidance to SSAP No. 7 and the annual statement instruction for the reporting of net negative (disallowed) IMR. The provisions within this interpretation are permitted as a short-term solution until December 31, 2025, and will be automatically nullified on January 1, 2026.

15. The effective date of this interpretation may be adjusted (nullified earlier or with an extended effective date timeframe) in response to Statutory Accounting Principles (E) Working Group actions to establish statutory accounting guidance specific to net negative (disallowed) IMR.

16. Further discussion is planned.

Net Negative (Disallowed) IMR

INT 23-01

Application Guidance for Admitting / Recognizing Net Negative (Disallowed) IMRGeneral Account:

1. Net negative IMR in the general account that exceeds net positive IMR in the separate accounts is considered “disallowed” general account IMR. (Determination of the disallowed IMR in the general account shall be compared against the aggregate IMR balance in all separate accounts.)
2. Net negative disallowed IMR in the general account shall be reported as an aggregate write-in for other-than-invested assets as “Admitted Disallowed IMR” on line 25 of the asset page and nonadmitted. The change in nonadmittance shall be reported on line 41 in the summary of operations.
3. To the extent the reporting entity is permitted to admit net negative disallowed IMR pursuant to the provisions in this interpretation, the reporting entity shall admit the disallowed IMR reported on line 25 of the asset page to the extent permitted, with the change in nonadmittance reflected on line 41 in the summary of operations.
4. Reporting entities shall report an amount equal to the general account admitted net negative (disallowed) IMR as an aggregate write-in for special surplus funds (line 34 of the Liabilities, Surplus and Other Funds page) named as “Admitted Disallowed IMR.”
5. Reporting entities shall include note disclosures in the quarterly and annual financial statements as required in paragraph 13 of the interpretation.

Separate Account:

6. Net negative IMR in the separate account (aggregated IMR in both insulated and non-insulated separate accounts) that exceeds net positive IMR in the general account is considered “disallowed” separate account IMR. If the aggregate separate IMR is positive, with a negative IMR in the insulated separate account and positive IMR in non-insulated separate account (or vice versa), then the negative IMR in the insulated separate account is not permitted to be reported as an asset. In those situations, the separate account has an aggregate positive IMR balance.
7. Net negative (disallowed) IMR in the separate account permitted to be recognized as an asset, as the admittance in the general account did not utilize the full percentage of adjusted capital and surplus permitted within this interpretation, shall be proportionately divided between insulated and non-insulated separate accounts if both separate accounts are in a negative position. If the separate account IMR is an aggregate net negative, but only one separate account blank is in a negative position, then only the separate account blank with a net negative position can recognize disallowed IMR as an asset.
8. If negative IMR in the separate account has previously been recognized as a direct charge to surplus, the reporting entity shall recognize an asset as an aggregate write-in for other-than-invested assets as “Recognized Disallowed IMR” on line 15 of the separate account asset page, with an offsetting credit to surplus. This credit to surplus shall reverse the charge previously recognized. This process shall continue in subsequent quarters if additional separate account IMR is permitted as an asset to the extent IMR was previously taken as a direct charge to surplus. Once prior surplus impacts have been fully eliminated, then the entity shall follow the guidance for new net negative (disallowed) IMR as detailed in the following paragraph. If subsequent quarters result with a decline in the permitted IMR asset in the separate account, then the asset shall be credited with an offsetting charge to surplus.
9. If the reporting entity enters a net negative (disallowed) IMR position (meaning, there has not been a prior charge to surplus for net negative (disallowed) IMR), then the entity shall recognize the asset as

INT 23-01

Appendix B

an aggregate write-in for other-than-invested assets as “Disallowed IMR” on line 15 of the separate account balance sheet, with an offsetting credit to IMR (line 3 of the liability page) until the IMR liability equals zero. This process shall continue in subsequent quarters if additional net negative IMR is generated from operations and is permitted as an asset under the provisions of this interpretation. If subsequent quarters result with a decline in the permitted IMR asset in the separate account, then the asset shall be credited with an offsetting charge to surplus.

10. Reporting entities shall report an amount equal to the asset recognized reflecting net negative (disallowed) IMR as an aggregate write-in for special surplus funds (line 19) (named as “Recognized Disallowed IMR.” This shall be included in each separate account statement (insulated and non-insulated) if net negative disallowed IMR is recognized as an asset in that statement.
11. Reporting entities shall include note disclosures in the quarterly and annual financial statements as required in paragraph 13 of the interpretation.


 Office of the Superintendent of Financial Institutions Canada / Bureau du surintendant des institutions financières Canada

NAIC Summer National Meeting

OSFI's Recent Journey with Insurance Data and Analytics August 15, 2023


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 Executive Director
 Risk Assessment and Intervention Hub



Outline

- Personal background
- It started with the FCT
- Another winter holiday, another analytics project (RADAR)
- Meltwater media monitoring tool
- More AI in use – reinsurance NLP pilot
- OSFI Blueprint and transformation
- OSFI data and analytics and next steps


2

Personal background – provides context for the story

- Actuary by training
- More than 35 years in industry (consulting and insurers)
- Author of CAS and SOA textbooks used for actuarial examinations
- Advisory committee member of University of Waterloo and University of Toronto actuarial programs
- Transformation expertise
- Mantra: enhance efficiency and effectiveness (neither at the expense of the other)
- Joined OSFI fall 2020 in P&C insurance
- Was not (am not) your typical supervisor


3

It started with FCT

- Obligation of AA to conduct FCT annually
- Single most important report from the perspective of prudential regulation – too important to only be understood by actuarial specialists
- Rigorous actuarial standards of practice and very strong relationship of CIA and OSFI have led to high quality of FCT reports
- FCT includes solvency and going concern scenarios
- Challenge I faced:
 - How do I teach supervisors (not actuarial specialists) how to use and what to look for in the FCT
 - How do I make the process for review of FCT reports most efficient and effective
- Benefits I had:
 - Teaching experience
 - President of the CIA


4

Looking for efficiency and effectiveness

- o Estimates of time to analyze FCT report:
 - 2 days max per insurer
 - ½ day read text with focus on executive summary and charts / tables
 - 1 day use FCT tool to help develop conclusions with respect to risk assessment
 - ½ day document findings and ratings
- o Use tool to answer questions such as:
 - Were the current selected scenarios, assumptions, and ripple effects, consistent with prior year for the same insurer and were they consistent with peers?
 - Was the affect of a particular adverse scenario on key financial metrics consistent with prior year for the same scenario for the insurer and consistent with peers for the same scenario?
 - Were the differences in actual results and expected results (which could be calculated given data entry from the prior year FCT) within a reasonable range, and specifically were they greater than the standard of materiality selected by the AA?
 - Were key financial ratios that could be derived from the base scenario (which is required by actuarial standards to be based on the insurer's plan) consistent with historical experience?
 - Were changes in the insurer's strategy appropriately reflected in the base and adverse scenarios?

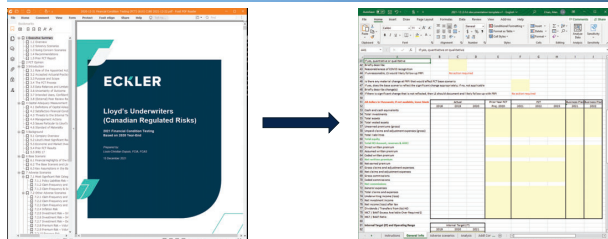


FCT version 1 – P&C and mortgage insurers only

- o Started during Christmas break (2022), with six colleagues willing to be testers (tremendous benefits of early adopters)
- o Excel-based tool with five tabs: instructions, general information, adverse scenarios, analysis, VU (OSFI's supervisory system of record)
- o Clearly marked cells for data entry vs. calculations, conditional formatting drew user's attention in analysis tab, conditional tests made it clear where action was needed
- o Create Users Guide at same time that tool was developed (translation to French)
- o Special coding for each row and column to enable aggregation for peer group and trend analyses by our analytics teams
- o Roll out in January, require use immediately (training and drop-in sessions)
- o Data input in version 1 by lead supervisors (LSs)
- o First year of use, LS needed to enter prior and current year information

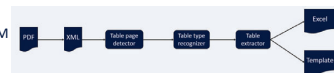


FCT version 1.5 – Intelligent Automation Information Extraction and Template Filling (AI / NLG)



FCT version 1.5 Conclusions – 1 of 2

- o Automated NLP tool was used to extract data from FCT report to validate quality of the FCT template submissions across 147 P&C insurers
- o The tool was developed in Python to identify and extract data from tables in PDF documents using several applications, including:
 - Coding via Jupyter Notebook in TES DSVM
 - Ghostscript – pdf interpreter
 - Pooler – pdf to xml converter
 - Python – delegator, Pandas, openpyxl
- o Each FCT report contained ~100 to 300+ pages and 100+ tables with limited standardized format
- o Results were promising as it was found that 85% of data were correctly extracted and filled, 11% were missing, and 4% were incorrectly captured
- o Causes of incorrect data capture primarily related to differing formats and non-standardized data (e.g., reporting in \$000 or \$M)



FCT version 1.5 Conclusions – 2 of 2

- o Data extracted from FCT (PDF) Report were compared against data submitted through FCT template to identify potential reporting errors across 95 P&C insurers’ base scenarios, about 10k data points
- o We discovered that 5.5% of data points in the base scenario were inconsistent
 - Some data divergence (3.7%) was due to unit difference, rounding, and negative sign
 - 1.3% of data points had potential reporting errors
 - 0.5% were due to data extraction errors



9

FCT version 2

- o Discussed work with FCT at OSFI’s P&C Actuarial Advisory Committee and with relevant CIA committees
- o P&C AAs agreed to complete the FCT template for FCTs prepared in 2022 (big saving for LSs)
- o FCT template (in Excel) became a regulatory return
- o Expanded to life AAs in 2023
- o No push back from AAs
- o Significant retooling required in 2023 due to IFRS 17
- o Test and learn – lots of learning as move to Power BI and then back to Excel
- o Still a work in progress!



10

Another winter holiday, another analytics project

- o Serve in new role with new industries, new data, and new metrics
- o See tons of Power BI dashboards but missing the “so what”
- o Ask for an Excel dump with ten years of quarterly data for each industry (P&C insurance, life insurance, and banks) and begin to play
- o Pull out my university statistics textbook (with a 1981 copyright date)
- o Begin to create Users Guide as I create the tool
- o Build with colleagues who will be the early adopters
- o Collaborate widely across teams – expect this will be big (and it was!)
- o Align metrics to OSFI’s new Supervisory Framework with emphasis on business risk and financial resilience
- o Strive to deliver v1 working in environment where the following are prioritized:
 - Efficiency over perfection
 - Innovation over status quo
 - Transparency over harmony



11

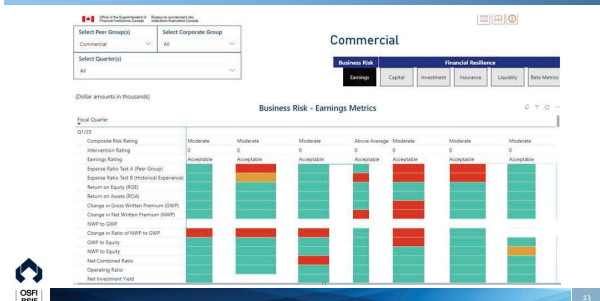
Risk Assessment Data Analytics Report (RADAR)

- o Interactive dashboard of common financial risk indicators across insurance and banking
- o Integrated with the new Supervisory Framework focusing on financial resilience
- o Includes business risk components and supervisory ratings
- o Initial step in the risk assessment and monitoring process for all institutions
 - For smaller, less complex institutions, use of RADAR may be all an LS needs
 - For larger institutions, use of RADAR helps focus and prioritize an LS’s work
- o Colour coding indication for areas of potential concern or follow up (calibrated across peers and historical trends)
- o Supported by comprehensive user guides and interactive training



12

Risk Assessment Data Analytics Report (RADAR)



Risk Assessment Data Analytics Report (RADAR)

How to Use RADAR

RADAR generates key financial metrics based on financial information obtained from FRIF's quarterly regulatory returns. For each quarter, monitoring would begin with a review of the FRIF's financial metrics. The LS would note any metrics outside of the usual ranges and the amounts by which such values deviate from the set ranges, if applicable.

A FRIF's financial metrics are used to determine the level of supervisory attention required. A metric that falls outside of the usual range is not necessarily considered adverse. In some quarters, it may not be unusual for financially stable FRIFs to have more than one metric with results outside of the usual range. For example, a rise or decline in the equity market may result in a significant change in shareholder equity for a company (or not available assets if a branch). Because shareholder equity (or not available assets) is used as the divisor in some of the metric calculations, these metrics may fall outside of their usual range. The metrics and trends are valuable in identifying FRIFs likely to experience financial difficulties. The metrics are not, in themselves, indicative of an adverse financial condition.

RADAR will be modified over time to reflect continuous improvement initiatives. Ongoing feedback to the SD&I team from LSs is strongly encouraged.¹

1. Earnings

1.1 Expense Ratio, Test A (Peer Group)
1.2 Expense Ratio, Test B (Historical Experience)

Purpose²

An insurer's expense ratio is a measure of profitability calculated by dividing the expenses associated with acquiring, underwriting, and servicing policies by the insurance revenue of the insurer. An insurer's expenses include (but are not limited to) advertising and marketing, employees' wages, commissions for the sales force, technology expenses, rental costs, and office equipment. The expense ratio is a measure of an insurer's efficiency before factoring in claims on the policies underwritten or investment gains or losses. The expense ratio is combined with the [solvency ratio](#) to determine an insurer's [solvency ratio](#).

Calculation

Under FRIS 4, the calculation of the expense ratio was:

$$\text{Expense ratio} = (\text{gross commissions} - \text{ceded commissions} + \text{taxes} + \text{other acquisition expenses} + \text{general expenses}) / \text{net earned premium}$$

Under FRIS 12, the calculation of the expense ratio is:

$$\text{Expense ratio} = (\text{amortization of insurance acquisition cash flows} - \text{amortization of reinsurance acquisition cash flows} + \text{general and operating expenses} - \text{interest on debt} - \text{other interest expense} - \text{other finance costs}) / (\text{insurance revenue} + \text{allocation for reinsurance premiums})$$

Test A (Peer Group)

This test compares the current quarter expense ratio to values that were selected based on a detailed review of the historical experience by different product types³ for federally regulated PFC insurers.

Meltwater Media Monitoring Tool (real AI) – 1 of 5

- o From the viewpoint of the leader who was never a supervisor ... what do I need to do to a successful LS?
 - Read, understand, assess the material sent by the insurer to me at quarter-end and year-end
 - Read, understand, assess the major actuarial reports including the valuation of insurance contract liabilities and the FCT reports
 - Conduct reviews (on-site, off-site, desk, thematic, etc.) on specific topics of interest and / or concern
 - Stay aware of what is happening with the insurer
- o Are there tools that can help me do any of the above more efficiently and effectively?
- o Meltwater is tremendous for staying aware
- o In our RMOG team, there are LSs with portfolios of 12-15 insurers, use of Meltwater is critical to their success in being informed in a timely manner – equally critical for our largest IAIGs



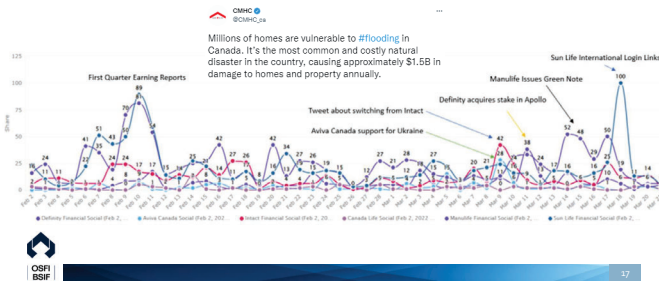
Meltwater Media Monitoring Tool – 2 of 5

- o Allows for monitoring of media and social media across companies, industries, and topics
- o Used for institution and parent company monitoring
- o Ability to identify media spikes, trends, risks, and sentiment



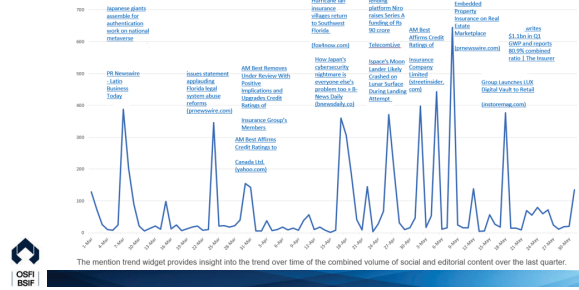
Meltwater Media Monitoring Tool – 3 of 5

Tracking customers comments about insurance and perceived climate risk issues.



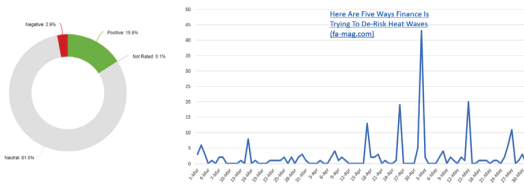
Meltwater Media Monitoring Tool – 4 of 5

Key Mentions



Meltwater Media Monitoring Tool – 5 of 5

Negative Sentiment



More AI in use ... Reinsurance NLP Pilot

- o Rough reinsurance renewal season year-end 2022
- o Seeking details about reinsurance use (attachment points, percentage participation, limits, etc.)
- o Information exists in AA reports on liabilities and FCT but in varied, unstructured formats that lack consistency across insurers and time
- o Experimenting with natural language processing to extract details from actuarial reports
- o Quality of extraction is dependent on defined parameters and ability to train extraction model
- o Test and learn

Event Name	Event Reported Period	Type	Customer Interest Category	Depth of Analysis	Level	Relevant AA Report
Aviva in AA	Aviva in AA	Report in AA	Report in AA	Report in AA	Report in AA	Report in AA
Marine NCL	Jan 1, 2022 to Sep 30, 2022	Excess of Loss				
Marine NCL	Jan 1, 2022 to Sep 30, 2022	Excess of Loss				
Trade Credit OS	Jan 1, 2022 to Sep 30, 2022	Quota Share				
Trade Credit OS	Jan 1, 2022 to Sep 30, 2022	Quota Share				
Trade Credit OS	Jan 1, 2022 to Sep 30, 2022	Excess of Loss				
Trade Credit OS	Jan 1, 2022 to Sep 30, 2022	Excess of Loss				
Personal Accident - Marine NCL Treaty	Jan 1, 2022 to Sep 30, 2022	Excess of Loss				
Personal Accident - Marine NCL Treaty	Jan 1, 2022 to Sep 30, 2022	Excess of Loss				
Personal Accident - Marine NCL Treaty	Jan 1, 2022 to Sep 30, 2022	Excess of Loss				
Aviva in OS	Jan 1, 2022 to Sep 30, 2022	Quota Share				
Aviva in OS	Jan 1, 2022 to Sep 30, 2022	Quota Share				
Aviva in OS	Jan 1, 2022 to Sep 30, 2022	Quota Share				
Aviva in OS	Jan 1, 2022 to Sep 30, 2022	Quota Share				

OSFI BSIF 20

OSFI Blueprint and Transformation



Become a leading data and analytics driven regulator that makes well-informed decisions and is able to supervise and regulate pro-actively to changes in the risk environment

Continuously improve our data technology infrastructure to support leading-edge data and analytical capabilities

Make investments to build, support, and promote the development of leaders and staff in becoming agile, proficient, and forward-looking in data trends and analytics



OSFI Data and Analytics

Communities

- Risk and Data Analytics (RDA)
- Supervision Data and Analytical Insights (SD&AI)
- Insurance Financial Risk (IFR) and other specialist groups

Initiatives

- Data Collection Modernization Initiative (DCM)
- SupTech Network
- Advanced Analytics Working Group
- Technology Exploration Space (TES) and Advanced Data Analytics Platform and Technologies (ADAPT)
- Data Analytics Community of Practice (DACoP)
- Data Literacy Strategy



Next Steps for SD&AI



Questions?



ACCOUNTING PRACTICES AND PROCEDURES (E) TASK FORCE

Accounting Practices and Procedures (E) Task Force Aug. 14, 2023, Minutes	9-144
Statutory Accounting Principles (E) Working Group Aug. 13, 2023, Minutes (Attachment One)	9-150
Statutory Accounting Principles (E) Working Group July 5, 2023, Minutes (Attachment One-A)	9-166
Statutory Accounting Principles (E) Working Group June 28, 2023, Minutes (Attachment One-B)	9-167
Interpretation (INT) of the Statutory Accounting Principles (E) Working Group; INT 20-01T: 2023 Net Negative (Disallowed) Interest Maintenance Reserve (IMR) (Attachment One-B1).....	9-176
Statutory Accounting Principles (E) Working Group Maintenance Agenda Submission Form A; Ref #2022-19; Negative IMR (Attachment One-B2)	9-181
Memorandum to Dale Bruggeman, Chair of the Statutory Accounting Principles (E) Working Group, and Kevin Clark, Vice Chair of the Statutory Accounting Principles (E) Working Group; From Rachel Hemphill, Chair of the Life Actuarial (A) Task Force, and Craig Chupp, Vice Chair of the Life Actuarial (A) Task Force; Dated June 15, 2023, Regarding Response on Negative IMR (Attachment One-B3)	9-193
Memorandum to Thomas Botsko, Chair of the Capital Adequacy (E) Task Force, Philip Barlow, Chair of the Risk-Based Capital Investment Risk and Evaluation (E) Working Group, and Dale Bruggeman, Chair of the Statutory Accounting Principles (E) Working Group; From Carrie Mears, Chair of the Valuation of Securities (E) Task Force; Dated June 1, 2023; Regarding Proposed Amendment to Update the Definition of an NAIC Designation in the <i>Purposes and Procedures Manual of the NAIC Investment Analysis Office</i> (P&P Manual) (Attachment One-B4)	9-195
Statutory Accounting Principles (E) Working Group May 16, 2023, Minutes (Attachment One-C)	9-197
INT of the Statutory Accounting Principles (E) Working Group; INT 20-02: Third Quarter 2022 through Second Quarter 2023 Reporting of the Inflation Reduction Act— Corporate Alternative Minimum Tax (Attachment One-C1).....	9-202
<i>Accounting Practices and Procedures Manual</i> (AP&P Manual) Editorial and Maintenance Update; May 16/2022-01, 2023 (Attachment One-C2).....	9-207
Statutory Accounting Principles (E) Working Group April 12, 2023, Minutes (Attachment One-D)	9-219
Statutory Accounting Principles (E) Working Group April 10, 2023, Minutes (Attachment One-E).....	9-220
Comment Letters Received (Attachment One-F).....	9-221
Statutory Accounting Principles (E) Working Group Maintenance Agenda Submission Form A; Ref #2023-02; <i>Statement of Statutory Accounting Principles (SSAP) No. 43R—Loan-Backed and Structured Securities – Collateralized Loan Obligation (CLO) Financial Modeling</i> (Attachment One-G)	9-276
Statutory Accounting Principles (E) Working Group Maintenance Agenda Submission Form A; Ref #2023-05; <i>Accounting Standards Update (ASU) 2022-06, Reference Rate Reform (Topic 848), Deferral of the Sunset Date of Topic 848</i> (Attachment One-H)	9-282
INT of the Statutory Accounting Principles (E) Working Group; INT 20-01: <i>ASUs 2020-04, 2021-01, and 2022-06—Reference Rate Reform</i> (Attachment One-I).....	9-285
Statutory Accounting Principles (E) Working Group Maintenance Agenda Submission Form A; Ref #2023-07; <i>ASU 2019-08, Codification Improvements to Topic 718 and Topic 606</i> (Attachment One-J).....	9-289
Statutory Accounting Principles (E) Working Group Maintenance Agenda Submission Form A; Ref #2023-08; <i>ASU 2019-07, Codification Updates to SEC Sections</i> (Attachment One-K).....	9-296
Statutory Accounting Principles (E) Working Group Maintenance Agenda Submission Form A; Ref #2023-09; <i>ASU 2020-09, Amendments to SEC Paragraphs Pursuant to SEC Release No. 33-10762—Debt (Topic 470)</i> (Attachment One-L)	9-298

Statutory Accounting Principles (E) Working Group Maintenance Agenda Submission Form A; Ref #2023-10; ASU 2022-05, <i>Transition for Sold Contracts</i> (Attachment One-M)	9-300
Statutory Accounting Principles (E) Working Group Maintenance Agenda Submission Form A; Ref #2023-13; PIK Interest Disclosure Clarification (Attachment One-N)	9-305
SSAP No. 26— <i>Bonds</i> (Attachment One-O)	9-309
SSAP No. 43— <i>Loan-Backed and Structured Securities – Asset-Backed Securities</i> (Attachment One-P)	9-340
Bond Definition – Revisions to Other SSAPs Adopted Aug. 13, 2023 (Attachment One-Q)	9-363
Statutory Accounting Principles (E) Working Group Maintenance Agenda Submission Form A; Ref #2022-01; Conceptual Framework—Updates (Attachment One-R)	9-375
Statutory Accounting Principles (E) Working Group Maintenance Agenda Submission Form A; Ref #2022-01; Statutory Issue Paper No. 168—Updates to the Definition of a Liability (IP No. 168) Attachment One-S)	9-389
Statutory Accounting Principles (E) Working Group Maintenance Agenda Submission Form A; Ref #2022-19; Negative IMR (Attachment One-T).....	9-398
INT of the Statutory Accounting Principles (E) Working Group; INT 23-01: Net Negative (Disallowed) IMR (Attachment One-U).....	9-410
Statutory Accounting Principles (E) Working Group Maintenance Agenda Submission Form A; Ref #2023-06; Additional Updates on ASU 2021-10, <i>Government Assistance</i> (Attachment One-V).....	9-418
Review of U.S. Generally Accepted Accounting Principles (GAAP) Exposures for Statutory Accounting (Attachment One-W)	9-421
Blanks (E) Working Group July 27, 2023, Minutes (Attachment Two)	9-426
Blanks (E) Working Group May 31, 2023, Minutes (Attachment Two-A)	9-428
Blanks (E) Working Group Agenda Item Submission Form; Agenda Item #2022-17BWG Modified (Attachment Two-A1)	9-434
Blanks (E) Working Group Agenda Item Submission Form; Agenda Item #2023-01BWG Modified; Effective Jan. 1, 2024 (Attachment Two-A2)	9-441
Blanks (E) Working Group Agenda Item Submission Form; Agenda Item #2023-02BWG Modified; Effective Annual 2023 (Attachment Two-A3).....	9-459
Blanks (E) Working Group Agenda Item Submission Form; Agenda Item #2023-03BWG; Effective Annual 2023; Remove Life Crosschecks for Columns 2, 6, and 10 on the Accident and Health Policy Experience Exhibit (AHPEE) (Attachment Two-A4)	9-462
Blanks (E) Working Group Agenda Item Submission Form; Agenda Item #2023-04BWG Modified; Effective Annual 2023; Add Instructions for the Appointed Actuary and Qualified Actuary Contacts to the Jurat Electronic-Only Section (Attachment Two-A5).....	9-465
Blanks (E) Working Group Agenda Item Submission Form; Agenda Item #2023-08BWG; Effective Annual 2023 (Attachment Two-A6).....	9-469
Blanks (E) Working Group Agenda Item Submission Form; Agenda Item #2023-10BWG Modified; Effective Annual 2023; Update the Three Primary Issue Periods on Long-Term Care (LTC) Experience Reporting Form 2 (Attachment Two-A7)	9-471
Blanks (E) Working Group Agenda Item Submission Form; Agenda Item #2023-11BWG Modified; Effective Annual 2023; Add Additional Instructions and Illustration to Be Data Captured for Note 7—Investment Income in the Notes to Financial Statement to Disclose More Information on Interest (Attachment Two-A8).....	9-474
Blanks (E) Working Group Editorial Revisions to the Blanks and Instructions Presented at the May 31, 2023, Meeting (Attachment Two-A9)	9-477
Blanks (E) Working Group Editorial Revisions to the Blanks and Instructions Presented at the July 27, 2023, Meeting (Attachment Two-B)	9-483
Accounting Practices and Procedures (E) Task Force 2024 Proposed Charges (Attachment Three)	9-486

Draft: 8/21/23

Accounting Practices and Procedures (E) Task Force
Seattle, Washington
August 14, 2023

The Accounting Practices and Procedures (E) Task Force met in Seattle, WA, Aug. 14, 2023. The following Task Force members participated: Cassie Brown, Chair, represented by Jamie Walker (TX); Mike Causey, Vice Chair, represented by Jackie Obusek (NC); Mark Fowler represented by Sheila Travis (AL); Alan McClain represented by Chris Erwin (AR); Ricardo Lara represented by Kim Hudson (CA); Andrew N. Mais represented by William Arfanis (CT); Karima M. Woods represented by Yohannes Negash (DC); Trinidad Navarro represented by Rylynn Brown (DE); Michael Yaworsky represented by Ainsley Hurley (FL); Doug Ommen represented by Kevin Clark (IA); Dean L. Cameron represented by Eric Fletcher (ID); Vicki Schmidt represented by Tish Becker (KS); Sharon P. Clark represented by Bill Clark (KY); James J. Donelon represented by Melissa Gibson (LA); Gary D. Anderson represented by Debra Kaplan (MA); Timothy N. Schott represented by Vanessa Sullivan (ME); Anita G. Fox represented by Judy Weaver and Steve Mayhew (MI); Chlora Lindley-Myers represented by Debbie Doggett (MO); Troy Downing represented by Erin Synder (MT); Jon Godfread represented by Matt Fischer (ND); Eric Dunning represented by Jill Gleason (NE); Justin Zimmerman represented by John Sirovetz (NJ); D.J. Bettencourt represented by Pat Gosselin (NH); Adrienne A. Harris represented by Bob Kasinow (NY); Judith L. French represented by Dale Bruggeman (OH); Glen Mulready represented by Diane Carter (OK); Andrew R. Stolfi represented by Kirsten Anderson (OR); Michael Humphreys represented by Diana Sherman (PA); Elizabeth Kelleher Dwyer represented by Ted Hurley (RI); Michael Wise represented by Thomas Baldwin (SC); Larry D. Deiter represented by Johanna Nickelson (SD); Carter Lawrence represented by Trey Hancock (TN); Jon Pike represented by Jake Garn (UT); Scott A. White represented by David Smith (VA); Kevin Gaffney represented by Dan Petterson (VT); Mike Kreidler represented by Steve Drutz (WA); and Nathan Houdek represented by Amy Malm (WI).

1. Adopted its Spring National Meeting Minutes

Walker directed the Task Force to its Spring National Meeting minutes. Obusek made a motion, seconded by Doggett, to adopt the Task Force's March 23 minutes (*see NAIC Proceedings – Spring 2023, Accounting Practices and Procedures (E) Task Force*). The motion passed unanimously.

2. Adopted its 2024 Proposed Charges

Walker directed the Task Force to its proposed 2024 charges, noting that the charges were unchanged from the prior year, as many of the charges are continuous in nature. Bruggeman made a motion, seconded by Hudson, to adopt the Task Force's 2024 proposed charges (Attachment Three). The motion passed unanimously.

3. Adopted the Report of the Statutory Accounting Principles (E) Working Group

Bruggeman provided the report of the Statutory Accounting Principles (E) Working Group, which met Aug. 13. During this meeting, the Working Group adopted its July 5, June 28, May 16, April 12, April 10, and Spring National Meeting minutes. The May 16 meeting included adoption of editorial item 2023-11EP and adoption of Interpretation (INT) 22-02: *Third Quarter 2022 through Second Quarter 2023 Reporting of the Inflation Reduction Act Corporate – Alternative Minimum Tax*, which extended the interpretation for the second quarter 2023 statutory financial statements.

Bruggeman stated that during its Aug. 13 meeting, the Working Group adopted the following clarifications to statutory accounting guidance:

- A. *Statement of Statutory Accounting Principles (SSAP) No. 5R—Liabilities, Contingencies, and Impairments of Assets* and *Issue Paper No. 168—Updates to the Definition of a Liability*: Adopted revisions to the definition of a liability under statutory accounting. (Ref #2022-01)
- B. *SSAP No. 24—Discontinued Operations and Unusual or Infrequent Items*: Adopted revisions to SSAP No. 24 to reject Accounting Standards Update (ASU) 2021-10, *Government Assistance*, and the incorporation of disclosures regarding government assistance. (Ref #2023-06)
- C. *SSAP No. 26R—Bonds*, *SSAP No. 43R—Loan-Backed and Structured Securities*, and other affected SSAPs to refine guidance for the principles-based bond project. (Note that SSAP No. 26R and SSAP No. 43R have updated titles effective Jan. 1, 2025.) (Ref #2019-21)
- D. *SSAP No. 34—Investment Income Due and Accrued*: Adopted revisions to clarify and incorporate a practical expedient to the paid-in-kind (PIK) interest aggregate disclosure for SSAP No. 34 and annual statement instruction purposes. (Ref #2023-13)
- E. SSAP No. 43R: Adopted revisions to incorporate changes to add collateralized loan obligations (CLOs) to the financial modeling guidance and to clarify that CLOs are not captured as legacy securities. (Ref #2023-02)
- F. *SSAP No. 95—Nonmonetary Transactions* and *SSAP No. 104R—Share-Based Payments*: Adopted, with modification, *ASU 2019-08, Compensation—Stock Compensation (Topic 718) and Revenue from Contracts with Customers (Topic 606): Codification Improvements—Share-Based Consideration Payable to a Customer*. The revisions add guidance to include share-based consideration payable to customers. (Ref #2023-07)
- G. *INT 20-01: ASU 2020-04 and 2021-01 – Reference Rate Reform*: Adopted proposal to revise the expiration date of INT 20-01 to Dec. 31, 2024. (Ref #2023-05)
- H. *INT 23-01: Net Negative (Disallowed) Interest Maintenance Reserve* was adopted with three editorial revisions. This INT provides optional, limited-time guidance, which allows the admittance of net negative (disallowed) interest maintenance reserve (IMR) up to 10% of adjusted capital and surplus. As detailed within the INT, it will be effective until Dec. 31, 2025, and automatically nullified on Jan. 1, 2026, but the effective date can be adjusted (e.g., nullified earlier or extended). In addition, the Working Group directed the formation of an ad hoc subgroup to work on a long-term solution. Upon adoption of the INT, NAIC staff will provide the Blanks (E) Working Group with a disclosure memorandum for posting on their website for year-end 2023. Additionally, a blanks proposal will be sponsored to incorporate the disclosures and attestation requirements into the notes and general interrogatories for year-end 2024. (Ref #2022-19)
- I. Appendix D—Nonapplicable GAAP Pronouncements: The following U.S. generally accepted accounting principles (GAAP) standards were rejected as they are not applicable to statutory accounting:
 - i. *ASU 2019-07—Codification Updates to SEC Sections: Amendments to SEC Paragraphs Pursuant to SEC Final Rule Releases No. 33-10532, Disclosure Update and Simplification, and Nos. 33-10231 and 33-10442, Investment Company Reporting Modernization, and Miscellaneous Updates*. (Ref #2023-08)
 - ii. *ASU 2020-09, Amendments to SEC Paragraphs Pursuant to SEC Release No. 33-10762—Debt (Topic 470)*. (Ref #2023-09)

iii. *ASU 2022-05, Transition for Sold Contracts.* (Ref #2023-10)

Bruggeman stated that the Working Group exposed the following statutory accounting principle (SAP) concepts and clarifications to statutory accounting guidance until Sept. 29, except for INT 23-02T, INT 23-03T, Ref #2022-11, and Ref #2023-12, which have a comment deadline of Sept. 12:

- A. *SSAP No. 2R—Cash, Cash Equivalents, Drafts, and Short-Term investments:* Exposed revisions to further restrict the investments that are permitted for cash equivalent or short-term investment reporting. These revisions are proposed to ensure that certain investment types are captured on designated Schedule BA reporting lines and to eliminate the potential to design investments to specifically qualify for short-term reporting. (Ref #2023-17)
- B. *SSAP No. 5R, SSAP No. 92—Postretirement Benefits Other Than Pensions, SSAP No. 102—Pensions, and SSAP No. 103R—Transfers and Servicing of Financial Assets and Extinguishments of Liabilities:* Exposed revisions to adopt with modification certain aspects of *ASU 2016-19—Technical Corrections and Improvements*. Revisions also propose amending SSAP No. 92 guidance on insurance contracts to use the same terminology used in SSAP No. 102. (Ref #2023-18)
- C. *SSAP No. 7—Asset Valuation Reserve and Interest Maintenance Reserve:* Expose the overall concept for a long-term project to capture accounting guidance for asset valuation reserve (AVR) and IMR in SSAP No. 7. (Ref #2023-14)
- D. *SSAP No. 20—Nonadmitted Assets and SSAP No. 21R—Other Admitted Assets:* Re-exposed the revisions that clarify that pledged collateral must qualify as an admitted invested asset for a collateral loan to be admitted. The revisions require audits and the use of net equity value for valuation assessments when the pledged collateral is in the form of partnerships, limited liability companies (LLCs), or joint ventures. (Ref #2022-11)
- E. *SSAP No. 21R and Bond Issue Paper:* Exposed a revised SSAP No. 21R to provide guidance for the accounting for debt securities that do not qualify as bonds, as well as proposed measurement guidance for residuals. (Ref #2019-21)
- F. *SSAP No. 43R:* Exposed an updated proposal to reflect revisions from the interim discussions and coordination on revisions to clarify the scope and reporting for investment structures that represent residual interests within SAPs. (Ref #2023-12)
- G. *SSAP No. 48—Joint Ventures, Partnerships, and Limited Liability Companies:* Exposure requests industry and regulator comment on a proposal to further define and provide examples for the investments captured as non-registered private funds, joint ventures, partnerships or LLCs, or residual interests and reported based on the underlying characteristics of assets. (Ref #2023-16)
- H. *SSAP No. 54R—Individual and Group Accident and Health Contracts:* Exposed clarifying revisions and an illustration to SSAP No. 54R to clarify that gross premium valuation (under A-010) and cash-flow testing (under *Actuarial Guideline LI—The Application of Asset Adequacy Testing to Long-Term Care Insurance Reserves* [AG 51]) are both required if indicated. (Ref #2023-22)
- I. *SSAP No. 92 and SSAP No. 102:* Exposed revisions to SSAP No. 92 and SSAP No. 102 to remove the transition guidance that was included in the initial adoption of SSAP No. 92 and SSAP No. 102, as it is past the 10-year effective period for that transition. (Ref #2023-21)

- J. *SSAP No. 93—Low-Income Housing Tax Credit Property Investments and SSAP No. 94R—Transferable and Non-Transferable State Tax Credits*: Exposed interested party comments on revisions to SSAP No. 93 and SSAP No. 94R and updates made in response to the comments received. (Ref #2022-14)
- K. *INT 03-02: Modification to an Existing Intercompany Pooling Arrangement*: Exposed the intent to nullify INT 03-02, as it is inconsistent with *SSAP No. 25—Affiliates and Other Related Parties*. (Ref #2022-12)
- L. *INT 23-02: Third Quarter 2023 Inflation Reduction Act – Corporate Alternative Minimum Tax*: Exposed a proposed INT that recommends that for third-quarter 2023, reporting entities should disclose whatever information is available regarding their applicable reporting entity status. (INT 23-02)
- M. *INT 23-03: Corporate Alternative Minimum Tax Guidance*: Exposed the INT, which provides guidance effective beginning year-end 2023 reporting of the corporate alternative minimum tax, which applies *SSAP No. 101—Income Taxes* with modification and provides disclosures. The exposed INT 23-03 includes that paragraph 11c of *SSAP No. 101* should be followed. (Ref #2023-04)
- N. *IMR/AVR Specific Allocations*: Exposed revisions to the *Annual Statement Instructions* to remove the guidance that permits the specific allocation of non-interest-related losses to IMR. (Ref #2023-15)
- O. *Appendix D—Nonapplicable GAAP Pronouncements*: The following U.S. GAAP standards were exposed with revisions to reject, as they are not applicable to statutory accounting:
 - i. *ASU 2018-09—Codification Improvements* (Ref #2023-19)
 - ii. *ASU 2020-10—Codification Improvements* (Ref #2023-20)

Bruggeman stated that the Working Group directed NAIC staff on the following items:

- A. *Review Annual Statement Instructions for Accounting Guidance*: To proceed with a broad project to review the annual statement instructions and ensure accounting guidance is included within the SSAPs. (Ref #2023-01)
- B. *Schedule BA Reporting*: Directed NAIC staff to sponsor a blanks proposal to revise Schedule BA: Other Long-Term Assets in accordance with the bond project for debt securities that do not qualify as bonds, with formal notice to the Valuation of Securities (E) Task Force and the Capital Adequacy (E) Task Force on the proposal to allow life reporting entities the ability to use existing Schedule BA reporting provisions for Securities Valuation Office (SVO)-assigned designations in determining risk-based capital (RBC) for debt securities that do not qualify as bonds. (Ref #2019-21)

Bruggeman stated that the Working Group received an update on U.S. GAAP exposures, noting that pending items will be addressed during the normal maintenance process.

Bruggeman made a motion, seconded by Clark, to adopt the report of the Statutory Accounting Principles (E) Working Group (Attachment One). The motion passed unanimously.

4. Adopted the Report of the Blanks (E) Working Group

Gosselin provided the report of the Blanks (E) Working Group which met July 27. During this meeting, the Working Group adopted its May 31 minutes, which included adoption of its March 7 minutes. During its May 31 meeting, the Working Group adopted its editorial listing and the following proposals:

- A. 2022-17BWG Modified – Add a new disclosure paragraph for Note 8 – Derivative Instruments and Illustration. The new disclosure is to be data captured. Add electronic-only columns related to derivatives with excluded components to Schedule DB, Part A and Part B for both Section 1 and Section 2. Add new code column instructions for Schedule DB, Part A and B (SAPWG 2021-20).
- B. 2023-01BWG Modified – Remove pet insurance from the inland marine line of business and add a new line of business to Appendix – P/C Lines of Business. Add a pet insurance line within the existing property/casualty (P/C) blank for the Underwriting and Investment Exhibits, Exhibit of Premiums and Losses (State Page), and Insurance Expense Exhibit. Add new Schedule P Parts 1 through 4, specific to pet insurance.
- C. 2023-02BWG Modified – Add an exhibit to identify premiums that are reportable for Market Conduct Annual Statement (MCAS) purposes.
- D. 2023-03BWG – Remove life crosschecks for columns 2, 6, and 10 on the Accident and Health Policy Experience Exhibit (AHPEE).
- E. 2023-04BWG Modified – Add instructions for the appointed actuary and qualified actuary contacts to the Jurat electronic-only section.
- F. 2023-08BWG – Add clarifying language for mutual insurance companies on Schedule Y, Part 3.
- G. 2023-10BWG Modified – Update the three primary issue periods on Long-Term Care Experience Reporting Form 2.
- H. 2023-11BWG Modified – Add additional instructions and illustrations to be data captured for Note 7 – Investment Income in the notes to the financial statement to disclose more information on interest.

Gosselin stated that during its May 31 meeting, the Working Group deferred three proposals: 2023-05BWG – Changes to the Cybersecurity supplement; 2023-07BWG – Delete the legal entity identifier (LEI) column for the select investment schedules; and 2023-09BWG – Add a new financial statement Note 37 – Life Insurance Net Amount at Risk by Product Characteristics.

Gosselin stated that on July 27, the Working Group deferred the following proposals for an additional comment period:

- A. 2023-05BWG Modified – Changes to the cybersecurity supplement to remove the reference to identity theft insurance from the General Instructions; remove the interrogatory questions from Part 1 that pertain to identity theft insurance; and remove the column for Identity Theft Insurance from Part 2 and Part 3. Remove claims-made and occurrence breakdown, as well as first-party and third-party breakdowns from data collection, and remove the question in the interrogatories regarding tail policies.
- B. 2023-07BWG – Update the code column and delete the LEI column for the following investment schedules: Schedules A, B, BA, D Part 2, D Part 6, and E Part 1.

- C. 2023-09BWG – Add a new financial statement Note 37 – Life Insurance Net Amount at Risk by Product Characteristics to the life and accident and health/fraternal blank for the updates to the life C-2 mortality risk charges for life RBC.

Gosselin stated that on July 27, the Working Group adopted its editorial listing and re-exposed 2023-06BWG – Split the Schedule D, Part 1 into two sections: one for issuer credit obligations and the other for asset-backed securities (ABS). Update the other parts of the annual statement that reference the bond lines of business.

Gosselin made a motion, seconded by Hudson, to adopt the report of the Blanks (E) Working Group (Attachment Two). The motion passed unanimously.

Having no further business, the Accounting Practice and Procedures (E) Task Force adjourned.

[https://naiconline.sharepoint.com/sites/NAISupportStaffHub/Member Meetings/E CMTE/APPTF/2023-2 Summer/Summary and Minutes/Minutes APPTF Summer_National Meeting.docx](https://naiconline.sharepoint.com/sites/NAISupportStaffHub/Member%20Meetings/E%20CMTE/APPTF/2023-2%20Summer/Summary%20and%20Minutes/Minutes%20APPTF%20Summer_National%20Meeting.docx)

Draft: 8/28/23

Statutory Accounting Principles (E) Working Group
Seattle, Washington
August 13, 2023

The Statutory Accounting Principles (E) Working Group of the Accounting Practices and Procedures (E) Task Force met in Seattle, WA, Aug. 13, 2023. The following Working Group members participated: Dale Bruggeman, Chair (OH); Kevin Clark, Vice Chair (IA); Sheila Travis (AL); Kim Hudson (CA); William Arfanis (CT); Rylynn Brown (DE); Cindy Andersen (IL); Stewart Guerin and Melissa Gibson (LA); Judy Weaver and Steve Mayhew (MI); Doug Bartlett and Pat Gosselin (NH); Bob Kasinow (NY); Diana Sherman (PA); Jamie Walker and Amy Garcia (TX); David Smith (VA); and Amy Malm (WI).

1. Adopted its July 5, June 28, May 16, April 12, April 10, and Spring National Meeting Minutes

The Working Group conducted an e-vote that concluded July 5 to expose revisions to *Interpretation (INT) 23-01T: Net Negative (Disallowed) Interest Maintenance Reserve*. During its June 28 meeting, the Working Group took the following action: 1) heard comments and received Working Group direction on revisions to INT 23-01T. During its May 16 meeting, the Working Group took the following action: 1) heard comments and considered action on three items exposed during the Spring National Meeting, one of which has corresponding 2023 year-end blanks reporting revisions; and 2) exposed three agenda items. The Working Group conducted an e-vote that concluded April 12 to expose revisions to *INT 22-02: Third Quarter 2022 through Second Quarter 2023 Reporting of the Inflation Reduction Act - Corporate Alternative Minimum Tax*. The Working Group also conducted an e-vote that concluded April 10 to expose tentative INT 23-01.

Additionally, the Working Group met Aug. 8 in regulator-to-regulator session, pursuant to paragraph 3 (specific companies, entities or individuals) and paragraph 6 (consultations with NAIC staff related to NAIC technical guidance) of the NAIC Policy Statement on Open Meetings, to discuss the Summer National Meeting agendas.

Walker made a motion, seconded by Travis, to adopt the Working Group's July 5, (Attachment One-A), June 28 (Attachment One-B), May 16 (Attachment One-C), April 12 (Attachment One-D), April 10 (Attachment One-E) and March 22 (*see NAIC Proceedings – Spring 2023, Accounting Practices and Procedures (E) Task Force*) minutes. The motion passed unanimously.

2. Adopted Non-Contested Positions

The Working Group held a public hearing to review comments received on previously exposed items (Attachment One-F).

Malm made a motion, seconded by Hudson, to adopt the revisions detailed below as non-contested statutory accounting revisions. The motion passed unanimously.

A. Agenda Item 2023-02

Bruggeman directed the Working Group to agenda item 2023-02: Statement of Statutory Accounting Principles (SSAP) No. 43R – CLO Financial Modeling (Attachment One-G). Wil Oden (NAIC) stated that during the Spring National Meeting, the Working Group exposed statutory accounting principle (SAP) clarifications to *SSAP No.*

43R—*Loan-backed and Structured Securities* to incorporate changes to add collateralized loan obligations (CLOs) to the financial modeling guidance and to clarify that CLOs are not included as legacy securities.

B. Agenda Item 2023-05

Bruggeman directed the Working Group to agenda item 2023-05: ASU 2022-06, Reference Rate Reform (Topic 848), Deferral of the Sunset Date of Topic 848 (Attachment One-H). Jake Stultz (NAIC) stated that the Financial Accounting Standards Board (FASB) issued *Accounting Standards Update (ASU) 2022-06, Reference Rate Reform (Topic 848), Deferral of the Sunset Date of Topic 848* to extend the sunset date of the reference rate reform guidance that was included in *ASU 2020-04, Reference Rate Reform (Topic 848) Facilitation of the Effects of Reference Rate Reform on Financial Reporting* and *ASU 2021-01, Reference Rate Reform (Topic 848), Scope*. As background, reference rate reform refers to the transition away from referencing the London Interbank Offered Rate (LIBOR) and other interbank offered rates (IBORs), and moving toward alternative reference rates that are more observable or transaction-based. To address ASU 2020-04, the Working Group issued *INT 20-01: Reference Rate Reform*, and this INT was then revised to incorporate guidance from ASU 2021-01 (Attachment One-I). Stultz recommended adoption of the exposed revisions, which revise INT 20-01 to include the updated sunset date of Dec. 31, 2024, from ASU 2022-06.

C. Agenda Item 2023-07

Bruggeman directed the Working Group to agenda item 2023-07: *ASU 2019-08, Codification Improvements to Topic 718 and Topic 606* (Attachment One-J). Oden stated that in November 2019, the FASB issued *ASU 2019-08 Compensation, Stock Compensation (Topic 718) and Revenue from Contracts with Customers (Topic 606): Codification Improvements—Share-Based Consideration Payable to a Customer*, which includes amendments to Topics 718 and 606. The changes to Topic 718 include share-based payment transactions for acquiring goods and services from non-employees and superseded guidance in Subtopic 505-50, Equity—Equity-Based Payments to Non-Employees. The changes to Topic 606 expand the scope to include share-based payment awards granted to a customer in conjunction with selling goods or services. The exposed revisions were as follows: 1) revisions to *SSAP No. 104R—Share-Based Payments* to adopt ASU 2019-08, with modification, for statutory accounting; 2) revisions to *SSAP No. 95—Nonmonetary Transactions* to adopt ASU 2019-08, with modification by updating previously adopted U.S. generally accepted accounting principles (GAAP) guidance; and 3) revisions to *SSAP No. 47—Uninsured Plans*, which reject Topic 606 guidance in ASU 2019-08. For statutory accounting assessments, prior U.S. GAAP guidance related to share-based payments has been predominantly adopted with modification in SSAP No. 104R.

D. Agenda Item 2023-08

Bruggeman directed the Working Group to agenda item 2023-08: *ASU 2019-07, Codification Updates to SEC Sections* (Attachment One-K). Oden stated that the FASB issued *ASU 2019-07, Codification Updates to SEC Sections: Amendments to SEC Paragraphs Pursuant to SEC Final Rule Releases No. 33-10532, Disclosure Update and Simplification, and Nos. 33-10231 and 33-10442, Investment Company Reporting Modernization, and Miscellaneous Updates*, which primarily affects the codifications of Financial Services—Depository and Lending (Topic 942), Financial Services—Insurance (Topic 944), and Financial Services—Investment Companies (Topic 946). The update amends and supersedes certain U.S. Securities and Exchange Commission (SEC) sections in Topic 942, Topic 944, and Topic 946 to align codification guidance with SEC Releases No. 33-10532, 33-10231, and 33-10442. These SEC releases amend a wide range of disclosure requirements that were determined to be redundant, duplicative, overlapping, outdated, or superseded by other relevant literature. Additionally, the SEC releases include several miscellaneous updates and corrections intended to clarify SEC guidance. Historically, SEC guidance

from ASUs has been rejected as not applicable for statutory accounting in *Appendix D—Nonapplicable GAAP Pronouncements*.

E. Agenda Item 2023-09

Bruggeman directed the Working Group to agenda item 2023-09: ASU 2020-09—Amendments to SEC Paragraphs Pursuant to SEC Release No. 33-10762—Debt (Topic 470) (Attachment One-L). Oden stated that the FASB issued *ASU 2020-09, Amendments to SEC Paragraphs Pursuant to SEC Release No. 33-10762—Debt (Topic 470)*, which affects the codification in debt (Topic 470). The update amends and supersedes certain SEC sections in Topic 470 to align codification guidance with SEC Release No. 33-10762. No. 33-10762 amends the SEC financial disclosure requirements for guarantors and issuers of guaranteed securities registered or being registered, and issuers' affiliates whose securities collateralize securities registered or being registered in Regulation S-X to improve those requirements for both investors and registrants. The changes are intended to provide investors with material information given the specific facts and circumstances, make the disclosures easier to understand, and reduce the costs and burdens to registrants. Oden recommended adoption of the exposed revisions to *Appendix D—Nonapplicable GAAP Pronouncements* to reject *ASU 2020-09, Amendments to SEC Paragraphs Pursuant to SEC Release No. 33-10762—Debt (Topic 470)* as not applicable to statutory accounting. This action is consistent with previous Working Group actions regarding similar SEC guidance.

F. Agenda Item 2023-10

Bruggeman directed the Working Group to agenda item 2023-10: *ASU 2022-05, Transition for Sold Contracts* (Attachment One-M). Oden stated that this agenda item has been drafted to consider *ASU 2022-05, Transition for Sold Contracts* for statutory accounting. The FASB issued the ASU in December 2022 to amend specific sections of *ASU 2018-12, Targeted Improvements for Long-Durations Contracts (LDTI)*. The amendments made by ASU 2022-05 are intended to reduce implementation costs and complexity associated with the adoption of LDTI for contracts that have been derecognized in accordance with the ASU before the LDTI effective date. The amendments in ASU 2022-05 amend the LDTI transition guidance to allow an insurance entity to make an accounting policy election on a transaction-by-transaction basis. An insurance entity may elect to exclude contracts that meet certain criteria from applying the amendments in the LDTI. Oden recommended adoption of the exposed revisions to reject ASU 2022-05 in *SSAP No. 50—Classifications of Insurance or Managed Care Contracts*; *SSAP No. 51R—Life Contracts*; *SSAP No. 52—Deposit-Type Contracts*; *SSAP No. 56—Separate Accounts*; *SSAP No. 71—Policy Acquisition Costs and Commissions*; and *SSAP No. 86—Derivatives*.

G. Agenda Item 2023-13

Bruggeman directed the Working Group to agenda item 2023-13: PIK Interest Disclosure Clarification (Attachment One-N). Oden stated that this agenda item has been developed to further clarify, and incorporate a practical expedient, to the paid-in-kind (PIK) interest aggregate disclosure adopted in *SSAP No. 34—Investment Income Due and Accrued*. In response to questions received on how paydowns or disposals would affect PIK interest included in the cumulative balance, it was noted that clarifying guidance would assist with consistent application. Furthermore, without clarification, it was identified that companies and investment software vendors may interpret the need to detail the retrospective PIK allocations and paydowns or disposals as evidence for the resulting amount. The previously adopted disclosure in *SSAP No. 34* is not intended to change, but the proposed clarification and practical expedient guidance would also be included in the annual statement instructions. This agenda item will be used to subsequently provide a memo to blanks for year-end 2023 application and to formally revise the instructions for 2024.

3. Reviewed Comments on Exposed Items

A. Agenda Item 2019-21

Bruggeman directed the Working Group to agenda item 2019-21: Principles-Based Bond Definition. Stultz stated that during the Spring National Meeting, the Working Group exposed revisions that reflect most of the interested parties' comments to the statutory accounting guidance that details the bond definition and the accounting and reporting guidance for bonds, including asset-backed securities (ABS), debt securities that do not qualify as bonds, and other SSAPs that were also affected or that referenced the prior bond guidance. The revisions exposed for comment included documents related to *SSAP No. 26R—Bonds*, *SSAP No. 43R—Loan-Backed and Structured Securities*, *SSAP No. 21R—Other Admitted Assets*, and other SSAPs that were affected. Stultz stated that in addition to the documents proposing SAP revisions, during the Spring National Meeting the Working Group exposed a proposal to revise the reporting lines on Schedule BA to include debt securities that do not qualify as bonds, as well as to consolidate existing reporting lines.

Stultz noted that interested parties had no comment on the last exposed revisions to SSAP No. 26R, SSAP No. 43R, and the other SSAPs, and he recommend that those be adopted.

Stultz noted that interested parties provided comments on the exposed revisions to SSAP No. 21R. As a result, NAIC staff had further revised the SSAP No. 21R, and Stultz recommended that it be re-exposed for public comment, along with the bond project issue paper that details the direction and discussions in developing this project.

Finally, Stultz also recommended that the Working Group sponsor a blanks proposal to revise Schedule BA for debt securities that do not qualify as bonds, with formal notice to the Valuation of Securities (E) Task Force and the Capital Adequacy (E) Task Force.

Mike Reis (Northwestern Mutual), representing interested parties, stated that interested parties support adoption of the revisions SSAP No. 26R, SSAP No. 43R, and the other affected SSAPs.

Walker made a motion, seconded by Clark, to adopt the bond definition revisions in SSAP No. 26R (Attachment One-O) and SSAP No. 43R (Attachment One-P) and the other impacted SSAPs document (Attachment One-Q), with an effective date of Jan. 1, 2025. The motion passed unanimously.

Clark made a motion, seconded by Hudson, to expose the revised SSAP No. 21R and the bond project issue paper as recommended by NAIC staff. The motion passed unanimously.

Walker made a motion, seconded by Weaver, for the Working Group to sponsor a blanks proposal to revise Schedule BA in accordance with the bond project for debt securities that do not qualify as bonds and to provide notice of the actions to the Valuation of Securities (E) Task Force and to the Capital Adequacy (E) Task Force. The motion passed unanimously.

B. Agenda Item 2022-01

Bruggeman directed the Working Group to agenda item 2022-01: Conceptual Framework – Updates. Marcotte stated that during the Spring National Meeting, the Working Group exposed additional revisions to *SSAP No. 5R—Liabilities, Contingencies and Impairment of Assets* and *Issue Paper No. 168—Updates to the Definition of a Liability* related to the definition change of a liability. The revisions incorporate the definition of a liability

from FASB *Concepts Statement No. 8, Conceptual Framework for Financial Reporting—Chapter 7, Presentation, and Concepts Statement No. 8, Conceptual Framework for Financial Reporting—Chapter 4, Elements of Financial Statements*, which updates the definition of an asset and of a liability. For U.S. GAAP, the FASB Conceptual statements definitions are not authoritative, but rather are concepts to consider when developing and applying guidance.

Marcotte stated that the Spring National Meeting exposure also included revisions to add an additional footnote to the definition of a liability in SSAP No. 5R, which defers to more topic-specific contradictory guidance in an SSAP, revises the relevant literature section of SSAP No. 5R to note the modification, and the additional exposure action in the issue paper. These clarifications were because of the authoritative treatment that statutory accounting provides to the definition of a liability SSAP No. 5R. The FASB basis for conclusions noted that some existing authoritative FASB literature regarding liabilities is inconsistent with the updates to Concepts Statement No. 8. Therefore, a modification regarding topic-specific liabilities guidance was incorporated to address variations from the definition of a liability.

Hudson made a motion, seconded by Weaver, to adopt the exposed revisions to SSAP No. 5R (Attachment One-R) and *Issue Paper No. 168—Updates to the Definition of a Liability* (Attachment One-S). The motion passed unanimously.

C. Agenda Item 2022-11

Bruggeman directed the Working Group to agenda item 2022-11: Collateral for Loans. Marcotte stated that during the Spring National Meeting, the Working Group re-exposed revisions to SSAP No. 21R to clarify that invested assets pledged as collateral for admitted collateral loans must qualify as admitted invested assets. She stated that interested parties support the proposed changes but that the Working Group also received two comment letters from Security Benefit Life Insurance Company (SBL) that opposed the changes, noting that in some cases the fair value of the collateral of these types of investments was higher than audited book value. Marcotte stated that the second comment letter from SBL was asking for an accounting policy election to use fair value. She stated that normally collateral is measured at fair value. However, when this issue was initially brought to the Working Group, one of the concerns was that using Level 3 fair values for a related party loan could essentially admit a greater amount than if the assets were directly held.

Weaver stated that optionality is not consistent with the general practice of statutory accounting, noting that there had been some recent receiverships and exam reports with significant comments regarding this type of investment.

Smith agreed with Weaver and stated that the proposed fair value election would be left to the discretion of the commissioner, which would lead to inconsistencies between states.

Caleb Brainerd (SBL) stated that SBL supports the clarification that collateral loan secured by *SSAP No. 48—Joint Ventures, Partnerships and Limited Liability Companies* and *SSAP No. 97—Investments in Subsidiary, Controlled and Affiliated Entities* investments require audits of the underlying collateral to be admissible assets under statutory accounting. He stated that the basis used to test the sufficiency of collateral for these types of collateral loans is a substantive change and recommended that the Working Group reconsider the issue prior to adopting this exposure. Specifically, SBL believes fair value is the most appropriate basis for determining the sufficiency of collateral. Fair value is the measure that reflects the value of assets that would be available to support policyholder liabilities in the event of foreclosure on collateral loans. Brainerd stated that fair value is also the basis upon which insurers have historically, and currently underwritten, collateral loans and aligns with covenants entered into

between the insurer and the borrowers within the corresponding loan agreements. Finally, continuing to use fair value will retain consistency across all collateral loans under statutory accounting and with the tests used for other types of collateralized financial instruments. He asked the Working Group to extend the exposure period to Sept. 12 to allow industry and the Working Group to further consider whether fair value should be retained as the basis for testing the sufficiency of collateral for collateral loans.

Bruggeman asked if the audited value of SSAP No. 48 and SSAP No. 97 entities which are pledged as such collateral approximates fair value in instances when the collateral was from investment entities. He noted that in his understanding, the audits of the pledged collateral from non-investment type entities, such as operating entities, may result in audited value that might not be a good proxy for fair value. That is, for such entities, the audited book value does not approximate fair value because many of the underlying assets are not reported as fair value.

Brainerd stated that in most instances, the SSAP No. 48 and SSAP No. 97 underlying collateral investments would likely be from entities that are considered investment companies. He noted that for investment entities, net asset value (NAV) is calculated, which approximates fair value. As such, audited equity and fair value of investment companies would be similar or the same. However, for some of the SSAP No. 48 and SSAP No. 97 investments that are not considered investment companies, their assets are not held at fair value. He noted that the investment company guidance is complex. As a result, the book value is often significantly lower than the fair value for non-investment entities. He stated that using book value could result in non-admitting loans that are in good standing that have been underwritten on the fair value of the collateral basis. In cases where collateral is not an investment company, SBL obtains independent fair value calculations or independent reviews of the fair value calculations, which are also subject to audit.

Bruggeman questioned whether a distinction needs to be made between affiliated and non-affiliated investments. He noted that the Working Group choice today was whether to adopt what was exposed or extend the exposure until after the Sept. 12 deadline. Additionally, he clarified that the question is whether non-investment companies should be allowed to use audits and measure the collateral at fair value instead of book value.

Clark stated that he agreed with the prior comments that there should not be optionality. He questioned what additional information should be provided if the decision-making process was extended. He asked if the rest of industry was willing to provide input.

Andrew Morse (Global Atlantic), representing interested parties, noted support for the current exposed guidance, but he stated that given the comments that fair value might be a better measurement for asset collateral adequacy, interested parties as a group feel that there are good arguments for using either the fair value measurement or the U.S. GAAP equity measurement. He stated that interested parties would support exposure until Sept. 12.

Bruggeman stated that for the non-investment entities, there would need to be more support for obtaining fair value. He noted that this agenda item originated because of a lack of support for the valuation of collateral, especially for level three fair values. Clark stated that he did not see the harm in allowing additional time for industry to build consensus on the issue.

Malm stated that as part of the extended comment period, industry should provide not just a consensus view, but if the consensus view is to use fair value, then also provide language around documentation and expectations of the valuations at fair value. She also requested that interested parties' comments also include details on the regulatory arbitrage related to going from book value to fair value, as well as the risk-based capital (RBC) impact.

Morse stated that the asset in question is a collateral loan, which has a value as a loan. That value does not change based on the underlying collateral unless part of the asset is nonadmitted. He stated that the asset itself is not fluctuating regularly based on the valuation of the collateral; it is typically carried at cost or amortized cost. He stated that the proposed revisions are just a check to see if there is sufficient collateral to support the collateral loan.

The Working Group noted no objections to re-exposing this agenda item until Sept. 12 to allow industry the opportunity to provide support for using fair value measurement.

D. Agenda Item 2022-12

Bruggeman directed the Working Group to agenda item 2022-12: Review of INT 03-02: Modifications to an Existing Intercompany Pooling Arrangement. Marcotte stated that on March 22, the Working Group re-exposed the intent to nullify INT 03-02, effective Dec. 31, 2023. The nullification is proposed because INT 03-02 is inconsistent with *SSAP No. 25—Affiliates and Other Related Parties* guidance regarding economic and non-economic transactions between related parties. Treatment of transfers of assets between affiliates should be consistent for all intercompany transactions, and there is not a compelling need to be different when valuing assets for intercompany reinsurance transactions. Marcotte stated that this agenda item was re-exposed to allow more time for comments. She recommended deferral of this agenda item to allow more time to review interested parties' comments and have further discussions with industry.

Hudson expressed support for the deferral recommendation.

Keith Bell (The Travelers Companies), representing interested parties, noted support for deferral and that he has started work on examples of when intercompany plan agreements would be modified. He stated that if INT 03-02 was nullified and the assets were changed to fair value, there would be a significant impact. He noted that changing interest rate environments could affect the amounts transferred. He stated that Travelers will provide a specific example to show the Working Group the mechanics of how it works.

Bruggeman requested that interested parties include examples to break out the differences between amending a pooling arrangement for existing members versus adding a company that was recently acquired and added to the pool. He stated that there are some definite distinctions between those situations.

The Working Group members had no objections to deferring action and re-exposing this item.

E. Agenda Item 2022-14

Bruggeman directed the Working Group to agenda item 2022-14: New Market Tax Credits. Oden stated that on May 16, the Working Group exposed revisions to *SSAP No. 93—Low-Income Housing Tax Credit Property Investments* and *SSAP No. 94R—Transferable and Non-Transferable State Tax Credits*.

Bruggeman stated that this agenda item was drafted in response to the federal Inflation Reduction Act and the subsequent issuance of ASU 2023-02, which amended U.S. GAAP guidance on the application of the proportional amortization method for income tax equity investments. Oden stated that since the project was started, its scope has been expanded in response to comments received. *SSAP No. 93* is proposed to include all qualifying tax credit investments irrespective of structure or tax credit program, and *SSAP No. 94R* is proposed to include all purchased and certain allocated state and federal tax credits. He stated that on June 30, the Working Group received comments from interested parties on the May 16 exposure drafts. Oden stated that the comments were included

in the hearing agenda for exposure in the Summer National Meeting, and staff responses were included in the agenda item. Oden provided a summary of the comments received and the proposed recommendations. He recommended the Working Group expose the revisions to SSAP No. 93 and SSAP No. 94R and direct staff to begin working with industry on revisions to the annual statement Schedule BA reporting lines, as well as how those reporting lines flow through to the asset valuation reserve.

Angelica Sanchez (New York Life), representing interested parties, commented that they agree with what has been proposed and reiterated the need for uniformity in accounting and reporting for tax credit investments and other types of tax credit certificates. She stated they also agree that the proportional amortization method is the right accounting to follow for investments where earnings are returned primarily through tax credits. She stated they appreciate the Working Group incorporating some of the interested parties' comments and providing such detailed explanations of issues where they did not necessarily agree with industry. She stated that interested parties agree with most of the changes made. Sanchez stated that there are two main items on which they will focus. First is that they did not intend to confuse things about referring to the retrospective accounting under U.S. GAAP. She stated that they will continue to work to obtain consensus with both industry and the Working Group on what makes the most sense for adoption and what the transition requirements should be. Second, currently all low-income housing tax credit investments are reported in a dedicated section on Schedule BA that allows them to have specific RBC charges that are different from most other investments on Schedule BA. She stated that interested parties recommend that the same should happen for any other type of tax credit investment that is within the scope of SSAP No. 93 since those investments tend to be very high credit quality investments.

Walker made a motion, seconded by Hudson, to direct NAIC staff to expose the additional revisions and to work with the Blanks (E) Working Group on drafting proposed revisions for Schedule BA. The motion passed unanimously.

F. Agenda Item 2022-19

Bruggeman directed the Working Group to agenda item 2022-19: Negative IMR (Attachment One-T). Marcotte stated this agenda item has been developed to discuss the interest maintenance reserve (IMR) within statutory accounting, specifically the current guidance for the nonadmittance of disallowed negative IMR. Although the statutory accounting guidance has been in place for several years, the rising interest rate environment has created an increased likelihood for reporting entities to move to a negative IMR position. Discussion of this topic began after receipt of an American Council of Life Insurers (ACLI) comment letter dated Oct. 31, 2022. Marcotte stated that since the receipt of the ACLI letter, the Working Group has discussed this issue and directed various actions. Most recently, on June 28, 2023, the Working Group met to hear comments on *INT 23-01: Net Negative (Disallowed) Interest Maintenance Reserve*, which was exposed to permit limited admittance of net negative (disallowed) IMR. As a result of that meeting, the Working Group directed NAIC staff to incorporate several revisions to the proposed INT 23-01. The revised INT was exposed via e-vote on July 5 for a shortened comment period ending July 21. Marcotte noted that interested parties provided three editorial revisions to the most recent exposure that were included in the meeting materials.

Marcotte recommended adoption of the exposed INT 23-01 with the editorial revisions noted. She stated that INT 23-01 would be automatically nullified on Jan. 1, 2026. NAIC staff would also provide the Blanks (E) Working Group with a disclosure memorandum for posting on its website. Marcotte stated that NAIC staff recommend the Working Group continue to work on a long-term solution. She stated that the ACLI suggested forming an ad hoc technical group, which would include members from the Working Group, the Life Actuarial (A) Task Force, industry, and the American Academy of Actuaries (Academy) as part of the long-term solution. She stated that

because INT 23-01 creates overrides of existing statutory accounting and annual statement instructions, the policy statement would require a two-thirds super majority vote of the Working Group present and voting to adopt.

Reis thanked state insurance regulators for working on an interim solution to not disincentivize prudent investment or risk management activity until the longer-term solution can be finalized. He said interested parties look forward to working with the Working Group or an ad hoc group. He stated that interested parties are supportive of the Life Actuarial (A) Task Force and the Academy being part of that group.

Bruggeman stated that this interpretation does not place any key reliance on asset adequacy testing. The asset adequacy testing will still use the interest maintenance reserve (IMR) as its natural process. He noted that, the larger the admitted asset within the asset adequacy testing, the greater the chance of an asset adequacy additional reserve requirement. He stated that the Working Group is not placing primary reliance on asset adequacy testing (AAT).

Hudson made a motion, seconded by Malm, to adopt *INT 23-01: Net Negative (Disallowed) Interest Maintenance Reserve*, reflecting the editorial revisions to the recent exposure discussed during the meeting (Attachment One-U). With this motion, the Working Group also agreed to form an ad hoc technical group, which would continue to work on this topic. The motion passed unanimously.

G. Agenda Item 2023-01

Bruggeman directed the Working Group to agenda item 2023-01: Review Annual Statement Instructions for Accounting Guidance. Stultz stated that this agenda item was developed to establish a project to review the annual and quarterly statement instructions to ensure that all accounting guidance is primarily reflected within the SSAPs. The focus of this project is to ensure that the annual or quarterly statement instructions are not the primary source of statutory accounting guidance. This agenda item and project was proposed due to limited situations in which the annual statement instructions have been identified as containing more detailed accounting guidance than the SSAPs.

Bruggeman directed NAIC staff to continue with this project.

H. Agenda Item 2023-04

Bruggeman directed the Working Group to agenda item 2023-04: Corporate Alternative Minimum Tax Guidance. Marcotte stated that this agenda item is to provide guidance regarding the corporate alternative minimum tax (CAMT) for year-end 2023 and after. Interested parties of the Working Group have submitted comments and a draft interpretation, which is included with the comment letters.

Marcotte provided a summary of the CAMT that is in effect for tax years beginning after 2022, noting that the CAMT is very different from the prior alternative minimum tax. She noted that the requirement to calculate the CAMT only applies to corporations on a tax-controlled basis with an average adjusted book income in excess of \$1 billion on average for the prior three years (with a \$100 million threshold for certain foreign-owned entities).

Marcotte stated that because the CAMT will only apply to a limited number of reporting entities, *INT 23-03: Inflation Reduction Act - Corporate Alternative Minimum Tax* had been developed separately from *SSAP No. 101 – Income Taxes*. She noted that INT 23-03 was organized to provide guidance for: 1) non-applicable reporting entities, which do not have to do the calculation; 2) applicable reporting entities, which must do the calculation

to determine the tax; and 3) applicable reporting entities with tax sharing agreements that exclude the entities from having to pay the CAMT.

Marcotte stated that the proposed INT 23-03 follows many of the principles in SSAP No. 101. For example, the consideration of the statutory valuation allowance assessment for the CAMT is determined on a group basis, and the statutory valuation allowance for other non-CAMT deferred tax assets (DTAs) is computed on a separate entity basis. She stated that INT 23-03 uses the applicable realization threshold limitations tables in SSAP No. 101, paragraph 11b. For example, most reporting entities will be above the 300% ex DTA RBC threshold in the tables and will admit CAMT credits in the admittance calculation that can be used within three years and up to 15% of statutory capital and surplus as adjusted in the SSAP No. 101 admissibility calculation. Marcotte stated that one of the exceptions to SSAP No. 101 that was proposed is to not require such entities (three-year/15%) to have to do the “with and without” calculation. She noted that the proposed guidance relies on tax allocation agreements for treatment of the CAMT and requires disclosures.

Marcotte highlighted that proposed transition guidance, which would allow reporting reliance on unapproved filed tax sharing agreements at year-end with domiciliary department of insurance consent, was not as specific as requested by industry because of *Insurance Holding Company System Regulatory Act* (Model #440) concerns. She noted that the transition guidance is focused on the subsequent events reporting exceptions. She noted that the meeting materials contained an updated attachment that tracked minor edits to the INT 23-03 since the initial materials posting.

Marcotte recommended exposure of INT 23-03 after the Working Group provides direction regarding paragraph 11.c. of SSAP No. 101. She stated that the third step in the SSAP No. 101 admissibility test admits DTAs to the extent of deferred tax liabilities (DTLs) if the DTAs can be offset on a tax return; this requires consideration of tax character. She stated that Working Group direction was requested on which version of paragraph 34 in the INT 23-03 discussion draft to include in the exposure. The first version would follow SSAP No. 101, paragraph 11.c. and admit CAMT credits to the extent of offsetting DTLs. The second version, which is a departure from SSAP No. 101, would not allow the admission of any CAMT credits under SSAP No. 101, paragraph 11.c.

Marcotte noted that Working Group direction was requested because although the CAMT credit does not expire, it has additional contingencies that make the use of the credit more questionable. The CAMT credit can only be used for non CAMT tax liabilities that are greater than the CAMT tax liability. She also noted that that if the tax-controlled group is a CAMT payor, the CAMT credit cannot be used. The CAMT is a credit, like a net operating loss carry forward, which does not have a reversal pattern. Instead, the entity must be eligible to use the CAMT credit. She also noted that while having more DTLs reverse increases the likelihood that the regular taxable income will exceed the CAMT liability, the result is not guaranteed.

Bruggeman stated that much of the INT 23-03 follows a general pattern of what is already in SSAP No. 101 with some subtle differences. He stated that he prefers to continue to follow the general pattern of SSAP No. 101, including allowing DTL offset in SSAP No. 101, paragraph 11.c. He stated that this avoids some misinterpretation by companies and auditors by continuing a pattern that has already been in place.

Hudson expressed support for the use of language consistent with SSAP No. 101, paragraph 11c. He stated that as the Working Group receives comments, it can evaluate them. Clark, Walker and Sherman also stated support following SSAP No. 101, paragraph 11.c.

Aimee Hoke (Nationwide), representing interested parties, stated that CAMT is a unique accounting consideration as the tax is consolidated in nature and applies an applicability test. She stated that industry supports the position

that the CAMT credits should be admitted against deferred tax losses under SSAP No. 101, paragraph 11.c. She stated that the CAMT credit operates in the same way as the prior alternative minimum tax (AMT) that was in place before 2018. The AMT DTAs were allowed to be used on the tax return and admitted against DTLs for that prior AMT. She stated that CAMT DTAs are no different from the other DTAs. They represent a future tax benefit. The premise of admitting DTAs against DTLs rests on the fact that DTLs will create future taxable income. In the case of CAMT DTAs, regular tax must exceed CAMT to be used. But for all other DTAs to be admitted, that entity would also need taxable income, so the basic mechanics are the same. A good example of a similar DTA is net operating losses (NOLs). NOL DTAs can only be used if the taxable group has taxable income but cannot be used to offset DTLs in the tax return. CAMT DTAs are evaluated for a valuation allowance, meaning that if the CAMT DTA is not expected to be realized, a valuation allowance would be set up.

Bruggeman asked whether industry supports having an earlier comment deadline for this exposure. He noted that tax sharing agreements for some entities will need to be updated prior to year-end. He summarized the proposed transition guidance, noting that statutory accounting cannot override Model #440 in the states but that the Working Group was trying to provide acceptable subsequent events transition guidance for the recognition of needed pending agreement updates, which may not be final until after the first of the year. Hoke stated support for the earlier comment deadline of Sept. 12.

Hudson made a motion, seconded by Walker, to expose INT 23-03 with the revisions to paragraph 34, which incorporate allowing admittance of the CAMT credits following the concepts in SSAP No. 101, paragraph 11.c. This exposure has a Sept. 12 comment deadline. Marcotte stated that because INT 23-03 creates overrides of existing guidance, the policy statement would require a two-thirds super majority vote of the Working Group present and voting to adopt. The motion passed unanimously.

I. Agenda Item 2023-06

Bruggeman directed the Working Group to agenda item 2023-06: Additional Updates on ASU 2021-10, Government Assistance. Marcotte stated that on Aug. 10, 2022, the Statutory Accounting Principles (E) Working Group adopted revisions to *SSAP No. 24—Discontinued Operations and Unusual or Infrequent Items* in agenda item 2022-04. The revisions incorporated certain disclosures, adopted with modification from ASU 2021-10, to supplement existing disclosures regarding unusual or infrequent items.

Marcotte stated that with the follow-up questions about the adoption of the disclosures, most were regarding whether adoption with modification of the disclosures were intended to allow insurers to use the grant and contribution model. She stated that the intent was not to change accounting but to adopt the disclosures. The most recent exposure is to reject ASU 2021-10 instead of adopting it with modification, but still maintain government assistance disclosures. Marcotte stated that interested parties indicated they agreed with the proposed revisions but noted that some entities were using the grant and contribution model, and the discussion did not indicate whether it should be applied. She stated that there is no specific accounting guidance addressing accounting for government assistance transactions, and some of the health industry noted that in the absence of specific guidance, companies have looked to non-authoritative GAAP guidance, which supports the use of that model. Marcotte recommended adopting the exposed revisions to SSAP No. 24 to reject the ASU 2021-10 and include certain government assistance disclosures. She stated that the alternative is the disclosures could also be wholly rejected.

Hudson made a motion, seconded by Sherman, to adopt revisions to SSAP No. 24 as exposed (Attachment One-V). These revisions include the rejection of ASU 2021-10, while also maintaining government assistance disclosures. The motion passed unanimously.

J. Agenda Item 2023-12

Bruggeman directed the Working Group to agenda item 2023-12: *Residuals in SSAP No. 48 Investments*. Stultz stated that this agenda item proposes revisions to clarify the scope and reporting for investment structures that represent residual interests within statutory accounting principles. Previously, revisions have been incorporated in SSAP No. 43R to address the reporting of residual interests within securitization structures. With these revisions, residual interests, as defined within SSAP No. 43R, were required to be reported on Schedule BA on designated reporting lines beginning year-end 2022. After reviewing the 2022 reporting results, it was identified that the information for residuals may be underrepresented because of the various legal forms that residual investments can take. For example, a reporting entity could hold investments that have the substance of residual interests in the form of limited partnerships, joint ventures, or other equity fund investments. To ensure consistent reporting of all residual interests, this agenda item proposes guidance to clarify the reporting of in-substance residuals regardless of the structure of the investment vehicle in SSAP No. 48. Stultz stated that the application is really the issue, not the definition itself, and NAIC staff believe that these proposed changes address those issues. NAIC staff recommend the Working Group expose the agenda item with the expanded update proposal to reflect revisions to the interim discussions and coordination with interested parties, and they recommend this exposure have a shortened deadline of Sept. 12 with the intent of this agenda item being adopted for 2023 reporting.

Rose Albrizio (Equitable), representing interested parties, agreed with the shortened comment period.

Clark stated that he wanted to make clear that there are two separate agenda items discussing residuals at this meeting. He noted that this agenda item is more focused on reporting. The other agenda item provides more accounting and is also exposed.

Clark made a motion, seconded by Sherman, to expose the clarifying guidance for residuals in SSAP No. 48 until Sept. 12. The motion passed unanimously.

4. Considered Maintenance Agenda – Active Listing

Hudson made a motion, seconded by Kasinow, to expose the following agenda items for a public comment period. The motion passed unanimously. The comment deadline for exposures was Sept. 29 for all exposures except INT 23-02, which had a comment deadline of Sept. 12. The motion passed unanimously.

A. Agenda Item 2023-14

Bruggeman directed the Working Group to agenda item 2023-14: *Asset Valuation Reserve and Interest Maintenance Reserve*. Marcotte stated that this agenda item is a broad concept agenda item developed with the goal of incorporating accounting guidance for the AVR and the IMR into *SSAP No. 7—Asset Valuation Reserve and Interest Maintenance Reserve*. Historically, this statement has included a brief overview of the AVR and IMR with the calculation and reporting guidance determined as directed by individual SSAPs or in accordance with the *Annual Statement Instructions for Life, Accident and Health/Fraternal Companies*. It has also been noted that there are some disconnects between the SSAPs and the IMR/AVR guidance included in the Annual Statement Instructions and that there are limited financial reporting cross-checks to the reporting within the AVR. Marcotte recommended the Working Group move this item to the maintenance agenda as a new SAP concept and expose this agenda item with an overall concept for a long-term project to capture accounting and reporting for IMR/AVR in SSAP No. 7.

B. Agenda Item 2023-15

Bruggeman directed the Working Group to agenda item 2023-15: IMR/AVR Specific Allocations. Marcotte stated that this agenda item has been developed to update guidance for IMR/AVR in the Annual Statement Instructions that currently establish specific allocation guidance. The principal concept of the IMR and AVR is that interest-related losses go to IMR, and non-interest-related losses go to AVR. This agenda item is to correct instructions that appear to direct an entity to allocate non-interest-related losses to IMR rather than correctly to the AVR.

Although the presence of examples for illustration are beneficial, the current annual statement instructions permit unintended allocations that do not reflect the intent of the principles. These have been specifically noted through inquiries to NAIC staff, particularly within the last year. NAIC staff believe these inquiries have been spurred by the discussions regarding the industry request to admit net negative IMR, therefore creating an incentive to allocate losses to IMR instead of AVR. This agenda item will focus on specific allocations within the annual statement instructions for NAIC designation changes for debt securities (excluding loan-backed and structured securities [LBSS]) and mortgage loans. Marcotte recommended the Working Group move this item to the maintenance agenda as a new SAP concept and expose the annual statement revisions to remove guidance that permits specific allocation and non-interest-related losses to IMR.

C. Agenda Item 2023-16

Bruggeman directed the Working Group to agenda item 2023-16: *Schedule BA Reporting Categories*. Oden stated that this agenda item has been developed to incorporate more detailed definitions for the annual statement reporting categories of SSAP No. 48 and residual interests on Schedule BA: Other Long-Term Invested Assets. Discussions identified that variations exist across industry on the types of investments included within each of the existing categories shown in Schedule BA. Oden stated that it was also noted that the annual statement instructions provide limited guidance, and the examples were not helpful for determining the reporting classifications. The intent of the recommended changes is to reduce reporting difficulty, improve consistency, and allow regulators to better assess the type and volume of investment types. Oden recommended that the Working Group move this item on the maintenance agenda as an SAP clarification and potential blank reporting change and expose the agenda item with a request for industry and regulator feedback. Specifically, comments were requested on what should be included as an investment with the underlying asset characteristics of the following categories: fixed income instruments, common stocks, real estate, mortgage loans, and others.

Bruggeman stated that as part of the discussion on this exposure, NAIC staff should coordinate with NAIC staff for the RBC items.

D. Agenda Item 2023-17

Bruggeman directed the Working Group to agenda item 2023-17: Short-Term Investments. Oden stated that this agenda item has been developed to review the guidance in SSAP No. 2R—*Cash, Cash Equivalents, Drafts, and Short-Term investments* and establishes principal concepts for the types of investments that should be permitted for reporting as either cash equivalents or short-term investments. This agenda item is in response to noted situations in which certain types of investments, particularly collateral loans or other Schedule BA items, have been specifically designed to meet the parameters for short-term reporting. Effectively, this agenda item, and the prior revisions to exclude certain investments from SSAP No. 2R, which were discussed as part of the bond project, will eliminate investments (except money market mutual funds and cash pooling dynamics) from being reported as cash equivalents or short-term investments unless they would qualify under SSAP No. 26R as an issuer credit obligation. Such investments will then only qualify as a cash equivalent or short-term investment if they have a

maturity date within three months (cash equivalents) or 12 months (short-term) from the date of acquisition or meet the specific requirements for money market mutual funds or cash pooling arrangements. This agenda item proposes to retain the guidance in SSAP No. 2R that prevents cash equivalent or short-term reporting for related party investments if the reporting entity does not reasonably expect to terminate the investment, the original maturity time has passed, and if the reporting entity reacquired a substantially similar investment. Oden recommended the Working Group move this item to the maintenance agenda as a new SAP concept and expose this agenda item with proposed revisions to further restrict the investments that are permitted to be reported as cash equivalent or short-term investments. With the adoption consideration of the bond definition, including the edits to exclude ABS and debt securities that do not qualify as bonds from SSAP No. 2R, this agenda item proposes edits to reflect the bond project changes, and it is proposed to have an effective date of Jan. 1, 2025. Additionally, subsequent blanks reporting changes will be considered to modify the cash equivalent and short-term reporting lines accordingly.

E. Agenda Item 2023-18

Bruggeman directed the Working Group to agenda item 2023-18: ASU 2016-19, *Technical Corrections and Improvements*. Oden stated that In December 2016, the FASB issued *ASU 2016-19, Technical Corrections and Improvements*, as part of a standing project on its agenda to address suggestions received from stakeholders on FASB codifications and to make other incremental improvements to U.S. GAAP. The changes made by ASU 2016-19 included minor clarifications, corrections, the addition of codification references, guidance relocations, and removal of redundant, outdated, or superseded guidance. Oden recommended that the Working Group move this item to the active listing as an SAP clarification and expose revisions to adopt with modification *ASU 2016-19, Technical Corrections and Improvements* for statutory accounting. The agenda item includes the details of the revisions to be exposed and the rationale for which guidance is recommended for inclusion and which was recommended for rejection. Unless noted otherwise, Oden recommended that all other amendments made within ASU 2016-10, as detailed in the agenda item, be rejected for statutory accounting in SSAP No. 5R, *SSAP No. 92—Postretirement Benefits Other Than Pensions*, *SSAP No. 102—Pensions*, and *SSAP No. 103R—Transfers and Servicing of Financial Assets and Extinguishments of Liabilities*.

F. Agenda Item 2023-19

Bruggeman directed the Working Group to agenda item 2023-19: ASU 2018-09, *Codification Improvements*. Oden stated that in July 2018, the FASB issued *ASU 2018-09, Codification Improvements*. This ASU is part of its standing project to facilitate FASB codification updates for technical corrections, clarifications, and other minor improvements. The changes made by ASU 2018-09 included minor clarifications, corrections, the addition of codification references, guidance relocations, and the removal of redundant, outdated, or superseded guidance. NAIC staff recommended that the ASU be rejected in *Appendix D—Nonapplicable GAAP Pronouncements* as not applicable for statutory accounting purposes.

G. Agenda Item 2023-20

Bruggeman directed the Working Group to agenda item 2023-20: *ASU 2020-10, Codification Improvements*. Oden stated that in October 2020, the FASB issued *ASU 2020-10 Codification Improvements*. The changes made by the ASU either move disclosure guidance to the disclosure section of the codification or add codification references to direct readers to the disclosure section, and this ASU does not provide any relevant new guidance. NAIC staff recommended that the ASU be rejected in *Appendix D—Nonapplicable GAAP Pronouncements* as not applicable for statutory accounting purposes.

H. Agenda Item 2023-21

Bruggeman directed the Working Group to agenda item 2023-21: *Removal of Transition Guidance from SSAP No. 92 and SSAP No. 102*. Stultz stated that on Dec. 18, 2012, the Statutory Accounting Principles (E) Working Group adopted SSAP No. 92 and SSAP No. 102. The adopted SSAPs included transition guidance that expired after 10 years, and this agenda item intends to remove that expired transition guidance from SSAP No. 92 and SSAP No. 102.

I. INT 23-02

Bruggeman directed the Working Group to *INT 23-02: Third Quarter 2023 Inflation Reduction Act – Corporate Alternative Minimum Tax*. Marcotte stated that this proposed new interpretation, *INT 23-02: Third Quarter 2023 Corporate Alternative Minimum Tax* is to provide temporary guidance for third quarter 2023 reporting for the corporate alternative minimum tax (CAMT). The Working Group has previously adopted *INT 22-02: Third Quarter 2022 through Second Quarter 2023 Reporting of the Inflation Reduction Act – Corporate Alternative Minimum Tax*, which requires disclosure if the reporting entity is an applicable entity but does not require accrual of CAMT payable amounts, noting that a reasonable estimate is not possible. The Inflation Reduction Act was passed in August 2022, and it provides that the CAMT is effective beginning with the 2023 tax year. The proposed INT recommends that for third-quarter 2023, reporting entities should disclose whatever information is available regarding their applicable reporting entity status. If the reporting entity is able to make a reasonable estimate regarding the CAMT 2023 liabilities, such an estimate should be disclosed for third-quarter 2023. If a reasonable estimate is not possible because of pending material information, the fact that a reasonable estimate is not feasible should be disclosed. This agenda item is proposed to be exposed with a comment deadline of Sept.12. Marcotte stated that because INT 23-02 creates overrides of existing SSAP and annual statement instructions, the policy statement would require a two-thirds super majority vote of the Working Group present and voting to adopt.

J. Agenda Item 2023-22

Bruggeman directed the Working Group to agenda item 2023-22: Actuarial Guideline 51 and Appendix A-010 Interaction. Marcotte stated that this agenda item addresses the Feb. 23 request from the Financial Reporting and Solvency Committee of the Health Practice Council to the Long-Term Care Actuarial (B) Working Group of the American Academy of Actuaries, and to the Statutory Accounting Principles (E) Working Group requesting clarifications regarding some observed diversity in practice across issuers of long-term care insurance (LTCI) with regard to how the guidance in *Actuarial Guideline LI—The Application of Asset Adequacy Testing to Long Term Care Insurance Reserves* (AG 51), specifically Section 4.C, on determining when additional reserves may be necessary interacts with existing guidance on accident and health insurance reserve adequacy in *SSAP No. 54R—Individual and Group Accident and Health Contracts*, and Appendix A-010, *Minimum Reserve Standards for Individual and Group Accident and Health Insurance Contracts*. The Academy referenced a survey that provided examples of the diversity of practices that have been observed. The fundamental question is regarding whether gross premium valuation only, cash-flow testing only, or both cash-flow testing and gross premium valuation are required. Marcotte recommended the Working Group add this agenda item to the maintenance agenda classified as an SAP clarification and expose clarifying revisions and an illustration to SSAP No. 54 to clarify that gross premium valuation under *Appendix A-010* and cash-flow testing under AG 51 are both required if indicated. In addition, Marcotte recommended providing notice of the exposure to the Long-Term Care Actuarial (B) Working Group and the Valuation Analysis (E) Working Group.

5. Discussed Other Matters

A. Review of U.S. GAAP Exposures

Marcotte identified two GAAP exposures with comment deadlines from July to August that are recommended for review by the Working Group in the normal maintenance process (Attachment One-W).

B. Comment Deadline

Marcotte stated that the comment deadline for exposures is Sept. 29 for all exposures except INT 23-02 (CAMT third quarter), INT 23-03 (CAMT year-end 2023); agenda item 2022-11: Collateral for Loans; and agenda item 2023-12: Residuals in SSAP No. 48 Investments, which have a comment deadline of Sept. 12.

Having no further business, the Statutory Accounting Principles (E) Working Group adjourned.

[https://naiconline.sharepoint.com/sites/NAICSupportStaffHub/Member Meetings/E CMTE/APPTF/2023-2 Summer/Summary and Minutes/SAPWG/Att1-SAPWG Minutes 08.13.23.docx](https://naiconline.sharepoint.com/sites/NAICSupportStaffHub/Member%20Meetings/E%20CMTE/APPTF/2023-2%20Summer/Summary%20and%20Minutes/SAPWG/Att1-SAPWG%20Minutes%2008.13.23.docx)

Draft: 7/11/23

Statutory Accounting Principles (E) Working Group
E-Vote
July 5, 2023

The Statutory Accounting Principles (E) Working Group of the Accounting Practices and Procedures (E) Task Force conducted an e-vote that concluded April 10, 2023. The following Working Group members participated: Dale Bruggeman, Chair (OH); Kevin Clark, Vice Chair (IA); Kim Hudson (CA); Bill Arfanis (CT); Rylynn Brown (DE); Judy Weaver (MI); Doug Bartlett (NH); Bob Kasinow (NY); Jamie Walker (TX); David Smith (VA); and Amy Malm (WI).

1. Exposed INT 23-01

The Working Group considered an e-vote exposure of a revised *Interpretation (INT) 23-01: Net Negative (Disallowed) Interest Maintenance Reserve*. This tentative INT proposes a limited-time, optional exception to statutory accounting to admit net negative (disallowed) interest maintenance reserve (IMR) up to 10% of adjusted capital and surplus. Revisions from the prior exposure as directed by the Working Group on June 28, include:

- Requirement for RBC over 300% after adjustment to remove admitted positive goodwill, EDP equipment and operating system software, DTAs and admitted IMR.
- Allowance to admit up to 10% of adjusted capital and surplus – first in the GA, and then if all disallowed IMR in the GA is admitted and the percentage limit is not reached, then to the SA account proportionately between insulated and non-insulated accounts. (The adjustments are the same that occur for the RBC adjustment and reduce capital and surplus before applying the 10% percentage limit.)
- There is no exclusion for derivatives losses included in negative IMR if the company can demonstrate historical practice in which realized gains from derivatives were also reversed to IMR (as liabilities) and amortized.
- Inclusion of a new reporting entity attestation.
- Effective date through Dec. 31, 2025, with a note that it could be nullified earlier or extended based on WG actions to establish specific guidance on net negative (disallowed) IMR.
- Application guidance for admitting / recognizing IMR in both the general and separate accounts.

Clark made a motion, seconded by Hudson, to expose the revised INT 23-01T for a public comment period ending July 21. The motion passed with 11 Working Group members responding with affirmative votes, meeting the NAIC Policy Statement on Statutory Accounting Principles Maintenance Agenda Process requirement for a 2/3 vote of the membership for INTs that conflict with existing statutory accounting.

Having no further business, the Statutory Accounting Principles (E) Working Group adjourned.

[https://naiconline.sharepoint.com/sites/NAICSupportStaffHub/Member Meetings/E CMTE/APPTF/2023-2 Summer/SAPWG/Attachments/Att1A-SAPWG 7.5.23 E-vote.docx](https://naiconline.sharepoint.com/sites/NAICSupportStaffHub/Member%20Meetings/E%20CMTE/APPTF/2023-2%20Summer/SAPWG/Attachments/Att1A-SAPWG%207.5.23%20E-vote.docx)

Draft: 7/26/23

Statutory Accounting Principles (E) Working Group
Virtual Meeting
June 28, 2023

The Statutory Accounting Principles (E) Working Group of the Accounting Practices and Procedures (E) Task Force met June 28, 2023. The following Working Group members participated: Dale Bruggeman, Chair (OH); Kevin Clark, Vice Chair (IA); Sheila Travis (AL); Kim Hudson (CA); William Arfanis (CT); Rylynn Brown and Tom Hudson (DE); Cindy Andersen (IL); Stewart Guerin (LA); Judy Weaver (MI); Doug Bartlett and Pat Gosselin (NH); Bob Kasinow and Bill Carmello (NY); Diana Sherman (PA); Amy Garcia (TX); Doug Stolte and David Smith (VA); and Amy Malm (WI). Also participating was: David Wolf (NJ).

1. Reviewed Comments on Exposed Items

a. INT 23-01T

Bruggeman directed the Working Group to *Interpretation (INT) 23-01T: Net Negative (Disallowed) IMR* (Attachment One-B1) and the corresponding agenda item 2022-19: Negative IMR (Attachment One-B2). He directed Julie Gann (NAIC) to summarize the Life Actuarial (A) Task Force response letter dated June 15 (Attachment One-B3). Gann stated that the Task Force is moving forward with the development of an interest maintenance reserve (IMR) template, drafting guidance for 2023 and 2024 for the Working Group's potential admittance of some portion of aggregate negative IMR, and a recommendation to the Working Group to not rely on asset adequacy testing (AAT) as the sole or primary guardrail for aggregate negative IMR. Bruggeman noted that the key part of the recommendation was using AAT as the "sole or primary" guardrail, and the Working Group has been discussing the usage of AAT as the first-level safeguard and how it should be used in combination with other safeguards. IMR is included as a long-term agenda item for the Task Force as one of its primary concerns, which means it should be captured in the valuation documentation for the years ending 2022 and 2023.

Gann stated that in April, the Working Group exposed the limited-time optional INT to allow the admittance of net negative disallowed IMR in the general account up to 5% of adjusted capital and surplus. That 5% limit was directed by the Working Group at the Spring National Meeting. The exposed INT proposed restrictions as to what is permitted to be captured specifically for derivatives that have been reported at fair value and then for only general account IMR, with an exclusion for separate accounts. Detailed comments were received from the American Council of Life Insurers (ACLI), and NAIC staff request that the Working Group hear, discuss, and provide direction on the requested revisions to the INT. If the INT is revised, NAIC staff anticipate exposing a revised INT with a shortened comment period to allow for potential adoption consideration at the Summer National Meeting. Gann recommended that the Working Group defer the adoption of the INT until the Summer National Meeting, as there are a significant number of comments to consider. She then noted that the ACLI comment letter broke out eight key topics, and the first two topics—Surplus Considerations and Exclusion of Fair Value Derivatives from Determining Admitted Net Negative IMR—appeared to be the most significant. She also requested that the Working Group provide direction on the effective duration of the INT and whether there should be a sunset time frame. Bruggeman requested that the ACLI provide its overall comments to the Working Group prior to going through each of the eight topics individually.

Mike Reis (Northwestern Mutual), representing the ACLI, stated that he would like to begin by reading from the Financial Condition (E) Committee's *Asset Valuation Reserves and Interest Maintenance Reserves Blue Book* report from December 2002, which can be found at <https://naic.soutrounglobal.net/Portal/Public/en-US/RecordView/Index/547>, as it includes some foundational concepts. He stated that the main driver of the development of IMR

and asset valuation reserve (AVR) is that without these mechanisms, many circumstances gave rise to inappropriate results from the statutory formula valuation methods. For example, changes in value due to interest rate swings were recognized inconsistently on the asset and liability sides of the balance sheet. Liabilities are valued using interest rates fixed at issue, while some assets may be valued using current interest rates through trading activities. The development of AVR and IMR also recognized that trading gains and losses were transitory with reinvestment, where they are offset with new lower-yielding and higher-yielding assets, respectively; IMR should, theoretically, apply symmetrically. So, all points in the ACLI letter and items discussed today emanate from these concepts; consequently, with the non-admittance of negative IMR, the financial statements are not fairly represented. Reis continued by stating that to avoid incentivizing companies to manage the financial reporting outcomes rather than affect appropriate risk management practices, the ACLI believes an interim solution should have a surplus cap of at least 10% or greater, along with no adjustments to surplus or exclusions. The rationale for this is that IMR is different from other intangibles, and it is more akin to unrealized losses on bonds with no change in immediate claims-paying ability after trading.

Reis stated that for the interim solution, non-hedge accounting derivatives, which are still economically effective hedges and appropriate for the duration and risk management, should not be changed from current industry practice. The industry has been deferring effective hedge gains to IMR for decades. For the interim solution, book value separate accounts, both insulated and non-insulated, have the same products and risk management issues as the general account and should not be excluded. Also, any proof of reinvestment should be on a macro basis looking at the totality of the NAIC framework and recognizing the fungibility of cash. Reis suggested that a new technical working group with members of the Working Group, the Life Actuarial (A) Task Force, the American Academy of Actuaries (Academy), and industry members may be needed to help develop a long-term solution to these issues. Beyond this, the ACLI does not believe it is in the collective best interest to make interim changes to current IMR deferral practices, as this would drastically change longstanding and important risk management practices.

Bruggeman stated that the Working Group will begin its discussion of the second topic—Exclusion of Fair Value Derivatives from Determining Admitted Net Negative IMR—and he noted that non-accounting-effective hedges are recorded at fair value, and the unrealized gain/loss would already be in surplus. Disposal of a fair value hedge would result in an immediate adjustment to surplus via the IMR irrespective of the IMR's positive/negative position. This issue is one of the discussion points that the Working Group wants to understand better, as there is a difference between accounting-effective hedges and economic-effective hedges, and if it is not one of those two, then it would likely be a speculative hedge.

Mike Huff (Teachers Insurance and Annuity Association of America—TIAA), representing the ACLI, stated that Bruggeman made a good distinction between hedges that are accounting-effective versus economic-effective. He also noted that he would not even consider speculative hedges to be a hedge derivative position, as speculative hedges are not allowed under insurance law or company derivative use plans. The industry's interpretation is that accounting-effective and economic-effective hedges are both considered equally economically effective, but accounting-effective just happens to be specifically defined within the accounting guidance. All interest rate derivatives, both hedge accounting and fair-valued interest rate derivatives, are instruments that industry uses interchangeably with fixed-rate bonds as asset and liability management tools. As these instruments are used interchangeably, consistent treatment is considered important and within the spirit of the development of IMR. Historical industry practice has been to defer gains from fair value derivatives when the gain is related to a change in interest rates, and that has previously resulted in a significant deferral of gains into IMR and not into surplus. Huff noted that industry's position is that this is the appropriate accounting treatment, as it does not artificially inflate surplus, given the fact that there is then reinvestment into lower-rate assets. He stated that the ACLI wants to avoid the potentially adverse outcome of disincentivizing the prudent use of derivatives in asset-liability management (ALM) and risk management to ensure that financial statements reflect the fairest representation

of financial condition for companies, particularly in surplus. He then discussed the examples included in the ACLI's comment letter.

Bruggeman noted that the example scenarios place an emphasis on the income statement impact, whereas the Working Group has noted that the hedge is at fair value, which means that surplus has already been affected irrespective of whether the derivative has been disposed of. He then inquired as to whether disposals occur when derivatives are still economically effective or if that occurs after effectiveness has lapsed. Additionally, he requested clarification on what industry considers a derivative that is not economically effective. Huff stated that a hedge will occasionally become economically ineffective, but for the most part, this does not happen. Hedges that industry feels have become speculative are immediately taken off the books; likewise, industry would never put a derivative on the books that was not an economically effective hedge.

Bruggeman asked if, in the second scenario described in the ACLI comment letter, the hedge was to become economically ineffective, whether industry would dispose of the hedge before or after it became ineffective, and whether the gain/loss would be recorded through IMR. Huff responded that in all three scenarios, the hedge would be considered effective, as it has locked in the rate at 5%. Bruggeman clarified that he is trying to assess industry's practice for recording through IMR in the event that the hedge did become ineffective. Huff responded that he believes that while the hedge is effective, any realized gain/loss would go to IMR, and after it becomes ineffective, it would not. Bruggeman stated that there is a distinction that needs to be made between when there is an ineffective hedge that has been disposed of/terminated based on when it became ineffective. If the derivative is not interest-rate sensitive, it would not meet the blanks instructions on interest-rate sensitivity. The issue is gaining a proper understanding of what happens when a derivative becomes ineffective and how state insurance regulators would get assurance that when a derivative was disposed of it would roll through IMR only if it was still effective. He stated that he believes there is a breakpoint where, once it is ineffective, it is no longer an interest-rate-sensitive type of disposal that qualifies for IMR. Bruggeman stated that there is a need for these detailed discussions as part of a long-term IMR assessment, but he does not want to put reporting entities in a whipsaw position where they have been deferring all derivative gains to IMR over the years; now the derivative losses are not permitted through IMR.

Gann noted that due to the complexity of this discussion, she would like to make some clarifying comments. In the scenarios presented by the ACLI, she clarified that these are not actual hedges of specific assets. Rather, these are derivative hedges for the portfolio, which is why they do not qualify as accounting-effective hedges under statutory accounting. Industry considers these to be economic-effective hedges because they are in line with a company's derivative use plan; however, there is no metric or assessment that could occur to prove that the derivative is effective as required for accounting-effective hedges. So, if the hedge is in accordance with a company's derivative use plan, then industry considers them to be effective, and there would be very limited situations, if any, where a derivative would move from being considered an effective hedge. Gann noted that what industry is identifying as an effective hedge is not an accounting-effective hedge. As such, industry's interpretation would encompass many more derivatives than are considered effective hedges for accounting purposes under *Statement of Statutory Accounting Principles (SSAP) No. 86—Derivatives*. Gann stated that she just wants to make sure that that was clear because the example appears to reflect a hedge of a single asset, but hedges of single assets could be designed to qualify as accounting-effective. Reis noted that hedges from the example scenarios could be assigned to assets that are subsequently purchased, and if that is to occur, the derivative arrangement could qualify as accounting-effective. The company would have to end up buying those assets for them to be assigned to the hedge, so the hedge is not assigned to a specific asset when it is initiated, but if assets are purchased, the hedge could be assigned. If the assets were purchased with a maturity duration of two years instead of a planned 10-year time frame, this could be a situation in which the hedge becomes ineffective.

Tom Karafin (Prudential) noted that hedges generate a gain or loss while they are effective, and the moment a derivative is to become ineffective, they take them off. However, the gain or loss was in existence during the hedge's effective life, and the current model says that gain/loss has become permanent and should follow the hedged item. As such, the gain/loss would continue to be reported through IMR.

Smith asked how certain the industry representatives are that during the periods in which interest rates were decreasing, everyone in industry was consistently applying this approach to defer gains in IMR over the life of the hedge versus recognizing all gains in surplus at the time of disposal. Reis responded that while no one would suggest that this is an absolute statement, all attendees to the ACLI working group meeting (approximately 30–40 representatives) responded that they were deferring hedge gains through IMR. Smith reiterated his concern that some of the more aggressive companies were not involved in the industry's discussion. For companies that have been deferring the gains, it would be punitive to not defer the losses, but there is a concern that some companies historically recognized the gains and now want to defer the losses. Bruggeman noted that they are looking to avoid an imbalance in which gains are recognized immediately in surplus, but the realized losses are deferred through IMR. He proposed a solution to have companies that have been following the approach in which derivative gains were historically taken to IMR continue doing so with derivative losses, but companies that have not previously recognized derivative gains through IMR would not be permitted to begin that practice under the INT with derivative losses. He stated that while it is a bit inconsistent, it would avoid the imbalance issue of reporting gains and losses differently.

Huff stated that he believes he can safely state that all the major players have been deferring derivative gains through IMR, and the big four accounting firms agreed with that treatment. Bruggeman noted that the Working Group wants to provide some kind of direction for NAIC staff, and in the long-term, they will need to work with the Life Actuarial (A) Task Force for a solution; however, for the short-term, there needs to be some kind of assurance that hedges were disposed of while they were still economically effective in order for gains or losses to go through IMR. This would provide state insurance regulators with some amount of comfort that ineffective hedges are not being run through IMR, especially if resulting in a loss. That said, economically effective hedges do not have any kind of metric for determining if the hedge is still economically effective, so state insurance regulators need more assurance that something was not deferred through IMR that should not have been. Huff stated that the vast majority of the time when hedges are unwound, as illustrated in the example scenarios, they are done so on a schedule, and the company will know the approximate time at which the hedge would be disposed of. While it is possible that a hedge may be unexpectedly unwound, it would be quite unusual for a company to have a hedge become ineffective prior to disposal because of this.

Clark stated that it does not make any sense to have different accounting treatment between unrealized and realized changes. The concept of IMR exists to create consistency for bonds for unrealized and realized losses. The same should hold for derivatives. It does not make sense to mark derivatives to market (fair value) when it is open (unrealized) only to reverse that treatment at termination (realized). This disconnect is one of the two things, at least in the long-term, that need to change to get accounting consistency. The second thing is the lack of measurement parameters around the effectiveness of a hedge. There is a reason U.S. generally accepted accounting principles (U.S. GAAP) and statutory accounting have a concept of effective hedge accounting, but with industry's interpretation, there is essentially a way around effective hedge accounting without any kind of overarching parameters, and that is a concern. Given the historical practice, the least disruptive thing to do would be to allow companies to continue with the practices they have already been doing. Clark stated that as for Smith's point, a company should not change its practice because of this interpretation, and in the interim, it would be appropriate for companies to continue with the practices they have already been doing.

Wolf stated that he supports that approach, and the guidance must specify that the company needs to continue following its past practices. If a company has been amortizing gains in IMR for similar derivative positions in the

past based on documented internal accounting policies, then it can continue to do so with like derivative positions that are now resulting in losses, but allowing new practices permitting derivative losses in IMR to go forward at this point should be avoided.

Bruggeman then directed the Working Group to discuss book value guaranteed separate accounts. He stated that he believes it makes sense to permit admitted IMR in a separate account. Although there is a distinction between insulated and non-insulated, he would like to avoid that discussion for this interpretation. Separate accounts for certain products are still general accounts affected, but that is not relevant for IMR purposes. Bruggeman then recapped the annual statement blanks instructions of how IMR from separate and general accounts are presented. He then inquired about the operational mechanics, such as if there was a cap based on surplus, whether it was 5% or 10%, and how that would affect the instructions for reporting negative IMR within general and separate accounts. Specifically, he inquired about whether the cap should first apply to the general account, with the separate account only admitting if the admittance in the IMR does not exceed the percentage permitted. He stated that he believes there is support for book value guaranteed separate accounts recognizing negative IMR, but it is an order of operations question between the general and separate accounts.

Brad Caprari (Prudential), representing the ACLI, stated that there has been a bit of back and forth on what the order of operations should be. The initial discussion was for negative IMR to be applied to the general account first and then to the extent that there remains availability within that 10% surplus limit, which would then apply to the separate account. This is also to say that the ACLI supports a 10% surplus limit. That said, the ACLI believes there should be proportionate admittance between insulated and non-insulated separate accounts. Caprari noted that he does not see any distinction between insulated versus non-insulated as it relates to the discussion of IMR, and there should be proportionate admittance there to the extent that someone has negative IMR that can be captured within the available cap of 10%.

Carmello asked for clarification on whether it is an insulated account with the negative IMR asset and whether the IMR would be held in that insulated account. Caprari replied that any admitted negative IMR asset or contra-liability would be held in the insulated account. Carmello noted that this does not really help the customers that have the insulated accounts, as they can only acquire real assets in the event of an insolvency, and he is concerned that this may be somehow benefiting the insulated customers, but that does not appear to be the case. Caprari said he agrees, and he noted that it is only tangible if taken into consideration with the reinvestment of funds, which will make up for the initial loss over time. Carmello then asked for clarification on how the order of operations would proceed if the general account is negative but the separate account is positive in excess of the general account. Caprari responded that it would be the cumulative total of the two accounts to determine the net negative position. If there is a cumulative net negative position, then it depends on whether one or both accounts are negative to determine how the cap is applied. If both accounts are negative, then the general account would apply first, and the separate account would be eligible for any amount of the cap left over.

Gann noted that the concept of admitted and non-admitted assets does not exist in the separate accounts, and the current process in the separate accounts is to take negative IMR as a direct charge to surplus. So, if the direction of the Working Group is to include separate accounts in the interpretation, NAIC staff will include this order of operation that was discussed. NAIC staff will also detail how to reflect this asset in the separate accounts, which would likely be a reversal of the prior hit to surplus, with a recognition of a miscellaneous aggregate write-in asset to reflect what is going to be permitted as admitted. NAIC staff do not recommend reporting it as a contra-liability, as it could be commingled with the non-disallowed negative IMR. Gann stated that it can be identified in the financial statements when reported separately as miscellaneous aggregate assets. When there are changes on what is permitted to be admitted in the separate account, the entry would be to remove the asset with a charge in surplus. As such, companies may be reversing and re-entering entries as the balance in IMR changes based on what is permitted to be admitted from percentage limitations. Gann stated that if separate accounts are

captured, the interpretation will include the recognition process to ensure consistency across industry. Bruggeman stated that there should be a proportional allowance in the insulated and non-insulated separate accounts if IMR is permitted without exceeding the percentage cap. He noted that there are separate account surpluses, and he asked if that counts when adding up all the surpluses.

Caprari stated that if you look at the general account blank, the reported surplus is the surplus the ACLI believes should be used for the cap, and it is inclusive of a separate account surplus. As such, there would not need to be any aggregation, and the ACLI prefers to use it as the cap instead of trying to aggregate out a separate account cap versus a general account cap. Gann stated that NAIC staff should have what they need to move forward with updating the interpretation, and she noted that the agenda does identify other things that may need to be considered in the future, perhaps as a long-term project for separate accounts with regard to the products that are used for book value. She also noted that on a broad scale, variations from what is permitted for book value under *SSAP No. 56—Separate Accounts* are not detailed, identifying that only three permitted practice disclosures were reported for items that were held at book value beyond what was permitted in SSAP No. 56. She also noted the need to assess overall accounting, reporting, and risk-based capital (RBC), if the separate account blanks are being used as an extension of the general account or a segregated general account, as the accounting and reporting in the separate account is not designed with that original intent. Bruggeman noted that this might represent an add-on to the current project, but IMR interpretation will proceed with IMR to be recognized from book value guaranteed separate accounts, whether insulated or non-insulated; and, as proposed by Caprari, if there is net negative IMR, then the amount admitted by the surplus cap goes to the general account first, and then whatever is left will be allocated to the insulated and non-insulated separate accounts proportionally.

Linus Waelti (New York Life Insurance Company), representing the ACLI, noted that state insurance regulators understand the importance of being able to distinguish between what they refer to as the good scenario, where the sale proceeds from the asset sale are going into a reinvestment, versus what they call the bad scenario, where that is happening inadequately and the proceeds from asset sales go to pay major cash outflows, whether they are expenses, claims, or withdrawals. To do a granular asset-to-asset mapping of proof of reinvestment is not going to be practical and will be highly challenging. So, the question comes down to what the package of safeguards should be that would give state insurance regulators comfort that the reinvestments are occurring adequately and appropriately. The ACLI recommended that state insurance regulators use existing safeguards, like AAT, to provide comfort in the activity. While AAT would not be considered the sole or primary safeguard, it certainly should play a role in combination with other safeguards, at least in the context of proof of reinvestment, to ensure that assets and reinvested assets are generating returns adequate to cover claim liabilities. The ACLI's position is that if claims payments become compromised by inadequate reinvestment or inappropriate reinvestment, the AAT analysis would identify that shortfall. The AAT shortfall would cause reserve strengthening, which would result in a direct impact on surplus, much like what would be seen if negative IMR was written off.

Waelti noted that in terms of other recommendations, the ACLI proposes the inclusion of a macro demonstration of reinvestment. This could involve the use of the cash flow statement to provide an aggregate view of cash activity, with a comparison of investment proceeds to the cost of investments acquired. This also helps navigate some of the problems with the fungibility of cash that would plague other demonstrations of proof of reinvestment. There are some imperfections with using a macro demonstration, as proceeds reported in the cash flow include maturities, and the amount reported as reinvestments includes cash in-flows from other sources, but at least at a high level, this would provide state insurance regulators with a view of the reinvestment occurring and whether it is at a healthy level. Another proposal from the ACLI is a company attestation that confirms that investment activities are in line with documented investment strategies and policies of the company. This company attestation could also be expanded to provide additional comfort to state insurance regulators as needed. Additionally, the ACLI suggests that a company will attest that asset sales are not being compelled by liquidity pressures, whether they are coming from collateral calls or from excess withdrawal activity.

Carmello asked if companies could potentially capture the information needed to perform granular asset-to-asset mapping as proof of reinvestment as a goal of the long-term project. Waelti responded that while some of this information is available on Schedule D, it would still be very difficult to perform asset-to-asset mapping due to the complexity and volume of activity. Carmello noted that in his mind, he is envisioning a short report that maps together and provides comfort to state insurance regulators that there is not a situation where asset sale proceeds are being used to cover claims instead of being reinvested. He stated that it seems Waelti is proposing that state insurance regulators would be able to get this type of report prepared by the companies if requested. Waelti responded that this would likely include some information from Schedule D, and they would need to work with state insurance regulators to determine what other information and commentary state insurance regulators are looking for. Bruggeman noted that this conforms with what is in the instructions; if there are excess withdrawal situations, those asset sale gains/losses do not go through IMR. The bigger question of the fungibility of cash is when a company sells a newly purchased asset, but they are not buying a fixed-income instrument with the proceeds. This may be something better addressed in the long term, but for the short term, what Carmello is requesting is a more distinct disclosure of the transactions or how they are done.

Carmello said he agrees, and he noted that on the long-term project, they should consider looking at the 150% factor to determine if it is still appropriate since it was a factor developed around 30 years ago when IMR was established. Bruggeman then asked Gann if state insurance regulators could ask for additional disclosure within AAT or if it would require a referral to the Life Actuarial (A) Task Force. Gann stated that this would likely require a referral to the Task Force. She also noted that the exposed interpretation was drafted with reference to an “immediate” investment of sale proceeds in another fixed-income instrument. While this language has been identified as potentially problematic, she noted that it was not intended to imply instantaneous action, but the company is investing directly in fixed-income instruments, not holding onto the cash, and investing six months down the road or in equities. Gann stated that the industry-proposed attestation can be included as an additional disclosure. Bruggeman clarified that he is not sure where this attestation disclosure would actually be reported. Gann noted that this could be done as a narrative disclosure for year-end 2023, but it is too late in the year for a data-captured disclosure. If the INT were to go on for a period of time, the disclosure could be included in the financial statements as a general interrogatory or as a new data-captured disclosure. Bruggeman noted that he would like to see some kind of distinct matching as part of the long-term solution and an assessment of whether the 150% factor for excess withdrawals still makes sense.

Bruggeman noted that there was not any disagreement on the topic of special surplus accounts, and the only comment he has is that the wording should be specific to ensure that everyone is using the same terminology so information entered can be easily aggregated. He noted that as soon as a “write-in” line is provided, state insurance regulators tend to lose all ability to aggregate data by line and column number. Specific wording should also be developed to make it easier to consistently identify and aggregate year-end data.

Bruggeman directed the Working Group to the topic of existing safeguards. Reis noted that industry is not opposed to additional safeguards, but he wants to make sure the rationale for each safeguard is clearly understood. Gann stated that the Life Actuarial (A) Task Force has communicated that AAT should not be relied on as the sole safeguard for the admittance of negative IMR. There is the ability for permitted practices, but there is the desire for a uniform standard, and there were only two permitted practices for year-end 2022. For derivatives, there is the reliance on a company’s filed derivative use plan, but NAIC staff do not receive these plans and cannot comment on what is included or how much is included regarding interest rate derivatives or what is going through IMR. For the long-term project, the Working Group could potentially expand Schedule DB to get more information, but that is not something that could be done for this year-end. NAIC staff are requesting comments on the ACLI proposed safeguards and direction on whether there are other safeguards that should be incorporated. Bruggeman noted that the Working Group’s direction is that what is included in the exposure is sufficient for consideration; although, it should be noted that AAT should not be the primary safeguard, and individual

circumstances that vary from what is permitted in the ultimate interpretation can still go through the permitted practice process. States should also be aware that derivative use plans are key components for the potential admittance of net negative IMR, as they review and assess those submissions. Wolf asked whether there would still be a safeguard around minimum RBC. Bruggeman confirmed that the 300% threshold for potential action would still be in place. Wolf stated that negative IMR should not be permitted for admittance when a reporting entity hits the 300% threshold. Wolf also noted support for calculating the 300% threshold with the removal of admitted negative IMR, goodwill, operating system software and electronic data processing equipment, and deferred tax assets similar to the calculation of adjusted capital and surplus.

Bruggeman noted that to have a line on RBC sensitivity would require a structure change to RBC, which cannot be completed for year-end 2023, as it would have needed to be exposed by at least the end of January. He noted that RBC sensitivity would be appropriate, especially if it resulted in an email sent to the domestic regulators, noting that the company's RBC, with or without this IMR, is well above 300%. Hudson noted that his understanding of Wolf's request was regarding whether the Working Group wants to include language that companies could not admit negative IMR if RBC was below 300%. Bruggeman responded that this should be included. Gann responded that this is included in the INT, but the comment was to calculate 300% after adjustments. Wolf agreed that this was his comment, as he wants to make sure that the 300% RBC is determined after adjustments to remove admitted negative IMR, goodwill, operating system software and electronic data processing equipment, and deferred tax assets. Reis noted that the industry is not opposed to providing disclosures, but he wants to make sure that the disclosures are discussed in the context of the cap.

Bruggeman asked the Working Group whether there should be a termination date for the INT, and he proposed a termination date three years after adoption. Hudson agreed with Bruggeman on including an end date on the INT, as it will provide pressure to resolve the issue. Bruggeman suggested an end date of Jan. 1, 2026. Reis stated that the industry is also supportive of an end date, and while the ACLI has not discussed a three-year end date, his opinion is that this time frame sounds reasonable for developing a long-term solution. Bruggeman said that three years is the best option, as it allows for that extra year that is often needed to develop and put the structure in place.

Bruggeman then directed the Working Group to discuss the proposed 5% cap on adjusted capital and surplus, and he asked if this cap should be adjusted surplus or straight surplus without any adjustments. He noted that the Working Group had previously discussed and settled on 5%, but he believes 10% makes more sense, as it would line up with the goodwill admittance limitation. Hudson asked whether the prior concern about the 300% company action level RBC was that the soft assets, including negative IMR, could not be used by the company after reaching the action level, which Wolf confirmed. Reis stated that negative IMR is akin to unrealized losses, and it is deferred because they are transitory due to the company reinvesting the proceeds in a higher or lower-yielding asset, and it does not change the claims accountability. It can be distinguished from other soft assets, and it is more akin to the soft asset of unrealized gains/losses that are on the balance sheet. Reis expressed that it is cleaner and more theoretically appropriate not to lump IMR in with other soft assets, as to do so would miss the point of why IMR was developed. Clark agreed and noted that the interim proposal to cap IMR based on capital and surplus is more related to the fact that the Working Group is not comfortable enough with all the existing safeguards to allow unlimited admittance of negative IMR. He noted that he would be ok with the 10% cap and no adjustments, as this is a different type of intangible compared to other soft assets.

Weaver stated concern that these intangibles are starting to add up, and if a company were in trouble, it would not be able to pay claims right away with some of these intangible assets. Reis responded that in the ACLI's comment letter, it details its position that the bonds are on the books at amortized cost, which is not the sales price at which bonds could be sold to pay claims, and IMR is no different. Clark stated that the 300% RBC threshold is intended to address this, as once the company reaches the solvency concern, it no longer gets to report IMR as

a soft asset, and the accounting becomes closer to a liquidation basis of accounting. Hudson stated that a reasonable compromise would be to go up to 10% but to use adjusted surplus and capital, noting that he would be uncomfortable going up to 10% using unadjusted surplus and capital. Bruggeman noted that the reason the ACLI is trying to make the distinction of using the RBC below 300% and then using adjusted surplus is if a company did get to 300% without all those soft assets and without negative IMR, then the company has to eliminate IMR as an admitted asset earlier as opposed to using the 10% of surplus as a cap.

Bruggeman then requested further comments and questions from the Working Group, noting that NAIC staff need to be provided with direction for drafting an updated INT for exposure, specifically requesting responses from members on the 10% cap and unadjusted versus adjusted surplus. Bartlett, Brown, Andersen, and Arfanis stated support for a 10% cap with adjusted surplus and capital. Smith stated that he prefers 5% with adjusted surplus and capital but could live with 10% adjusted surplus and capital, and Sherman agreed. Kasinow requested clarification on the calculation of adjusted surplus and capital. Gann clarified which items are excluded, and she noted that the calculation is further detailed in the meeting materials, found in paragraph 9a of the exposed INT. Kasinow stated support for 10% with adjusted surplus and capital. Reis asked the Working Group members voting for the use of adjusted surplus and capital what their theoretical basis for this was and if a higher cap could be considered since adjusted surplus and capital would further reduce the admitted amounts of IMR. He stated that the ACLI agreed that the 10% cap is reasonable, but he does not understand the foundation for using adjusted surplus and capital outside of a desire to be conservative. Malm stated support for 10% with unadjusted surplus and capital. Bruggeman noted that at this point, the vote is approximately eight for 10% adjusted versus two for 10% unadjusted out of 15 members.

Bruggeman noted that this majority vote would indicate that the Working Group is directing NAIC staff to draft the exposure with a 10% limitation using adjusted surplus and capital. Clark asked if Working Group members could change their minds when the vote for the adoption of the INT comes up. Bruggeman stated that members could, as this was originally exposed with a 5% limitation of adjusted capital and surplus, and now the Working Group is directing NAIC staff to draft an exposure with 10% using adjusted capital and surplus. Bruggeman noted that the Working Group will perform an e-vote exposure vote on the updated draft exposure.

2. Discussed Other Matters

Bruggeman requested any additional comments or discussion on other matters. Gann noted that the other items on the agenda are just notices. First, NAIC staff received an extension for comments from the June 1 referral from the Valuation of Securities (E) Task Force (Attachment One-B4) until July 7. The second thing is letting everyone know that the Insurance Core Principals (ICPs) 14 and 17 have been released for comments, both of which are available for review and comment on the International Association of Insurance Supervisors (IAIS) website.

Having no further business, the Statutory Accounting Principles (E) Working Group adjourned.

[https://naiconline.sharepoint.com/sites/naicsupportstaffhub/member meetings/e cmte/apptf/2023-2 summer/summary and minutes/sapwg/attachments/att1b-sapwg 6.28.23 minutes.docx](https://naiconline.sharepoint.com/sites/naicsupportstaffhub/member%20meetings/e%20cmte/apptf/2023-2%20summer/summary%20and%20minutes/sapwg/attachments/att1b-sapwg%206.28.23%20minutes.docx)

Interpretation of the Statutory Accounting Principles (E) Working Group

2023 Net Negative (Disallowed) Interest Maintenance Reserve

INT 23-01T Dates Discussed

March 22, 2023

INT 23-01 References

Current:

*SSAP No. 7—Asset Valuation Reserve and Interest Maintenance Reserve
Annual Statement Instructions*

INT 23-01T Issue

1. The statutory accounting guidance for interest maintenance reserve (IMR) and the asset valuation reserve (AVR) is within *SSAP No. 7—Asset Valuation Reserve and Interest Maintenance Reserve*, but the guidance within *SSAP No. 7* is very limited. It provides a general description, identifies that IMR/AVR shall be calculated and reported per the guidance in the applicable SSAP, and if not explicit in the SSAP, in accordance with the annual statement instructions. The SSAPs most often simply direct allocation to (or between) IMR and AVR, with the bulk of the guidance residing within the annual statement instructions.
2. As detailed in *SSAP No. 7*, paragraph 2, the guidance for IMR and AVR applies to life and accident and health insurance companies and focuses on IMR and AVR liability recognition and distinguishing between IMR and AVR:
 2. Life and accident and health insurance companies shall recognize liabilities for an AVR and an IMR. The AVR is intended to establish a reserve to offset potential credit-related investment losses on all invested asset categories excluding cash, policy loans, premium notes, collateral notes and income receivable. The IMR defers recognition of the realized capital gains and losses resulting from changes in the general level of interest rates. These gains and losses shall be amortized into investment income over the expected remaining life of the investments sold. The IMR also applies to certain liability gains/losses related to changes in interest rates. These gains and losses shall be amortized into investment income over the expected remaining life of the liability released.
3. The IMR guidance in the annual statement instructions provides information on the net balance. A positive IMR represents net interest rate realized gains and is reported as a liability on a dedicated reporting line. A negative disallowed IMR represents net interest rate realized losses and is reported as a miscellaneous other-than-invested write-in asset in the general account and nonadmitted.
4. IMR balances between the general account and separate accounts are separate and distinct. Meaning, a net negative IMR in the general account only represents activity that occurred in the general account that was allocated to IMR. However, the net positive or negative balance of the general account influences how the net positive or negative balances are reported in separate account statements (and vice versa). (A net negative IMR balance in the general account may not be disallowed if there is a covering net positive IMR in the separate account. Negative IMR that is not disallowed is reported as a contra-liability.) The instructions for reporting the net negative and positive balances are detailed in the annual statement instructions:

Line 6 – Reserve as of December 31, Current Year

Record any positive or allowable negative balance in the liability line captioned "Interest Maintenance Reserve" on Page 3, Line 9.4 of the General Account Statement and Line 3 of the Separate Accounts Statement. A negative IMR balance may be recorded as a negative liability in either the General Account or the Separate Accounts Statement of a company only to the extent that it is covered or offset by a positive IMR liability in the other statement.

If there is any disallowed negative IMR balance in the General Account Statement, include the change in the disallowed portion in Page 4, Line 41 so that the change will be appropriately charged or credited to the Capital and Surplus Account on Page 4. If there is any disallowed negative IMR balance in the Separate Accounts Statement, determine the change in the disallowed portion (prior year less current year disallowed portions), and make a direct charge or credit to the surplus account for the "Change in Disallowed Interest Maintenance Reserve" in the write-in line, in the Surplus Account on Page 4 of the Separate Accounts Statement. The following information is presented to assist in determining the proper accounting:

<u>General Account IMR Balance</u>	<u>Separate Account IMR Balance</u>	<u>Net IMR Balance</u>
Positive	Positive	Positive (See rule a)
Negative	Negative	Negative (See rule b)
Positive	Negative	Positive (See rule c)
Positive	Negative	Negative (See rule d)
Negative	Positive	Positive (See rule e)
Negative	Positive	Negative (See rule f)

Rules:

- a. If both balances are positive, then report each as a liability in its respective statement.
- b. If both balances are negative, then no portion of the negative balances is allowable as a negative liability in either statement. Report a zero for the IMR liability in each statement and follow the above instructions for handling disallowed negative IMR balances in each statement.
- c. If the general account balance is positive, the separate accounts balance is negative and the combined net balance is positive, then all of the negative IMR balance is allowable as a negative liability in the Separate Accounts Statement.
- d. If the general account balance is positive, the separate account balance is negative, and the combined net balance is negative, then the negative amount not covered by the positive amount is not allowable. Report only the allowable portion as a negative liability in the Separate Accounts Statement and follow the above instructions for handling the disallowed portion of negative IMR balances in the Separate Accounts Statement.
- e. If the general account balance is negative, the separate account balance is positive, and the combined net balance is positive, then all of the negative IMR balance is allowable as a negative liability in the General Account Statement.
- f. If the general account balance is negative, the separate account balance is positive, and the combined net balance is negative, then the negative amount not covered by the positive amount is not allowable. Report only the allowable portion as a negative liability in the General Account Statement and follow the above instructions for handling the disallowed portion of negative IMR balances in the General Account Statement.

5. In October 2022, the ACLI requested the Statutory Accounting Principles (E) Working Group to reassess the guidance for net negative (disallowed) IMR, with a request to consider admittance of those amounts. The ACLI noted that the nonadmittance of disallowed negative IMR can have adverse negative ramifications for insurers with two key themes:

- a. In general, rising interest rates are favorable to the financial health of the insurance industry and policyholders. However, with negative IMR, there is an inappropriate perception of decreased financial strength through lower surplus and risk-based capital.
- b. Negative IMR could impact the rating agency view of the industry or incentivize companies to avoid prudent investment transactions that are necessary to avoid mismatches between assets and liabilities. In either scenario, negative IMR encourages short-term non-economic activity that is not in the best long-term interest of a reporting entity's financial health or its policyholders.

6. In considering the request, the Working Group concluded that for year-end 2022, there would be no change to statutory accounting guidance and deviations from statutory accounting principles would need to be approved via a permitted or prescribed practice. The Working Group then held company-specific educational sessions in January 2023 to receive detailed information regarding negative IMR and received a subsequent comment letter from the ACLI.

7. During the 2023 Spring National Meeting, the Working Group further discussed the topic of negative IMR and directed NAIC staff to proceed with drafting guidance for both a 2023 solution and to begin work towards a long-term solution.

INT 23-01T Discussion

8. This tentative interpretation prescribes limited-time, optional, statutory accounting guidance, as an exception to the existing guidance detailed in SSAP No. 7 and the annual statement instructions that requires nonadmittance of net negative (disallowed) IMR in the general account as a short-term solution for 2023. This interpretation is specific for general account treatment only and assessment of possible revisions for the separate account will be considered as part of the long-term solution. Specifically, this interpretation impacts the annual statement instruction rules regarding disallowed negative IMR in the general account, detailed in rules 'b' and 'f' shown in paragraph 4. (As detailed within, admittance in the general account does not impact the determination or reporting of IMR in the separate accounts.) As this interpretation overrides existing guidance, it will require a 2/3rd vote.

9. Reporting entities are permitted to admit net negative (disallowed) IMR in the general account with the following restrictions:

- a. Reporting entities with an RBC greater than 300% are permitted to admit net negative (disallowed) IMR, as defined in paragraph 9.b., up to 5% of the reporting entity's general account capital and surplus as required to be shown on the statutory balance sheet of the reporting entity for its most recently filed statement with the domiciliary state commissioner adjusted to exclude any net positive goodwill, EDP equipment and operating system software, net deferred tax assets and admitted net negative IMR. Reporting entities with a 300% or lower RBC are not permitted to admit net negative (disallowed) IMR.
- b. Negative (disallowed) IMR admitted pursuant to paragraph 9.a. is limited to IMR generated from losses incurred from the sale of bonds, or other qualifying fixed income investments, that were reported at amortized cost prior to the sale, and for which the proceeds of the sale

were immediately used to acquire bonds, or other qualifying fixed income investments, that will be reported at amortized cost. (This provision intends to explicitly exclude derivative losses from derivatives reported at fair value that have been allocated to IMR from being admitted under this guidance¹.)

10. Reporting entities that admit net negative disallowed IMR in the general account pursuant to paragraph 9 shall report the admittance in the balance sheet as follows:

- a. Reporting entities shall report the net negative (disallowed) IMR as a write-in to miscellaneous other-than-invested asset (named as “Disallowed IMR”) on the asset page. The net negative (disallowed) IMR shall be admitted to the extent permitted per paragraph 9, with the remaining net negative (disallowed) IMR balance nonadmitted.
- b. Reporting entities shall allocate an amount equal to the general account admitted net negative (disallowed) IMR to special surplus. Although dividends are contingent on state specific statutes and laws, the intent of this reporting is to provide transparency and preclude the ability for admitted negative IMR to be reported as funds available to dividend.

11. Reporting entities admitting net negative (disallowed) IMR are required to complete the following disclosures in the annual and quarterly financial statements for IMR:

- a. Reporting entities that have allocated gains/losses to IMR from derivatives that were reported at fair value prior to the closing / termination / settlement / expiration of the derivative shall disclose the non-amortized impact to IMR from these allocations separately between gains and losses. This disclosure shall illustrate the removal of these balances from the total general account IMR to determine the net negative amount that is permitted to be admitted under paragraph 9.b.
- b. Reporting entities shall complete a note disclosure that details the gross negative (disallowed) IMR, the amounts of negative IMR admitted and nonadmitted, adjusted capital and surplus per paragraph 9.a. and the percentage of adjusted capital and surplus for which the admitted negative IMR represents.

12. The provisions in this interpretation intend to be specific on the following prohibitions:

- a. Negative IMR permitted to be admitted shall not include losses from derivatives that were reported at fair value prior to settlement / termination / expiration / closing of the derivative. (Only derivative losses from derivatives that qualified as effective hedges (and reported under ‘hedge accounting’ as detailed in *SSAP No. 86—Derivatives*), which hedged an item that had offsetting adjustments to IMR, are permitted to be included in the admittance calculation.) The allocation of derivative losses to IMR, for derivatives held at fair value and were not offset by a hedged asset that was also subject to IMR, is not in line with the original intent of the IMR guidance in *SSAP No. 86* or the annual statement instructions.

¹ It has been identified that some reporting entities have allocated derivative losses to IMR for derivatives that were reported at fair value throughout the derivative life, as they did not qualify as effective hedges under statutory accounting, and that were not hedging assets with offsetting amounts to the IMR. As detailed in paragraph 9.b., these losses shall be removed from the IMR balance in determining the net negative (disallowed) IMR balance permissible for admittance.

Consideration of this industry interpretation and clarification of derivatives through the IMR will be addressed as part of the long-term proposal.

- b. The admittance of net negative (disallowed) IMR in the general account shall have no impact on the reporting of IMR in the separate account. The comparison of general account and separate account IMR shall occur on the gross positive and negative balances prior to any admittance in the general account. Disallowed negative IMR in the separate account shall continue to be fully disallowed as a direct charge to surplus. The IMR annual statement instructions predate current guidance that requires insulated and non-insulated separate account blanks. Consideration of separate account treatment of IMR will be addressed in a long-term proposal that will assess the concepts of insulated separate accounts and whether the balances of the general account shall have any influence on how IMR shall be reported in those separate account statements.

INT 23-01T Status

13. The consensuses in this interpretation were adopted on _____, to provide limited-time exception guidance to SSAP No. 7 and the annual statement instruction for the reporting of negative (disallowed) IMR in the general account. The provisions within this interpretation are permitted until _____ and will be automatically nullified on _____.

14. Further discussion is planned.

[https://naiconline.sharepoint.com/sites/naicsupportstaffhub/member meetings/e cmte/apptf/2023-2 summer/sapwg/attachments/att1b1-int 23-01t-imr.docx](https://naiconline.sharepoint.com/sites/naicsupportstaffhub/member%20meetings/e%20cmte/apptf/2023-2%20summer/sapwg/attachments/att1b1-int%2023-01t-imr.docx)

**Statutory Accounting Principles (E) Working Group
Maintenance Agenda Submission Form
Form A**

Issue: Negative IMR**Check (applicable entity):**

	P/C	Life	Health
Modification of Existing SSAP	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
New Issue or SSAP	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Interpretation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Description of Issue: This agenda item has been developed to discuss the interest maintenance reserve (IMR) within statutory accounting, specifically the current guidance for the nonadmittance of disallowed negative IMR. Although the statutory accounting guidance has been in place for several years, the rising interest rate environment has created an increased likelihood for reporting entities to move to a negative IMR position. This agenda item intends to provide information on the background of IMR, current accounting guidance, recent discussions of the Life Actuarial (A) Task Force and some broad financial results from year-end 2021 and interim 2022 financial statements. The intent is to provide this information to facilitate Working Group discussion.

The following provides a high-level overview of the use of the terms positive IMR and negative IMR for entities filing the Life, Accident & Health / Fraternal annual statement blank:

- A positive IMR means that the net realized interest related gains which are amortized in the IMR calculation are greater than net realized interest related losses which are being amortized in the IMR calculation. A positive IMR is reported as a statutory liability and amortized to income over time.
- A negative IMR means that net realized interest related losses which are amortized in the IMR calculation are greater than net realized interested related gains which are amortized in the IMR calculation. A disallowed negative IMR is reported as a nonadmitted asset and amortized to income as a loss over time.

As IMR occurs in the general and separate account, there are specific guidelines in determining whether the IMR reflects a net disallowed negative or position in the annual statement instructions. These are on page 5.

A letter from the American Council of Life Insurers (ACLI) dated Oct. 31, 2022, raised concerns with existing statutory accounting requirements on the nonadmittance of disallowed negative IMR noting negative ramifications for insurers. Key summarized positions from this ACLI letter include:

- In general, rising interest rates are favorable to the financial health of the insurance industry and policyholders. However, with negative IMR, there is an inappropriate perception of decreased financial strength through lower surplus and risk-based capital.
- Negative IMR could impact the rating agency view of the industry or incentivize companies to avoid prudent investment transactions that are necessary to avoid mismatches between assets and liabilities. In either scenario, negative IMR encourages short-term non-economic activity that is not in the best long-term interest of a reporting entity's financial health or its policyholders.

Background of IMR

The IMR was first effective in statutory accounting in 1992 and requires that a realized fixed income gains or losses attributable to changes in interest rates (excluding gains/losses that are credit related), be amortized into income over the remaining term to maturity of the fixed-income investments (and related hedging programs) sold rather than being reflected in income immediately.

Minutes, including adopted materials – in the Blue Book (Life Statement), from the 2002 4th Quarter NAIC Proceedings discussing IMR are provided below. Please note the last section that includes “Future Directions” which identifies recognition of negative IMR as a major area of effort.

Description and other components of IMR from the Blue Book, captured in the 2002 4th Quarter NAIC Proceedings, provides the following definition and other details: (*Only key excerpts included.*)

The Interest Maintenance Reserve (IMR): captures for all types of fixed income investments, all of the realized capital gains and losses which result from changes in the overall level of interest rates as they occur. Once captured, these capital gains or losses are amortized into income over the remaining life (period to maturity) of the investments sold. Realized gains and losses on derivative investments, which alter the interest rate characteristics of assets/liabilities, also are allocated to the IMR and are to be amortized into income over the life of the associated assets/liabilities. Note: certain significant unusual transactions may require immediate recognition of any realized capital gains or losses, as described in a later section. This reserve is not subject to any maximum.

VII. IMR MINIMUMS/MAXIMUMS: A. Minimums: **The IMR can be negative for any line of business as long as the aggregate IMR for the Company is not less than zero. Any otherwise negative IMR value is carried over to subsequent years.** B. Maximums: There is no maximum of the IMR

VIII. BACKGROUND/PERSPECTIVE: To insure solvency of a company, its assets should be invested so that the company has a very high probability of paying its contractual liabilities when they become due. In order to assess whether a company is able to fulfill its obligations, it must present its liabilities and assets on a financially integrated basis. Since the accounting practices prescribed for the life insurance annual statement are an important element in this discipline, it is imperative that the accounting practices be consistent for assets and liabilities. If they are inconsistent, then the annual statement will not reveal whether assets exceed liabilities; more importantly, neither regulators nor management can determine the risk of insolvency for the company.

The Valuation Actuary’s Opinion includes a statement that the assets backing the liabilities make adequate provision for the company’s liabilities. That is, the Actuary must look beyond the statutory valuation formulas and satisfy himself that the cash flows generated by the assets will probably be sufficient to discharge the liabilities. Prior to the AVR and IMR, there were many circumstances under which the statutory formula valuation methods gave rise to inappropriate results. Some examples were:

- Changes in values due to interest rate swings were recognized inconsistently on the asset and liability sides of the balance sheet. Liabilities are valued using interest rates fixed at issue while some assets may be valued using current interest rates through trading activity.
- When the assets are poorly matched to the liabilities, a significant adverse swing in the interest rates will reduce financial strength and could lead to insolvency even though the balance sheet value of the assets exceeds the balance sheet value of the liabilities. Using long term assets to back demand liabilities is dangerous if there is a significant upswing in interest rates. In addition, individual insurance premiums are received and invested for many years after the issue date on which the reserve interest rate is determined, creating a potential for inadequate yields that is not reflected in standard accounting procedures.
- The potential for future asset losses was not well reflected in the balance sheet or earnings statement.

It is desirable that the valuation of the assets and liabilities be made as consistent as possible to 1) minimize the instances where, in order to render a clean opinion, the actuary must establish extra reserves due to interest rate gains or potential for defaults and 2) increase the likelihood that assets supporting liabilities are sufficient even in the absence of an Actuarial Opinion. The development of an AVR and IMR will correct many of these deficiencies in consistency.

XII. AVR AND IMR BUILT ON AND COMPLEMENT EXISTING VALUATION PRACTICES: The existing framework of asset and liability valuation practices, as augmented by the NAIC Model Standard Valuation Law, played a key role in designing the AVR and IMR, including:

A. Reserve valuation standards should contain a provision for future losses. Although it is well understood that in cash flow testing provision must be made for future asset losses, it may not be as well understood that historically the minimum valuation standards implicitly contained such a provision.

B. Interest assumptions in reserve valuation generally recognize the potential for mismatch. Dynamic valuation rates are lower for ordinary life than for guaranteed investment contracts, for example, because the mismatch is almost inevitable on the former. In addition, it is required in other regulations, and in the NAIC Model Standard Valuation Law, that cash flow testing should be used and may result in the adoption of lower than the dynamic valuation rates if mismatch exists. Hence, with the one exception noted in section (c), there is no need for the IMR reserves to make provision for the risk of mismatch.

C. Asset valuations for fixed interest securities usually reflect the outlook at the time of purchase of an asset. In particular, bond amortization tends to reflect the yields available at time of purchase and the expected cash flow. Liabilities are established at the same time, and the interest rate assumptions on them are those appropriate to the outlook at that time. **But if securities are traded, a new amortization schedule is established that may be based on an entirely different yield environment, which may not be consistent with the liabilities that have been established. Using the IMR to absorb trading gains is desirable and appropriate to eliminate this subsequently created mismatch.**

D. Equities present special valuation problems. Common stocks are valued at market rather than amortized value; hence they require different treatment. Real estate and similar investments, although usually valued at depreciated value, require special consideration because of the great likelihood of major changes in yield and yield expectation after purchase.

XXII. RESERVE MAXIMUM AND MINIMUM LEVELS: No maximum is placed on the Interest Maintenance Reserve. The aggregate minimum value for the IMR for the Company is zero. The IMR may be negative for any Line of Business as long as the aggregate for all lines equals zero. Provision is made in the accounting rules that if an aggregate negative IMR is developed in the absence of the zero minimum, that negative value is carried over to subsequent years.

The basic rationale for the IMR would conclude that neither a maximum nor a minimum is appropriate. If the liability values are based on the assumption that the assets were purchased at about the same time as the liabilities were established, then there should be no bounds to the reserve which corrects for departures from that assumption; if a company has to set up a large reserve because of trading gains, it is in no worse position than if it had held the original assets. As for negative values of the IMR, the same rationale applies. However, the concept of a negative reserve in the aggregate has not been adopted.

XXVIII. EXCESSIVE WITHDRAWALS:

A. Background: Major book-value withdrawals or increases in policy loans can occur at a time of elevated interest rates. If these withdrawals or increases are far in excess of the withdrawals provided for in the company's reserving and cash flow testing, and **if asset sales at this point are, in effect, forced**

sales to fund liabilities that are no longer on the books, the allocation of a negative amount to the IMR is not correct.

A company may also experience a “run on the bank” due to adverse publicity. This could occur even during a period of low interest rates, and the sale of assets to meet a run would conceivably produce gains. It is appropriate to register the gains immediately.

If the withdrawals were scheduled payments under a GIC, then there is a presumption that any gains or losses that might occur at the time of withdrawal should be added to the IMR since the gains or losses would be spurious if the company has followed a policy of matching its assets to its liabilities. Note that many of the situations where an upsurge in withdrawal activity generates real losses arise when a company has a severe mismatch between its assets and its liabilities. Such losses can be present even in the absence of any realized gains or losses. The primary protection as to the adequacy of reserves in these circumstances is the requirement for an actuary’s opinion.

- B. IMR Exclusions: All realized interest-related gains or losses which arise from the sale of investments required to meet “Excess Withdrawal Activity” as defined below will be excluded from the IMR and will be reflected in net income.

STANDARDS FOR ACTUARIAL RESERVES WITH AN IMR AND AN AVR

LXX. IMR RESERVE STANDARD The Interest Maintenance Reserve is a true actuarial reserve, and actuaries should use the assets supporting the Interest Maintenance Reserve when opining that the assets supporting the company’s reserves make adequate provision for the company’s obligations. **In the case of a negative IMR, the actuarial opinion should include an explicit statement that the impact of the negative IMR on reserve adequacy has been considered and that the reserves after deduction of the negative IMR still make adequate provision for the liabilities.**

LXXI. GENERAL EXPLANATION The IMR is designed to work with minimum statutory reserves based on formulas contained in laws or regulations. Where, for example, the valuation rate is based on the interest rate conditions prevailing in the year of deposit, the assets supporting the liabilities will be consistent with the liability assumptions. Disposal of the assets during a period of declining interest rates will produce interest-related gains, but these gains will be needed to support the liabilities that are still valued at the interest rate levels prevailing at time of deposit. Thus, it is appropriate in the case of positive IMR to treat the IMR as an additional reserve requirement above and beyond formula minimums.

In cash-flow-testing actuaries take future cash flows into account from existing assets. In an example such as described above, existing assets may well have been purchased at rates below those prevailing at the time reserves were established. The positive IMR that has been built up has captured the gains and not allowed them to be available for distribution. The IMR is recognized as part of the reserves available to meet future obligation cash flows.

Thus from either point of view a positive IMR is treated as a true actuarial reserve. The same arguments should apply equally well in the case of a negative IMR, but some concern has been expressed that in this case the net reserves are in effect lower than statutory formulas minimums, and therefore special considerations are required.

FUTURE DIRECTIONS

In late 2002, the interested persons (as its name had become) considered refinements of the AVR/IMR for the next several years, from that vantage point, some of the major areas of effort appear to be as follows:

- 1. There should be recognition of negative values of the IMR. The group had long recognized that the philosophical basis for the IMR supports negative values of the reserve as well as positive.**

There is a need to have investment return match the liabilities associated with the investment; and a need to remove the incentive for a company to make investment decisions based on the shortterm balance sheet effect; and these needs exist also on the negative side of the IMR.

No doubt there are concerns that a negative reserve of this type could somehow lead to an unsound condition, so there has been appended to this report a discussion entitled “Why Are Negative Values For the IMR Necessary?” It also seems as though there should be additional safeguards in the case of a negative IMR. Rather than put arbitrary limits on the amount of the negative reserve, however, consideration is being given to an actuary’s statement that an asset adequacy analysis has been carried out that demonstrates the soundness of the reserves.

(Staff Note: The NAIC library does not have a record of the report noted in the above paragraph.)

Current Accounting Guidance

The statutory accounting guidance for IMR (and the Asset Valuation Reserve – AVR) is within *SSAP No. 7—Asset Valuation Reserve and Interest Maintenance Reserve*, but the guidance within that SSAP is very limited. It provides a general description, identifies that IMR/AVR shall be calculated and reported per the guidance in the applicable SSAP, and if not explicit in the SSAP, in accordance with the Annual Statement Instructions. The SSAPs most often simply direct allocation to (or between) IMR and AVR, with the bulk of the guidance within the Annual Statement Instructions.

The guidance in the Annual Statement instructions provides information on the net IMR balance, which takes into consideration both the positive and negative balances in the general and separate accounts. As detailed, disallowed negative IMR is reported so that it is a direct reduction to surplus on the Summary of Operations, page 4, line 41 change in nonadmitted assets:

Line 6 – Reserve as of December 31, Current Year

Record any positive or allowable negative balance in the liability line captioned “Interest Maintenance Reserve” on Page 3, Line 9.4 of the General Account Statement and Line 3 of the Separate Accounts Statement. A negative IMR balance may be recorded as a negative liability in either the General Account or the Separate Accounts Statement of a company only to the extent that it is covered or offset by a positive IMR liability in the other statement.

If there is any disallowed negative IMR balance in the General Account Statement, include the change in the disallowed portion in Page 4, Line 41 so that the change will be appropriately charged or credited to the Capital and Surplus Account on Page 4. If there is any disallowed negative IMR balance in the Separate Accounts Statement, determine the change in the disallowed portion (prior year less current year disallowed portions), and make a direct charge or credit to the surplus account for the “Change in Disallowed Interest Maintenance Reserve” in the write-in line, in the Surplus Account on Page 4 of the Separate Accounts Statement.

The following information is presented to assist in determining the proper accounting:

<u>General Account IMR Balance</u>	<u>Separate Account IMR Balance</u>	<u>Net IMR Balance</u>
Positive	Positive	Positive (See rule a)
Negative	Negative	Negative (See rule b)

Positive	Negative	Positive (See rule c)
Positive	Negative	Negative (See rule d)
Negative	Positive	Positive (See rule e)
Negative	Positive	Negative (See rule f)

Rules:

- a. If both balances are positive, then report each as a liability in its respective statement.
- b. If both balances are negative, then no portion of the negative balances is allowable as a negative liability in either statement. Report a zero for the IMR liability in each statement and follow the above instructions for handling disallowed negative IMR balances in each statement.
- c. If the general account balance is positive, the separate accounts balance is negative and the combined net balance is positive, then all of the negative IMR balance is allowable as a negative liability in the Separate Accounts Statement.
- d. If the general account balance is positive, the separate account balance is negative, and the combined net balance is negative, then the negative amount not covered by the positive amount is not allowable. Report only the allowable portion as a negative liability in the Separate Accounts Statement and follow the above instructions for handling the disallowed portion of negative IMR balances in the Separate Accounts Statement.
- e. If the general account balance is negative, the separate account balance is positive, and the combined net balance is positive, then all of the negative IMR balance is allowable as a negative liability in the General Account Statement.
- f. If the general account balance is negative, the separate account balance is positive, and the combined net balance is negative, then the negative amount not covered by the positive amount is not allowable. Report only the allowable portion as a negative liability in the General Account Statement and follow the above instructions for handling the disallowed portion of negative IMR balances in the General Account Statement.

The Statutory Accounting Statement of Concepts in the Preamble to the AP&P provides the following on Recognition:

Recognition

35. The principal focus of solvency measurement is determination of financial condition through analysis of the balance sheet. However, protection of the policyholders can only be maintained through continued monitoring of the financial condition of the insurance enterprise. Operating performance is another indicator of an enterprise's ability to maintain itself as a going concern. Accordingly, the income statement is a secondary focus of statutory accounting and should not be diminished in importance to the extent contemplated by a liquidation basis of accounting.

36. The ability to meet policyholder obligations is predicated on the existence of readily marketable assets available when both current and future obligations are due. Assets having economic value other than those which can be used to fulfill policyholder obligations, or those assets which are unavailable due to encumbrances or other third party interests should not be recognized on the balance sheet but rather should be charged against surplus when acquired or when availability otherwise becomes questionable.

37. Liabilities require recognition as they are incurred. Certain statutorily mandated liabilities may also be required to arrive at conservative estimates of liabilities and probable loss contingencies (e.g., interest maintenance reserves, asset valuation reserves, and others).

Life Actuarial (A) Task Force 2022 Guidance

The Life Actuarial (A) Task Force considered comments from the ACLI that the inclusion of a negative IMR balance in asset adequacy testing, the disallowance of a negative IMR could result in double counting of losses (i.e., through the disallowance on the balance sheet and the potential AAT-related reserve deficiency). The Task Force identified that VM-20 Section 7.D.7.b notes that "...the company shall use a reasonable approach to allocate any portion of the total company balance that is disallowable under statutory accounting procedures (i.e., when the total company balance is an asset rather than a liability)." Question 22 of the AAA's Asset Adequacy Practice Note (Attachment 2) states that "... a negative IMR is not an admitted asset in the annual statement. So, some actuaries do not reflect a negative value of IMR in the liabilities used for asset adequacy analysis." However, Question 22 also notes a 2012 survey data that showed varying practices across companies, including some companies that allocated negative IMR.

On Nov. 17, 2022, in order to assist state regulators in achieving uniform outcomes for year-end 2022, the Task Force exposed guidance until November 30, 2022:

Recommendation In order to assist state regulators in achieving uniform outcomes for year-end 2022, we have the following recommendation: the allocation of IMR in VM-20, VM-21, and VM-30 should be principle-based, "appropriate", and "reasonable". Companies are not required to allocate any non-admitted portion of IMR (or PIMR, as applicable) for purposes of VM-20, VM-21, and VM-30, as being consistent with the asset handling for the nonadmitted portion of IMR would be part of a principle-based, reasonable and appropriate allocation. However, if a company was granted a permitted practice to admit negative IMR as an asset, the company should allocate the formerly non-admitted portion of negative IMR, as again a principle-based, reasonable and appropriate IMR allocation would be consistent with the handling of the IMR asset. This recommended guidance is for year-end 2022, to address the current uncertainty and concerns with the "double-counting" of losses. This recommended guidance will help ensure consistency between states and between life insurers in this volatile rate environment. Refinement of this guidance may be considered beyond year-end 2022.

The Oct. 31, 2022 ACLI Letter also identified the following references to IMR in the valuation manual and Risk-Based Capital Calculations:

Regulation	Use	IMR references
Actuarial Opinion and Memorandum Regulation (VM-30)	Asset adequacy analysis for annual reserve opinion	An appropriate allocation of assets in the amount of the IMR, whether positive or negative, shall be used in any asset adequacy analysis.
Life principle-based reserves (VM-20)	Calculation of deterministic reserve	Calculate the deterministic reserve equal to the actuarial present value of benefits, expenses, and related amounts less the actuarial present value of premiums and related amounts, less the positive or negative pre-tax IMR balance at the valuation date allocated to the

		group of one or more policies being modeled
Life principle-based reserves (VM-20)	Calculation of stochastic reserve	Add the CTE amount (D) plus any additional amount (E) less the positive or negative pre-tax IMR balance allocated to the group of one or more policies being modeled
Variable annuities principle-based reserves (VM-21)	Reserving for variable annuities	The IMR shall be handled consistently with the treatment in the company's cash-flow testing, and the amounts should be adjusted to a pre-tax basis.
C3 Phase 1 (Interest rate risk capital)	RBC for fixed annuities and single premium life	IMR assets should be used for C3 modeling.

Assessment of 2020-2022 IMR Balances:

Note – The following amounts reflect the general account IMR Reserve balance. (This is the amount shown as a liability and shows the decrease in the positive IMR reported since 2020.) This detail does not show the disallowed negative IMR reported as an asset and nonadmitted. Also, information on the separate account IMR, which is a factor in determining in disallowed negative IMR, will not be known until the year-end financial statements are filed (March 1, 2023).

	GA 2022 – Q3	GA 2022 – Q2	GA 2022 – Q1	GA YE – 2021	GA YE – 2020
Aggregate IMR	27,601,001,445	31,859,274,989	37,697,176,149	40,598,068,038	35,229,578,726
Change from Prior	(4,258,273,544)	(5,837,901,160)	(2,900,891,889)	5,368,489,312	
% Change	(13.4%)	(21.5%)	(7.1%)	15.2%	

Review of GA IMR Reserve Decrease:

- From the first quarter (Q1) to second quarter (Q2), 25 companies had decreases in the IMR reserve balance over \$50M totaling \$4,717,657,986, representing 80% of the overall change. 13 of these companies had decreases of IMR over \$100M, totaling \$3,959,569,339, representing 68% of the change. Four of these companies had decreases of IMR over \$400M. One of these companies reported a zero IMR liability and reported a disallowed IMR on the asset page of approx. \$570M.
- From the first quarter (Q1) to second quarter (Q2), 49 companies increased their prior reported positive IMR by \$61,390,564. From the second quarter (Q2) to third quarter (Q3), 56 companies increase their prior reported positive IMR by \$60,316,403
- From the second quarter (Q2) to third quarter (Q3), 16 companies had decreases in the IMR reserve balance over \$50M totaling \$3,161,570,362, representing 74% of the change. 8 of these companies had decreases of IMR over \$100M, totaling \$2,580,832,015, representing 60% of the change. All of these companies were still in a net positive IMR position.
- For the 30 companies that reflected the largest decline in reported IMR between the first to second quarter and then the second to third quarter, the following key details are noted.
 - From the first (Q1) to second quarter (Q2), the top 30 companies reflected a decrease in \$4,923,166,733, which is 84% of the total decrease.
 - From the second (Q2) to third quarter (Q3), the top 30 companies reflected a decrease in \$3,642,088,165, which is 85.5% of the total decrease.
 - 19 companies were noted as being in the population for both periods. 29 of the 30 companies reported a net positive IMR in the third quarter. One company reported a zero IMR in Q3.
- For the 15 companies that had the largest declines between the first quarter (Q1) to second quarter (Q2), eight of those companies also had the largest declines from second quarter (Q2) to third quarter (Q3).
- A limited number of companies are reporting a negative IMR on the liabilities side. Seven companies reported a net negative IMR balance in the third quarter (Q3) for a total of 11,031,998. One company made up \$10.5M of the aggregate balance and this company initially went negative in the second quarter (Q2).

Six companies reported a net negative IMR balance for Q2 for a total of \$9,815,594. (The other companies with negative IMR were immaterial amounts.) *(Under the guidance in the A/S instructions, these companies should stop at zero and report the negative as disallowed nonadmitted asset.)*

Review of Disallowed IMR:

Although the assessment of the liability balance shows the decrease in positive IMR, it no longer tracks the decline for companies that go negative, as the reserve balance on the liability page should stop at zero. (This info may be identifiable from the IMR schedule, but not within the quarterly financials from a review of the IMR reported on the liability page.) As such, NAIC staff completed a review of the data to identify the companies that moved to a zero balance (from a prior positive balance) at year-end 2021 or in the 2022 quarters:

Companies that moved from a positive IMR (liability) to a zero balance:

- Initially went to zero in 2022 – Q3: 20 companies
- Initially went to zero in 2022 – Q2: 20 companies
- Initially went to zero in 2022 – Q1: 11 companies
- Initially went to zero YE 2021 – 20 companies (This is a comparison to YE 2020.)

For these 71 companies, NAIC staff has completed a manual review to the 2022 third quarter financial statements to determine if a disallowed IMR was reported as an aggregate write-in on the asset page. For these companies, 60 were identified with a disallowed IMR for a total of \$1 Billion as of the third quarter 2022.

Existing Authoritative Literature:

SSAP Authoritative Guidance:

- *SSAP No. 7—Asset Valuation Reserve and Interest Maintenance Reserve*
- Life Annual Statement Instructions

(Guidance included as part of discussion.)

Activity to Date (issues previously addressed by the Working Group, Emerging Accounting Issues (E) Working Group, SEC, FASB, other State Departments of Insurance or other NAIC groups):

- Nov. 17, 2022, Discussion by Life Actuarial (A) Task Force as discussed above.

Information or issues (included in *Description of Issue*) not previously contemplated by the Working Group:
None

Convergence with International Financial Reporting Standards (IFRS): NA

Recommendation:

NAIC staff recommend that the Working Group include this item on their maintenance agenda as a New SAP Concept for discussion to assess the current guidance for disallowed negative IMR. NAIC staff recommend that at the Working Group's conclusion, documentation of the discussion, and resulting decisions, be captured for historical purposes in an Issue Paper.

Staff Review Completed by: Julie Gann - NAIC Staff, November 2022

Status:

On December 13, 2022, the Statutory Accounting Principles (E) Working Group moved this agenda item to the active listing, categorized as a New SAP Concept and exposed the agenda item with a request for comments by industry on potential guardrails and details on unique considerations. The Working Group directed NAIC staff to coordinate with the Life Actuarial (A) Task Force and request regulator-only sessions with industry to receive specific company information.

On March 22, 2023, the Statutory Accounting Principles (E) Working Group directed NAIC staff regarding the consideration of negative interest maintenance reserve (IMR) with an intent to work on both a 2023 solution and a long-term solution as follows:

- a. Draft a referral to the Life Actuarial (A) Task Force on further consideration of the asset adequacy implications of negative IMR. Items to include: 1) developing a template for reporting within asset adequacy testing (AAT); 2) considering the actual amount of negative IMR that is admitted to be used in the AAT; 3) better consideration of cash flows within AAT (and documentation), as well as any liquidity stress test (LST) considerations; 4) ensuring that excessive withdrawal considerations are consistent with actual data (sales of bonds because of excess withdrawals should not use the IMR process); and 5) ensuring that any guardrails for assumptions in the AAT are reasonable and consistent with other aspects.
- b. Draft a referral to the Capital Adequacy (E) Task Force for the consideration of eliminating any admitted net negative IMR from total adjusted capital (TAC) and the consideration of sensitivity testing with and without negative IMR.
- c. Develop guidance for future Working Group consideration that would allow the admission of negative IMR up to 5% of surplus using the type of limitation calculation similar to that used for goodwill admittance. The guidance should also provide for a downward adjustment if RBC ratio is less than 300.
- d. Review and provide updates on any annual statement instructions for excess withdraws, related bond gains/losses and non-effective hedge gains/losses to clarify that those related gains/losses are through asset valuation reserve (AVR), not IMR.
- e. Develop accounting and reporting guidance to require the use of a special surplus (account or line) for net negative IMR.
- f. Develop governance related documentation to ensure sales of bonds are reinvested in other bonds.
- g. Develop a footnote disclosure for quarterly and annual reporting.

On April 10, 2023, the Working Group exposed a limited-time, optional INT to allow admittance of net negative (disallowed) IMR in the general account up to 5% of adjusted capital and surplus. The exposed INT proposed restrictions on what is permitted to be captured in the net negative IMR balance eligible for admittance as well as reporting and disclosure requirements.



MEMORANDUM

TO: Dale Bruggeman, Chair of the Statutory Accounting Principles (E) Working Group
Kevin Clark, Vice-Chair of the Statutory Accounting Principles (E) Working Group

FROM: Rachel Hemphill, Chair, Life Actuarial (A) Task Force
Craig Chupp, Vice-Chair, Life Actuarial (A) Task Force

RE: Life Actuarial (A) Task Force Response on Negative IMR

DATE: June 15, 2023

Background

On March 27, 2023 a memorandum from the Statutory Accounting Principles (E) Working Group (SAPWG) was received by the Life Actuarial (A) Task Force (LATF) with a referral for consideration of the Asset Adequacy Testing (AAT) implications of negative IMR. Specifically, the Working Group recommended a referral to the Task Force to consider the following:

1. Development of a template summarizing how IMR (positive and negative) is reflected within AAT.
2. Consideration of the actual amount of negative IMR that is to be used in AAT, noting that as negative IMR is included, there is a greater potential for an AAT liability.
3. Better consideration and documentation of cash flows within AAT, as well as any liquidity stress test considerations.
4. Ensuring that excessive withdrawal considerations are consistent with actual data. (Insurers selling bonds because of excess withdrawals should not use the IMR process.)
5. Ensuring that any guardrails for assumptions in AAT are reasonable and consistent with other financial statement / reserving assumptions.

Recommendation

On its April 27th call, LATF discussed the referral from SAPWG. LATF agreed on the following actions:

Develop IMR Template

LATF is drafting a template with additional disclosures on the reflection of IMR in Principle-Based Reserving (PBR) and AAT. We have requested input from the American Academy of Actuaries and the American Council of Life

Washington, DC 444 North Capitol Street NW, Suite 700, Washington, DC 20001-1509	p | 202 471 3990	f | 816 460 7493
Kansas City 1100 Walnut Street NW, Suite 1500, Kansas City, MO 64106-2197	p | 816 842 3600	f | 816 783 8175
New York One New York Plaza, Suite 4210, New York, NY 20004	p | 212 398 9000	f | 212 382 4207

www.naic.org

Insurers on a potential template. The template's disclosures would aim to support verification of the requirements SAPWG is considering for potential admittance of negative IMR, including confirming:

1. That IMR is appropriately allocated for PBR and AAT,
2. That any negative IMR amounts reflected in starting assets do not generate income and so increase reserves in PBR and/or decrease reserve sufficiency in AAT,
3. That admitted negative IMR does not reflect bonds sold due to historical or anticipated future excess withdrawals, and
4. That admitted negative IMR only reflects bonds sold and replaced with similar bonds.

For items three and four above, we note that while LATF can request verification and justification from companies, this may be difficult for companies to demonstrate. For item three, we can require additional disclosures including actual to expected experience for withdrawals. For item four, it is not yet clear what verification companies could provide.

This template would be optional but recommended starting with 2023 reporting and could be required starting in 2025. Individual regulators could request this information during reviews if warranted before 2025.

Issue Guidance on Consistency

LATF is drafting guidance for year-end 2023 and 2024, consistent with the guidance LATF issued for year-end 2022 but updated for SAPWG's potential admittance of some portion of aggregate negative IMR. That is, LATF continues to affirm that a principle-based, reasonable, and appropriate allocation of IMR for PBR and AAT would be consistent with handling of the IMR asset for statutory reporting. LATF will also consider an Amendment Proposal Form to make changes directly in the Valuation Manual to clarify the treatment of negative IMR starting with the 2025 Valuation Manual. This work continues to address the concern raised that there would be a "double hit" if negative IMR were not admitted while being required to be reflected in PBR and/or AAT.

Recommendation to SAPWG Regarding AAT

LATF recommends to SAPWG that any decision to admit or not admit aggregate negative IMR should not rely on AAT at this time. We wish to clarify that AAT is not formulaic, is heavily judgment-based, and generally does not contain prescriptive guardrails on that judgment, such as the reinvestment guardrail and other guardrails that apply in PBR. In response to specific concerns around a lack of consistency in AAT asset assumptions, Actuarial Guideline (AG) 53 was developed to provide regulators with additional disclosures, but again does not contain guardrails. AG 53 review work is currently under way. Moreover, this is not the only area where concerns could arise regarding the reliability of specific AAT results. We do not believe it would be appropriate to admit negative IMR if doing so was depending on AAT as the sole or primary safeguard for any related solvency concerns.

[https://naiconline.sharepoint.com/sites/naicsupportstaffhub/membermeetings/e/cmte/apptf/2023-2/summer/summaryandminutes/sapwg/attachments/att1b3-latf to sapwg referral.docx](https://naiconline.sharepoint.com/sites/naicsupportstaffhub/membermeetings/e/cmte/apptf/2023-2/summer/summaryandminutes/sapwg/attachments/att1b3-latf%20to%20sapwg%20referral.docx)



TO: Thomas Botsko, Chair, Capital Adequacy (E) Task Force
 Philip Barlow, Chair, Risk-Based Capital Investment Risk and Evaluation (E) Working Group
 Dale Bruggeman, Chair, Statutory Accounting Principles (E) Working Group

FROM: Carrie Mears, Chair, Valuation of Securities (E) Task Force

CC: Charles A. Therriault, Director, NAIC Securities Valuation Office (SVO)
 Marc Perlman, Managing Investment Counsel, NAIC Securities Valuation Office (SVO)
 Eric Kolchinsky, Director, NAIC Structured Securities Group (SSG) and Capital Markets Bureau
 Julie Gann, Assistant Director, NAIC Solvency Policy
 Dave Fleming, Sr. Life RBC Analyst, NAIC Financial Regulatory Affairs
 Eva Yeung, Sr. P/C RBC Analyst/Technical Lead, NAIC Financial Regulatory Affairs

RE: Referral regarding a Proposed Amendment to Update the Definition of an NAIC Designation in the Purposes and Procedures Manual of the NAIC Investment Analysis Office (P&P Manual)

DATE: June 1, 2023

Summary – The Valuation of Securities (E) Task Force (VOSTF) requested that the Securities Valuation Office (SVO) staff make a comprehensive review of the definition of an NAIC Designation in the P&P Manual. The SVO identified that there are portions of the definition in both Parts One and Two some of which are redundant. In addition to the redundancy, this splitting of the definition has led to some users to the interpretation that there are two meanings of an NAIC Designation: one meaning, found in Part One, applicable to all securities, whether assigned NAIC Designations pursuant to the Filing Exemption process or by the SVO and a second meaning, found in Part Two, applicable only to securities assigned NAIC Designations by the SVO. It is the SVO staff's belief that there is only one definition of an NAIC Designation and that it is applicable however the NAIC Designation is assigned. The revisions proposed in the amendment, which is included with this referral, reflect a consolidation of the instructions that define an NAIC Designation to make a single uniform definition. It also includes updates to the definition to address questions and concerns raised about the purpose of NAIC Designations versus credit rating provider ratings. Additionally, the SVO is recommending consolidating the current "NAIC Designation Subscript S" section in Part Two into the revised NAIC Designation section in Part One because the application of a Subscript S to an NAIC Designation for other non-payment risks signifies a change in the meaning of the NAIC Designation and is a policy of the Task Force.

The majority of this proposed amendment involves moving text from Part Two, the "*Operational and Administrative Instructions Applicable to the SVO*", into Part One, the "*Policies of the NAIC Valuation of Securities (E) Task Force*". A clean version of the amendment was included to simplify the review, with the new text also clearly highlighted.

Referral Request – Given the importance of NAIC Designations in quantifying investment risk for various NAIC regulatory purposes and guidance, the Task Force is sending this referral with a request that your groups consider the revised definition and assess whether or not it meets your needs. If the definition meets your needs, please informally let the SVO staff know that no response will be submitted. If the definition does not meet your needs, please notify the SVO staff by June 29th that you will be proposing modification to the definition and we request that you submit those modification or a request for

additional time by July 31st so that the revisions or matter can be considered and discussed at the NAIC's Summer National Meeting. Thank you for your consideration of this request.

Please contact Charles Therriault or Marc Perlman with any questions.

<https://naiconline.sharepoint.com/teams/SVOVOSTaskForce/Shared Documents/Meetings/2023/Referrals/To CATF and SAPWG/VOSTF Referral to SAPWG CATF RBCIRE - NAIC Designation Def 2023-06-01.docx>

Draft: 5/25/23

Statutory Accounting Principles (E) Working Group
Virtual Meeting
May 16, 2023

The Statutory Accounting Principles (E) Working Group of the Accounting Practices and Procedures (E) Task Force met May 16, 2023. The following Working Group members participated: Dale Bruggeman, Chair (OH); Kevin Clark, Vice Chair (IA); Sheila Travis (AL); Kim Hudson (CA); William Arfanis and Michael Estabrook (CT); Rylynn Brown (DE); Stewart Guerin and Melissa Gibson (LA); Judy Weaver (MI); Doug Bartlett (NH); Bob Kasinow (NY); Diana Sherman and Matt Milford (PA); Jamie Walker (TX); and Doug Stolte and David Smith (VA).

1. Reviewed Comments on Exposed Items

a. INT 22-02

Bruggeman directed the Working Group to *Interpretation (INT) 22-02: Extension of INT 22-02 Through Second Quarter 2023*. Robin Marcotte (NAIC) stated that on April 12, the Working Group conducted an e-vote to expose *INT 22-02: Third Quarter 2022 through Second Quarter 2023 Reporting of the Inflation Reduction Act - Corporate Alternative Minimum Tax*. The exposure proposed to extend INT 22-02 from June 15 to July 1 to allow it to be applied to the second quarter of 2023 financial statements. Disclosures continue to be required. Marcotte stated that interested parties support the extension of INT 22-02, but they recommend that it be extended to Aug. 16, the day after the quarterly statements are due to be filed. She stated that NAIC staff recommend that the Working Group adopt the exposed INT 22-02 with a minor modification to incorporate the Aug. 16 extension date suggested by interested parties.

Hudson made a motion, seconded by Walker, to adopt INT 22-02 (Attachment One-C1) and its proposed extension from June 15 to Aug. 16. The motion passed unanimously.

b. Agenda Item 2023-03

Bruggeman directed the Working Group to agenda item 2023-03: C-2 Mortality Risk Note. Marcotte stated that the exposure proposes the addition of new financial statement notes that calculate the net amount at risk, which is used in the C-2 mortality risk charge calculation. She stated that the Blanks (E) Working Group proposal 2023-09BWG is being simultaneously exposed, and the Life Risk-Based Capital (E) Working Group is working on a project to modify its C-2 mortality risk charges. She stated that the purpose of the note was to provide the development of the net amount at risk and have financial statement links to the elements used in the risk-based capital (RBC) charge. She stated that comments from Connie Jasper Woodroof (CJW Associates) focused on possible redundancy issues in the proposed note because some items in the disclosure could currently be directly referenced from Exhibit 5 – Aggregate Reserve for Life Contracts or the similar Exhibit 3 – Aggregate Reserve of Life, Annuity and Accident and Health Contracts in the separate account statement. She stated that Woodroof recommended removing these elements from the proposal and noted that some of the elements in the exposure were not needed for the C-2 mortality risk charge. She stated that the interested parties' comments were focused on moving the proposed information out of the footnotes and to another location. She stated that NAIC staff reached out to the Life Risk-Based Capital (E) Working Group chair and its NAIC support staff, who confirmed that the annual statement notes for the 2023 year-end would be helpful, but they were not strictly necessary for the planned update to the C-2 mortality risk charges. She stated that NAIC staff recommend that the Statutory Accounting Principles (E) Working Group defer action on this agenda item and refer the comments received to the Life Risk-Based Capital (E) Working Group.

Rose Albrizio (Equitable) stated that interested parties believe this is something that should not be in Statements of Statutory Accounting Principles (SSAPs) or the annual statement footnotes because it is a data capture for the net amount of risk needed for the C-2 mortality risk. She stated that maybe it should be in the interrogatories if it is not currently available. She stated that interested parties reached the same conclusion that this would not impede their ability to do the C-2 mortality this year because the current format can be used to deliver the data.

Bruggeman stated that he does not have an issue with deferring this agenda item. In response to his inquiry, no other Statutory Accounting Principles (E) Working Group members noted a concern with deferral.

c. Agenda Item 2023-11EP

Bruggeman directed the Working Group to agenda item 2023-11-EP: AP&P Manual Editorial Updates. Julie Gann (NAIC) stated that at its March 23 meeting, the Working Group voted to expose various maintenance updates providing revisions to the *Accounting Practices and Procedures Manual* (AP&P Manual), such as editorial corrections, reference changes, and formatting. She stated that the primary revision to note was to *SSAP No. 86—Derivatives*. She stated that the change in the disclosure category from intrinsic value to volatility value was done because of a corresponding comment made to the Blanks (E) Working Group to improve that disclosure category. She stated that other editorial changes are to streamline references to the *Purposes and Procedures Manual of the NAIC Investment Analysis Office* (P&P Manual), as well as to address inconsistencies with how percentages are referenced—using a symbol (%) versus spelling out “percent.” She stated that interested parties support the changes. She stated that NAIC staff recommend that the Statutory Accounting Principles (E) Working Group adopt the exposed maintenance updates providing revisions to the AP&P Manual.

Weaver made a motion, seconded by Hudson, to adopt agenda item 2023-11EP (Attachment One-C2). The motion passed unanimously.

2. Exposed its Maintenance Agenda

Clark made a motion, seconded by Arfanis, to expose the following agenda items for a public comment period ending June 30. The motion passed unanimously.

a. Agenda Item 2023-12

Bruggeman directed the Working Group to agenda item 2023-12: Residuals in SSAP No. 48 Investments. Gann stated that this agenda item proposes revisions to clarify the scope and reporting for investments that represent residual interests that are not captured in the scope of *SSAP No. 43R—Loan-Backed and Structured Securities*. She stated that at the Spring National Meeting, there was a lot of discussion on how residual interests can exist in other investment structures and that previously adopted guidance only captured those that were in the scope of SSAP No. 43R, which requires those to be reported on Schedule BA – Other Long-Term Invested Assets on a dedicated reporting line for year-end 2022. She stated that the Working Group received a referral from the Valuation of Securities (E) Task Force. She stated that this agenda item is in response to that referral, as well as other discussions on this topic at the Spring National Meeting. She stated that the current population of residuals on the dedicated reporting line on Schedule BA may not reflect the entire population of residuals that are captured in other investment structures. She stated that this agenda item proposes to capture guidance in *SSAP No. 48—Joint Ventures, Partnerships and Limited Liability Companies*, so those investment structures would be separately reported on the residual line. The agenda item also has conforming edits to SSAP No. 43R and the *Annual Statement Instructions*. She stated that for those items that are not reported as residuals now because they are in the scope of SSAP No. 48, it is strictly a Schedule BA reporting line change because those items would currently

be under the joint venture, limited liability, or partnership line. Therefore, those investments that represent residuals will move to the Schedule BA residual line.

b. Agenda Item 2023-13

Bruggeman directed the Working Group to agenda item 2023-13: PIK Interest Disclosure Clarification. Gann stated that this agenda item was developed to further clarify and incorporate a practical expedient to the paid-in-kind (PIK) interest aggregate disclosure adopted in *SSAP No. 34—Investment Income Due and Accrued* for year-end 2023 that identifies the amount of PIK interest as a cumulative balance on an aggregate basis. She stated that since adoption, NAIC staff have received questions on how that should be calculated, whether it be on a first in, first out (FIFO) basis or a weighted average basis. She stated that this agenda item proposes clarifying revisions to ensure consistency in identifying the amount of PIK interest included in the cumulative principal par balance. She stated that it does not change accounting or any ultimate amounts reported as assets on the balance sheet or income statement. She stated that this identifies the amount of PIK interest that is still being reported as an asset. She stated that the recommendation is to identify that any paydowns that occur would first be applied to reported PIK interest. She stated that there is also a practical expedient that says one can identify the PIK interest from the original par through to the current par, not to go less than zero. She stated that this is to provide clarification to the investment software vendors who are asking if they had to do a retroactive analysis to identify all the PIK interest received and the paydowns. She responded that the answer is no, and the resulting calculation should be the same. She stated that NAIC staff proposed revisions in a footnote to *SSAP No. 34*; however, most of the edits are proposed for inclusion in the *Annual Statement Instructions*, are editorial only, and can be provided by the Working Group in a memorandum to the Blanks (E) Working Group if they are adopted after the deadline to include them in the *Annual Statement Instructions* for year-end 2023.

c. Agenda Item 2022-14

Bruggeman directed the Statutory Accounting Principles (E) Working Group to agenda item 2022-14: New Market Tax Credit Projects. Wil Oden (NAIC) stated that this agenda item was drafted in response to the federal Inflation Reduction Act and the subsequent issuance of *Accounting Standards Update (ASU) 2023-02—Investments—Equity Method and Joint Ventures (Topic 323): Accounting for Investments in Tax Credit Structures Using the Proportional Amortization Method (A Consensus of the Emerging Issues Task Force)*, which amends U.S. generally accepted accounting principles (GAAP) guidance on the application of the proportional amortization method (PAM) for income tax equity investments. He stated that based on direction from the Working Group and feedback received from interested parties, this agenda item now includes *SSAP No. 94R—Transferable and Non-Transferable State Tax Credits*, and it has expanded the scope of *SSAP No. 93—Low-Income Housing Tax Credit Property Investments*.

Oden stated that *SSAP No. 93* is proposed to include all qualifying tax credit investments, irrespective of the structure or tax credit program. He stated that this represents a departure from U.S. GAAP, as *ASU 2023-02* only applies to income tax equity investments that elect to use PAM. He stated that as part of the proposed revisions, both *SSAPs* are intended to work together. *SSAP No. 93* provides guidance on the tax investment itself, whereas *SSAP No. 94R* provides guidance on tax credits allocated from the investments and purchase tax credits.

Oden stated that the proposed scope of *SSAP No. 94R* has been expanded to include all state and federal tax credits, whether allocated or purchased. Additionally, the revised version proposes to amend the requirement to report tax credits at cost, which effectively results in an off-balance sheet asset for tax credits purchased at a discount. Oden stated that tax credits would now be recorded at face value upon receipt; acquisitions at a premium would immediately realize the loss; and acquisitions at a discount would defer the gain as an Other liability until the reporting entity has utilized tax credits in excess of those acquisition costs. He stated that NAIC

staff recommend that the Working Group expose the draft revisions to SSAP No. 93 and SSAP No. 94R as new SSAP concepts with a public comment period ending June 30.

3. Discussed Other Matters

a. Valuation of Securities (E) Task Force Referral Response

Gann stated that the Working Group reviewed the Valuation of Securities (E) Task Force referral on the acquisition of commercially available data and deemed that a response was not necessary.

b. Update on the Referral to the Life Actuarial (A) Task Force on Negative IMR

Hemphill stated that there are a few action items that the Life Actuarial (A) Task Force would take in response to this referral.

First, the Task Force is working on a template that will have additional disclosures on the reflection of interest maintenance reserve (IMR) in principle-based reserving (PBR) and asset adequacy testing (AAT). Those disclosures would support the verification of the requirements that the Working Group is considering for admittance of negative IMR, including: 1) the admitted IMR is appropriately allocated for PBR and AAT; 2) negative IMR is reflected in starting assets and would not generate subsequent income; and 3) that would increase reserves in PBR or decrease reserve sufficiency for AAT. Hemphill noted that the template would include verifications for the company that any admitted negative IMR not reflecting bonds sold due to historical or anticipated future excess withdrawals and bonds generating admitted negative IMR would only be those sold and replaced with similar bonds. She stated that the Task Force was outlining a potential template that is consistent with the current Working Group exposure. She stated that if there were changes by the Working Group, the template would be modified accordingly. She stated that due to the *Valuation Manual* timing constraints, this template would be optional but could be recommended starting with year-end 2023 reporting. The earliest it could be required would be 2025; although, individual state insurance regulators could request or require the information earlier. She stated that the Task Force was working on a draft and had requested input from the American Academy of Actuaries (Academy) and the American Council of Life Insurers (ACLI) on the template.

Second, Hemphill stated that the Task Force was drafting guidance for companies for year-end 2023 and 2024, consistent with what was put out for 2022, to address the potential double-counting issue. She stated that the Task Force was continuing to affirm that a principle-based, reasonable, and appropriate allocation of IMR for PBR and AAT would be consistent with the handling of the IMR asset for statutory reporting. She stated that the Task Force does not believe any double counting is required because the language currently in the *Valuation Manual* endorses a principle-based, appropriate allocation and so would not imply a double hit. This guidance would be for 2023 and 2024, as any change in the *Valuation Manual* at this time would be applicable for 2025. Hemphill stated that the Task Force would work on an amendment proposal form to make clarifying changes directly to the *Valuation Manual* so the Task Force does not have to keep producing guidance each year-end, noting that a principle-based, appropriate allocation does not require such double counting.

Finally, Hemphill stated that the Task Force recommends to the Working Group that any decision to admit or not admit aggregate negative IMR would not rely on AAT as a guardrail at this time. The Task Force wants to clarify that national AAT is not formulaic and is heavily judgment-based, without prescriptive guardrails on that judgment, such as with the reinvestment guardrail or other guardrails that apply in PBR. She stated that in response to the specific concerns around the lack of consistency in AAT asset assumptions, *Actuarial Guideline LIII—Application of the Valuation Manual for Testing the Adequacy of Life Insurer Reserves* (AG 53) was developed. She stated that AG 53 has additional disclosures but no prescriptive guardrails. She stated that the actuaries and

others are now working on reviewing initial AG 53 disclosures, but that it is not the only area where concerns could arise regarding the reliability of specific AAT assumptions or results. She stated that, in summary, the Task Force does not believe it would be appropriate to admit negative IMR if doing so depends on AAT as the sole or primary safeguard for any related solvency concerns. She stated that the Task Force has a few workstreams to work on over the upcoming months and would update the Working Group as it has additional work products.

Having no further business, the Statutory Accounting Principles (E) Working Group adjourned.

[https://naiconline.sharepoint.com/sites/naicsupportstaffhub/member meetings/e cmte/apptf/2023-2 summer/sapwg/attachments/att1c-sapwg 5.16.23 minutes.docx](https://naiconline.sharepoint.com/sites/naicsupportstaffhub/member%20meetings/e%20cmte/apptf/2023-2%20summer/sapwg/attachments/att1c-sapwg%205.16.23%20minutes.docx)

Interpretation of the Statutory Accounting Principles (E) Working Group

INT 22-02: Third Quarter 2022 through ~~First~~Second Quarter 2023 Reporting of the Inflation Reduction Act - Corporate Alternative Minimum Tax

INT 22-02 Dates Discussed

October 6, 2022; October 24, 2022, November 16, 2022; December 13, 2022; [April 12, 2023](#); [May 16, 2023](#)

INT 22-02 References

Current:

SSAP No. 9—Subsequent Events

SSAP No. 101—Income Taxes

INT 22-02 Issue

Key Provisions of the Inflation Reduction Act

1. The Inflation Reduction Act (Act) was enacted on August 16, 2022, and included a new corporate alternative minimum tax (CAMT). The Act and the CAMT go into effect for tax years beginning after 2022. Reporting entities shall refer to the Act and the resulting regulations and other tax guidance to determine application, but a non-authoritative high-level summary based on information at the time of initial INT discussion regarding the CAMT is as follows:

- a. The CAMT is 15% of the corporation's "adjusted financial statement income" for the tax year, reduced by corporate alternative minimum foreign tax credit.
- b. The CAMT will only apply to "applicable corporations" (determined on an affiliated group basis) with average adjusted financial statement income in excess of \$1 billion for the three prior tax years. This threshold is reduced to \$100 million in the case of certain foreign-parented corporations. When a corporation becomes subject to the CAMT, it remains an applicable corporation for purposes of the CAMT, even if its average adjusted financial statement income is less than \$1 billion, unless an exception applies.
- c. A corporation's adjusted financial statement income is the amount of net income or loss the corporation reports on its applicable financial statement. The income is adjusted for various purposes including certain adjustments in the case of consolidated returns or for foreign income.
- d. The Act includes references to the tax codes which provides a hierarchy for determining the "applicable financial statement." At a high level, the first choice is U.S. generally accepted accounting principles (GAAP) financial statements; the second choice is international financial reporting standards (IFRS) financial statements. If GAAP and IFRS financial statements are not available, the financial statements filed by the taxpayer with any other regulatory or government body is acceptable. If the taxpayer is part of an affiliated group of corporations filing a consolidated return, the adjustable financial statement income for the group considers the group's applicable financial statement.
- e. To determine its U.S. federal income tax liability, an applicable corporation will need to compute taxes under both systems—the regular tax system and the CAMT system. The CAMT is payable

to the extent the tentative CAMT exceeds the regular corporate income tax. Any CAMT paid is available indefinitely as a credit carryover that could reduce future regular tax in future years if the regular tax liability is in excess of CAMT tax liability.

- f. The Act directs the Treasury to issue regulations and other guidance relate to implementing the CAMT, so several issues are pending detailed clarifications including clarifying the definition of an applicable corporation, and providing guidance on the starting point for, and adjustments to, adjusted financial statement income, as well as the handling of separate company tax returns when required under current tax law that are unique to the insurance industry.

Interpretation Issues

2. This interpretation is focused on addressing third quarter 2022 transition accounting and reporting aspects of the new CAMT. While most insurers will not be subject to the CAMT, for those that know that they are subject, and those that could be subject to the CAMT, there are a variety of reporting uncertainties, particularly regarding reporting for third quarter 2022.

3. The CAMT is effective for the tax years on or after 2023.

4. Both statutory accounting principles and U.S. GAAP require the effects of tax changes on deferred taxes, including the valuation allowance (future realizability of existing DTAs) in the period in which the legislation is enacted (third quarter 2022). *SSAP No. 101—Income Taxes*, paragraph 7.e. requires the statutory valuation allowance adjustment as a direct reduction in the gross DTA if, based on the weight of available evidence, it is more likely than not that some or all of the gross DTAs will not be realized. Gross DTA less the statutory valuation allowance results in adjusted gross DTAs. The statutory valuation allowance adjustment is not reported as a separate line in the statutory financial statements (it is an off-balance sheet item that reduces the gross DTAs). The statutory valuation allowance is disclosed.

5. The statutory accounting calculation for admissible DTAs is determined using adjusted gross DTAs (gross DTAs reduced by the valuation allowance). For statutory accounting, admittance of adjusted gross DTAs in *SSAP No. 101* depends on a three-component calculation, for which the second step limits admittance of adjusted gross DTAs to those that are expected to be realized in a timeframe that does not exceed three years. The actual number of years permitted depends on specifics for each reporting entity (type and other information about the reporting entity), but the maximum timeframe is three years. The last step admits DTAs which can be offset by DTLs.

6. Guidance in *SSAP No. 9—Subsequent Events* requires consideration of Type I and Type II¹ subsequent events through the date of the statutory financial statements and the date of issuance of the audited financial statements, or the date in which audited financial statements are available to be issued. For subsequent events identified after the statutory financial statements are filed (example, March 1), but before the audited financial statements are issued (example, June 1), reporting entities are generally required by their domestic state to amend their filed statutory financial statements to ensure that the statutory financial statements and the audited financial statements are consistent. Under this guidance, as additional information is made available on the impact of the Act, or information becomes available to update estimates and assessments, under existing statutory accounting guidance in *SSAP No. 9*, reporting entities would need to identify updated estimates as a Type I subsequent event in the audited financial statements.

¹ A Type I subsequent event relates to an event or transaction that provides additional evidence with respect to conditions that existed at the date of the balance sheet, including the estimates inherent in the process of preparing financial statements. Under *SSAP No. 9*, entities shall recognize in the financial statements the effects of all material Type I subsequent events. A Type II subsequent event pertains to events or transactions that provide evidence to conditions that did not exist at the balance sheet date but arose after that date. Type II events are disclosed in the financial statements.

Issue 1 – Consideration of the Act for Third Quarter 2022 Financial Statements

7. During the period of enactment (third quarter 2022) reporting entities filing statutory financial statements would normally have to consider the applicability of the CAMT and if applicable, determine the impact on the statutory valuation allowance as well as assess DTAs for admissibility (e.g., realization timeframe). These elements will be collectively referred to as “calculations impacted by the Act” or “calculations impacted by the CAMT.”

8. This interpretation will address the issue for what reporting entities are required to report or disclose regarding the calculations impacted by the CAMT for September 30, 2022, financial statements.

Issue 2 – Consideration of Subsequent Events for Third Quarter 2022 Financial Statements

9. SSAP No. 9 requires consideration of subsequent events through the date of the statutory financial statements and the date of issuance of the audited financial statements, or the date in which audited financial statements are available to be issued.

10. For reporting entities that materially revise or establish calculations impacted by the CAMT subsequent to September 30, 2022 (including the statutory valuation allowance, the timing of determination of net admitted DTAs, and the determination of the applicability of the CAMT), this interpretation will address the extent a Type I or Type II subsequent event assessment is required for third quarter 2022 financial reporting.

INT 22-02 Discussion

11. The Statutory Accounting Principles (E) Working Group consensuses to the noted issues are included below.

Response: Issue 1 – Consideration of the Act for Third Quarter 2022 Financial Statements

12. Reporting entities that are aware they will be subject to the CAMT would normally reflect the effects of the Act on the calculations impacted by the CAMT if reasonably estimable for third quarter 2022. Because of the timing of the adoption of the Act and the considerable number of unknown variables for September 30, 2022, reporting, the Working Group has determined that a reasonable estimate is not determinable for third quarter 2022 interim financial statements for the calculations impacted by the CAMT.

13. Because reasonable estimates of calculations impacted by the CAMT are not determinable, reporting entities shall not recognize impacts related to CAMT for third quarter 2022 financial statements, but shall make the following disclosures regarding the CAMT and the Act:

- a. The Act was enacted during the reporting period on August 16, 2022.
- b. A statement regarding whether the reporting entity (or the controlled group of corporations of which the reporting entity is a member) has determined if it expects to be liable for CAMT in 2023. For example:
 - i. The reporting entity (or the controlled group of corporations of which the reporting entity is a member) has determined that it does not expect to be liable for CAMT in 2023.
 - ii. The reporting entity (or the controlled group of corporations of which the reporting entity is a member) has not determined as of the reporting date if it will be liable for CAMT in 2023. The third quarter 2022 financial statements do not include an estimated impact of the CAMT because a reasonable estimate cannot be made.

- iii. The reporting entity (or the controlled group of corporations of which the reporting entity is a member) has determined that it expects to be liable for CAMT in 2023. The third quarter 2022 financial statements do not include an estimated impact of the CAMT, because a reasonable estimate cannot be made.

Response: Issue 2 – Consideration of Subsequent Events for Third Quarter 2022 Financial Statements

14. For third quarter 2022 reporting, CAMT updated estimates or other calculations affected by the Act determined subsequent to third quarter statutory financial statement or filing date shall not be recognized as Type I subsequent events. Meaning, amended financial statements are not required to reflect updated estimates subsequent to the third quarter filing date and prior to the filing the third quarter financial statements. With the disclosure required under Issue 1, additional subsequent event disclosure (such as what would be required for Type II event) is not required.

15. Reporting entities shall be working in good faith to complete the accounting for the changes adopted under the Act.

INT 22-02 Status

16. The consensuses in this interpretation were adopted on October 24, 2022, to provide reporting guidance regarding the calculations impacted by the CAMT and provide limited-scope, limited-time exceptions to the valuation allowance and DTA calculations in response to legislation under SSAP No. 101 as well as Type I subsequent event requirements in SSAP No. 9 for September 30, 2022, statutory reporting. As detailed, the exceptions to SSAP No. 101 and SSAP No. 9 are effective for third quarter 2022.

17. On December 13, 2022, the Working Group adopted a consensus to extend this interpretation for December 31, 2022, and first quarter 2023 statutory financial statements. For application as of year-end 2022 and first quarter 2023:

- a. Consistent with paragraphs 12 and 13, the Working Group has concluded that a reasonable estimate is not determinable for December 31, 2022, and March 31, 2023, therefore impacts related to the CAMT in the year-end 2022 and March 31, 2023, financial statements are not required.
- ~~b. The reporting entity shall include disclosures in paragraph 13 in the year-end 2022 and March 31, 2023, financial statements. In addition, the reporting entity shall disclose the following:~~
 - ~~i. If, based on information regarding the projected adjusted financial statement income for 2023, the entity or the controlled group of corporations of which the reporting entity is a member has determined if it is an “applicable corporation” to determine if CAMT exceeds the regular federal income tax payable. That is, disclose if the reporting entity (or the controlled group of corporations of which the reporting entity is a member) has determined if average “adjusted financial statement income” is above the thresholds for 2023 tax year that they expect to be required to perform the CAMT calculations. This disclosure is about being applicable corporation, not if the entity is required to pay.~~
- e.b. Consistent with paragraph 14, CAMT updated estimates or other calculations affected by the Act determined subsequent to filing the December 31, 2022, and March 31, 2023, financial statements shall not be recognized as Type I subsequent events.
- d.c. For year-end 2022 financial statements, the subsequent event exception is expanded to encompass events that occur prior to the issuance of statutory financial statements as well as events that occur

before the date the audited financial statements are issued, or available to be issued. This provision intends to prevent reporting entities from having to amend statutory financial statements from material Type I subsequent events as a result of updated information / estimates received after the reporting date of year-end 2022 statutory financial statements pertaining to the accounting for the enactment of the Act.

18. On May 16, 2023, the Working Group adopted a consensus to extend this interpretation for the second quarter 2023 statutory financial statements. For application to the second quarter 2023 financial statements, reporting entities shall follow the guidance in this interpretation paragraphs 17.a. through 17.c.

~~18.~~19. With the extension, this interpretation will be automatically nullified on ~~June 15, 2023~~August 16, 2023.

~~19.~~20. No. further discussion is planned.

[https://naiconline.sharepoint.com/sites/naicsupportstaffhub/member meetings/e cmte/apptf/2023-2 summer/summary and minutes/sapwg/att1c1-int 22-02-may 23.docx](https://naiconline.sharepoint.com/sites/naicsupportstaffhub/member%20meetings/e%20cmte/apptf/2023-2%20summer/summary%20and%20minutes/sapwg/att1c1-int%2022-02-may%2023.docx)

NAIC Accounting Practices and Procedures Manual
Editorial and Maintenance Update
May 16, 2023

Maintenance updates provide revisions to the *Accounting Practices and Procedures Manual*, such as editorial corrections, reference changes and formatting.

SSAP/Appendix	Description/Revision
SSAP No. 86	Paragraph 43.g.ii.: Revise “Intrinsic Value” to reflect “Volatility Value”
P&P Manual References	All citations to the <i>Purposes and Procedures Manual of the NAIC Investment Analysis Office</i> (P&P Manual) are proposed to be reviewed and streamlined so they do not reflect a specific location in the P&P Manual or web page. These references will be eliminated to prevent inappropriate citations.
Percent References	Instances in which ‘percent’ is spelled out in combination with a number will be eliminated with retention of the % sign. This is a consistency change as the usage is currently inconsistent within the AP&P Manual.

Recommendation:

NAIC staff recommend that the Statutory Accounting Principles (E) Working Group move this agenda item to the active listing, categorize as a SAP Clarification, and expose editorial revisions as illustrated within.

SSAP No. 86R—Derivatives

Revise the reference to “Intrinsic Value” to reflect “Volatility Value.” This change was proposed by industry to clarify the disclosure category for the excluded component to the Blanks (E) Working Group and a corresponding revision is needed in SSAP No. 86R.

- 43.a. For hedging instruments with excluded components for determining hedge effectiveness:
- i. In the investment schedule, identify hedging instruments with excluded components and report the current fair value of the excluded component, the fair value of the excluded component that is reflected in the reported BACV for the hedging instrument (this item would not be applicable for foreign-currency forwards and currency swaps where the forward points or cross-currency basis, respectively, are the excluded component), and the change in fair value reported as an unrealized gain/loss.
 - ii. In the notes to the financial statements, provide information on the aggregate excluded components by category: Time Value, ~~Intrinsic~~-Volatility Value, Forward Points and Cross Currency Basis Spread. The aggregate amounts reported should include the following (as applicable): current fair value, recognized unrealized gain/loss, the fair value reflected in BACV, and for the excluded forward points (e.g., forward spot rates), the aggregate amount owed at maturity, along with current year and remaining amortization.

Purposes and Procedure Manual References

The following SSAPs will be revised to update references to the P&P Manual.

SSAP No. 25—Affiliates and Other Related Parties

- 21.h. The amount deducted from the value of an upstream intermediate entity or ultimate parent owned, either directly or indirectly, via a downstream subsidiary, controlled, or affiliated entity, in accordance with [SSAP No. 97—Investments in Subsidiary, Controlled and Affiliated Entities](#), ~~the Purposes and Procedure Manual of the NAIC Investment Analysis Office, “Procedures for Valuing Common Stocks and Stock Warrants.”~~

SSAP No. 26R—Bonds

- 4.a. Exchange traded funds (ETFs), which qualify for bond treatment, as identified in ~~Part Three of the Purposes and Procedures Manual of the NAIC Investment Analysis Office~~ and published on the SVO web page ~~at <https://content.naic.org/industry/securitiesvaluation-office>~~. (SVO-identified ETFs are reported on Schedule D – Part 1.)

SSAP No. 30R—Unaffiliated Common Stock

- 4.c. Shares of SEC registered Investment Companies³ captured under the Investment Company Act of 1940 (open-end investment companies (mutual funds), closed-end funds and unit investment trusts), regardless of the types or mix of securities owned by the fund (e.g., bonds or stocks), including shares of funds referenced in the “NAIC Fixed Income-Like SEC Registered Funds List” as identified in ~~Part Three of the Purposes and Procedures Manual of the NAIC Investment Analysis Office~~ [and published on the SVO web page](#);
- 4.d. Exchange Traded Funds, except for those identified for bond or preferred stock treatment, as identified in ~~Part Three of the Purposes and Procedures Manual of the NAIC Investment Analysis Office~~ and published on the SVO web page ~~at <https://content.naic.org/industry/securities-valuation-office>~~;

SSAP No. 32R—Preferred Stock

- 4.a. Exchange Traded Funds, which qualify for preferred stock treatment, as identified in ~~Part Three of the Purposes and Procedures Manual of the NAIC Investment Analysis Office~~ and published on the SVO web page ~~at <https://content.naic.org/industry/securities-valuationoffice>~~. SVO-identified preferred stock ETFs shall follow the accounting provisions for perpetual preferred stock.

SSAP No. 97—Investments in Subsidiary, Controlled and Affiliated Entities

64. By August 31 or one month after the audit report date of each year, the NAIC shall initiate a review of all SCA investments for which new Sub 2 form filings have been received as well as an annual update review of Sub 2 SCA investments already logged in the VISION database. The NAIC review shall encompass a review of the most recent annual statutory reporting by the parent insurance company's Schedule Y (to ascertain the identity of the members of the holding company system and to ensure that information for all SCA companies has been submitted), a review of the parent's financial statement blank to review the last reported value for the SCA investments and a review of the VISION database to determine whether SCA debt and SCA preferred securities have been assigned NAIC designations. As part of its analysis, the NAIC shall review the portion of the bond investments carried by the parent or a subsidiary insurer with a **Z** notation. If the NAIC determines that the portion of the **Z** bonds shown on the documentation is significant, the NAIC shall not

process the Sub 2 filing until the insurance company reports the bonds to permit removal of the Z notation. Beginning with year-end 2019, two new suffixes will apply: **YE** and **IF**. YE means that the security is a properly filed annual update that the SVO has determined will not be assigned an NAIC designation by the close of the year-end reporting cycle. The symbol YE is assigned by the SVO pursuant to the carryover administrative procedure described in ~~Part One, Section 3 f) (iii) of the Purposes and Procedures Manual of the NAIC Investment Analysis Office~~. When the SVO assigns the symbol YE it also assigns the NAIC designation in effect for the previous reporting year. IF means that the security is an initial filing that has been properly filed with the SVO but which the SVO has determined will not be assigned an NAIC designation by the close of the year-end reporting cycle. The symbol IF is assigned by the SVO and communicates that the insurer should self-designate the security for year-end and identify it with the symbol IF. IF, therefore, also communicates to the regulator that the NAIC designation reported by the insurance company was not derived by or obtained from the SVO, but has been determined analytically by a reporting insurance company.

Percent References

The following SSAPs will be revised to update the percent reference.

SSAP No. 5R—Liabilities, Contingencies and Impairment of Assets:

13. As directed by SSAP No. 101—*Income Taxes*, tax loss contingencies (including related interest and penalties) for current and all prior years, shall be computed in accordance with this SSAP, with the following modifications:
 - a. The term “probable” as used in this standard shall be replaced by the term “more likely than not (a likelihood of more than ~~50% percent~~)” for federal and foreign income tax loss contingencies only.
 - b. For purposes of the determination of a federal and foreign income tax loss contingency, it shall be presumed that the reporting entity will be examined by the relevant taxing authority that has full knowledge of all relevant information.
 - c. If the estimated tax loss contingency is greater than ~~50% percent~~ of the tax benefit originally recognized, the tax loss contingency recorded shall be equal to ~~100% percent~~ of the original tax benefit recognized.

As noted in SSAP No. 101, state taxes (including premium, income and franchise taxes) shall also be computed in accordance with this SSAP. These items (as detailed in SSAP No. 101) are not impacted by the modifications detailed in paragraphs 13.a.-13.c.

SSAP No. 16R—Electronic Data Processing Equipment and Software

4. The aggregate amount of admitted EDP equipment and operating system software (net of accumulated depreciation) shall be limited to ~~3% three percent~~ of the reporting entity’s capital and surplus as required to be shown on the statutory balance sheet of the reporting entity for its most recently filed statement with the domiciliary state commissioner adjusted to exclude any EDP equipment and operating system software, net deferred tax assets and net positive goodwill.^(INT 01-18)

SSAP No. 43R—Loan-Backed and Structured Securities

FN 10: Changes in the interest rate of a “plain-vanilla,” variable-rate beneficial interest (a plain-vanilla, variable-rate beneficial interest does not include those variable-rate beneficial interests with interest

rate reset formulas that involve either leverage or an inverse floater) generally should not result in the recognition of an other-than-temporary impairment. For plain-vanilla, variable-rate beneficial interests, the yield is changed to reflect the revised interest rate based on the contractual interest rate reset formula. For example, if a beneficial interest pays interest quarterly at a rate equal to LIBOR plus ~~2% percent~~, the yield of that beneficial interest is changed prospectively to reflect changes in LIBOR. However, changes in the fair value of a plain-vanilla, variable-rate beneficial interest due to credit events should be considered when evaluating whether there has been an other-than-temporary impairment.

SSAP No. 57—Title Insurance

- 19.g. An investment in a title plant or plants in an amount equal to the actual cost shall be allowed as an admitted asset for title insurers. The aggregate carrying value of an investment in a title plant or plants shall not exceed the lesser of 20% of admitted assets or ~~forty percent (40%)~~ of surplus to policyholders, both as required to be shown on the statutory balance sheet of the insurer for its most recently filed statement with the domiciliary state commissioner; if the amount of the investment exceeds the above limits, the excess amount shall be recorded as a nonadmitted asset.

SSAP No. 60—Financial Guarantee Insurance

10. The contingency reserve shall be the greater of ~~50% fifty percent~~ of premiums written for each category or the amount provided by applying the following percentages to the principal guaranteed in each calendar year. The premiums written shall be net of reinsurance if the reinsurer has established a contingency reserve.
- | | | |
|----|--|---------------------------|
| a. | Municipal obligation bonds | 0.55% percent |
| b. | Special revenue bonds | 0.85% percent |
| c. | Investment grade Industrial Development Bonds (IDBs) secured by collateral or having a term of seven years or less, and utility first mortgage obligations | 1.00% percent |
| d. | Other investment grade IDBs | 1.50% percent |
| e. | Other IDBs | 2.50% percent |
| f. | Investment grade obligations, secured by collateral or having a term of seven years or less | 1.00% percent |
| g. | Other investment grade obligations not secured | 1.50% percent |
| h. | Non-investment grade consumer debt obligations | 2.00% percent |
| i. | Non-investment grade asset backed securities | 2.00% percent |
| j. | All other non-investment grade obligations | 2.50% percent |

SSAP No. 62R—Property and Casualty Reinsurance

- 116.a. The written premium ceded to the reinsurer by the reporting entity or its affiliates represents ~~fifty percent (50%)~~ or more of the entire direct and assumed premium written by the reinsurer based on its most recently available financial statement; or

- 116.b. ~~Twenty-five percent (25%)~~ or more of the written premium ceded to the reinsurer has been retroceded back to the reporting entity or its affiliates in separate reinsurance contract.

Exhibit C – Assumptions

Premium = \$1,000 (assumes no commissions or allowances)
 Coverage Period = 1 year
 Initial expected recoveries = \$225 per year (at end of year) for five years
 Initial Implicit rate = ~~4% percent~~*

*present value of \$225 per year for five years at ~~4% percent~~ = \$1,000

At the end of Year 2, the timing of anticipated recoveries under the reinsurance contract changes. A reevaluation of the implicit interest rate produces a rate of 3.63% ~~percent~~ and an asset of \$640 at the end of the year.

SSAP No. 65—Property and Casualty Contracts

37. If the reporting entity does not hold specific collateral for the policy, amounts accrued for reimbursement of the deductible shall be billed in accordance with the provisions of the policy or the contractual agreement and shall be aged according to the contractual due date. In the absence of a contractual due date, billing date shall be utilized for the aging requirement. Deductible recoverables that are greater than ninety days old shall be nonadmitted. However, if the reporting entity holds specific collateral for the high deductible policy, ~~10% ten percent~~ of deductible recoverable in excess of collateral specifically held and identifiable on a per policy basis, shall be reported as a nonadmitted asset in lieu of applying the aging requirement; however, to the extent that amounts in excess of the 10% are not anticipated to be collected they shall also be nonadmitted. The collateral requirements of this paragraph may be satisfied when an insured provides one collateral instrument to secure amounts owed under multiple policies, provided that the reporting entity has the contractual right to apply the collateral to the high deductible policy. Collateral obtained at a group level that is not supported by an existing pooling agreement requires a written allocation agreement among all collateral beneficiaries. The terms of such agreement must be fair and equitable. Documentation supporting any allocation of collateral among reporting entities must be maintained to allow proper calculation of the nonadmitted amounts and prohibit double counting of collateral.

SSAP No. 78—Multiple Peril Crop Insurance

3. Catastrophic insurance is designed to provide farmers with protection against extreme crop losses for a small processing fee. Buy-up insurance provides protection against more typical and smaller crop losses in exchange for a policyholder-paid premium. The government subsidizes the total premium for catastrophic insurance and a portion of the premium for buy-up insurance. Farmers who purchase buy-up crop insurance must choose both the coverage level (the proportion of the crop to be insured) and the unit price (such as, per bushel) at which any loss is calculated. With respect to the coverage level of production, farmers can choose to insure as much as ~~85% percent~~ of normal production or as little as ~~50% percent~~ of normal production at different price levels. With respect to the unit price, farmers choose whether to value their insured production at FCICs full estimated market price or at a percentage of the full price.
5. Companies participate in the MPCl program with FCIC through the Standard Reinsurance Agreement (SRA) per the terms of which the insurance companies share in the underwriting results of each policy. The SRA reinsurance terms provide a company the flexibility to limit its exposure on a state-by-state basis. MPCl premium is not expense loaded, therefore FCIC pays the insurance companies, on behalf of the policyholder, a percent of premium for administrative expenses

- associated with selling and servicing crop insurance policies, including the expenses associated with adjusting claims.
15. FCIC pays the insurance companies a percent of premium for administrative expenses associated with selling and servicing crop insurance policies, including the expenses associated with adjusting claims. The expense payment associated with the catastrophic coverage shall be recorded as a reduction of loss expenses whereas the expense payment for the buy-up coverage shall be recorded as a reduction of other underwriting expenses. The company shall disclose the total amounts received for each type of coverage.

SSAP No. 86—Derivatives

- 26.c. The term highly effective describes a cash flow hedging relationship where the change in fair value of the derivative hedging instrument is within 80 to 125% ~~percent~~ of the opposite change in the fair value of the hedged item attributable to the hedged risk. It shall also apply when an R-squared of .80 or higher is achieved when using a regression analysis technique. Further guidance on determining effectiveness can be found within Exhibit A;
- 27.c. The term highly effective describes a cash flow hedging relationship where the change in cash flows or present value of cash flows of the derivative hedging instrument is within 80 to 125% ~~percent~~ of the opposite change in the cash flows or present value of the cash flows of the hedged item attributable to the hedged risk. It shall also apply when an R-squared of .80 or higher is achieved when using a regression analysis technique. Further guidance on determining effectiveness can be found within Exhibit A.
- Exhibit A, 19.c.ii. The variable-rate asset or liability has a floor or cap and the interest rate swap has a floor or cap on the variable interest rate that is comparable to the floor or cap on the variable-rate asset or liability. For purposes of this paragraph, comparable does not necessarily mean equal. For example, if an interest rate swap's variable rate is based on LIBOR and an asset's variable rate is LIBOR plus 2% ~~percent~~, a 10% ~~percent~~ cap on the interest rate swap would be comparable to a 12% ~~percent~~ cap on the asset.
- Exhibit A, 22 The fixed interest rate on a hedged item need not exactly match the fixed interest rate on an interest rate swap designated as a fair value hedge. Nor does the variable interest rate on an interest-bearing asset or liability need to be the same as the variable interest rate on an interest rate swap designated as a cash flow hedge. An interest rate swap's fair value comes from its net settlements. The fixed and variable interest rates on an interest rate swap can be changed without affecting the net settlement if both are changed by the same amount. That is, an interest rate swap with a payment based on LIBOR and a receipt based on a fixed rate of 5% ~~percent~~ has the same net settlements and fair value as an interest rate swap with a payment based on LIBOR plus 1% ~~percent~~ and a receipt based on a fixed rate of 6% ~~percent~~.

SSAP No. 92—Postretirement Benefits Other Than Pensions

49. As a minimum, amortization of a net gain or loss included in unassigned funds (surplus) shall be included as a component of net periodic postretirement benefit cost for a year if, as of the beginning of the year, that net gain or loss exceeds 10% ~~percent~~ of the greater of the accumulated postretirement benefit obligation or the fair value of plan assets. If amortization is required, the minimum amortization shall be that excess divided by the average remaining service period of active plan participants. If all or almost all of a plan's participants are inactive, the average remaining life expectancy of the inactive participants shall be used instead of the average remaining service period.

75. An employer shall disclose the amount of contributions to multiemployer plans for each annual period for which a statement of income is presented. An employer may disclose total contributions to multiemployer plans without disaggregating the amounts attributable to pension plans and other postretirement benefit plans. The disclosures shall include a description of the nature and effect of any changes affecting comparability, such as a change in the rate of employer contributions, a business combination, or a divestiture. This disclosure shall identify whether the contributions represent more than ~~5% percent~~ of total contributions to the plan as indicated in the plan's most recently available annual report.

- 108.b.i ~~Ten 10% percent~~ of the calculated surplus impact as of the transition date; and

SSAP No. 93—Low-Income Housing Tax Credit Property Investments

Exhibit A Assumptions

1. All cash flows (except initial investment) occur at the end of each year.
2. Depreciation expense is computed, for book and tax purposes, using the straight-line method with a 27.5 year life (the same method is used for simplicity).
3. The investor made a \$100,000 investment for a ~~5% percent~~ limited partnership interest in the project at the beginning of the first year of eligibility for the tax credit.
4. The partnership finances the project cost of \$4,000,000 with ~~50% percent~~ equity and ~~50% percent~~ debt.
5. The annual tax credit allocation (equal to ~~4% percent~~ of the project's original cost) will be received for a period of 10 years.
6. The investor's tax rate is ~~40% percent~~.

Chart Footnotes:

- (1) End-of-year investment for a ~~5% percent~~ limited liability interest in the project net of amortization in Column (2).
- (3) ~~4% Four percent~~ tax credit on \$200,000 tax basis of the underlying assets.

SSAP No. 100R—Fair Value

- 52.g. If a group of investments would otherwise meet the criteria in paragraph 45 but the individual investments to be sold have not been identified (for example, if a reporting entity decides to sell ~~20% percent~~ of its investments in private equity funds but the individual investments to be sold have not been identified), so the investments continue to qualify for the practical expedient in paragraph 39, the reporting entity shall disclose its plans to sell and any remaining actions required to complete the sale(s).

SSAP No. 101—Income Taxes

2. For purposes of accounting for federal and foreign income taxes, reporting entities shall adopt *FASB Statement No. 109, Accounting for Income Taxes* (FAS 109) with modifications for state income taxes^(INT 18-03), the realization criteria for deferred tax assets, and the recording of the impact of changes in deferred tax balances. One objective of accounting for income taxes is to recognize the estimated amount of taxes payable or refundable for the current year as a tax liability or asset.

A second objective is to recognize deferred tax liabilities and assets for the future tax consequences of events that have been recognized in a reporting entity's statutory financial statements or tax returns. However, the second objective is realistically constrained because (a) the tax payment or refund that results from a particular tax return is a joint result of all the items included in that return, (b) taxes that will be paid or refunded in future years are the joint result of events of the current or prior years and events of future years, and (c) information available about the future is limited. As a result, financial statements will recognize current and deferred income tax assets and liabilities in accordance with the provisions of this statement based upon estimates and approximations. For purposes of this statement, only adjusted gross deferred tax assets that are more likely than not (a likelihood of more than 50% ~~percent~~) to be realized shall be considered in determining admitted adjusted gross deferred tax assets.

- 3.a.i The term "probable" as used in SSAP No. 5R shall be replaced by the term "more likely than not (a likelihood of more than 50% ~~percent~~)" for federal and foreign income tax loss contingencies only.
- 7.e. Gross DTAs are reduced by a statutory valuation allowance adjustment if, based on the weight of available evidence, it is more likely than not (a likelihood of more than 50% ~~percent~~) that some portion or all of the gross DTAs will not be realized. The statutory valuation allowance adjustment, determined in a manner consistent with paragraphs 20-25 of FAS 109, shall reduce the gross DTAs to the amount that is more likely than not to be realized (the adjusted gross deferred tax assets).
- 1.3 SSAP No. 101 – Gross DTAs are reduced by a statutory valuation allowance adjustment that is determined on a separate company, reporting entity basis. Pursuant to paragraphs 2 and 7.e. of SSAP No. 101, gross DTAs are adjusted to an amount that is more likely than not to be realized (a likelihood of more than 50% ~~percent~~). Only adjusted gross DTAs shall be considered in determining admitted adjusted gross DTAs. See Question 2 for further discussion of the statutory valuation allowance adjustment. See Question 4 for a further discussion of the admissibility test. See Question 12 for further discussion of presentation and disclosure of the statutory valuation allowance adjustment.
- 1.11 SSAP No. 101 – FIN 48 is rejected for statutory accounting pursuant to paragraph 31 of SSAP No. 101. SSAP No. 5R—Liabilities, Contingencies and Impairments of Assets provides guidance in determining the amount of federal and foreign income tax loss contingencies with the following modifications. The term "probable" as used in SSAP No. 5R is replaced by the term "more likely than not (a likelihood of more than 50% ~~percent~~)". In determining the amount of a federal or foreign income tax loss contingency, it shall be assumed that the reporting entity will be examined by the tax authority that has full knowledge of all relevant information. If the estimated tax loss contingency is greater than 50% of the tax benefit originally recognized, the tax loss contingency recorded shall be equal to 100% of the original tax benefit recognized. See Question 9 for further discussion of income tax loss contingencies.
- 2.1 A – An enterprise shall record a gross deferred tax liability or asset for all temporary differences and operating loss, capital loss and tax credit carryforwards. Temporary differences include unrealized gains and losses and nonadmitted assets but do not include AVR, IMR, Schedule F penalties and, in the case of a mortgage guaranty insurer, amounts attributable to its statutory contingency reserve to the extent that "tax and loss" bonds have been purchased. In general, temporary differences produce taxable income or result in tax deductions when the related asset is recovered or the related liability is settled. A deferred tax asset or liability represents the increase or decrease in taxes payable or refundable in future years as a result of temporary differences and carryforwards at the end of the current year. Additionally, gross DTAs are reduced by a statutory valuation allowance adjustment if, based on the weight of available evidence, it is more likely than not (a likelihood of more than 50% ~~percent~~) that some portion or all of the gross DTAs will not be realized. The statutory valuation allowance adjustment, determined in a manner consistent with paragraphs 20-25 of FAS 109, shall reduce gross DTAs to the amount that is more likely than not to be realized (the adjusted gross deferred tax assets). This answer only addresses the recognition

of adjusted gross DTAs and gross DTLs and does not address the admissibility of such amounts. See Question 4 for a discussion of the admissibility criteria of SSAP No. 101.

- 5.12 The temporary difference related to property and casualty unearned premiums is typically ~~twenty percent (20%)~~ of the outstanding statutory unearned premium reserve. If a company issues only one-year policies, it is reasonable to assume that the entire temporary difference will reverse in one year. If a company writes multi-year contracts, management will be required to estimate the percentage of the unearned premium that will be earned within each year of the applicable reversal period and apply these percentages to the outstanding temporary difference.
- 5.14 For those temporary differences that do not have a defined reversal period, such as unrealized losses on common stock or deferred compensation liabilities, management will need to determine when the temporary difference is “expected” to reverse. For instance, assume a company has an unrealized loss of \$200 in its equity portfolio and that, on average, the portfolio turns over ~~twenty percent (20%)~~ per year. It would be appropriate for the company to conclude that \$40 of the temporary difference will reverse in each year in the applicable reversal period. When determining when the temporary difference would be “expected” to reverse, management should normally consider events that are likely to occur using information, facts and circumstances in existence as of the reporting date. The estimates used in this circumstance should not be extended to other tests of impairment. For instance, when the entity assumed a 20% turnover in its equity portfolio, it is not involuntarily required to record an impairment in accordance with paragraph 10 of SSAP No. 30R—Unaffiliated Common Stock.
- 10.3 As an example, assume Company X files its 20X1 federal income tax return and reports \$1,000,000 of taxable income comprised of \$800,000 of ordinary income and \$200,000 of capital gain income. Since the company is subject to taxation at a ~~21% percent~~ tax rate on all its income, it incurred federal income tax expense of \$210,000. In preparing its 20X1 statutory income tax provision, the company estimated that its liability for 20X1 federal income tax would be \$147,000 based on \$600,000 of ordinary income and \$100,000 realized capital gains.
- 10.8 For example, assume the reporting entity has DTAs of \$1,000 relating to temporary differences other than unrealized losses, and a \$100 DTL relating to unrealized gains as of the beginning of the year. Since the entity is subject to tax at ~~21% percent~~ and all of its DTAs are expected to reverse within one year, the entity recorded a \$900 net admitted DTA as of the beginning of the year.
- 12.20 The Company has not recognized a deferred tax liability of approximately \$30,000 of foreign withholding taxes for the undistributed earnings of its ~~100% percent~~ owned foreign subsidiaries that arose in 20X2 and prior years because the Company does not expect those unremitted earnings to reverse and become taxable to the Company in the foreseeable future. A deferred tax liability will be recognized when the Company expects that it will recover those undistributed earnings in a taxable manner, such as through receipt of dividends or sale of the investments. As of December 31, 20X2, the undistributed earnings of these subsidiaries were approximately \$200,000.

SSAP No. 102—Pensions

22. As a minimum, amortization of a net gain or loss included in unassigned funds (surplus) shall be included as a component of net pension cost for a year if, as of the beginning of the year, that net gain or loss exceeds ~~10% percent~~ of the greater of the projected benefit obligation or the fair value of plan assets. If amortization is required, the minimum amortization shall be that excess divided by the average remaining service period of active employees expected to receive benefits under the plan. If all or almost all of a plan's participants are inactive, the average remaining life expectancy of the inactive participants shall be used instead of average remaining service.
79. A reporting entity shall disclose the amount of contributions to multiemployer plans for each annual period for which a statement of income is presented. A reporting entity may disclose total

contributions to multiemployer plans without disaggregating the amounts attributable to pension plans and other postretirement benefit plans. The disclosures shall include a description of the nature and effect of any changes affecting comparability, such as a change in the rate of employer contributions, a business combination, or a divestiture. This disclosure shall identify whether the contributions represent more than ~~5% percent~~ of total contributions to the plan as indicated in the plan's most recently available annual report.

93.b.i. ~~Ten~~10% percent of the calculated surplus impact as of the transition date;

SSAP No. 103R—Transfers and Servicing of Financial Assets and Extinguishments of Liabilities

22. An exchange of debt instruments with substantially different terms is also considered a debt extinguishment and shall be accounted for in accordance with paragraph 21. A debtor's exchange of debt instruments (in a nontroubled debt situation) is accomplished with debt instruments that are substantially different if the present value of the cash flows under the terms of the new debt instrument is at least ~~10% percent~~ different from the present value of the remaining cash flows under the terms of the original instrument. If the difference between the present value of the cash flows under the terms of the new debt instrument and the present value of the remaining cash flows under the terms of the original debt instrument is less than ~~10% percent~~, a creditor should evaluate whether the modification is more than minor based on the specific facts and circumstances (and other relevant considerations) surrounding the modification.
91. The reporting entity shall receive collateral having a fair value as of the transaction date at least equal to ~~102% percent~~ of the fair value of the loaned securities at that date. If at any time the fair value of the collateral received from the counterparty is less than ~~100% percent~~ of the fair value of the loaned securities, the counterparty shall be obligated to deliver additional collateral by the end of the next business day, the fair value of which, together with the fair value of all collateral then held in connection with the transaction at least equals ~~102% percent~~ of the fair value of the loaned securities. If the collateral received from the counterparty is less than ~~100% percent~~ at the reporting date, the difference between the actual collateral and ~~100% percent~~ will be nonadmitted. Collateral value is measured and compared to the loaned securities in aggregate by counterparty.
92. In the event that foreign securities are loaned and the denomination of the currency of the collateral is other than the denomination of the currency of the loaned foreign securities, the amount of collateral shall be at least equal to ~~105% percent~~ of the fair value of the loaned securities at that date. If at any time the fair value of the collateral received from the counterparty is less than ~~102% percent~~ of the fair value of the loaned securities, the reporting entity must obtain additional collateral by the end of the next business day, the fair value of which together with the fair value of all collateral then held in connection with the transaction at least equals ~~105% percent~~ of the fair value of the loaned securities. If the collateral received from the counterparty is less than ~~100% percent~~ at the reporting date, the difference between the actual collateral and ~~100% percent~~ will be nonadmitted. Collateral value is measured and compared to the loaned securities in aggregate by counterparty.
113. The collateral requirements for repurchase and reverse repurchase agreements are as follows:

Repurchase Transaction

- a. The reporting entity shall receive collateral having a fair value as of the transaction date at least equal to ~~95% percent~~ of the fair value of the securities transferred by the reporting entity in the transaction as of that date. If at any time the fair value of the collateral received from the counterparty is less than ~~95% percent~~ of the fair value of the securities so transferred, the counterparty shall be obligated to deliver additional collateral by the end of the next business day the fair value of which, together with the fair value of all collateral

then held in connection with the transaction, at least equals ~~95% percent~~ of the fair value of the transferred securities. If the collateral is less than ~~95% percent~~ at the reporting date, the difference between the actual collateral and ~~95% percent~~ will be nonadmitted.

Reverse Repurchase Transaction

- b. The reporting entity shall receive as collateral transferred securities having a fair value at least equal to ~~102% percent~~ of the purchase price paid by the reporting entity for the securities. If at any time the fair value of the collateral is less than ~~100% percent~~ of the purchase price paid by the reporting entity, the counterparty shall be obligated to provide additional collateral, the fair value of which, together with fair value of all collateral then held in connection with the transaction, at least equals ~~102% percent~~ of the purchase price.
130. Exchanges of debt instruments or debt instrument modifications are considered extinguishments if the exchange or modification results with substantially different terms or is considered more than minor. If the cash flows under the terms of the new debt instrument are at least ~~10% percent~~ different from the present value of the remaining cash flows under the terms of the original instrument, then the exchange of, or modification to, debt instruments is consider substantially different and/or more than minor.

Illustration 3 Company C originates \$1,000 of loans that yield ~~10% percent~~ interest income for their estimated lives of 9 years. Company C transfers the entire loans to an entity and the transfer is accounted for as a sale. Company C receives as proceeds \$1,000 cash, a beneficial interest to receive ~~1% percent~~ on the contractual interest on the loans (an interest-only strip receivable), and an additional ~~1% percent~~ of the contractual interest as compensation for servicing the loans. The fair values of the servicing asset and the interest-only strip receivable are \$40 and \$60, respectively.

Illustration 4 – Facts

Transferor's carrying amount and fair value of security loaned	\$1,000
Cash "collateral"	1,020
Transferor's return from investing cash collateral at a 5% percent annual rate	5
Transferor's rebate to the securities borrower at a 4% percent annual rate	4

SSAP No. 104R—Share-Based Payments

- 117.a.ii. Any purchase discount from the market price does not exceed the per-share amount of share issuance costs that would have been incurred to raise a significant amount of capital by a public offering. A purchase discount of ~~5% percent~~ or less from the market price shall be considered to comply with this condition without further justification. A purchase discount greater than ~~5% percent~~ that cannot be justified under this condition results in compensation cost for the entire amount of the discount. Note that an entity that justifies a purchase discount in excess of ~~5% percent~~ shall reassess at least annually, and no later than the first share purchase offer during the fiscal year, whether it can continue to justify that discount pursuant to this paragraph.
122. Changes in total employee withholdings during a purchase period that occur solely as a result of salary increases, commissions, or bonus payments are not plan modifications if they do not represent changes to the terms of the award that was offered by the employer and initially agreed to by the employee at the grant (or measurement) date. Under those circumstances, the only incremental compensation cost is that which results from the additional shares that may be purchased with the additional amounts withheld (using the fair value calculated at the grant date). For example, an employee may elect to participate in the plan on the grant date by requesting that ~~5% percent~~ of the employee's annual salary be withheld for future purchases of stock. If the

employee receives an increase in salary during the term of the award, the base salary on which the ~~5% percent~~ withholding amount is applied will increase, thus increasing the total amount withheld for future share purchases. That increase in withholdings as a result of the salary increase is not considered a plan modification and thus only increases the total compensation cost associated with the award by the grant date fair value associated with the incremental number of shares that may be purchased with the additional withholdings during the period. The incremental number of shares that may be purchased is calculated by dividing the incremental amount withheld by the exercise price as of the grant date (for example, ~~85% percent~~ of the grant date stock price).

SSAP No. 108—Derivatives Hedging Variable Annuity Guarantees

11. The term “highly effective” describes a fair value hedging relationship where the change in fair value of the derivative instrument is within 80 to 125% ~~percent~~ of the opposite change in fair value of the hedged item attributed to the hedged risk. It shall also apply when an R-squared of .80 or higher is achieved when using a regression analysis technique.

Status:

On March 22, 2023, the Statutory Accounting Principles (E) Working Group moved this agenda item to the active listing, categorized as a SAP clarification, and exposed editorial revisions as illustrated within the agenda item.

On May 16, 2023, the Statutory Accounting Principles (E) Working Group adopted, as final, the exposed editorial revisions, as illustrated above, to the *Accounting Practices and Procedures Manual*.

<https://naiconline.sharepoint.com/sites/NAICSupportStaffHub/Member Meetings/E CMTE/APPTF/2023-2 Summer/Summary and Minutes/SAPWG/Att1C2-2023-11EP.docx>

Draft: 4/25/23

Statutory Accounting Principles (E) Working Group

E-Vote

April 12, 2023

The Statutory Accounting Principles (E) Working Group of the Accounting Practices and Procedures (E) Task Force conducted an e-vote that concluded April 12, 2023. The following Working Group members participated: Dale Bruggeman, Chair (OH); Kevin Clark, Vice Chair (IA); Sheila Travis (AL); Kim Hudson (CA); William Arfanis (CT); Rylynn Brown (DE); Stewart Guerin (LA); Judy Weaver (MI); Doug Bartlett (NH); Bob Kasinow (NY); Doug Stolte and David Smith (VA); and Amy Malm (WI).

1. Exposed INT 22-02

The Working Group considered exposure of *Interpretation (INT) 22-02: Third Quarter 2022 through Second Quarter 2023 Reporting of the Inflation Reduction Act – Corporate Alternative Minimum Tax*. This proposes to extend the existing INT 22-02 from June 15 to July 1 so that the Interpretation can be used through the second quarter of 2023.

Key elements of INT 22-02 are that it does not require accrual of the Corporate Alternative Minimum Tax (CAMT), it requires disclosures. INT 22-02 provides overrides to existing guidance in *Statement of Statutory Accounting Principles (SSAP) No. 9—Subsequent Events* and *SSAP No. 101—Income Taxes*. The Working Group anticipates having calls this quarter to address accounting for the CAMT.

Arfanis made a motion, seconded by Clark, to expose INT 22-02 with a comment deadline of May 5. The motion passed unanimously. This meets the NAIC Policy Statement on Statutory Accounting Principles Maintenance Agenda Process requirement for a 2/3 vote of the membership for INTs that conflict with existing statutory accounting.

Having no further business, the Statutory Accounting Principles (E) Working Group adjourned.

<https://naiconline.sharepoint.com/sites/NAICSupportStaffHub/MemberSummer/SAPWG/Attachments/Att1D-SAPWG 4.12.23 evote.docx>

Meetings/E

CMTE/APPTF/2023-2

Draft: 4/25/23

Statutory Accounting Principles (E) Working Group
E-Vote
April 10, 2023

The Statutory Accounting Principles (E) Working Group of the Accounting Practices and Procedures (E) Task Force conducted an e-vote that concluded April 10, 2023. The following Working Group members participated: Dale Bruggeman, Chair (OH); Kevin Clark, Vice Chair (IA); Sheila Travis (AL); Kim Hudson (CA); Rylynn Brown (DE); Stewart Guerin (LA); Judy Weaver (MI); Doug Bartlett (NH); Bob Kasinow (NY); Jamie Walker (TX); David Smith (VA); and Amy Malm (WI).

1. Exposed INT 23-01

The Working Group considered an e-vote exposure of *Interpretation (INT) 23-01: Net Negative (Disallowed) Interest Maintenance Reserve*. This INT proposes a limited-time, optional exception to statutory accounting to admit net negative (disallowed) interest maintenance reserve (IMR) in the general account up to 5% of adjusted capital and surplus. The tentative INT includes limitations on the negative IMR permitted to be admitted, with an explicit exclusion for losses captured in the IMR from derivatives that were reported at fair value prior to termination/settlement. It also specifically excludes separate account negative (disallowed) IMR from the admittance provisions. The INT details reporting requirements, which include an allocation to special surplus for the admitted net negative (disallowed) IMR, as well as disclosures on the derivative losses removed from IMR in determining the amount that could be admitted and disclosures on the overall IMR admittance calculation and the percentage of adjusted capital and surplus.

Hudson made a motion, seconded by Walker, to expose INT 23-01 for a public comment period ending May 5. The motion passed with 11 Working Group members responding with affirmative votes, meeting the NAIC Policy Statement on Statutory Accounting Principles Maintenance Agenda Process requirement for a 2/3 vote of the membership for INTs that conflict with existing statutory accounting.

Having no further business, the Statutory Accounting Principles (E) Working Group adjourned.

Subsequent to the e-vote, the comment period for this exposure was extended to June 9.

<https://naiconline.sharepoint.com/sites/NAICSupportStaffHub/Member Meetings/E CMTE/APPTF/2023-2 Summer/SAPWG/Attachments/Att1E-SAPWG 4.10.23 evote.docx>

**Statutory Accounting Principles (E) Working Group
Summer National Meeting
Comment Letters Received**

TABLE OF CONTENTS

COMMENTS / DOCUMENT	PAGE REFERENCE
Comment Letters Received for Items Exposed for the Summer National Meeting	
Interested Parties – May 31, 2023 <ul style="list-style-type: none"> ○ Corporate Alternative Minimum Tax (CAMT) 	2-14
Interested Parties – June 9, 2023 <ul style="list-style-type: none"> ○ Principles-Based Bond Definition ○ Ref #2022-01: Conceptual Framework – Updates ○ Ref #2022-11: Collateral for Loans ○ Ref #2022-12: Review of INT 03-02: Modification to an Existing Intercompany Pooling Arrangement ○ Ref #2022-19: Negative IMR ○ Ref #2023-01: Review Annual Statement Instructions for Accounting Guidance ○ Ref #2023-02: SSAP No. 43R – CLO Financial Modeling ○ Ref #2023-05: <i>ASU 2022-06, Reference Rate Reform (Topic 848), Deferral of the Sunset Date of Topic 848</i> ○ Ref #2023-06: Additional Updates on ASU 2021-10, Government Assistance ○ Ref #2023-07: ASU 2019-08, Codification Improvements to Topic 718 and Topic 606 ○ Ref #2023-08: ASU 2019-07, Codification Updates to SEC Sections ○ Ref #2023-09: <i>ASU 2020-09—Amendments to SEC Paragraphs Pursuant to SEC Release No. 33-10762—Debt (Topic 470)</i> ○ Ref #2023-10: ASU 2022-05, Long-Durations Contracts 	15-32
Security Benefit Life Insurance Company – June 9 and August 7, 2023 <ul style="list-style-type: none"> ○ Ref #2022-11: Collateral for Loans 	33-36
Interested Parties – June 30, 2023 <ul style="list-style-type: none"> ○ Ref #2022-14: New Market Tax Credits ○ Ref #2019-21e - Principles-Based Bond Definition: Schedule BA ○ Ref #2023-13: PIK Interest Disclosure Clarification ○ Ref #2023-12: Residuals in SSAP No. 48 Investments 	37-53
Interested Parties – July 14, 2023 <ul style="list-style-type: none"> ○ Ref #2023-12: Residuals in SSAP No. 48 Investments 	54-55

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May 31, 2023

Mr. Dale Bruggeman, Chairman
Statutory Accounting Principles Working Group
National Association of Insurance Commissioners
1100 Walnut Street, Suite 1500
Kansas City, MO 64106-2197

RE: Interested Parties' Proposal for Statutory Accounting for CAMT

Dear Mr. Bruggeman:

Interested parties would like to thank you for the continued meetings with the Statutory Accounting Principles Working Group (SAPWG) staff to discuss the interested parties' proposal for accounting for the Corporate Alternative Minimum Tax (CAMT). Over the past five months, interested parties has provided materials illustrating its proposal.

Interested parties is now providing a draft of suggested language for a recommended Interpretation addressing the statutory accounting for the CAMT. This draft is intended to aid the SAPWG staff by providing the interested parties' proposal in direct language suitable for an Interpretation. The draft Interpretation is more detailed than the previously provided material and also includes transitional guidance, as well as suggested disclosures. We believe this detailed language should help prevent different interpretations among the industry and the accounting firms.

In drafting this proposal, interested parties followed the guiding principles that you previously communicated. First, given that CAMT only applies to a limited number of large and profitable companies, *SSAP No. 101 – Income Taxes* does not need to, and should not, be opened and rewritten. Although guidance is necessary to address how the consolidated tax should be accounted for under statutory accounting, revising *SAAP No. 101* is not necessary as this draft clarifies the existing guidance in *SSAP No. 101*. Following this guiding principle, interested parties drafted guidance through an Interpretation, leaving *SSAP No. 101* intact. Next, given that the CAMT is calculated based on consolidated book income and not taxable income, you suggested the use of the tax sharing agreement to bridge the CAMT calculation to the separate company statutory statements. As such, the proposed Interpretation relies on tax sharing

agreements to allocate the consolidated CAMT for purposes of the admittance calculation. In addition, all insurance companies will have different organizational structures, various book income starting points (U.S. GAAP, STAT or IFRS), and other facts and circumstances that will lead to unique situations under the CAMT. To avoid situational guidance, you indicated the solution should be principles-based and cover all insurance companies. By using a hierarchy of filers, the proposal covers all insurance companies without the need to address company specific issues. Finally, you suggested the solution should be developed between the working group and the industry, not external audit firms. Utilizing industry and working group representatives to develop the guidance prevents external audit firms from deviating in how they require insurance companies to account for the CAMT.

Thank you for the attention you have given to the impact that CAMT will have on statutory accounting and for considering the interested parties' proposed treatment.

Please feel free to contact either one of us with any questions you may have.

Sincerely,

D. Keith Bell

Rose Albrizio

cc: Interested parties
NAIC staff

Interpretation of the Statutory Accounting Principles (E) Working Group

INT 23-XX: Inflation Reduction Act – Corporate Alternative Minimum Tax

INT 23-XX References

Current:

SSAP No. 3 – Accounting Changes and Corrections of Errors

SSAP No. 9 – Subsequent Events

SSAP No. 101 – Income Taxes

INT 23-XX Issue

Key Provisions of the Inflation Reduction Act

1. The Inflation Reduction Act (Act) was enacted on August 16, 2022 and included a new corporate alternative minimum tax (CAMT). The CAMT is effective for tax years beginning after December 31, 2022. Reporting entities shall refer to the Act and the related regulations and other tax guidance to determine application, but a non-authoritative high-level summary regarding the CAMT is as follows:
 - a. The tentative CAMT is 15% of the corporation’s “adjusted financial statement income” for the taxable year, reduced by the CAMT foreign tax credit for the taxable year.
 - b. The CAMT applies only to corporations (determined on a controlled group basis as defined for Federal income tax purposes) with average annual adjusted financial statement income in excess of \$1 billion for three prior taxable years. The threshold is reduced to \$100 million in the case of certain foreign-owned corporations. A corporation that meets the applicable threshold is an “applicable corporation.” Applicable corporations generally remain applicable corporations for subsequent taxable years, unless certain limited exceptions apply.
 - c. A corporation’s adjusted financial statement income is the amount of net income or loss the corporation reports on its applicable financial statement, adjusted by various enumerated adjustments.
 - d. The Act provides a hierarchy for determining the applicable financial statement. At a high level, the first choice is U.S. generally accepted accounting principles (GAAP) financial statements; the second choice is international financial reporting standards (IFRS) financial statements. If GAAP and IFRS financial statements are not available, the financial statements filed by the taxpayer with any other regulatory or governmental body is acceptable. If the taxpayer is part of a tax-controlled group of corporations, the group’s applicable financial statement is the applicable financial statement for each member of the group.

- e. To determine its U.S. federal income tax liability, a corporation will need to compute taxes under both systems – the regular tax system and the CAMT system. The CAMT is payable to the extent the tentative CAMT exceeds the sum of the regular corporate income tax plus the base erosion anti-abuse tax (BEAT). Any CAMT paid is available indefinitely as a credit carryover that would reduce regular tax in future years when the regular tax liability is in excess of CAMT tax liability.
- f. The Act directs the Treasury to issue regulations and other guidance relating to implementing the CAMT, and many issues are pending detailed clarification, including issues that are unique to the insurance industry.

Interpretation Issues

2. This interpretation addresses statutory accounting and reporting aspects of the CAMT for year-end 2023 and subsequent reporting periods. While most insurers will not be applicable corporations, this interpretation provides comprehensive statutory accounting guidance for all reporting entities with respect to the CAMT. This interpretation incorporates a principles-based approach which progressively categorizes reporting entities for purposes of statutory accounting for the CAMT so that each step in the interpretation is dependent on the prior steps.
3. Although it is likely that most insurers that are applicable corporations will be members of a tax-controlled group of corporations and included in a consolidated Federal income tax return with other members of the group, this interpretation applies to all reporting entities, whether an unaffiliated corporation¹ that files a separate tax return, a member of a tax-controlled group not included in the common parent company's consolidated tax return that files a separate company tax return or a separate consolidated tax return with other members of the group, or as a member of the common parent's consolidated return group. For reporting entities that are included in a consolidated tax return, the fundamental statutory tax accounting issue for the CAMT is how to reflect in the reporting entity's separate company financial statements a portion of what is essentially an add-on tax for a consolidated tax return group that is based on the group's financial statement income. Unlike the alternative minimum tax (AMT) that applied under pre-2018 tax law, the new CAMT does not apply to every corporation and is not based on the corporation's regular taxable income with adjustments for minimum tax purposes. Instead, the determination of whether the CAMT applies is made on a tax-controlled group basis (scope determination), the tentative CAMT is based on the group's adjusted financial statement income (not adjusted regular taxable income), and any tax actually due (liability determination) is based on a comparison of consolidated tentative CAMT to consolidated regular tax. Even if a member of a tax-controlled group of corporations files its own separate Federal income tax return, the tax law does not provide for a separate company scope determination, but rather looks to the tax-controlled group for applicable corporation status and determination of the applicable financial statement.

¹ As used herein, an "unaffiliated" corporation is one that is not a member of a tax-controlled group.

4. As described in the rules below, this interpretation is based on the principle that the statutory tax accounting for the CAMT for reporting entities included in a consolidated tax return should be matched to the CAMT charges and credits that actually are expected to be paid by or to the reporting entity. For such reporting entities, this interpretation applies the provisions of the intercompany tax allocation agreement (also referred to as a tax sharing agreement or TSA) that governs allocation of consolidated taxes to individual members of the group.
 - a. Paragraph 16. of *SSAP No. 101* provides that in the case of a reporting entity that files a consolidated income tax return with one or more affiliates, income tax transactions between the affiliated parties shall be recognized if such transactions are economic transactions as defined in *SSAP No. 25*; are pursuant to a written TSA; and income taxes incurred are accounted for in a manner consistent with the principles of FAS 109 (the forerunner of what is now ASC 740), as modified by *SSAP No. 101*.
 - b. This interpretation provides the applicable statutory tax accounting rules for the CAMT for a reporting entity that is included in a consolidated tax return and is subject to a TSA. In such case, the rules are applied consistently with the modifications to ASC 740 pursuant to both *SSAP No. 101* and this interpretation, and CAMT expense or benefit is recognized in accordance with the TSA.
 - c. Consistent with paragraph 4 of *SSAP No. 3 – Accounting Changes and Corrections of Errors*, application of this interpretation shall not be considered a change in accounting principle.

INT 23-XX Discussion

5. A reporting entity is an “applicable corporation” for purposes of this interpretation if, either as an unaffiliated corporation or as a member of a tax-controlled group of corporations, the reporting entity is an “applicable corporation” as defined for CAMT purposes in the tax code or guidance thereunder. With limited exceptions, once a corporation is an applicable corporation under the tax law, it remains an applicable corporation for subsequent taxable years and for purposes of this interpretation. Applicable corporation status means that CAMT must be tentatively determined and compared to regular tax liability. However, no CAMT is actually payable unless tentative CAMT exceeds regular tax liability. CAMT in excess of regular tax liability gives rise to a credit that is carried forward indefinitely for use when regular tax liability exceeds CAMT.

Categories of Reporting Entities

6. In an annual determination, all reporting entities are separated into one of four categories – the first three of which are not required to account for CAMT in determining current or deferred income taxes under *SSAP No. 101*.
 - a. Category a. consists of unaffiliated reporting entities that do not reasonably expect to be an applicable corporation for the taxable year that includes the reporting period. A reporting entity that was an applicable corporation for the preceding taxable year is deemed to reasonably expect to be an applicable corporation for

- the current taxable year, unless one of the tax law exceptions to continued applicable corporation status applies. Category a. reporting entities are not required to recognize CAMT in any current or deferred tax computations under *SSAP No. 101*. Accordingly, non-applicable corporation status for the current reporting period applies both for purposes of determination of current taxes and determination of the amount “expected to be realized within the applicable period” in the admitted DTA calculation in paragraph 11.b.i. of *SSAP No. 101*.
- b. Category b. includes a reporting entity that is a member of a tax-controlled group of corporations, and the tax-controlled group does not reasonably expect to be an applicable corporation for the taxable year that includes the reporting period. As with category a. reporting entities, a category b. reporting entity that is a member of a tax-controlled group of corporations that was an applicable corporation for the preceding taxable year is deemed to reasonably expect to be an applicable corporation for the current taxable year, unless one of the tax law exceptions to continued applicable corporation status applies. On the other hand, because the tax law does not provide for a separate company scope determination for members of a tax-controlled group, but instead determines applicable corporation status on a tax-controlled group basis, a category b. reporting entity is not required to make a separate company scope determination as if it was an unaffiliated corporation. Like category a. reporting entities, category b. reporting entities are not required to recognize CAMT in any current or deferred tax computations under *SSAP No. 101*, and non-applicable corporation status for the current reporting period applies both for purposes of determination of current taxes and determination of the amount “expected to be realized within the applicable period” in the admitted DTA calculation in paragraph 11.b.i. of *SSAP No. 101*.
 - c. Category c. includes a reporting entity that is a member of a tax-controlled group of corporations, and the tax-controlled group reasonably expects to be an applicable corporation for the taxable year that includes the reporting period. However, the reporting entity is included in a consolidated Federal income tax return with other members of the tax-controlled group and is a party to a TSA that is in effect for the reporting period and pursuant to the terms of which the category c. reporting entity i) is excluded from charges for any portion of the group’s CAMT, and ii) is not allocated any portion of the group’s utilization of CAMT credit carryover. Paragraph 8.3 of *SSAP No. 101 Exhibit A – Implementation Questions and Answers (Q&A)* is not applicable to Category c. reporting entities with respect to the CAMT. Like category a. and b. reporting entities, category c. reporting entities are not required to recognize CAMT in any current or deferred tax computations under *SSAP No. 101*, and this accounting treatment for the current reporting period applies both for purposes of determination of current taxes and determination of the amount “expected to be realized within the applicable period” in the admitted DTA calculation in paragraph 11.b.i. of *SSAP No. 101*. See *Example 1d* in paragraph 10.b. of this interpretation for an illustration.
 - d. Category d. includes all other reporting entities. Accordingly, category d. includes a reporting entity that reasonably expects to be an applicable corporation for the

taxable year that includes the reporting period, either as an unaffiliated corporation or as a member of a tax-controlled group of corporations if, in the latter case, the reporting entity is not included in category c. A category d. reporting entity may be the common parent company of a consolidated return group. It may also be a member of an affiliated group of corporations (as defined for Federal income tax purposes) but excluded from the consolidated tax return and filing its own separate return (if, for example, the reporting entity is a life insurance company and i) the group has not made a “life-nonlife” consolidated return election, or ii) the reporting entity has been recently-acquired and is excluded from the life-nonlife consolidated return for a period of 5 years). Category d. reporting entities are required to consider CAMT in *SSAP No. 101* current and deferred tax computations in the manner set forth in the following paragraphs. Because CAMT is not payable by an applicable corporation unless it is in excess of regular tax liability, the calculations under category d. may or may not result in different current and deferred income taxes than if the CAMT was not taken into account.

Operational Rules for Category d. Reporting Entities

7. Category d. reporting entities are required to take CAMT into account under *SSAP No. 101* to the extent it is reasonably expected that the tax actually is (for the current period) or could be (for future years in the *SSAP No. 101* paragraph 11.b. applicable period) incurred a) by the reporting entity (if unaffiliated or affiliated but excluded from a consolidated tax return) or b) by the consolidated tax return group of which the reporting entity is a member and the consolidated CAMT is allocable in some part to the reporting entity pursuant to the group’s intercompany income tax allocation agreement. Such reporting entities recognize CAMT, if any, as a current tax expense for the taxable year that includes the reporting period and recognize CAMT credit utilization as a current tax benefit for such period. If the reporting entity is a party to a TSA, CAMT expense or CAMT credit utilization is based on the amount determined under the TSA. If the reporting entity pays CAMT or utilizes the CAMT credit to offset regular tax liability, its CAMT expense or CAMT credit utilization is based on the amount of such payments or receipts less allocations to other members of the consolidated tax group pursuant to the TSA.
8. A reporting entity is allowed an accounting policy election to either consider or disregard CAMT when evaluating the need for a valuation allowance for its regular tax DTAs.² The accounting policy election applies for valuation allowance purposes only - that is, in the determination of adjusted gross DTAs other than CAMT-related DTAs. This accounting policy election cannot be used to avoid a valuation allowance analysis for CAMT credit carryforward DTAs. The accounting policy election must be disclosed in the notes to the financial statements and applied consistently in subsequent reporting periods.

² ASC 740 does not specifically address whether future years’ CAMT should be anticipated in a valuation allowance assessment for regular tax DTAs. Accordingly, an accounting policy election is allowed for GAAP purposes as to whether to consider or disregard CAMT when evaluating the need for a valuation allowance for regular tax DTAs.

9. An adjusted gross deferred tax asset (DTA) is recognized for any CAMT credit carryforward that is more likely than not to be recognized (that is, after reduction of the gross DTA by any required valuation allowance) and is admissible under the conditions described in paragraph 10 of this interpretation. The valuation allowance analysis should include, for example, the risk that the reporting entity, or the tax-controlled group of corporations of which the reporting entity is a member, more likely than not may be unable to realize the CAMT credit carryforward. Because the CAMT credit utilization is determined at the consolidated group level for reporting entities that are part of a consolidated group, the reporting entity valuation allowance determination shall be consistent with the consolidated group determination. A valuation allowance analysis for a CAMT credit carryforward is required regardless of the accounting policy election described in paragraph 8.
10. The admissible amount of adjusted gross DTAs for a category d. reporting entity is determined under paragraph 11 of *SSAP No. 101* with the modifications set forth below.
- a. An RBC-reporting entity with an ExDTA Authorized Control Level Risk Based Capital (RBC) percentage – calculated as described in footnote 3 of paragraph 11.b. of *SSAP No. 101* - of greater than [450]% if a life insurance company and [400]% in all other cases is not required to take the CAMT into account in calculating the “with and without” tax liability for purposes of determining the amount expected to be realized under paragraph 11.b.i. of *SSAP No. 101* within the 3-year applicable period determined under paragraph 11.b. **[NOTE TO DRAFT:** An RBC ratio is being proposed for this financial strength test in part because *SSAP No. 101* already includes an RBC threshold in paragraph 11.b. An alternative financial strength test might incorporate an approach similar to that of Section 8.B.(3)(c) of the Credit for Reinsurance Model Regulation relating to certified reinsurers, wherein an assuming insurer must maintain financial strength ratings from two or more rating agencies deemed acceptable by the commissioner. For this purpose, acceptable rating agencies include Standard & Poor’s, Moody’s Investor Service, Fitch Ratings, A. M. Best Company, or any other nationally recognized statistical rating organization.] The post-valuation allowance adjusted gross DTA for any CAMT credit carryforward is admitted by such entities without regard to paragraph 11.b.i. The 15% limitation of capital and surplus limitation of paragraph 11.b.ii. of *SSAP No. 101* continues to apply to admitted adjusted gross DTAs, including the adjusted gross DTA for any CAMT credit carryforward. See *Example 1c* below. A category d. reporting entity that accounts for CAMT pursuant to this paragraph 10.a. shall disclose that fact in the notes to the financial statements.
 - b. If this financial strength threshold is not met, the amount expected to be realized under paragraph 11.b.i. of *SSAP No. 101* within the applicable period determined under paragraph 11.b. is based on the reporting entity’s “with and without” regular tax liability reduced by CAMT, if any, reasonably expected to be incurred during the paragraph 11.b. applicable period. In the case of a reporting entity included in a consolidated Federal income tax return, the amount expected to be realized is reduced

by the portion of the consolidated CAMT, if any, reasonably expected to be allocable to the reporting entity pursuant to the group's TSA. CAMT credit utilization during the applicable period is recognized based on the same principles, with the opposite effect – that is, as an admitted DTA. The purpose of these computations is to account for CAMT in deferred taxes in the same manner as CAMT would be reflected in current taxes. The DTA for any CAMT credit carryforward not admitted under paragraph 11b. of *SSAP No. 101* is available to offset liabilities under paragraph 11c. of *SSAP No. 101* without any other considerations.

- c. Paragraph 8.3 of the *SSAP No. 101 Q&A* is not applicable to Category d. reporting entities with respect to the CAMT.
- d. Examples

Example 1a: Insurance company IC is a member of a tax-affiliated group of corporations that files consolidated Federal income tax return and that reasonably expects to be an applicable corporation for 20X3. For 20X3, IC falls below the financial strength threshold applicable for category d. but exceeds the RBC threshold in paragraph 11.b. of *SSAP No. 101* for use of a 3-year applicable period. At the end of 20X3, IC has a \$50x CAMT credit carryover DTA (pursuant to the consolidated group's TSA, IC was allocated a portion of the group's expected 20X3 current CAMT expense, which IC included in its 20X3 current tax expense). IC also has \$200x of regular tax adjusted gross DTAs (i.e., as already reduced by any required valuation allowance), of which \$150x reverses over the 3-year applicable period 20X4-20X6 and is expected to be realized in IC's with and without calculation under paragraph 11.b.i. of *SSAP No. 101*. The consolidated group expects to absorb its entire CAMT credit carryover, including the \$50x allocated to IC, in 20X4, and expects to incur CAMT in each of 20X5 and 20X6, of which \$5x each year is expected to be allocated under the TSA to IC. IC's 15% of surplus limitation under paragraph 11.b.ii. of *SSAP No. 101* is \$225x.

Ignoring for purposes of this example any DTA admittance under paragraphs 11.a. and 11.c. of *SSAP No. 101*, IC admits the \$50x adjusted gross DTA for the CAMT credit carryover expected to be utilized in 20X4 and reduces its \$150x of regular tax admitted DTAs by the \$10x CAMT expected to be incurred in 20X5 and 20X6, resulting in \$190x of DTA admitted under paragraph 11.b.i., which is less than the \$225x paragraph 11.b.ii. limitation. However, if the 15% of capital and surplus limitation was \$175x instead of \$225x, the \$190x would be limited to \$175x.

	DTAs	Regular DTAs Admitted Standalone	Impact of Consolidated CAMT	Admitted DTAs under 11.b.i	15% Surplus limitation under 11.b.ii	Non Admitted DTAs
Adjusted gross DTAs reversing in 3 years	200	150	(10)	140		60
CAMT Credit DTA	50		50	50		-
	250	150	40	190	225	60

Example 1b. The facts are the same as in *Example 1a* except that the consolidated group of which IC is a member expects to absorb in 20X4 only a portion of its CAMT credit carryover, of which \$30x would be allocated to IC, and expects to incur CAMT in each of 20X5 and 20X6, of which \$5x each year is expected to be allocated under the TSA to IC. The consolidated group also concludes that its remaining consolidated CAMT credit carryforward, of which \$20x would be allocated to IC, is not more likely than not to be realized.

In accordance with paragraph 9 of this interpretation, IC establishes a \$20x valuation allowance against its \$50x AMT credit carryforward DTA, resulting in an adjusted gross DTA of \$30x. Under paragraph 8 of this interpretation, IC makes an accounting policy election to disregard CAMT when evaluating the need for a valuation allowance for its regular tax DTAs. IC admits \$150x of regular tax adjusted gross DTAs and the \$30x adjusted gross DTA for its allocated portion of the CAMT credit carryforward. IC reduces its admitted adjusted gross DTAs by its \$10x share of the consolidated CAMT expected to be incurred in 20X5 and 20X6. The result is an admitted DTA of \$170x, \$20x less than an *Example 1a*, attributable to the \$20x valuation allowance against the CAMT credit carryforward.

Example 1c. The facts are the same as in *Example 1a* except that IC exceeds the financial strength threshold applicable for category d. Accordingly, IC would not reduce its admitted regular tax DTA by any CAMT for years after 20X3. However, IC would still have to perform a valuation allowance analysis on its \$50x CAMT credit carryforward at the end of 20X3 and reduce the adjusted gross DTA for such credit to the amount more likely than not to be realized. Assume the valuation allowance is \$20x and the adjusted gross DTA for the CAMT credit carryover is reduced to \$30x. IC's admitted DTA would be \$180x. Additionally, if IC's 15% of surplus limitation under paragraph 11.b.ii. was \$175x, IC's admitted adjusted gross DTA would be further reduced to \$175x.

Example 1d. If, in *Example 1a*, the TSA to which IC is a party excluded IC from any allocation of CAMT or CAMT credit utilization, IC would be a category c. reporting entity for 20X3, CAMT would be excluded from the calculations, and IC's admitted adjusted gross DTA would be \$150x.

- e. Also recognized are CAMT credit carryovers arising during the applicable period that become utilizable within the applicable period.

Example 2: The facts are the same as *Example 1a* except that the consolidated group (and IC) have no CAMT credit carryovers at the end of 20X3. Furthermore, the consolidated group reasonably expects to incur CAMT liability in each of 20X4 and 20X5 (instead of 20X5 and 20X6) and to utilize in 20X6 a portion of the CAMT credit carryovers generated in 20X4 and 20X5. Of these amounts, IC is expected to be allocated under the TSA \$5x of CAMT in each of 20X4 and 20X5, and \$6x of

CAMT credit utilization in 20X6. In determining admitted adjusted gross DTAs for the 20X3 reporting period, IC reduces its regular tax admitted adjusted gross DTA by its \$10x TSA-allocated portion of the consolidated group's CAMT for 20X4 and 20X5 but increases such admitted amount by its \$6x TSA-allocated portion of the consolidated group's CAMT credit utilization for 20X6.

- f. Projections of CAMT liability, if any, (and CAMT credit utilization) during the applicable period involve forward-looking data, groupings, estimates and other adjustments for both the reporting entity and the group of which it is a member. The manner in which this is done shall be conducted in a reasonable and consistent manner. A reporting entity shall retain internal documentation to support these computations and the methodologies so employed. Modifications are permitted should events or circumstances change from a previous period – such as a change in materiality or administrative costs associated with the computations, or system changes that affect the level of detail available. Entities that make such modifications should be prepared to rationalize the changes. Disclosure of material modifications, and the general reason for such, should be made in the notes to the financial statements.³
- g. *SSAP No. 101* provides that tax-planning strategies are required to be considered in the valuation allowance analysis and may be considered in determining the admission of DTAs under *SSAP No. 101* paragraph 11. A reporting entity may consider tax-planning strategies in making the determinations required under this interpretation. Because the CAMT scope and liability determinations are made at a group level, tax-planning strategies may be considered both at a group level and at the reporting entity level. However, tax-planning strategies at the group level shall not conflict with tax-planning strategies at the reporting entity level and vice versa.
- h. CAMT arising during the *SSAP No. 101* paragraph 11.b. applicable period that reduces the amount expected to be realized under paragraph 11.b. results in DTAs for CAMT credit carryforwards that may be taken into account in the *SSAP No. 101* paragraph 11.c. calculation.

Example 3: The facts are the same as in Example 2. The remaining \$4x of CAMT credit carryforward arising during the 3-year applicable period is taken into account in IC's 20X3 paragraph 11 calculation as part of the amount of adjusted gross DTAs, after application of paragraphs 11.a. and 11.b., that can be offset against existing gross DTLs.

Disclosures

11. The reporting entity shall disclose whether it is a category a., b., c., or d. reporting entity. Additionally, the following disclosures shall be made in the notes to the financial statements of category d. reporting entities:
 - a. The accounting policy election described in paragraph 8. of this interpretation.
 - b. Application of the RBC reporting threshold described in paragraph 10.a. of this interpretation

³ See paragraph 2.9 of the *SSAP No. 101 Q&A* for similar requirements in the context of grouping of assets and liabilities for measurement.

- c. Any disclosure required by paragraph 10.f. of this interpretation.
- d. In the disclosure required by paragraph 28.b. of *SSAP No. 101*, a statement as to whether the reporting entity may be charged with a portion of CAMT incurred by the consolidated group (or credited with a portion of the consolidated group's CAMT credit utilization).
- e. Inclusion of CAMT credit carryforwards, if any, in the disclosure required by paragraph 26.a. of *SSAP No. 101*.
- f. The impact of CAMT tax-planning strategies, if any, in the disclosure required by paragraph 22.f. of *SSAP No. 101*.

Transition Guidance

12. Even though the CAMT was enacted in 2022 and generally became effective January 1, 2023, the requirements for statutory tax accounting for the CAMT have effectively been deferred by INT 22-02.⁴ It is well understood that reporting entities have been awaiting the guidance provided in this interpretation to file requests for approval of TSA amendments or a new TSA relating to the CAMT. This paragraph 11. provides the applicable transition rules for year-end 2023 statutory accounting for requests for a timely-filed TSA amendment or a new TSA for the 2023 taxable year.

- a. Because the CAMT was newly-enacted effective for 2023, TSAs in effect for periods prior to the 2023 taxable year include no explicit provisions relating to the CAMT.⁵ Thus, category c. and category d. reporting entities may need to amend TSAs to deal with the CAMT effective for the entire 2023 taxable year. A reporting entity would file a request for amendment to a TSA or a new TSA on Form D – Prior Notice of a Transaction with its applicable domiciliary regulator(s) and commercial domiciliary regulator(s).
- b. Time is of the essence in both requesting and approving TSA amendments or a new TSA relating to the CAMT for the 2023 taxable year to be applicable to the 2023 reporting period. Accordingly, if, within [45] days after adoption of this interpretation, a reporting entity files the applicable Form D request(s) for TSA amendment or a new TSA to address the CAMT for 2023 and subsequent taxable years,⁶ such TSA amendment or new TSA shall be accounted for as applicable for the entire 2023 reporting period, regardless of whether the approved TSA allocates consolidated CAMT (or utilization of consolidated AMT credit carryforwards) to the reporting entity.
 - i. If the final approved TSA differs in its treatment of the CAMT allocation from the TSA originally requested on the Form D, the difference shall be recorded as follows:
 - 1. If Form D approval occurs subsequent to the balance sheet date, but before the issuance of the statutory financial statements and before

⁴ INT 22-02: Third Quarter 2022 through Second Quarter 2023 Reporting of the Inflation Reduction Act – Corporate Alternative Minimum Tax (last updated April 12, 2023).

⁵ TSAs may include provisions relating to the pre-2018 AMT if not previously amended to remove such provisions.

⁶ That is, with an effective date of January 1, 2023, or, if not a calendar year taxpayer, the first day of the 2023 taxable year.

the date the audited financial statements are issued, or available to be issued, such approval shall be considered a Type I subsequent event within the meaning of *SSAP No. 9 – Subsequent Events*.

2. In the extraordinary circumstance that a Form D approval occurs after the period which defines a subsequent event in *SSAP No. 9*, the difference created by such approval shall be recognized and disclosed in the period in which the approval is given.
- ii. The transition guidance in this paragraph 12. does not apply to a reporting entity that does not file a Form D request for a CAMT-related TSA amendment or a new TSA within the time period specified in subparagraph b.

Interested Parties Draft

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June 9, 2023

Mr. Dale Bruggeman, Chairman
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National Association of Insurance Commissioners
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RE: Interested Parties Comments on Exposures with Comments due June 9

Dear Mr. Bruggeman:

Interested parties appreciate the opportunity to comment on the items exposed for comment by the Statutory Accounting Working Group (the Working Group) during its March 22, 2023, meeting with comments due June 9.

Ref #2022-19: Negative IMR

The Working Group directed NAIC staff regarding the consideration of negative interest maintenance reserve (IMR) with an intent to work on both a 2023 solution and a long-term solution as follows:

- a. Draft a referral to the Life Actuarial (A) Task Force on further consideration of the asset adequacy implications of negative IMR. Items to include: 1) developing a template for reporting within asset adequacy testing (AAT); 2) considering the actual amount of negative IMR that is admitted to be used in the AAT; 3) better consideration of cash flows within AAT (and documentation), as well as any liquidity stress test (LST) considerations; 4) ensuring that excessive withdrawal considerations are consistent with actual data (sales of bonds because of excess withdrawals should not use the IMR process); and 5) ensuring that any guardrails for assumptions in the AAT are reasonable and consistent with other aspects.
- b. Draft a referral to the Capital Adequacy (E) Task Force for the consideration of eliminating any admitted net negative IMR from total adjusted capital (TAC) and the consideration of sensitivity testing with and without negative IMR.

- c. Develop guidance for future Working Group consideration that would allow the admission of negative IMR up to 5% of surplus using the type of limitation calculation similar to that used for goodwill admittance. The guidance should also provide for a downward adjustment if RBC ratio is less than 300.
- d. Review and provide updates on any annual statement instructions for excess withdraws, related bond gains/losses and non-effective hedge gains/losses to clarify that those related gains/losses are through asset valuation reserve (AVR), not IMR.
- e. Develop accounting and reporting guidance to require the use of a special surplus (account or line) for net negative IMR.
- f. Develop governance related documentation to ensure sales of bonds are reinvested in other bonds.
- g. Develop a footnote disclosure for quarterly and annual reporting.

Please see the comments in the letter submitted by ACLI on May 17th.

Principles-Based Bond Definition

The Working Group exposed changes to several SSAP's that propose statutory accounting changes under the principles-based bond project.

The exposure also proposes changes to Schedule BA to encompass debt securities that do not qualify as bonds and consolidate existing reporting lines.

Interested parties' comments are shown below related to each of the five separate documents exposed for comment.

SSAP No. 26R, SSAP No. 43R, and Other SSAPs

Interested parties have no comments on these exposures and are appreciative of the changes made and the responsiveness to interested parties' previous comments.

Schedule BA

Interested parties will respond to this exposure under separate cover as comments are more involved and not due until June 30, 2023.

SSAP No. 21R

Paragraphs 22 and 29

Interested parties understand that proposed paragraph 22 of SSAP No. 21 requires that the underlying collateral in an asset-backed security that fails the bond definition must qualify as admitted assets for the security to be admitted. Paragraph 22 also proposes to report these bonds at a value that does not exceed the fair value of the collateral with any amount above the fair value of the collateral being non-admitted. Interested parties have concerns with the proposal as this would be operationally very difficult to do since some asset-backed securities can have a

large number of assets and the fair value of the underlying collateral in the asset-backed security may not be readily available. This is very different from collateral loans in SSAP No. 21 where there are generally fewer assets that compose the underlying collateral. In addition, this would be costly as currently the servicer/trustee reports do not usually include fair value of the collateral so this would be a new service for which we would have to pay. Interested parties believe that accounting for these securities at the lower of cost or market of the security owned by the insurer will consider the performance of the underlying collateral. The unit of account is the security owned by the insurer and not the underlying collateral for the asset-backed security. The fair value of the bond will consider the fair value of the collateral to a great extent, but it will also take into account other key characteristics of the bond itself that impact the bond's fair value and will better reflect the consideration expected to be received upon maturity or sale of the security. If the collateral is an admitted asset, the entire carrying balance of the security should be admitted without having to quantify collateral fair value given the cost and complexity in doing so. Interested parties propose changes to paragraph 22 as a result of the comments above.

Interested parties also have comments regarding the new paragraph 29 that was added to clarify the accounting for residual tranches. We believe that the intent of paragraph 29 is to require non-admission of a residual tranche only if another tranche from the same securitization owned by the insurer fails the bond definition and the collateral is not an admitted investment. Interested parties propose changes to paragraph 29 to further clarify what we believe to be the intent of the paragraph.

We proposed the following changes to paragraphs 22 and 29 to address the aforementioned comments:

22. Debt securities in scope of this standard that do not qualify as bonds under SSAP No. 26R and for which the primary source of repayment is derived through rights to underlying collateral, qualify as admitted assets ~~only to the extent they are secured~~ if the underlying collateral primarily qualify as admitted invested assets. Any residual tranches or first loss positions held from the same securitization that did not qualify as a bond under SSAP No. 26R also only qualify as admitted assets to the extent the underlying collateral primarily qualify as admitted invested assets. Any amounts in excess of the fair value of the underlying admitted invested assets shall be non-admitted.

29. As stated in paragraph 22, Residuals are permitted to be admitted if debt securities from the same securitization qualify as bonds under SSAP No. 26R as an issuer credit obligation or an asset backed security. For example, if a debt security from a securitization does not qualify as a bond, and the source of repayment is derived through rights to the underlying collateral, the debt security is only permitted to be admitted if the underlying assets qualify as admitted assets. If the debt security from a securitization is nonadmitted due to the requirements under paragraph 22, then any residual interests or first loss positions held from the same securitization also do not qualify as admitted assets and would be reported as nonadmitted assets.

Paragraph 25

Interested parties also note that the way paragraph 25 below was written implies that the only securities that can fail the definition are asset-backed securities. Since an issuer credit obligation could also fail the bond definition (i.e., does not reflect a creditor relationship in substance), we believe the changes recommended below are needed to reference the appropriate accounting guidance under either SSAP No. 26 for issuer credit obligations or SSAP No. 43R for asset-backed securities.

25. Debt securities that do not qualify as bonds ~~are captured~~included in the scope of this statement. Debt securities included in the scope of this statement shall follow the guidance in SSAP No. 43R—Asset-Backed Securities or SSAP No. 26R Bonds, depending on whether they would have been classified as asset-backed securities or issuer credit obligations, respectively, should they have qualified as bonds. This includes the guidance, for calculating amortized cost, for determining and recognizing other-than-temporary impairments and for allocating unrealized and realized gains and losses between the asset valuation reserve (AVR) and interest maintenance reserve (IMR).

Paragraphs 30 and 31

In paragraph 31 of the exposure, NAIC asks the following question:

Exposure Question: Industry is requested to provide information on how residual tranches have been amortized and how they have been assessed for OTTI as there are no contractual principal or interest payments.

Regarding the calculation of amortized cost and the assessment of OTTI for residuals, it has generally been industry practice to follow the SSAP No. 43R guidance for beneficial interests (i.e., paragraphs 21-25 of the bond definition proposal titled “Accretable Yield and Changes to Effective Yield for Application of Prospective Method”), which requires estimates of cash flows to be calculated quarterly with prospective yield adjustments. If there is an adverse change in estimated cash flows at the reporting date, an OTTI is recorded. Under those circumstances, the residual is written down to the current estimate of cash flows discounted at a rate equal to the current yield used to accrete the residual with the resulting change being recognized as a realized loss. If the cash flows increase from the prior period, the yield is adjusted upward. To require recognition of a loss for the entire amount of the residual would not be a reasonable accounting result. Also, for insurers who are US GAAP filers, they also apply the prospective method discussed above for their US GAAP financial statements, if they have not elected the fair value option. As a result, interested parties propose the edits below to paragraphs 30 and 31, which also include clarification on AVR treatment of residuals:

30. Residuals shall be initially reported at cost, or allocated cost (using proportional fair values) if acquired along with debt tranches from the securitization. Subsequent to initial acquisition, residuals shall be reported at the lower of amortized cost or fair value, with changes in fair value (or from amortized cost to fair value) reported as unrealized gains or losses. To determine amortized cost, the reporting entity should apply SSAP No. 43R,

paragraphs 21-25 (i.e., prospective method). Unrealized and realized gains and losses on residuals are reported in the AVR.

31. Residuals shall be assessed for other-than-temporary impairment (OTTI) on an ongoing basis based on SSAP No. 43R. An OTT shall be considered to have occurred if it is probable that the reporting entity will not receive cash flows distributed to the residual tranche to cover the reported amortized cost basis. Upon identification of a probable OTTI, the reporting entity shall recognize a realized loss equal to the remaining amortized cost basis. Subsequent to the recognition of OTTI, the residual shall be reported with a zero book adjusted carrying value. Any subsequent cash flows received attributed to the residual tranche shall be reported as interest income.

Interested parties also note that the recent exposure by the Working Group that intends to expand the scope of what is considered a residual investment may require significant changes to the accounting laid out above. The accounting model for residuals issued in a securitization that we explain above is in line with the accounting for residuals that are more akin to a debt security. If the scope of a residual is expanded to include other types of residuals, this model may not fit those types of investments. Given this linkage, interested parties may have additional recommendations for the accounting discussed above as the residual investment definition is finalized.

Ref #2022-01: Conceptual Framework – Updates

The Working Group exposed additional revisions to *Issue Paper No. 16X—Updates to the Definition of a Liability* related to the definition change of a liability in *SSAP No. 5R—Liabilities, Contingencies and Impairment of Assets*. The revisions to: 1) add an additional footnote to the definition of a liability in SSAP No. 5R which defers to more topic specific contradictory guidance 2) revise the relevant literature section of SSAP No. 5R to note the modification and 3) note the additional exposure action in the Issue Paper paragraph 18.

These clarifications were because of the authoritative treatment that statutory accounting provides to the definition of an asset and a liability in SSAP No. 4 and SSAP No. 5R. For GAAP, the FASB Conceptual statements definitions are not authoritative, but rather are concepts to consider when developing and applying guidance. The FASB basis for conclusions noted that some existing authoritative FASB literature regarding liabilities is inconsistent with the updates to Concepts Statement No. 8. Therefore, a modification regarding topic specific liabilities guidance was incorporated to address variations from the definition of a liability. Examples of existing SAP variations from the definition of a liability include but are not limited to:

- a. *SSAP No. 7—Asset Valuation Reserves and Interest Maintenance Reserves – AVR* and *IMR* establish liabilities for regulatory objectives.
- b. *SSAP No. 62R—Property and Casualty Reinsurance* – contains the provision for reinsurance liability guidance which results in a liability that is a regulatory valuation allowance for overdue and slow paying reinsurance and also enforces *Credit for Reinsurance (Model No. 785)* collateral requirements.

- c. *SSAP No. 92—Post Retirement Benefits Other than Pensions*, provides liability recognition, which adopts several GAAP standards with modifications.

The additional exposed revisions to SSAP No. 16X and SSAP No. 5R are reflected in the Issue Paper and also shown below.

- **Exposed revisions – Topic Specific Footnote** - This language is proposed for incorporation as a footnote to the liability definition in SSAP No. 5R and its related and *Issue Paper No. 16X—Updates to the Definition of a Liability*.

New Footnote to paragraph 3 of SSAP No. 5R:

The guidance in this Statement regarding the definition of a liability is applicable unless another authoritative statement of statutory accounting principles provides more topic specific contradictory guidance. In such cases the topic specific guidance shall apply.

- Exposed revisions to *SSAP No. 5R—Liabilities, Contingencies and Impairment of Assets* and *Issue Paper No. 16X—Updates to the Definition of a Liability* (New language shaded):

Relevant Literature

39. This statement adopts *FASB Statement No. 5, Accounting for Contingencies* (FAS 5), *FASB Statement 114, Accounting by Creditors for Impairment of a Loan* only as it amends in part FAS 5 and paragraphs 35 and 36 of *FASB Statement of Financial Accounting Concepts No. 6—Elements of Financial Statements*. *FASB Interpretation No. 14, Reasonable Estimation of the Amount of a Loss, An Interpretation of FASB Statement No. 5* (FIN No. 14) is adopted with the modification to accrue the loss amount as the midpoint of the range rather than the minimum as discussed in paragraph 3 of FIN No. 14. This statement adopts with modification *ASU 2013-04, Obligations Resulting from Joint and Several Liability Arrangements for Which the Total Amount of the Obligation is Fixed at the Reporting Date* with the same statutory modification adopted for FIN 14. This statement incorporates the definition of a liability from *FASB Statement of Financial Accounting Concepts No. 8, Chapter 4, Elements of Financial Statements*, paragraphs E37 and E38 with modification reflected in this Statement regarding topic specific guidance.

Interested parties believe the proposed changes above are responsive to our previous comments and address the issue of having statutory accounting guidance in other authoritative sources, e.g., the *NAIC Annual Statement Instructions*.

Ref #2022-11: Collateral for Loans

The Working Group exposed revisions to *SSAP No. 21 – Revised—Other Admitted Assets* which clarify that the invested assets pledged as collateral for admitted collateral loans must qualify as admitted invested assets. These revisions clarify that for specific investments, the comparison for admittance is between the net equity audited value of the pledged collateral to the collateral loan

balance. In addition, a consistency revision to *SSAP No. 20—Nonadmitted Assets*, paragraph 4.b. was exposed.

Interested parties support the proposed changes.

Ref #2022-12: Review of INT 03-02: *Modification to an Existing Intercompany Pooling Arrangement*

The Working Group re-exposed the intent to nullify INT 03-02, effective December 31, 2023. The nullification is proposed as INT 03-02 is inconsistent with SSAP No. 25 – *Affiliates and Other Related Parties*, guidance regarding economic and non-economic transactions between related parties. The guidance in INT 03-02 can result with, in essence, unrecognized gains (dividends) or losses through the use of statutory book valuation when using assets (bonds) to make payments to affiliates for modifications to existing intercompany reinsurance pooling agreements. Treatment of transfers of assets between affiliates should be consistent for all intercompany transactions and there is not a compelling need to be different when valuing assets for intercompany reinsurance transactions.

Interested parties note that there are several issues associated with nullifying INT 03-02 and transferring the assets that support the insurance liabilities at fair value versus book value as provided in the current guidance in the INT including the following:

- Inconsistent accounting among affiliates for a modification of the intercompany pooling agreement when some of the transfers generate a realized gain and others do not, depending on the assets transferred;
- The transfer of a bond in an intercompany pooling transaction that generates a realized gain would cause the intercompany pooling modification to be accounted for as retroactive reinsurance, which would violate the accounting guidance currently contained in SSAP No. 63;
- The use of retroactive reinsurance contradicts the basis of presentation in Schedule P for business subject to intercompany pooling agreements;
- Inconsistent presentation of underwriting assets and liabilities among participants in the pooling agreement; and
- Inconsistent accounting for intercompany transactions, as some gains would be deferred while other gains will be realized at the parent level, depending on the insurer's corporate ownership structure.

Depending on market interest rates at the time of a pooling modification, a gain or loss will result from the transfer of bonds at fair value. In times of declining interest rates, the fair value of bonds generally increase. During these times, if a bond with a fair value in excess of book value is transferred as part of a pooling modification and the transfer is accounted for at fair value, the transferor will recognize a gain. This gain will disqualify the transferor and transferee from accounting for the pooling modification as prospective reinsurance based on the accounting guidance in SSAP No. 62R paragraph 36d. However, the same pooling modification can have other participants qualify for prospective reinsurance due to no gain on transfer of the assets.

Prospective reinsurance versus retroactive reinsurance

The transferors, i.e., the ceding pool entities, that qualify for prospective reinsurance will record the premium and loss accounts as prospective reinsurance (i.e., the cedent's participation share of the total intercompany pool written and earned premium, reserves and losses are reported in the cedent's financial statements).

The transferors, i.e., the ceding pool entities, that do not qualify for prospective reinsurance will report written premiums, earned premiums, loss and loss adjustment reserves and losses and loss adjustment expenses without recognition of the retroactive reinsurance. Therefore, insurance accounts subject to pooling will not be reduced for cessions to the lead company of the pool or retrocessions by the lead company to the pool participants. Similarly, any transferees that do not qualify for prospective reinsurance, i.e., the assuming pool entities, will exclude the retroactive reinsurance from loss and loss expense reserves and all schedules and exhibits. SSAP No. 62R requires the following for retroactive reinsurance:

- The ceding entity and the assuming entity shall report by write-in item on the balance sheet, the total amount of all retroactive reinsurance, identified as retroactive reinsurance reserve ceded or assumed, recorded as a contra-liability by the ceding entity and as a liability by the assuming entity;
- The ceding entity shall, by write-in item on the balance sheet, restrict surplus resulting from any retroactive reinsurance as a special surplus fund, designated as special surplus from retroactive reinsurance account;
- The surplus gain from any retroactive reinsurance shall not be classified as unassigned funds (surplus) until the actual retroactive reinsurance recovered exceeds the consideration paid;
- The special surplus from retroactive reinsurance account for each respective retroactive reinsurance agreement shall be reduced at the time the ceding entity begins to recover funds from the assuming entity in amounts exceeding the consideration paid by the ceding entity.

As a result of the inconsistent accounting between pool entities that are required to account for the intercompany pooling as prospective reinsurance and the pool entities that are required to use retroactive reinsurance, the financial statements of the pool will be extremely confusing and lack useful financial information. The stand-alone financial statements of the legal entities of the pool will not be consistent and the combined audited financial statements of the pool will reflect insurance accounts that are accounted for and reported using different accounting methodologies for the same underlying transactions.

As a practical matter, it would be nearly impossible for an insurer to report intercompany pooling results and balances using both prospective and retroactive reinsurance. Premium, claim, and loss systems are not built to handle such inconsistent accounting for the same underlying transactions.

SSAP No. 62R versus SSAP No. 63

The application of retroactive reinsurance as a result of the nullification of INT 03-02 would also result in a conflict with the guidance in SSAP No. 63, *Underwriting Pools*. The highlighted wording in paragraphs 8 and 9 of SSAP No. 63 instructs the preparer to record the premiums and losses based on the legal entity's participation in the pool. The use of retroactive reinsurance would violate that guidance. Regarding the last sentence of paragraph 7, the use of retroactive reinsurance would also result in timing differences between entities in the pool as a result of certain entities deferring gains in surplus.

7. Intercompany pooling arrangements involve establishment of a conventional quota share reinsurance agreement under which all of the pooled business is ceded to the lead entity and then retroceded back to the pool participants in accordance with their stipulated shares. Arrangements whereby there is one lead company that retains 100% of the pooled business and all or some of the affiliated companies have a 0% net share of the pool may qualify as intercompany pooling. In these arrangements, only the policy issuing entity has direct liability to its policyholders or claimants; other pool participants are liable as reinsurers for their share of the issuing entity's obligations. Although participants may use different assumptions (e.g., discount rates) in recording transactions, the timing of recording transactions shall be consistently applied by all participants.

8. Underwriting results relating to voluntary and involuntary pools shall be accounted for on a gross basis whereby the participant's portion of premiums, losses, expenses, and other operations of the pools are recorded separately in the financial statements rather than netted against each other. Premiums and losses shall be recorded as direct, assumed, and/or ceded as applicable. If the reporting entity is a direct writer of the business, premiums shall be recorded as directly written and accounted for in the same manner as other business which is directly written by the entity. To the extent that premium is ceded to a pool, premiums and losses shall be recorded in the same manner as any other reinsurance arrangement. A reporting entity who is a member of a pool shall record its participation in the pool as assumed business as in any other reinsurance arrangement.

9. Underwriting results relating to intercompany pools shall be accounted for and reported as described in paragraph 8. While it is acceptable that intercompany pooling transactions be settled through intercompany arrangements and accounts, intercompany pooling transactions shall be reported on a gross basis in the appropriate reinsurance accounts consistent with other direct, assumed and ceded business.

Schedule P

Data reported in Schedule P is required to be reported net of intercompany pooling (i.e., only the reporting entity's share of the pool business is reported in Schedule P). This includes data related to premiums, losses and loss adjustment expenses, and claim counts.

Additionally, the *NAIC Annual Statement Instructions* for Schedule P require that when changes to pooling agreements impact prior accident years, historical data values in Schedule P must be

restated based on the new pooling percentages. This instruction effectively recognizes that Schedule F only provides useful information related to changes in intercompany pooling agreements if such changes are treated as prospective reinsurance.

Because intercompany pooling data would not be reflected in the Schedule P of the pool entities that are required to use retroactive reinsurance accounting, distorted data would result because only a portion of the intercompany pool's loss, premium, and claim count data would be reported on Schedule P (i.e., the only pooled data reported in Schedule P would be of the pool participants that qualify for using prospective reinsurance). Note that the use of retroactive reinsurance will apply until all of the claims subject to retroactive reinsurance are settled; therefore, the distortion of Schedule P for the pool entities will likely occur for decades depending on the underlying business. As a result, the Schedule P data for the intercompany pool used by actuaries, analysts, regulators, and the NAIC (including analysis used to update RBC factors) will not be useful or meaningful.

Other intercompany pooling issues

Because intercompany pooling agreements subject certain insurance assets (e.g., agents balances) to pooling, a mismatch would occur in the financial statements of pool participants that are required to use retroactive reinsurance accounting versus the participants that are not. For the ceding entities, insurance assets would reflect the reporting entity's share of the pool business, but premiums and losses will reflect the entity's business excluding the pooling. This would occur because insurance assets such as agents balances are not subject to retroactive reinsurance accounting.

Consistency of accounting

The NAIC has noted concerns that the "guidance in INT 03-02 can result with in essence, unrecognized gains (dividends) or losses through the using the statutory book valuation when using assets (bonds) to make payments to affiliates for modifications to existing intercompany reinsurance pooling agreements." The NAIC also notes that the "treatment of transfers of assets between affiliates should be consistent for all intercompany transactions and there is not a compelling need to be different when valuing assets for intercompany reinsurance transactions." Interested parties note the following:

- As our examples illustrate, the transfer of assets using fair value in an intercompany pooling modification can result in reported realized gains reflected in certain pool participants' financial statements, as well as the combined audited statutory financial statements of the intercompany pool even though the assets remain in the pool.
- The transfer of assets at fair value in an intercompany pooling modification can also result in inconsistent accounting for intercompany transactions, as some gains would be deferred while other gains will be realized at the parent level, depending on the ownership structure of the entities in the intercompany pool.

SSAP No. 63

SSAP No. 63 has limited accounting guidance related to intercompany pooling agreements and instead primarily provides a discussion of what an intercompany pooling agreement is and contains a reference to INT 03-02 in paragraph 5. We believe that a more effective approach to addressing the concerns over moving invested assets at book value in a modification of an intercompany agreement would be to incorporate portions of INT 03-02 into SSAP No. 63, require that insurers settle the movement of assets and liabilities on a net basis (i.e., the net of pool assets less pool liabilities) to minimize the movement of assets, require disclosure if assets with fair values that differ from cost or amortized cost are transferred as part of the modification, and include a cross reference in SSAP No. 25 to the updated guidance in SSAP No. 63 for transfers of assets associated with a modification of an intercompany pooling agreement. This approach would also provide guidance on such modification where none would exist in the absence of INT 03-02. Please see recommended changes to SSAP No. 63 in the attached.

Since the guidance regarding the transfers of assets associated with modifications of intercompany agreements would be located in SSAP No. 63, we recommend that SSAP No. 25 include a new paragraph 4 to direct the reader to the guidance in SSAP No. 63 as follows:

4. If a company transfers assets or liabilities to effectuate a modification to an existing intercompany pooling arrangement, the transaction, including the transfer of assets, shall be accounted for in accordance with the guidance in SSAP No. 63 – *Underwriting Pools*.

Ref #2023-01: Review Annual Statement Instructions for Accounting Guidance

The Working Group moved this agenda item to the active listing, categorized as a SAP clarification, with a request for regulator and industry viewpoints on situations in which guidance in the annual statement instructions should be captured within a SSAP.

Interested parties are aware of Annual Statement guidance on IMR /AVR and Schedule F penalties that should be considered for inclusion in SSAP's as well as the guidance related to intercompany pooling arrangements discussed above. If additional items come to our attention, we will inform the Working Group.

Ref #2023-02: SSAP No. 43R – CLO Financial Modeling

The Working Group moved this agenda item to the active listing, categorized as a SAP clarification, and exposed revisions to SSAP No. 43R to incorporate changes to add CLOs to the financial modeling guidance and to clarify that CLOs are not captured as legacy securities.

Interested parties have no comments on this item.

Ref #2023-05: *ASU 2022-06, Reference Rate Reform (Topic 848), Deferral of the Sunset Date of Topic 848*

The Working Group moved this agenda item to the active listing, categorized as a SAP clarification, and exposed temporary (optional) expedient and exception interpretative guidance,

to revise the expiration date of the guidance in *INT 20-01: 2020-04, 2021-01 & 2022-06 - Reference Rate Reform* to be December 31, 2024, as reflected in INT 20-01.

Interested parties support the extension of the expiration date of *INT 20-01* to December 31, 2024.

Ref #2023-06: Additional Updates on ASU 2021-10, Government Assistance

The Working Group moved this agenda item to the active listing, categorized as a SAP clarification, and exposed revisions to SSAP No. 24 to specify rejection of *ASU 2021-10, Government Assistance* but that the statutory guidance does incorporate general disclosures regarding government assistance for all entity types.

Interested parties agree with the proposed revisions to SSAP No. 24, as exposed in Ref 2023-06, subject to the following comments.

Interested parties noted that the Working Group's discussion of Ref #2023-06 in the Spring 2023 Working Group meeting agenda, indicated that use of a grant or contribution model was not intended to be permitted when accounting for government assistance under statutory accounting principles. The discussion did not indicate what accounting model should be applied. Interested parties are not aware of specific statutory guidance addressing the accounting for government assistance transactions, and believe, in the absence of specific guidance, companies may look to industry practice and other nonauthoritative GAAP guidance, which supports the use of a grant or contribution model, to determine appropriate statutory accounting treatment. Additionally, interested parties believe the disclosure requirements in SSAP No. 24 provide sufficient detail to allow a user of the financial statements to adequately understand the impact of any government assistance received by an insurer on its results regardless of the accounting model used to recognize and measure the assistance. Given these considerations and the relative infrequent occurrence of such items, interested parties suggest that the Working Group clarify that the intent of the exposed revisions in Ref #2023-06 are to require disclosure of unusual or infrequent government assistance transactions regardless of how such transactions are accounted for, and are not intended to prohibit entities from accounting for government assistance transactions through the use of a grant or contribution model.

Ref #2023-07: ASU 2019-08, Codification Improvements to Topic 718 and Topic 606

The Working Group moved this agenda item to the active listing, categorized as a SAP clarification, and exposed revisions to SSAP No. 95, SSAP No. 104R, and SSAP No. 47 to adopt, with modification, *ASU 2019-08 Compensation—Stock Compensation (Topic 718)* and

Revenue from Contracts with Customers (Topic 606): Codification Improvements—Share-Based Consideration Payable to a Customer, as illustrated in the exposure draft.

Interested parties have no comments on this item.

Ref #2023-08: ASU 2019-07, Codification Updates to SEC Sections

The Working Group moved this agenda item to the active listing, categorized as a SAP clarification, and exposed revisions to Appendix D to reject *ASU 2019-07—Codification Updates to SEC Sections: Amendments to SEC Paragraphs Pursuant to SEC Final Rule Releases No. 33-10532, Disclosure Update and Simplification, and Nos. 33-10231 and 33-10442, Investment Company Reporting Modernization, and Miscellaneous Updates* as not applicable to statutory accounting.

Interested parties have no comments on this item.

Ref #2023-09: ASU 2020-09—Amendments to SEC Paragraphs Pursuant to SEC Release No. 33-10762—Debt (Topic 470)

The Working Group moved this agenda item to the active listing, categorized as a SAP clarification, and exposed revisions to Appendix D to reject *ASU 2020-09, Amendments to SEC Paragraphs Pursuant to SEC Release No. 33-10762—Debt (Topic 470)* as not applicable to statutory accounting.

Interested parties have no comments on this item.

Ref #2023-10: ASU 2022-05, Long-Durations Contracts

The Working Group moved this agenda item to the active listing, categorized as a SAP clarification to reject *ASU 2022-05, Transition for Sold Contracts* in *SSAP No. 50—Classifications of Insurance or Managed Care Contracts; SSAP No. 51R—Life Contracts; SSAP No. 52—Deposit-Type Contracts; SSAP No. 56—Separate Accounts; SSAP No. 71—Policy Acquisition Costs and Commissions* and *SSAP No. 86—Derivatives*, which is consistent with prior agenda items related to this topic.

Interested parties support the conclusion reached for this guidance

* * * *

Thank you again for your consideration of interested parties' comments regarding the exposures discussed above. Please feel free to contact either one of us with any questions you may have.

Sincerely,

D. Keith Bell

Rose Albrizio

cc: Interested parties
NAIC staff

Statement of Statutory Accounting Principles No. 63

Underwriting Pools

STATUS

Type of Issue	Common Area
Issued	Initial Draft
Effective Date	January 1, 2001
Affects	No other pronouncements
Affected by	No other pronouncements
Interpreted by	INT 03-02
Relevant Appendix A Guidance	None

STATUS	1
SCOPE OF STATEMENT	1
SUMMARY CONCLUSION	1
Disclosures	3
Effective Date and Transition.....	4
REFERENCES	4
Relevant Issue Papers	4

SCOPE OF STATEMENT

1. This statement establishes statutory accounting principles for underwriting pools and associations.

SUMMARY CONCLUSION

2. Underwriting pools and associations can be categorized as follows: (a) involuntary, (b) voluntary, and (c) intercompany.
3. Involuntary pools represent a mechanism employed by states to provide insurance coverage to those with higher than average probability of loss who otherwise would be excluded from obtaining coverage. Reporting entities are generally required to participate in the underwriting results, including premiums, losses, expenses, and other operations of involuntary pools, based on their proportionate share of similar business written in the state. Involuntary plans are also referred to as residual market plans, involuntary risk pools, and mandatory pools.

SSAP No. 63

Statement of Statutory Accounting Principles

4. Voluntary pools are similar to involuntary pools except they are not state mandated and a reporting entity participates in the pool voluntarily. In addition, voluntary pools are not limited to the provision of insurance coverage to those with higher than average probability of loss, but often are used to provide greater capacity for risks with exceptionally high levels of insurable values (e.g., aircraft, nuclear power plants, refineries, and offshore drilling platforms).

5. Intercompany pooling relates to business which is pooled among affiliated entities who are party to a pooling arrangement.^(INT 03-02)

6. Participation in a pool may be on a joint and several basis, i.e., in addition to a proportional share of losses and expenses incurred by the pool, participants will be responsible for their share of any otherwise unrecoverable obligations of other pool participants. In certain instances, one or more entities may be designated as servicing carriers for purposes of policy issuance, claims handling, and general administration of the pooled business, while in other cases a pool manager or administrator performs all of these functions and simply bills pool participants for their respective shares of all losses and expenses incurred by the pool. In either case, liabilities arising from pooled business are generally incurred on a basis similar to those associated with non-pooled business, and should therefore be treated in a manner consistent with the guidelines set forth in *SSAP No. 5R—Liabilities, Contingencies and Impairments of Assets*.

7. Intercompany pooling arrangements involve establishment of a conventional quota share reinsurance agreement under which all of the pooled business is ceded to the lead entity and then retroceded back to the pool participants in accordance with their stipulated shares. Arrangements whereby there is one lead company that retains 100% of the pooled business and all or some of the affiliated companies have a 0% net share of the pool may qualify as intercompany pooling. In these arrangements, only the policy issuing entity has direct liability to its policyholders or claimants; other pool participants are liable as reinsurers for their share of the issuing entity's obligations. Although participants may use different assumptions (e.g., discount rates) in recording transactions, the timing of recording transactions shall be consistently applied by all participants.

7.8. Insurance groups that utilize intercompany pooling arrangements often modify these arrangements from time to time for various business reasons. These business reasons commonly include mergers, acquisitions, dispositions, or a restructuring of the group's legal entity structure. In order to effectuate a relatively simple modification, such as changing pooling participation percentages without changing the pool participants, companies often simply amend the existing pooling agreement. Alternatively, in order to effectuate a more complex modification, such as changing (by adding or removing) the number of pool participants, a company may commute the existing pooling agreement and execute a new pooling agreement(s). In conjunction with executing the appropriate intercompany pooling agreements, a transfer of assets and liabilities amongst the impacted affiliates may also be required in order implement the new pooling agreement(s). The following subparagraphs provide guidance specific to modifications of intercompany pooling arrangements and shall not be applied to an analogous transaction or event.

- a) The appropriate valuation basis to be used for assets and liabilities that are transferred among affiliates in conjunction with the execution of a new intercompany pooling agreement(s) that serves to substantively modify an existing intercompany pooling arrangement is statutory book value for assets and statutory value for liabilities.
- b) The net amount of the assets and liabilities being moved among entities as a result of a modification to an intercompany pooling shall be used to settle the intercompany payable/receivable (i.e., the assets that are transferred in conjunction with the modification) to minimize the amount of assets transferred in the modification.

Underwriting Pools**SSAP No. 63**

~~8.9.~~ Underwriting results relating to voluntary and involuntary pools shall be accounted for on a gross basis whereby the participant's portion of premiums, losses, expenses, and other operations of the pools are recorded separately in the financial statements rather than netted against each other. Premiums and losses shall be recorded as direct, assumed, and/or ceded as applicable. If the reporting entity is a direct writer of the business, premiums shall be recorded as directly written and accounted for in the same manner as other business which is directly written by the entity. To the extent that premium is ceded to a pool, premiums and losses shall be recorded in the same manner as any other reinsurance arrangement. A reporting entity who is a member of a pool shall record its participation in the pool as assumed business as in any other reinsurance arrangement.

~~9.10.~~ Underwriting results relating to intercompany pools shall be accounted for and reported as described in paragraph 8. While it is acceptable that intercompany pooling transactions be settled through intercompany arrangements and accounts, intercompany pooling transactions shall be reported on a gross basis in the appropriate reinsurance accounts consistent with other direct, assumed and ceded business.

~~10.11.~~ Equity interests in, or deposits receivable from, a pool represent cash advances to provide funding for operations of the pool. These are admitted assets and shall be recorded separately from receivables and payables related to a pool's underwriting results. Receivables and payables related to underwriting results shall be accounted for in accordance with the guidance in paragraphs 6-8. If it is probable that these receivables are uncollectible, any uncollectible amounts shall be written off against operations in the period such determination is made. If it is reasonably possible a portion of the balance is uncollectible but is not written off, disclosure requirements outlined in SSAP No. 5R shall be followed.

Disclosures

~~11.12.~~ If a reporting entity is part of a group of affiliated entities which utilizes a pooling arrangement under which the pool participants cede substantially all of their direct and assumed business to the pool, the financial statements shall include:

- a. A description of the basic terms of the arrangement and the related accounting;
- b. Identification of the lead entity and of all affiliated entities participating in the intercompany pool (include NAIC Company Codes) and indication of their respective percentage shares of the pooled business;
- c. Description of the lines and types of business subject to the pooling agreement;
- d. Description of cessions to non-affiliated reinsurers of business subject to the pooling agreement, and indication of whether such cessions were prior to or subsequent to the cession of pooled business from the affiliated pool members to the lead entity;
- e. Identification of all pool members which are parties to reinsurance agreements with non-affiliated reinsurers covering business subject to the pooling agreement and which have a contractual right of direct recovery from the non-affiliated reinsurer per the terms of such reinsurance agreements;
- f. Explanation of any discrepancies between entries regarding pooled business on the assumed and ceded reinsurance schedules of the lead entity and corresponding entries on the assumed and ceded reinsurance schedules of other pool participants;
- g. Description of intercompany sharing, if other than in accordance with the pool participation percentage, of the Aging of Ceded Reinsurance (Schedule F, Part 3) and the write-off of uncollectible reinsurance;

SSAP No. 63**Statement of Statutory Accounting Principles**

- h. Amounts due to/from the lead entity and all affiliated entities participating in the intercompany pool as of the balance sheet date.
- i. For modifications to an existing intercompany pooling arrangement that involve the transfer of assets with fair values that differ from cost or amortized cost, the statement value and fair value of assets received or transferred by the reporting entity.

~~12.~~13. Refer to the Preamble for further discussion regarding disclosure requirements.

Effective Date and Transition

~~13.~~14. This statement is effective for years beginning January 1, 2001. A change resulting from the adoption of this statement shall be accounted for as a change in accounting principle in accordance with *SSAP No. 3—Accounting Changes and Corrections of Errors*.

REFERENCES**Relevant Issue Papers**

- *Issue Paper No. 97—Underwriting Pools and Associations Including Intercompany Pools*



June 9, 2023

Mr. Dale Bruggeman, Chairman
Statutory Accounting Principles Working Group
National Association of Insurance Commissioners
1100 Walnut Street, Suite 1500
Kansas City, MO 64106-2197

Dear Mr. Bruggeman:

Re: Exposure Reference No. 2022-11 – Collateral for Loans

Security Benefit Life Insurance Company would like to thank the Statutory Accounting Principles Working Group (“SAPWG”) for the opportunity to provide comments for consideration on Reference No. 2022-11—Collateral for Loans (the “Exposure”)¹, which proposes revisions to Statements of Statutory Accounting principles (“SSAP”) No. 21R, *Other Admitted Assets* (“SSAP No. 21R”) as follows:

1. A joint venture, partnership, or limited liability company (“JV/LP/LLC”) or a subsidiary controlled or affiliated entity (“SCA”) that is pledged as collateral to support an outstanding collateral loan balance must each be audited annually to qualify as an admitted investment.
2. The audited net equity of a pledged JV/LP/LLC and/or SCA is the basis of measurement for comparison to an outstanding collateral loan balance. Any portion of the outstanding balance of a collateral loan that is greater than the audited net equity of a pledged JV/LP/LLC and/or SCA must be non-admitted.

Firstly, consistent with the separate and broader Interested Party comment letter dated February 10, 2023, we do not believe an audit is necessary. In addition, we believe considering book value as a measure of the adequacy of collateralization, or ability for a borrower to repay a collateral loan is not supportable. Book value of equity is not acknowledged to reflect the value of what an asset would be bought or sold for (*i.e.*, the ultimate source of repayment for the collateral loan). The concept of fair value (*vs.* book value) exists precisely to represent the price that would be received for the sale of an asset in an orderly transaction between market participants at the measurement date. This variance between book value and fair value is observed in markets every day, where trading and transaction prices vary significantly from the proportionate book value of equity (hence the concept of “price-to-book multiples”). Book value can be lower than or higher than fair value. Notably, for example, insurers often trade on public markets for less than one times price-to-book value ratio (*i.e.*, book value is greater than fair value).

Using the book value of equity in lieu of fair value when assessing collateralization for the admissibility of collateral loans will all but guarantee the carrying value of the collateral will differ from what it could ultimately be sold for to repay the collateral loan. This will create volatility for insurance companies and may lead borrowers to begin to manage to a metric in the short term that does not ultimately provide the highest proceeds to repay the collateral loan.

Please consider the following example: a borrower borrows \$100 on a collateral loan to make a \$100 equity investment in an equipment leasing business. The \$100 investment equates to 20% of the company upon investment, which implies that the total business is worth \$500. The total book value of the business is \$250 (equipment leasing businesses, for example, typically trade around 2x price/ book value). This means that, immediately upon making the \$100 investment, the borrower’s stake would be considered to have a collateral value of only \$50 (*i.e.*, 20% of the \$250 book value), resulting in an immediate loss of \$50 of collateral value. Further, this differs from the statutory accounting that would apply if the insurer had made the investment directly on its balance sheet (equity-method accounting). In accordance with SSAP No. 48, the insurer would record the initial investment in an investee at cost plus subsequent capital contributions to the investee. The carrying amount of the investment would then subsequently be adjusted for the amortization difference (difference between the cost and underlying GAAP equity) over a period of time as well as for the insurer’s pro-rata share of GAAP-basis earnings or losses and distributions of the investee. Therefore, under SSAP No. 48, the investment is worth its investment at cost (*i.e.*, \$100) on day one and subsequently amortized to the GAAP equity value of the investee over the period that the investing entity benefits economically rather than at a point in time as would occur under the proposed revisions in SSAP No. 21R.

We request consideration for the likely adverse effects to decision-making this exposed revision may cause, in addition to the operational disruptiveness of immediate adoption, as discussed further in this document.

Secondly, we believe the Exposure proposes substantive changes, not clarifications, and as a result, the process for a substantive change is not being followed. The Exposure will impose undue costs and efforts if adopted, as it substantively causes a change

¹ Dated March 22, 2023.



to the application of SSAP No. 48, *Joint Ventures, Partnerships and Limited Liability Companies* (“SSAP No. 48”) and SSAP No. 97, *Investments in Subsidiary, Controlled and Affiliated Entities* (“SSAP No. 97”). The Accounting Practices and Procedures Manual provides that “[n]onsubstantive revisions are characterized as language clarifications which do not modify the original intent of a SSAP . . .” Utilization of fair value equity of pledged JV/LP/LLC and/or SCA investments has long been utilized as required by SSAP No. 21R and subject to both independent audits and state insurance department examinations, without this practice being raised as an issue nor requiring adjustments to financial statements. Accordingly, the Exposure modifies the original intent of SSAP Nos. 21R, 48 and 97.²

The accelerated approach here is not supported by the analytical rigor that the SAPWG typically applies and denies affected parties the due process otherwise required when substantive changes are made. Should the Exposure be adopted with the proposed revisions to SSAP No. 21R to require audited net equity of pledged JV/LP/LLC and/or SCA investments, it would similarly be a material modification to an acceptable and supportable industry practice. It would also require insurers to disclose a change in accounting policy, which is further evidence that this is a substantive change. Furthermore, we would have to incur considerable cost and effort along with our borrowers (assuming that borrowers are willing to cooperate and, given that loan documentation was drafted prior to the changes being proposed here, there can be no assurance of such cooperation) to accurately determine the collateral value by applying the guidance prescribed in SSAP No. 48 with no assurance that we would be successful given the ability of borrowers to obtain the required information from their investees. Without the additional time typically afforded for a substantive modification, we find ourselves unable to consider effective alternative solutions in a timely manner and unable perform a full risk assessment of adoption impacts for both intended and potentially unintended consequences.

As a standard setting body (not a regulatory body), the NAIC has an obligation to adhere to proper processes and to base decisions on empirical data rather than hypotheses. Providing more process, rather than less, is critically important because decisions that the NAIC make can adversely affect competition in the industry; failing to do so can result in its decisions impermissibly choosing winners and losers in the marketplace. The Company believes that there have been other occasions where a proposed revision has been classified as “non-substantive” or a “SAP clarification,” despite the fact that the revisions have modified the intent of applicable SSAPs and thereby caused material changes in acceptable accounting practices.³

* * * * *

We appreciate your attention to the issues raised in this letter and would be pleased to discuss our questions and comments with the SAPWG or its staff at your convenience.

Kind Regards,

Tai D. Giang
Director, Accounting Policy
Security Benefit Life Insurance Company

² The same can be said of the Exposure’s requirement to perform audits of JV/LP/LLC and/or SCAs pledged in support of collateral loans. For years insurers have secured collateral loans with these types of interests and have been subject to both independent audit and state insurance department examinations without this practice being raised as an issue nor requiring adjustments to financial statements. We therefore believe requiring audits is a substantive change to SSAP No. 21R.

³ See, e.g., Exposure Ref No. 2019-24—Levelized and Persistency Commissions and Exposure Ref Nos. 2021-21—Related Party Reporting and 2022-15—Affiliate Reporting Clarification.



August 7, 2023

Mr. Dale Bruggeman, Chairman
Statutory Accounting Principles Working Group
National Association of Insurance Commissioners
1100 Walnut Street, Suite 1500
Kansas City, MO 64106-2197

Dear Mr. Bruggeman:

Re: Exposure Reference No. 2022-11 – Collateral for Loans

Security Benefit Life Insurance Company (“Security Benefit”, “our”, “we”) extends its appreciation to the Statutory Accounting Principles Working Group (“SAPWG”) for the opportunity to submit a new comment letter on Exposure Reference No. 2022-11—*Collateral for Loans* (the “Exposure”). After further consideration of the Exposure, we agree that clarification of the guidance in SSAP No. 21R is necessary, and we support the clarification that collateral pledged to secure a collateral loan must qualify as an admitted asset for the collateral loan itself to qualify as an admitted asset. Therefore, we also support the specific clarification that when the collateral pledged to secure a collateral loan would be in the scope of SSAP No. 48 or SSAP No. 97 if held directly by the reporting entity, audited financial statements are required for the collateral (and thus the collateral loan) to qualify as an admitted asset. However, we respectfully request that the SAPWG reconsider the proposed guidance that, if adopted, would require reporting entities to use the proportionate audited equity valuation (“book value”) when testing the sufficiency of the collateral (“collateral test”) for collateral loans secured by collateral that would be in the scope of SSAP No. 48 or SSAP No. 97 if held directly by the reporting entity. More specifically, we ask the SAPWG to revise the Exposure to allow reporting entities to make an accounting policy election, applied consistently and across all applicable collateral loans, to use either fair value or book value when performing the collateral test. Below is Security Benefit’s proposed revision to the Exposure (underlined, italicized and in green font, the underlined red text is the SAPWG’s currently exposed changes).

- b. Nonadmitted Asset – In Accordance with *SSAP No. 20—Nonadmitted Assets*, collateral loans secured by assets that do not qualify as investments which would otherwise be admitted shall be nonadmitted. Further, any amount of the loan outstanding which is in excess of the permitted relationship of fair value of the pledged investment to the collateral loan shall be treated as a nonadmitted asset. For qualifying investments which are pledged as collateral that would be in the scope of SSAP No. 48 or SSAP No. 97 if held directly by the reporting entity, such as joint ventures, partnerships and limited liability companies and investments that would qualify as SCAs if held directly, reporting entities shall elect to use either fair value or the proportionate audited equity valuation of the pledged investment for the comparison for the adequacy of pledged collateral. This election shall be considered an accounting policy election subject to the guidance in SSAP No. 3—Accounting Changes and Corrections of Errors and is required to be applied consistently to all such pledged investments. If the collateral loan exceeds the elected valuation basis of these pledged investments, then the excess shall be nonadmitted.

Security Benefit understands that SAPWG’s proposed change to the valuation basis used for the collateral test may have emanated from industry concerns over the need to obtain both audited financial statements and fair value measurements of these pledged investments. We believe our proposed revisions to the Exposure would simultaneously address those industry concerns and prevent unintended consequences, namely that reporting entities that have historically relied on the use of fair value as the basis for the collateral test may suddenly be required to nonadmit portions of their collateral loans. Furthermore, we believe that fair value continues to be the most appropriate measure of the sufficiency of collateral as fair value is the most representative measure of the value of assets that would be available to support policyholder liabilities in the event a reporting entity forecloses on the pledged collateral. Finally, allowing reporting entities to elect to continue to use fair value for the collateral test will retain a level of consistency with collateral loans secured by other forms of qualifying investments, and also, across other types of instruments where the sufficiency of collateral is based on fair value (i.e., repurchase agreements, securities lending agreements, derivatives, etc.).

Security Benefit also understands that state regulators may have concerns about the uncertainty inherent in fair value measurements, particularly Level 2 and Level 3 measurements, due to the use of unobservable inputs and/or assumptions, and these concerns may have also contributed to the desire to use the book value of these pledged investments for the collateral test. While we agree that Level 2 and Level 3 fair value measurements may have a greater level of uncertainty, Security Benefit obtains independent valuations, and independent reviews of our internal valuations, from reputable third-party valuation experts for these pledged investments, and in all cases, these valuations are subject to independent audit. It is our understanding that this is common industry practice, which we believe should sufficiently alleviate the regulatory concern. Additionally, we would like to note that the use of book value may not, and in many cases will not, reduce the reliance on Level 2 and Level 3 measurements when reporting entities perform the collateral test. Specifically, we expect that most of these pledged investments are considered



investment companies that recognize and measure all assets at fair value on their financial statements where many, and in some cases all, of those assets are valued using Level 2 and Level 3 fair value measurements.

In summary, Security Benefit supports the proposed clarifications to SSAP No. 21R; however, we believe the proposed change to the valuation basis for the collateral test represents a substantive change that could materially and adversely impact reporting entities that have historically underwritten collateral loans based on the fair value of the pledged collateral. We believe fair value remains the best and most appropriate measure of the sufficiency of collateral pledged to secure collateral loans. As a result, we respectfully request that the SAPWG revise the Exposure to allow reporting entities to continue to use fair value based on an accounting policy election.

* * * * *

We appreciate your attention to and consideration of our comments and would be pleased to discuss our comments with the SAPWG or its staff at your convenience.

Kind Regards,

Caleb Brainerd
SVP, Chief Financial Officer
Security Benefit Life Insurance Company

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June 30, 2023

Mr. Dale Bruggeman, Chairman
Statutory Accounting Principles Working Group
National Association of Insurance Commissioners
1100 Walnut Street, Suite 1500
Kansas City, MO 64106-2197

RE: Interested Parties Comments on Exposures with Public Comment Period ending June 30

Dear Mr. Bruggeman:

Interested parties appreciate the opportunity to comment on the items exposed for comment by the Statutory Accounting Working Group (the Working Group) on May 16th with the public comment period ending June 30th.

Ref #2022-14: New Market Tax Credits

Interested Parties appreciate the opportunity to comment on the substantive revisions exposed by the Working Group to SSAP No. 93 - *Low Income Housing Tax Credit Property Investments* and SSAP No. 94 *Transferable and Non-Transferable State Tax Credits*. As stated in our prior comment letter on this topic, interested parties agree with having uniformity in accounting and reporting for equity and debt investments for which the return is earned primarily through tax credits. Interested parties also agree that the proportional amortization method is an appropriate method to use for any type of investment (debt or equity) where the return is primarily earned through tax credits. We have a few comments on the exposure to make sure the guidance is clear and insurers know how to apply it.

SSAP No. 93

- 1) Paragraph 2 and 3– Paragraph 2 includes the criteria for investments in tax credit structures to apply the proportional amortization method. If an investment does not meet the criteria, then paragraph 3 states that the investment should follow the applicable statutory accounting statement. For equity investments, that means that SSAP No. 48 should be followed, which would require the use of equity method of accounting. For bonds in tax credit structures that

do not meet the definition, interested parties believe that the bond needs to be analyzed under the new proposed principles-based bond definition to determine if bond reporting or other-invested asset reporting is required. Interested parties recommend clarifying this in the standard if that is the case.

- 2) Paragraph 14 (a) –This paragraph states that tax credits under the SSAP No. 93 accounting guidance are to be recorded and assessed for admittance in accordance with SSAP No. 94. Interested parties found this confusing and subject to many different interpretations. There is a key difference between SSAP No. 93 and SSAP No. 94 tax credits in that SSAP No. 93 tax credits are only earned as part of the return on the investment so the only asset recorded on the insurer’s books is related to the investment itself. The tax credits are only recorded upon becoming available for use on a reporting entity’s tax return. Therefore, there is no tax credit to non-admit per se. In the rare case that the tax credit cannot be utilized in the year that it is allowed to be utilized due to the insurer not having enough income from operations in the case of federal tax credits or premium income in the case of state programs, the insurer would record a Deferred Tax Asset (DTA). Any DTA set up would be subject to the admissibility requirements under SSAP No. 101 - *Income Taxes*. For these reasons, interested parties recommend that paragraph 14 (a) be removed.
- 3) Paragraph 18 (a) and (b) and (c) - These paragraphs are intended to address admissibility considerations. Paragraph (c) states that if the tax credits cannot be utilized in the next three years, they will be non-admitted, while paragraphs (a) and (b) are intended to address instances when the credits cannot be utilized by the insurer, but the insurer has the ability to sell them to third parties or get a refund for the credits. We understand from discussions with the Working Group that the intent of this guidance is for an insurer to first start with the assessment in (c) to determine if it will be able to utilize the tax credits in the next three years. If not, then the insurer can consider whether the tax credits can be sold or whether the insurer can be reimbursed for the credits if unable to utilize them. Under the former, the insurer can admit the credits up to their fair value as the insurer would recover the fair value in a sale. Under the latter, the insurer can admit up to the amount of the expected refund.

Similar to our comments under #1 above, it is not clear to us what exactly we are non-admitting. As explained above, the only item that gets recorded on the balance sheet as an actual asset is the investment itself. The cost of the investment is amortized in proportion to the tax credits earned every year regardless of whether the credits are utilized or not. Admissibility requirements are already addressed for the investment itself in the proposal (i.e., the tax opinion and audited financial statements). As the tax credits are allocated to the insurer, they either reduce federal income taxes, or state/premium taxes. If the tax credits cannot be utilized in a given year, a DTA would be established. Any admissibility rules on the DTA itself are already addressed in SSAP No. 101 - *Income Taxes*.

If the DTA admissibility is what is being addressed in paragraph 18, interested parties recommend that be clarified. We understand that this may have been one of the reasons why the SSAP No. 93 proposal references SSAP No. 94. As stated above, to avoid any confusion regarding the accounting for the tax credits earned in a SSAP No. 93 investment, we suggest including all guidance in SSAP 93 (i.e., no reference to SSAP 94) regarding the credits

earned in a SSAP No. 93 investment. Interested parties also have the following suggested edits to make the admissibility rules on the tax credits themselves clear.

~~Paragraph 18 – If tax credits allocated to the reporting entity cannot be utilized in the year they have been allocated to the entity, a deferred tax asset (DTA) would be established. Under those circumstances, the reporting entity would follow the requirements under SSAP No. 101 *Income Taxes* regarding admissibility rules on DTAs. A reporting entity is required to assess the realization of tax credits against tax liability for both the tax year in which the credit can be initially utilized as well as in accordance with carry-forward and/or carryback periods to determine the extent the investments can be admitted:~~

- ~~a. Tax credit investments which allocate tax credits which are transferable in accordance with permitted IRS or state tax provisions are admitted up to the lesser of the proportional amortized cost, or fair value of the tax credits.~~
- ~~b. Tax credit investments which allocate tax credits eligible for direct payment are admitted up to the lesser of the proportional amortized cost, or the estimated proceeds.~~
- ~~e. For all other tax credits, if a reporting entity does not expect to fully utilize investment tax credits in the upcoming tax year or for a carryback year, the reporting entity shall perform an assessment to determine the extent it will be able to utilize the tax credits over the life of the investment. If assessment projections identify that the tax credits from investments in tax credit programs will exceed what can be utilized under IRS or state tax provisions (current and other applicable tax periods), the reporting entity shall nonadmit investments as necessary so that investments in scope of this statement (in aggregate) are only admitted to the extent tax credits are expected to be utilized. Additionally]. In making this assessment, the reporting entity is not permitted to assume increased operations (e.g., expanded product sales) beyond actual experience to conclude that additional federal or state tax liability will exist that would allow additional utilization of tax credits. A reporting entity can subsequently admit a previously nonadmitted tax credit investment, based on subsequent assessments in which the reporting entity determines that they will be able to utilize the tax credits.~~

- 4) Paragraph 34 - The SSAP No. 93 exposure states that reporting entities shall prospectively modify the recognition, accounting and reporting of tax credit investment structures to follow the guidance under SSAP No. 3. We believe this means that on day of adoption, the SSAP No. 93 investment's book value is the starting value of the investment and the prospective method will be applied using that book value and amortizing the book value at the date of adoption based on the future tax credits to be earned. If that is the case, some clarification on the application of the prospective method would be helpful. Those companies that are US GAAP reporters are to apply the FASB ASU on a retrospective basis and thus there will continue to be differences between US GAAP and Statutory proportional method results for already existing tax credit investments. We believe further clarification of how the prospective method is to be applied for Statutory reporting should be clarified to avoid inconsistent interpretation of the intent.

SSAP No. 94

- 1) Paragraph 1 – This paragraph explains the scope of the types of tax credits that fall within the SSAP No. 94 guidance. Interested parties believe that the key difference between SSAP No. 93 and SSAP No. 94 is that SSAP No. 93 relates to tax credits that are earned as a result of being an investor (i.e., an equity investor) in the entity earning the credits and SSAP No. 94 relates to tax credit certificates that are purchased outright without being an investor in the entity. To make sure that is clear, interested parties propose the following changes to paragraph 1

Paragraph 1 – This statement establishes statutory accounting principles for state and federal tax credits certificates that are purchased by the reporting entity without being an investor in the entity from which the tax credit certificates were purchased. ~~that are consistent with the Statutory Accounting Principles Statement of Concepts and Statutory Hierarchy (Statement of Concepts)~~

- 2) Paragraph 2 - The last sentence in this paragraph states that the tax credits received from SSAP No. 93 tax credit investments are within the scope of SSAP No. 94. For the reasons stated above in the SSAP No. 93 section of this comment letter, we do not think that SSAP No. 94 and SSAP No. 93 should be linked. As stated above, there are two very different assets that are recorded upon purchasing an investment under SSAP No. 93 versus SSAP No. 94. The only similarity in accounting for the tax credits relates to instances when the credits earned under a SSAP No. 93 investment cannot be utilized in the current year. Under that scenario, a DTA would be recorded, which would be subject to the admissibility rules under SSAP No. 101. For that reason, interested parties recommend removing the last sentence in paragraph 2 as suggested below.

Paragraph 2 - Investments in tax credits as discussed in SSAP No. 93R - *Investments in Tax Credit Structures*, which involve investments in projects or programs that generate general business federal tax credits or state tax credits, are not within the scope of this statement. ~~However, the tax credits received from tax credit investments are within the scope of this statement.~~

- 3) Paragraph 9 - This paragraph states that federal and state tax credits that can be utilized in the year allocated or purchased shall be reported in the income statement as an offset to federal taxes in accordance with SSAP No. 101 or state premium tax, respectively. Interested parties note that most tax certificates reduce a reporting entity's tax liability and do not directly impact the income statement at the time they are used. In addition, interested parties believe that upon purchase, the tax credits should be reported as an other-than-invested asset since the asset represents a right to receive future benefits. As the tax credits become available for use, a reduction to the insurer's income tax payable or premium/state taxes payable should take place. Based on that, we propose the following changes:

Paragraph 9 – Tax credits shall be recognized in the period that they are purchased or allocated to the reporting entity for tax purposes:

- a. ~~Federal and state tax credits are recorded as other-than-invested assets upon purchase. As the tax credits are redeemed, the carrying value of the tax credits is reduced dollar for dollar by the amount of tax credits applied toward the reporting entity's federal or state/premium tax liability, as applicable. that can be utilized in the year allocated or purchased shall be reported in the income statement as an offset to federal taxes in accordance with SSAP No. 101 *Income Taxes*. Federal tax credits that cannot be utilized in the year allocated or purchased and are carried forward to a future tax year shall be reported net of deferred tax asset (DTA) in accordance with SSAP No. 101.~~
- b. ~~Federal and State tax credits that can be utilized in the year allocated or purchased shall be reported in the income statement as an offset to state premium tax or state income tax, whichever is applicable, in the tax reporting year in which the credit is utilized. State tax credits that cannot be utilized in the year they are available for use allocated or purchased and are carried forward to a future tax year shall be reported as a deferred tax asset (DTA). gross of any related state tax liabilities and reported in the category of other than invested assets (not reported net).~~

We have updated the illustration that was included in Exhibit B below to reflect this as well.

- 7) Paragraph 7 - The accounting for purchased tax credits under the SSAP No. 94 exposure is different from the current guidance in that the credits will be recorded at face value instead of at cost. Interested parties do not have an issue with this accounting treatment per se, but we would like to point out that this is not consistent with the accounting treatment for other types of assets that are purchased at a premium or discount such as bonds and mortgage loans.
- 8) Exhibit B – Accounting for Non-Transferable Tax Credits

Interested parties recommend some edits to the illustration under Exhibit B to reflect the changes described in item 2) above. In addition, the edits below include other edits that we believe are necessary to show the appropriate flow of transactions and to add clarity to the accounting for federal tax credit certificates. These are our suggestions:

On 7/1/X1 LJW Insurance Company purchased non-transferable federal tax credits for a cost of \$100,000. The federal tax credits are redeemable for \$110,000 and expire on, April 1, 20x2. LJW expects to utilize the tax credits before expiration in the amount of \$110,000. The credits are earned pro-rata every quarter from acquisition date to expiration date. Therefore, the credits earned quarterly are about \$36,666. The illustration below assumes that LJW Insurance Company's quarterly income tax liability equals the amount of credits that were purchased.

7/1/x1	Federal tax credits	110,000	
	Deferred gains on acquired tax credits		10,000
	Cash		100,000
	<i>To record the purchase of the tax credits</i>		

9/30/x1	Income Premium tax expense Income Premium taxes payable to <i>To record quarterly income tax liability.</i>	36,666 36,666	36,666
10/1/x1	Income taxes payable Federal tax credits <i>To record the use of tax credits in the quarter</i>	36,666 36,666	36,666
12/31/x1	Income tax expense Income taxes payable <i>To record quarterly income tax liability</i>	36,666 36,666	36,666
1/1/x2	Income taxes payable Federal tax credits <i>To record the use of tax credits in the quarter</i>	36,666 36,666	36,666
3/31/x2	Income tax expense Income taxes payable <i>To record quarterly income tax liability</i>	36,666 36,666	36,666
4/1/x2	Income taxes payable Deferred gains on acquired tax credits Other Income Federal tax credits <i>To record the use of income tax credits in excess of cost and recognize a gain on premium tax credits in other income.</i>	36,666 10,000 36,666	10,000 36,666

4/1/x2

Ref #2019-21e - Principles-Based Bond Definition: Schedule BA

Interested parties have the following observations and suggestions to the proposed changes to the categories within Schedule BA (*Other Invested Assets*):

- Ensure that all reporting categories reflect the related SSAP within the instructions.
- Recommend exposing changes to the columns.

- For investments tagged as ‘Debt Securities That Do Not Quality as Bonds’ that are transferred from Schedule D, interested parties recommend that the investment will retain its’ NAIC Designation and its’ FE/ PLR status at the time of transfer.
- We believe the instructions for Tax Credit Investments (e.g., Guaranteed Low Income Housing Tax Credit Investments) are stale as the sentence ‘*There must be an all-inclusive guarantee from a CRP-rated entity that guarantees the yield on the investment*’ is no longer valid.
- The various types of Tax Credit Investments (e.g., Low Income Housing; New Market; Renewable Energy) have different risks and should be evaluated accordingly and be reported according to their risks. Recommend a referral to the RBC Investment Risk & Evaluation Working Group to evaluate the various risk categories such that changes could be implemented for Annual 2025 reporting.
- Based on Ref #2022-14 (*Tax Credits*), interested parties will provide additional comments when this item is adopted by the Statutory Accounting Principles Working Group (SAPWG).
- Based on Ref #2023-12 (*SSAP No. 48 - Residuals*), interested parties will provide comments when this item is adopted by SAPWG.
- Please refer to the attached markup version of the exposure as there are several editorial revisions that we are suggesting that clarify the descriptions within the categories and language within the instructions.

Interested parties have attached a markup version of the exposure with our detailed suggested changes.

Ref #2023-13: PIK Interest Disclosure Clarification

The Working Group moved this agenda item to the active listing, categorized as a SAP clarification, and exposed revisions to SSAP No. 34 and the Annual Statement Instructions to clarify and incorporate a practical expedient to the paid-in-kind (PIK) interest aggregate disclosure. These SSAP No. 34 revisions, when adopted, will also result in editorial changes to the annual statement instructions.

Interested parties have no comment on this item.

Ref #2023-12: Residuals in SSAP No. 48 Investments

The Working Group moved this agenda item to the active listing, categorized as an SAP clarification, and exposed revisions to SSAP No. 48 which clarify that investments structures captured in scope of SSAP No. 48 that represent residual interests or that predominantly hold residual interests, shall be reported on the dedicated residual reporting line on Schedule BA. Corresponding edits to ensure consistent language in SSAP No. 43R and revisions to the Schedule BA Annual Statement Instructions were also exposed.

Interested parties have received comments from NAIC staff that we are currently reviewing and will submit a separate comment letter at a later date.

* * * *

Please feel free to contact either one of us with any questions you may have.

Sincerely,

D. Keith Bell

Rose Albrizio

cc: Interested parties
NAIC staff

**Bond Definition
Proposed Reporting Lines – Schedule BA
2023 Spring NM Exposure**

This document proposes annual statement reporting line and descriptions for suggested reporting lines for investments reported as other invested assets on Schedule BA. The main focus is to categorize debt securities that do not qualify as bonds under SSAP No. 26—Bonds or SSAP No. 43R—Asset-Backed Securities and are captured in scope of SSAP No. 21R—Other *Invested Admitted Assets*. As detailed within, other revisions have also been proposed to update the schedule.

Comments are requested on all aspects of this document – including whether reporting lines should be added or deleted as well as the suggested instructions to clarify what should be captured in each location.

SCHEDULE BA – PARTS 1, 2 AND 3

OTHER LONG-TERM INVESTED ASSETS – GENERAL INSTRUCTIONS

Include only those classes of invested assets not clearly or normally includable in any other invested asset schedule, or that have been specifically identified for reporting on Schedule BA: Other Invested Assets. ~~Such assets should include any assets previously written off for book purposes, but which still have a market or investment value. Give a detailed description of each investment and the underlying security. If an asset is to be recorded in Schedule BA that is normally reported in one of the other invested asset schedules, make full disclosure in the Name or Description column of the reason for recording such an asset in Schedule BA.~~

For accounting guidance related to foreign currency transactions and translations, refer to SSAP No. 23—Foreign Currency Transactions and Translations.

If a reporting entity has any detail lines reported for any of the following required groups, categories, or subcategories, it shall report the subtotal amount of the corresponding group, category, or subcategory, with the specified subtotal line number appearing in the same manner and location as the pre-printed total or grand total line and number:

<u>Group or Category</u>	<u>Line Number</u>
--------------------------	--------------------

Debt Securities That Do Not Qualify as Bonds

Debt Securities That Do Not Reflect a Creditor Relationship in Substance

NAIC Designation Assigned by the Securities Valuation Office (SVO)

Unaffiliated

Affiliated

NAIC Designation Not Assigned by the Securities Valuation Office (SVO)

Unaffiliated

Affiliated

Debt Securities That Lack Substantive Credit Enhancement

NAIC Designation Assigned by the Securities Valuation Office (SVO)

Unaffiliated

Affiliated

NAIC Designation Not Assigned by the Securities Valuation Office (SVO)

Unaffiliated

Affiliated

Debt Securities That Do Not Qualify as Bonds Solely to a Lack Of Meaningful Cash Flows

NAIC Designation Assigned by the Securities Valuation Office (SVO)

<u>Unaffiliated</u>	
<u>Affiliated</u>	
<u>NAIC Designation Not Assigned by the Securities Valuation Office (SVO)</u>	
<u>Unaffiliated</u>	
<u>Affiliated</u>	

~~Non-Registered Private Funds with Underlying Assets Having Characteristics of:~~

~~Bonds~~

NAIC Designation Assigned by the Securities Valuation Office (SVO)	
Unaffiliated	0799999
Affiliated	0899999
NAIC Designation Not Assigned by the Securities Valuation Office (SVO)	
Unaffiliated	0999999
Affiliated	1099999

~~Mortgage Loans~~

Unaffiliated	1199999
Affiliated	1299999

~~Other Fixed Income Instruments~~

Unaffiliated	1399999
Affiliated	1499999

Equity Interests in Joint Ventures (Including Non-Registered Private Funds), Partnerships, or Limited Liability Companies
~~Interests or Non-Registered Private Funds~~ with Underlying Assets Having the Characteristics of:

~~Fixed Income Instruments~~

NAIC Designation Assigned by the Securities Valuation Office (SVO)	
Unaffiliated	1599999
Affiliated	1699999
NAIC Designation Not Assigned by the Securities Valuation Office (SVO)	
Unaffiliated	1799999
Affiliated	1899999

~~Common Stocks~~

Unaffiliated	1999999
Affiliated	2099999

~~Real Estate~~

Unaffiliated	2199999
Affiliated	2299999

~~Mortgage Loans~~

Unaffiliated	2399999
Affiliated	2499999

~~Other~~

Unaffiliated	2599999
Affiliated	2699999

~~Surplus Debentures, etc. Notes~~

Unaffiliated	2799999
Affiliated	2899999

Capital Notes

<u>Unaffiliated</u>	
<u>Affiliated</u>	

Collateral Loans	
Unaffiliated.....	2999999
Affiliated	3099999
Non-collateral Loans	
Unaffiliated.....	3199999
Affiliated	3299999
Capital Notes	
Unaffiliated.....	3399999
Affiliated	3499999
Guaranteed Federal Low Income Housing Tax Credit	
Unaffiliated.....	3599999
Affiliated	3699999
Non-Guaranteed Federal Low Income Housing Tax Credit	
Unaffiliated.....	3799999
Affiliated	3899999
Guaranteed State Low Income Housing Tax Credit	
Unaffiliated.....	3999999
Affiliated	4099999
Non-Guaranteed State Low Income Housing Tax Credit	
Unaffiliated.....	4199999
Affiliated	4299999
All Other Low Income Housing Tax Credit	
Unaffiliated.....	4399999
Affiliated	4499999

[NAIC Staff Note: The reporting lines for Low Income Housing Tax Credits are anticipated to be updated as part of the current tax credit investment statutory accounting review.](#)

Working Capital Finance Investment	
Unaffiliated.....	4599999
Residual Tranches or Interests with Underlying Assets Having Characteristics of:	
Fixed Income Instruments	
Unaffiliated.....	4699999
Affiliated.....	4799999
Common Stock	
Unaffiliated.....	4899999
Affiliated.....	4999999
Preferred Stock	
Unaffiliated.....	5099999
Affiliated.....	5199999
Real Estate	
Unaffiliated.....	5299999
Affiliated.....	5399999
Mortgage Loans	
Unaffiliated.....	5499999
Affiliated.....	5599999

Other	Unaffiliated	5699999
	Affiliated	5799999
Any Other Class of Assets		
	Unaffiliated	5899999
	Affiliated	5999999
Subtotals		
	Unaffiliated	6099999
	Affiliated	6199999
TOTALS		6299999

The following listing is intended to give examples of investments to be included in each category; however, the list should not be considered all-inclusive, ~~and it should not be implied that any invested asset currently being reported in Schedules A, B or D is to be reclassified to Schedule BA:~~

Oil and Gas Production

~~Include: Offshore oil and gas leases.~~

Transportation Equipment

~~Include: Aircraft owned under leveraged lease agreements.
Motor Vehicle Trust Certificates.~~

Mineral Rights

~~Include: Investments in extractive materials.

Timber Deeds.~~

Debt Securities That Do Not Qualify as Bonds

Include: Debt securities captured in SSAP No. 21R—Other Admitted Assets. This is specific to securities, as that term is defined in SSAP No. 26—Bonds, whereby there is a fixed schedule for one or more future payments (referred to as debt securities), but for which the security does not qualify for bond reporting under SSAP No. 26R as an issuer credit obligation or an asset-backed security.

Investments that have been assigned an NAIC designation by the Securities Valuation Office (SVO) pursuant to the policies in the Purposes and Procedures Manual of the NAIC Investment Analysis Office shall be reported on Lines ~~0799999~~TBD and ~~0899999~~TBD.

Investments that have not been assigned an NAIC designation by the Securities Valuation Office (SVO) pursuant to the policies in the Purposes and Procedures Manual of the NAIC Investment Analysis Office for this category. Designations received from an SEC NRSRO are permitted to be reported but are not required. Report these investments on Lines ~~0999999~~ TBD, ~~1099999~~ TBD, ~~1199999~~ TBD, ~~1299999~~ TBD, ~~1399999~~ TBD and ~~1499999~~ TBD.

Exclude: Any investment that does not qualify as a security. This term is defined in SSAP No. 26R – Bonds.

Any investment that is not captured as a debt security that does not qualify as a bond pursuant to SSAP No. 21R—Other Admitted Assets.

Non-Registered Private Funds with Underlying Assets Having Characteristics of a Bond, Mortgage Loan or Other Fixed Income Instrument

Include: ~~Fixed income instruments that are not corporate or governmental unit obligations (Schedule D) or secured by real property (Schedule B).~~

~~Any investments deemed by the reporting entity to possess the underlying characteristics of a bond or other fixed income instrument that has been assigned an NAIC designation by the Securities Valuation Office (SVO) pursuant to the policies in the *Purposes and Procedures Manual of the NAIC Investment Analysis Office* for this category. Report these investments on ~~Lines 0799999 and 0899999.~~~~

~~Any investments deemed by the reporting entity to possess the underlying characteristics of a bond or other fixed income investment that has not been assigned an NAIC designation by the Securities Valuation Office (SVO) pursuant to the policies in the *Purposes and Procedures Manual of the NAIC Investment Analysis Office* for this category. Report these investments on ~~Lines 0999999, 1099999, 1199999, 1299999, 1399999 and 1499999.~~~~

Equity interests in Joint Ventures (Including Non-Registered Private Funds), Partnerships or Limited Liability Company Companies or Non-Registered Private Funds ~~Interests with Underlying Assets Having the Characteristics:~~**Fixed Income Instruments**

Include: ~~Equity interests in Joint joint ventures (including non-registered private funds), partnerships, or limited liability companies or non-registered private funds investments that are engaged in bond or preferred stock fixed income strategies. Leveraged Buy-out Fund.~~

~~A fund investing in the “Z” strip of Collateralized Mortgage Obligations.~~

~~Investments on the NAIC List of Schedule BA Non-Registered Private Funds with Underlying Assets Having Characteristics of Bonds or Preferred Stock Any investments deemed by the reporting entity to possess the underlying characteristics of fixed income instruments that has been assigned an NAIC designation by the Securities Valuation Office (SVO) pursuant to the policies in the *Purposes and Procedures Manual of the NAIC Investment Analysis Office* for this category. Report these investments on Lines ~~TBD 1599999 and TBD 1699999.~~~~

~~Any investments deemed by the reporting entity to possess the underlying characteristics of fixed income instruments Investments that have not been assigned an NAIC designation by the Securities Valuation Office (SVO) pursuant to the policies in the *Purposes and Procedures Manual of the NAIC Investment Analysis Office* for this category. Designations received from an SEC NRSRO are permitted to be reported but are not required. Report these investments on Lines ~~1799999-TBD and TBD 1899999.~~~~

Common Stocks

Include: Venture Capital Funds ~~or other underlying equity investments.~~

Real Estate

Include: Real estate development interest. Reporting should be consistent with the detailed property analysis appropriate for the corresponding risk-based capital factor for this investment category. If the requisite details are not available for reporting, report under “Other” subcategory.

Mortgage Loans

Include: Mortgage obligations. Reporting should be consistent with the detailed property analysis appropriate for the corresponding risk-based capital factor for this

investment category. If the requisite details are not available for reporting, report under “Other” subcategory.

Other

Include: Limited partnership interests in oil and gas production.

Forest product partnerships.

Investments within the Joint Venture and Partnership Interests category that do not qualify for inclusion in the “Fixed Income Instruments,” “Common Stocks,” “Real Estate” or “Mortgage Loans” subcategories.

~~Reporting should be consistent with the corresponding risk-based capital factor for this investment category (i.e., Other Long-Term Assets).~~

Surplus ~~Debentures, etc.~~ Notes

Include: That portion of any subordinated indebtedness, surplus debenture, surplus note, debenture note, premium income note, bond, or other contingent evidence of indebtedness that is reported in the surplus of the issuer.

Capital Notes

Include: The portion of any capital note that is reported on the line for capital notes of the issuing insurance reporting entity.

Collateral Loans

Include: ~~Refer to SSAP No. 21R—Other Admitted Assets for a definition of collateral loans. Loans meeting the SSAP No. 21R—Other Admitted Assets definition of collateral loans that are backed by any form of collateral, regardless of if the collateral is sufficient to fully cover the loan, shall be captured in this category. Guidance in SSAP No. 21R shall be followed to determine nonadmittance.~~
Refer to SSAP No. 21R—Other Admitted Assets for a definition of collateral loans.

In the description column, the name of the actual borrower and state if the borrower is a parent, subsidiary, affiliate, officer or director. Also include the type of collateral held.

Non-collateral Loans

Include: ~~For purposes of this section, n~~Non-collateral loans are considered the unpaid portion of loans previously made to another organization or individual in which the reporting entity has a right to receive money for the loan, but for which the reporting entity has not obtained collateral to secure the loan.

Non-collateral loans shall not include those instruments that meet the definition of a bond, per SSAP No. 26R—Bonds, a mortgage loan per SSAP No. 37—Mortgage Loans, ~~loan-backed or structured~~asset-backed securities per SSAP No. 43R—Loan-Backed and Structured Securities, or a policy or contract loan per SSAP No. 49—Policy Loans, or a collateral loan in SSAP No. 21, Other Admitted Assets.

Non-collateral loans are nonadmitted unless they are to related parties and meet the criteria in SSAP No. 25—Affiliates and Other Related Parties. SSAP No. 20

[Nonadmitted Assets and SSAP No. 25 should be referred to for accounting guidance for Non-collateral loans](#)

In the description column, provide the name of the actual borrower. For affiliated entities, state if the borrower is a parent, subsidiary, affiliate, officer or director. ~~Refer to SSAP No. 20 Nonadmitted Assets and SSAP No. 25 Affiliates and Other Related Parties for accounting guidance.~~

Capital Notes

~~Include: The portion of any capital note that is reported on the line for capital notes of the issuing insurance reporting entity.~~

Low Income Housing Tax Credit

[Note: These instructions will be updated in accordance with the SAPWG tax credit agenda item.](#)

- Include:
- All Low Income Housing Tax Credit Investments (LIHTC or affordable housing) that are in the form of a Limited Partnership or a Limited Liability Company including those investments that have the following risk mitigation factors:
- A. Guaranteed Low Income Housing Tax Credit Investments. There must be an all-inclusive guarantee from a CRP-rated entity that guarantees the yield on the investment.
 - B. Non-guaranteed Low Income Housing Tax Credit Investments.
 - I. A level of leverage below 50%. For a LIHTC Fund, the level of leverage is measured at the fund level.
 - II. There is a Tax Credit Guarantee Agreement from General Partner or managing member. This agreement requires the General Partner or managing member to reimburse investors for any shortfalls in tax credits due to errors of compliance, for the life of the partnership. For a LIHTC Fund, a Tax Credit Guarantee is required from the developers of the lower tier LIHTC properties to the upper tier partnership and all other LIHTC investments.
 - III. There are sufficient operating reserves, capital replacement reserves and/or operating deficit guarantees present to mitigate foreseeable foreclosure risk at the time of the investment.

Non-qualifying LIHTCs should be reported in the “All Other” category

[\[placeholder for changes resulting from SAPWG 2022-14 \(New Market Tax Credits\)\]](#)

Working Capital Finance Investment

- Include:
- Investments in an interest in a Confirmed Supplier Receivables (CSR) under a Working Capital Finance Program (WCFP) that is designated by the SVO as meeting the criteria specified in the *Purposes and Procedures Manual of the NAIC Investment Analysis Office* for an NAIC “1” or “2.”

Working Capital Finance Program (WCFP)

Open account program under which an Investor may purchase interests, or evidence thereof, in commercial non-insurance receivables. A WCFP is created for the benefit of a commercial investment grade obligor and its suppliers of goods or services and facilitated by a financial intermediary.

Confirmed Supplier Receivables (CSR)

A first priority perfected security interest claim or right to payment of a monetary obligation from the Obligor arising from the sale of goods or services from the Supplier to the Obligor the payment of which the Obligor has confirmed by representing and warranting that it will not protest, delay, or deny, nor offer nor assert any defenses against, payment to the supplier or any party taking claim or right to payment from the supplier.

See *SSAP No. 105R—Working Capital Finance Investments* for accounting guidance.

Residual Tranches or Interests with Underlying Assets Having Characteristics of:

Investment in Residual Tranches or Interests should be assigned to the subcategory with the highest underlying asset concentration. There shouldn't be any bifurcation of the underlying assets among the subcategories.

Include: Residual tranches or interests captures securitization tranches and beneficial interests as well as other structures captured in scope of *SSAP No. 43R – ~~Loan-Backed and Structured Securities~~ Asset-Backed Securities*, that reflect loss layers without any contractual payments, whether interest or principal, or both. Payments to holders of these investments occur after contractual interest and principal payments have been made to other tranches or interests and are based on the remaining available funds. See *SSAP No. 43R* for accounting guidance.

[\[placeholder for changes resulting from SAPWG 2023-12 \(SSAP No. 48 – Residuals\)\]](#)

Fixed Income Instruments

Include: -Investments with underlying collateral which, if held individually, would be reported on *Schedule D – Part 1 – Long-Term Bonds*

Common Stocks

Include: Investments with underlying collateral which, if held individually, would be reported on *Schedule D – Part 2 – Section 2 – Common Stocks*

Preferred Stocks

Include: Investments with underlying collateral which, if held individually, would be reported on *Schedule D – Part 2 – Section 1 – Preferred Stocks*

Real Estate

Include: Investments with underlying collateral which, if held individually, would be reported on *Schedule A – Real Estate Owned*

Mortgage Loans

Include: Investments with underlying collateral which, if held individually, would be reported on *Schedule B – Mortgage Loans*

Other

Include: Items that do not qualify for inclusion in the above subcategories.

Any Other Class of Assets

Include: Investments that do not fit into one of the other categories. An example of items that may be included are reverse mortgages.

All structured settlement income streams acquired as investments where the reporting entity acquires the legal right to receive payments. (Valuation and admittance provisions are detailed in *SSAP No. 21R—Other Admitted Assets*.)

[This category shall also include oil and gas leases, aircraft owned under leveraged lease arrangements, investments in extractive materials and timber deeds that are not owned within a partnership, LLC or joint venture structure.](#)

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July 14, 2023

Mr. Dale Bruggeman, Chairman
Statutory Accounting Principles Working Group
National Association of Insurance Commissioners
1100 Walnut Street, Suite 1500
Kansas City, MO 64106-2197

RE: Interested Parties Comments on Ref #2023-12, Residuals in SSAP No. 48 Investments

Dear Mr. Bruggeman:

Interested parties appreciate the opportunity to comment on the following item that was exposed for comment by the Statutory Accounting Working Group (the Working Group).

Ref # 2023-12: Residuals in SSAP No. 48 Investments

This agenda item proposes revisions to clarify the scope and reporting for investment structures that represent residual interests or a residual security tranche (collectively referred to as residuals) within statutory accounting principles regardless of the legal form of the residual (e.g., debt, stock, LP/LLC equity ownership, etc.) It proposes guidance to clarify the reporting of in-substance residuals regardless of the structure of the investment vehicle.

Interested parties has been working with NAIC staff to clarify the definition in order to facilitate consistent interpretation by the industry and auditors, to avoid unintended consequences of certain equity investments being scoped into the definition of a residual when they were not intended to be in scope. We appreciate NAIC staff working with us on these clarifications and look forward to reviewing the next exposure. In addition to the redrafted exposure draft, we offer the following comments.

In reviewing the exposure, we understand that the residual definition is related to investment structures that issue debt securities created for the primary purpose of raising debt capital backed by collateral assets (ABS issuers as defined in paragraph 8 of the current bond exposure in SSAP Nos. 26R). As a result, interested parties do not believe the intent was to include the following types of investment structures:

- Private Funds (e.g., equity, debt, hedge)- that issued debt for liquidity / operating purposes rather than to raise capital backed by a discrete pool of collateral assets.
- Real Estate Funds (including REITs and JVs) (i.e., considered Issuer Credit Obligations, or “ICOs”, in the proposed bond standard)
- Non-US registered Funds (i.e., considered ICOs in the proposed bond standard)
- Other ICOs in the proposed bond definition, such as 40 Act Funds, Business Development Company, Operating Entities, and Holding Companies supported by operating companies.

The exposure currently addresses changes to SSAP No. 48 - Joint Ventures, Partnerships and Limited liability Companies, but we also believe the definition is relevant to SSAP Nos. 26R, 43R, and 21R and should be included in those other SSAPs. Also, consideration should be given to whether the definition should also be added to SSAPs where residuals may currently be in scope, such as SSAP No. 30R (e.g., from securitizations in legal form of a corporation).

Upon adoption of the Form A, interested parties believe the guidance would be effective immediately. Interested parties will need time to consider the guidance, develop accounting policies, and identify the residuals under the new definition. As a result, we recommend an effective date of six months after the adoption by Executive (Ex) Committee.

* * * *

Please feel free to contact either one of us with any questions you may have.

Sincerely,

D. Keith Bell

Rose Albrizio

cc: Interested parties
NAIC staff

<https://naiconline.sharepoint.com/:b:/r/sites/NAICSupportStaffHub/Member%20Meetings/E%20CMTE/APPTF/2023-2%20Summer/Summary%20and%20Minutes/SAPWG/Attachments/Att1F-Comment%20Letters.pdf?csf=1&web=1&e=8O3UKA>

**Statutory Accounting Principles (E) Working Group
 Maintenance Agenda Submission Form
 Form A**

Issue: SSAP No. 43R – CLO Financial Modeling

Check (applicable entity):

	P/C	Life	Health
Modification of Existing SSAP	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
New Issue or SSAP	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Interpretation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Description of Issue: This agenda item proposes revisions to *SSAP No. 43R—Loan-Backed and Structured Securities* to incorporate edits to reflect changes adopted by the Valuation of Securities (E) Task Force on Feb. 21, 2023, to include collateralized loan obligations (CLOs) in the SVO financial modeling process.

This agenda item has been drafted to ensure the financial modeling guidance summarized in *SSAP No. 43R—Loan-Backed and Structured Securities* reflects the practices as directed by the *Purposes and Procedures Manual of the NAIC Investment Analysis Office (P&P Manual)*. (Note, while the *Accounting Practices and Procedures Manual* is higher than the P&P manual in the statutory hierarchy, the primary source of authoritative guidance for financial modeling is the P&P manual. Only a general description of the modeling process is included in SSAP No. 43R). The methodology to model CLOs is still being developed, but guidance that permits the SVO to model CLOs has been adopted and should be followed once CLOs begin to be financially modeled.

Existing Authoritative Literature:

SSAP No. 43R—Loan-Backed and Structured Securities

Designation Guidance

27. For RMBS/CMBS securities within the scope of this statement, the initial NAIC designation used to determine the carrying value method and the final NAIC designation for reporting purposes is determined using a multi-step process or the NAIC designation assigned by the NAIC Securities Valuation Office. The P&P Manual provides detailed guidance. A general description of the processes is as follows:

- a. Financial Modeling: Pursuant to the P&P Manual, the NAIC identifies select securities where financial modeling must be used to determine the NAIC designation. For a modeled legacy security, meaning one which closed prior to January 1, 2013, the NAIC designation is based on financial modeling incorporating the insurers' carrying value. For a modeled non-legacy security, meaning one which closed after December 31, 2012, the NAIC designation and NAIC designation category assigned by the NAIC Securities Valuation Office must be used. For those legacy securities that are financially modeled, the insurer must use NAIC CUSIP specific modeled breakpoints provided by the modelers in determining initial and final designation for these identified securities. As specified in the P&P Manual, a modeled legacy security RMBS or CMBS tranche that has no expected loss, as compiled and published by the NAIC Securities Valuation Office, under any of the selected modeling scenarios would be assigned an NAIC 1 designation and NAIC 1.A designation category regardless of the insurer's book/adjusted carrying value. The three-step process for modeled legacy securities is as follows:
 - i. Step 1: Determine Initial Designation – The current amortized cost (divided by remaining par amount) of a loan-backed or structured security is compared to the modeled breakpoint values assigned to each NAIC designation and NAIC designation category for each CUSIP to establish the **initial** NAIC designation.

- ii. Step 2: Determine Carrying Value Method – The carrying value method, either the amortized cost method or the lower of amortized cost or fair value method, is then determined as described in paragraph 26 based upon the initial NAIC designation from Step 1.
 - iii. Step 3: Determine Final Designation – The final NAIC designation is determined by comparing the carrying value (divided by remaining par amount) of a security (based on paragraph 27.a.ii.) to the NAIC CUSIP specific modeled breakpoint values assigned to the NAIC designation and NAIC designation category for each CUSIP or is mapped to an NAIC designation category, according to the instructions in the P&P Manual. This final NAIC designation shall be applicable for statutory accounting and reporting purposes and the NAIC designation category will be used for investment schedule reporting and establishing RBC and AVR charges. The final NAIC designation is not used for establishing the appropriate carrying value method in Step 2 (paragraph 27.a.ii.).
- b. All Other Loan-Backed and Structured Securities: For securities not subject to paragraph 27.a. (financial modeling) follow the established designation procedures according to the appropriate section of the P&P Manual. The NAIC designation shall be applicable for statutory accounting and reporting purposes (including determining the carrying value method and establishing the AVR charges). The carrying value method is established as described in paragraph 26.

Specific Interim Reporting Guidance Financially Modeled Securities

28. For securities that will be financially modeled under paragraph 27, the guidance in this paragraph shall be applied in determining the reporting method for such securities acquired in the current year for quarterly financial statements. Securities reported as of the prior-year end shall continue to be reported under the prior-year end methodology for the current-year quarterly financial statements. For year-end reporting, securities shall be reported in accordance with paragraph 27, regardless of the quarterly methodology used.

- a. Reporting entities that acquired the entire financial modeling database for the prior-year end are required to follow the financial modeling methodology (paragraph 27.a.) for all securities acquired in the subsequent year that were included in the financial modeling data acquired for the prior year-end.
- b. Reporting entities that acquired identical securities (identical CUSIP) to those held and financially modeled for the prior year-end are required to follow the prior year-end financial modeling methodology (paragraph 27.a.) for these securities acquired subsequent to year-end.
- c. Reporting entities that do not acquire the prior-year financial modeling information for current-year acquired individual CUSIPS, and are not captured within paragraphs 28.a. or 28.b., are required to follow the analytical procedures for non-financially modeled securities (paragraph 27.b. as appropriate). Reporting entities that do acquire the individual CUSIP information from the prior-year financial modeling database shall use that information for interim reporting.
- d. Reporting entities that acquire securities not previously modeled at the prior year-end are required to follow the analytical procedures for non-financially modeled securities (paragraph 27.b. as appropriate).

SSAP No. 43R - EXHIBIT A – Question and Answer Implementation Guide Index to Questions

Questions 8-10 are specific to securities subject to the financial modeling process. (This process is limited to qualifying RMBS/CMBS securities reviewed by the NAIC Structured Securities Group.) The guidance in questions 8-10 shall not be inferred to other securities in scope of SSAP No. 43R.

8	Do LBSS purchased in different lots result in a different NAIC designation for the same CUSIP? Can reporting entities use a weighted average method determined on a legal entity basis?
9	The NAIC Designation process for LBSS may incorporate loss expectations that differ from the reporting entity's expectations related to OTTI conclusions. Should the reporting entities be required to incorporate recovery values obtained from data provided by the service provider used for the NAIC Designation process for impairment analysis as required by SSAP No. 43R?
10	For companies that have separate accounts, can the NAIC designation be assigned based upon the total legal entity or whether it needs to be calculated separately for the general account and the total separate account?

8. Question – Do LBSS purchased in different lots result in a different NAIC designation for the same CUSIP? Can reporting entities use a weighted average method determined on a legal entity basis?

8.1 Under the financial modeling process (applicable to qualifying RMBS/CMBS reviewed by the NAIC Structured Securities Group), the amortized cost of the security impacts the “final” NAIC designation used for reporting and RBC purposes. As such, securities subject to the financial modeling process acquired in different lots can result in a different NAIC designation for the same CUSIP. In accordance with the current instructions for calculating AVR and IMR, reporting entities are required to keep track of the different lots separately, which means reporting the different designations. For reporting purposes, if a SSAP No. 43R security (by CUSIP) has different NAIC designations by lot, the reporting entity shall either 1) report the aggregate investment with the lowest applicable NAIC designation or 2) report the investment separately by purchase lot on the investment schedule. If reporting separately, the investment may be aggregated by NAIC designation. (For example, all acquisitions of the identical CUSIP resulting with an NAIC 1 designation may be aggregated, and all acquisitions of the identical CUSIP resulting with an NAIC 3 designation may be aggregated.)

9. Question – The NAIC Designation process for LBSS subject to the financial modeling process may incorporate loss expectations that differ from the reporting entity's expectations related to OTTI conclusions. Should the reporting entities be required to incorporate recovery values obtained from data provided by the service provider used for the NAIC Designation process for impairment analysis as required by SSAP No. 43R?

9.1 In accordance with *INT 06-07: Definition of Phrase “Other Than Temporary,”* reporting entities are expected to “consider all available evidence” at their disposal, including the information that can be derived from the NAIC designation.

10. Question - For companies that have separate accounts, can the NAIC designation be assigned based upon the total legal entity or whether it needs to be calculated separately for the general account and the total separate account?

10.1 The financial modeling process for qualifying RMBS/CMBS securities is required for applicable securities held in either the general or separate account.

Activity to Date (issues previously addressed by the Working Group, Emerging Accounting Issues (E) Working Group, SEC, FASB, other State Departments of Insurance or other NAIC groups):

The following edits have previously been reflected in the financial modeling guidance:

- Agenda Item 2018-19: To be consistent with the prior SVO P&P Manual revisions, eliminated the multi-step designation guidance for modified filing exempt (MFE) securities. The elimination of MFE was effective March 31, 2019, with early application permitted for year-end 2018. With the elimination of

MFE, for securities that are filing exempt, the NAIC designation reported will correspond to the Credit Rating Provider (CRP) rating without adjustment based on carrying value.

- Agenda Item 2018-03: Clarified that securities acquired in lots shall not be reported with weighted average designations. With the adopted guidance, if a SSAP No. 43R security (by CUSIP) has different NAIC designations by lot, the reporting entity shall either 1) report the aggregate investment with the lowest applicable NAIC designation or 2) report the investment separately by purchase lot on the investment schedule. If reporting separately, the investment may be aggregated by NAIC designation. With the elimination of MFE, the instances of different designations by lot are not expected to be prevalent, but could still occur with the financial modeling process for residential mortgage backed securities (RMBS) and commercial mortgage backed securities (CMBS).
- Agenda Item 2020-21: Edits incorporated adopted guidance to the P&P manual detailing the use and mapping of NAIC designations to NAIC designation categories. Reporting entities were to then utilize the new NAIC designation categories for accounting and reporting purposes.
- Agenda Item 2021-23: Adopted changes to summarize the financial modeling guidance in SSAP No. 43R. This guidance continues to refer users to the detailed financial modeling guidance in the P&P Manual.

Information or issues (included in *Description of Issue*) not previously contemplated by the Working Group:
None

Convergence with International Financial Reporting Standards (IFRS): Not Applicable

Staff Recommendation: NAIC staff recommends that the Working Group move this item to the active listing, categorized as a SAP clarification, and expose revisions to *SSAP No. 43R—Loan-backed and Structured Securities* to incorporate changes to add CLOs to the financial modeling guidance and to clarify that CLOs are not captured as legacy securities. These revisions reflect the guidance adopted for the P&P Manual in February 2023.

Proposed Revisions to SSAP No. 43R—Loan-Backed and Structured Securities

Designation Guidance

27. For [Residential Mortgage-Backed Securities \(RMBS\)](#), [Commercial Mortgage-Backed Securities \(CMBS\)](#) and [Collateralized Loan Obligations \(CLOs\)](#), ~~RMBS/CMBS~~ securities within the scope of this statement, the initial NAIC designation used to determine the carrying value method and the final NAIC designation for reporting purposes is determined using a multi-step process or the NAIC designation assigned by the NAIC Securities Valuation Office. The P&P Manual provides detailed guidance. A general description of the processes is as follows:
- a. Financial Modeling: Pursuant to the P&P Manual, the NAIC identifies select securities where financial modeling must be used to determine the NAIC designation. For a modeled [RMBS/CMBS](#) legacy security, meaning one which closed prior to January 1, 2013, the NAIC designation is based on financial modeling incorporating the insurers' carrying value. For a modeled [RMBS/CMBS](#) non-legacy security, meaning one which closed after December 31, 2012, [or modeled CLO](#) the NAIC designation and NAIC designation category assigned by the NAIC Securities Valuation Office must be used. For those [RMBS/CMBS](#) legacy securities that are financially modeled, the insurer must use NAIC CUSIP specific modeled breakpoints provided by the modelers in

determining initial and final designation for these identified securities. As specified in the P&P Manual, a modeled legacy security RMBS or CMBS tranche that has no expected loss, as compiled and published by the NAIC Securities Valuation Office, under any of the selected modeling scenarios would be assigned an NAIC 1 designation and NAIC 1.A designation category regardless of the insurer's book/adjusted carrying value. The three-step process for modeled [RMBS/CMBS](#) legacy securities is as follows:

- i. Step 1: Determine Initial Designation – The current amortized cost (divided by remaining par amount) of a loan-backed or structured security is compared to the modeled breakpoint values assigned to each NAIC designation and NAIC designation category for each CUSIP to establish the initial NAIC designation.
 - ii. Step 2: Determine Carrying Value Method – The carrying value method, either the amortized cost method or the lower of amortized cost or fair value method, is then determined as described in paragraph 26 based upon the initial NAIC designation from Step 1.
 - iii. Step 3: Determine Final Designation – The final NAIC designation is determined by comparing the carrying value (divided by remaining par amount) of a security (based on paragraph 27.a.ii.) to the NAIC CUSIP specific modeled breakpoint values assigned to the NAIC designation and NAIC designation category for each CUSIP or is mapped to an NAIC designation category, according to the instructions in the P&P Manual. This final NAIC designation shall be applicable for statutory accounting and reporting purposes and the NAIC designation category will be used for investment schedule reporting and establishing RBC and AVR charges. The final NAIC designation is not used for establishing the appropriate carrying value method in Step 2 (paragraph 27.a.ii.).
- b. All Other Loan-Backed and Structured Securities: For securities not subject to paragraph 27.a. (financial modeling) follow the established designation procedures according to the appropriate section of the P&P Manual. The NAIC designation shall be applicable for statutory accounting and reporting purposes (including determining the carrying value method and establishing the AVR charges). The carrying value method is established as described in paragraph 26.

Specific Interim Reporting Guidance Financially Modeled Securities

28. For securities that will be financially modeled under paragraph 27, the guidance in this paragraph shall be applied in determining the reporting method for such securities acquired in the current year for quarterly financial statements. Securities reported as of the prior-year end shall continue to be reported under the prior-year end methodology for the current-year quarterly financial statements. For year-end reporting, securities shall be reported in accordance with paragraph 27, regardless of the quarterly methodology used.

- a. Reporting entities that acquired the entire financial modeling database for the prior-year end are required to follow the financial modeling methodology (paragraph 27.a.) for all securities acquired in the subsequent year that were included in the financial modeling data acquired for the prior year-end.
- b. Reporting entities that acquired identical securities (identical CUSIP) to those held and financially modeled for the prior year-end are required to follow the prior year-end financial modeling methodology (paragraph 27.a.) for these securities acquired subsequent to year-end.

- c. Reporting entities that do not acquire the prior-year financial modeling information for current-year acquired individual CUSIPS, and are not captured within paragraphs 28.a. or 28.b., are required to follow the analytical procedures for non-financially modeled securities (paragraph 27.b. as appropriate) until the current year financial modeling information becomes available and then follow the procedures for financially modeled securities (paragraph 27.a., as appropriate). Reporting entities that do acquire the individual CUSIP information from the prior-year financial modeling database shall use that information for interim reporting.
- d. Reporting entities that acquire securities not previously modeled at the prior year-end are required to follow the analytical procedures for non-financially modeled securities (paragraph 27.b. as appropriate) until the current year financial modeling information becomes available and then follow the procedures for financially modeled securities (paragraph 27.a., as appropriate).

Staff Review Completed by: Julie Gann, NAIC Staff – February 2023

Status:

On March 22, 2023, the Statutory Accounting Principles (E) Working Group moved this agenda item to the active listing, categorized as a SAP clarification, and exposed revisions to SSAP No. 43R to incorporate changes to add CLOs to the financial modeling guidance and to clarify that CLOs are not captured as legacy securities.

On August 13, 2023, the Statutory Accounting Principles (E) Working Group adopted, as final, the exposed revisions, as illustrated above, to SSAP No. 43R which incorporate changes to add collateralized loan obligations (CLOs) to the financial modeling guidance and to clarify that CLOs are not captured as legacy securities.

[https://naiconline.sharepoint.com/sites/NAICSupportStaffHub/Member Meetings/E CMTE/APPTF/2023-2 Summer/Summary and Minutes/SAPWG/Attachments/Att1G-2023-02 SSAP 43R.docx](https://naiconline.sharepoint.com/sites/NAICSupportStaffHub/Member%20Meetings/E%20CMTE/APPTF/2023-2%20Summer/Summary%20and%20Minutes/SAPWG/Attachments/Att1G-2023-02%20SSAP%2043R.docx)

**Statutory Accounting Principles (E) Working Group
 Maintenance Agenda Submission Form
 Form A**

Issue: ASU 2022-06, Reference Rate Reform (Topic 848), Deferral of the Sunset Date of Topic 848

Check (applicable entity):

	P/C	Life	Health
Modification of Existing SSAP	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
New Issue or SSAP	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Interpretation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Description of Issue:

The Financial Accounting Standards Board (FASB) issued *ASU 2022-06, Reference Rate Reform (Topic 848), Deferral of the Sunset Date of Topic 848* to extend the sunset date of the reference rate reform guidance that was included in *ASU 2020-04, Reference Rate Reform (Topic 848) Facilitation of the Effects of Reference Rate Reform on Financial Reporting* and *ASU 2021-01, Reference Rate Reform (Topic 848), Scope*.

As background, reference rate reform refers to the transition away from referencing the London Interbank Offered Rate (LIBOR), and other interbank offered rates (IBORs), and moving toward alternative reference rates that are more observable or transaction based. In July 2017, the governing body responsible for regulating LIBOR announced it would no longer require banks to continue rate submissions after 2021 – thus, likely sunsetting both the use and publication of LIBOR. An important item to note is that while LIBOR is the primary interbank offering rate, other similar rates are potentially affected by reference rate reform. For simplicity, LIBOR will be the sole IBOR referenced throughout this agenda item.

With a significant number of financial contracts referencing LIBOR, its discontinuance will require organizations to reevaluate and modify any contract which does not contain a substitute reference rate. A large volume of contracts and other arrangements, such as debt agreements, lease agreements, and derivative instruments, will likely need to be modified to replace all references of interbank offering rates that are expected to be discontinued. While operational, logistical, and legal challenges exist due to the sheer volume of contracts that will require modification, accounting challenges were presented as contract modifications typically require an evaluation to determine whether the modifications result in the establishment of a new contract or the continuation of an existing contract. As is often the case, a change to the critical terms (including reference rate modifications) typically requires remeasurement of the contract, or in the case of a hedging relationship, a dedesignation of the transaction.

To address ASU 2020-04 the Working Group issued *INT 20-01: Reference Rate Reform*, and this interpretation was then revised to incorporate guidance from ASU 2021-01. This agenda item intends to again revise INT 20-01 to include the revised sunset date of December 31, 2024.

Existing Authoritative Literature:

The Working Group adopted INT 20-01 to address ASU 2020-04, and further revised that interpretation to address ASU 2021-01. The modifications in ASU 2020-04 address hedge accounting and the allowance for a reporting entity to change the reference rate and other critical terms related to reference rate reform without having to dedesignate the hedging relationship. Alternative benchmark interest rates were previously addressed in agenda item 2018-46 – Benchmark Interest Rate.

ASU 2021-01 increased the scope of the optional, expedient accounting guidance for derivative instruments in ASU 2020-04 which would primarily affect *SSAP No. 86—Derivatives*. While detailed in the original agenda item (Ref

#2020-12), additional SSAPs impacted by ASU 2020-04 were *SSAP No. 15—Debt and Holding Company Obligations* and *SSAP No. 22R—Leases*.

Activity to Date (issues previously addressed by the Working Group, Emerging Accounting Issues (E) Working Group, SEC, FASB, other State Departments of Insurance or other NAIC groups):

The Working Group has taken several actions related to reference rate reform; each are summarized below.

1. Agenda item 2018-46 – Benchmark Interest Rate, incorporated revisions to SSAP No. 86, adding the Securities Industry and Financial Markets (SIFMA) Municipal Swap Rate and the Secured Overnight Financing Rate (SOFR) Overnight Index Swap (OIS) Rate as acceptable benchmark interest rates for hedge accounting. Prior to this change, only LIBOR and the Fed Funds Effective Swap Rate (also referred to as the Overnight Index Swap Rate) were considered acceptable benchmark interest rates.
2. Agenda item 2020-12 reviews ASU 2020-04, the foundation of which this agenda item and related ASU (2021-01) are based. Agenda item 2020-12 resulted in the Working Group adopting INT 20-01.
3. *INT 20-01: ASU 2020-04 - Reference Rate Reform*, adopted by the Working Group in April 2020, broadly adopted ASU 2020-04 for statutory accounting stating that for statutory accounting:
 - For all contracts within scope of ASU 2020-04, modifications due to reference rate reform are afforded an optional expedient to be accounted for as a continuation of the existing contract.
 - Debt and service agreement modifications, as a result of reference rate reform, should not typically rise to the level of requiring a reversal and rebooking of the liability, as *SSAP No. 15—Debt and Holding Company Obligations* states such liabilities should only be derecognized if extinguished.
 - Lease modifications, solely caused by reference rate reform and ones eligible for optional expedience, likely do not rise to the level of a modification requiring re-recognition as a new lease under *SSAP No. 22R—Leases*.
 - For derivative transactions within scope of ASU 2020-04, a change to the critical terms of the hedging relationship (due to reference rate reform), shall be afforded similar treatment in that the hedging relationship can continue the original hedge accounting rather than dedesignate the hedging relationship.
4. *INT 20-09: Basis Swaps as a Result of the LIBOR Transition*, adopted by the Working Group in July 2020, provided statutory accounting and reporting guidance for basis swaps issued by CCPs. This INT designated that basis swaps, issued by CCPs, in response to reference rate reform (i.e., the discounting transition), shall be classified as a derivative used for hedging. This categorization allowed for the basis swap derivatives to be admitted under SSAP No. 86. Additionally, the INT directed that basis swap derivatives shall not be reported as “effective” unless the instrument qualifies, with the required documentation, as highly effective under SSAP No. 86.
5. Agenda item 2021-09 further revised INT 20-01 and increased the scope of the optional, expedient accounting guidance for derivative instruments in ASU 2020-04.

Information or issues (included in *Description of Issue*) not previously contemplated by the Working Group:
None

Convergence with International Financial Reporting Standards (IFRS): None

Staff Recommendation:

NAIC staff recommends that the Working Group move this item to the active listing, categorized as SAP clarification and expose temporary (optional) expedient and exception interpretative guidance, to revise the expiration date of the guidance in *INT 20-01: ASU 2020-04 & 2021-01 - Reference Rate Reform* to be December 31, 2024.

The proposed modifications to INT 20-01 temporarily override SSAP No. 15, SSAP No. 22R and SSAP No. 86 guidance, therefore the policy statement in Appendix F requires 2/3rd (two-thirds) of the Working Group members to be present and voting and a supermajority of the Working Group members present to vote in support of the interpretation before it can be finalized.

Staff Review Completed by: Jake Stultz—February 2023

Status:

On March 22, 2023, the Statutory Accounting Principles (E) Working Group moved this agenda item to the active listing, categorized as a SAP clarification, and exposed temporary (optional) expedient and exception interpretative guidance, to revise the expiration date of the guidance in *INT 20-01: 2020-04, 2021-01 & 2022-06 - Reference Rate Reform* to be December 31, 2024, as reflected in INT 20-01.

On August 13, 2023, the Statutory Accounting Principles (E) Working Group adopted, as final, the exposed revisions, as reflected in *INT 20-01: ASUs 2020-04, 2021-01 & 2022-06 - Reference Rate Reform* which revises expiration date of the interpretation to December 31, 2024.

[https://naiconline.sharepoint.com/sites/NAICSupportStaffHub/Member Meetings/E CMTE/APPTF/2023-2 Summer/Summary and Minutes/SAPWG/Attachments/Att1H-2023-05 ASU 2022-06.docx](https://naiconline.sharepoint.com/sites/NAICSupportStaffHub/Member%20Meetings/E%20CMTE/APPTF/2023-2%20Summer/Summary%20and%20Minutes/SAPWG/Attachments/Att1H-2023-05%20ASU%2022-06.docx)

Interpretation of the Statutory Accounting Principles (E) Working Group

INT 20-01: *ASUs 2020-04, ~~& 2021-01~~ & 2022-06 – Reference Rate Reform*

INT 20-01 Dates Discussed

March 26, 2020; April 15, 2020; March 15, 2021, May 20, 2021, [March 22, 2023](#), [August 13, 2023](#)

INT 20-01 References

Current:

SSAP No. 15—*Debt and Holding Company Obligations*

SSAP No. 22R—*Leases*

SSAP No. 86—*Derivatives*

This INT applies to all SSAPs with contracts within scope of ASU 2020-04, which allows for modifications due to reference rate reform and provides for the optional expedient to be accounted for as a continuation of the existing contract.

INT 20-01 Issue

1. This interpretation has been issued to provide statutory accounting and reporting guidance for the adoption with modification of *ASU 2020-04, Reference Rate Reform (Topic 848): Facilitation of the Effects of Reference Rate Reform on Financial Reporting*, ~~and ASU 2021-01, Reference Rate Reform (Topic 848)~~, and ASU 2022-06, Reference Rate Reform (Topic 848) for applicable statutory accounting principles. The Financial Accounting Standards Board (FASB) issued ~~both~~ ASU 2020-04, ~~and~~ ASU 2021-01 and ASU 2022-06 to provide optional, transitional and expedient guidance as a result of reference rate reform.
2. “Reference rate reform” typically refers to the transition away from referencing the London Interbank Offered Rate (LIBOR), and other interbank offered rates (IBORs), and moving toward alternative reference rates that are more observable or transaction based. In July 2017, the governing body responsible for regulating LIBOR announced it will no longer require banks to continue LIBOR submissions after 2021 – likely sunseting both the use and publication of LIBOR. An important note is that while LIBOR is the primary interbank offering rate, other similar rates are potentially affected by reference rate reform.
3. With a significant number of financial contracts solely referencing IBORs, their discontinuance will require organizations to reevaluate and modify any contract that does not contain a substitute reference rate. A large volume of contracts and other arrangements, such as debt agreements, lease agreements, and derivative instruments, will likely need to be modified to replace all references of interbank offering rates that are expected to be discontinued. While operational, logistical, and legal challenges exist due to the sheer volume of contracts that will require modification, accounting challenges were presented as contract modifications typically require an evaluation to determine whether the modifications result in the establishment of a new contract or the continuation of an existing contract. As is often the case, a change to the critical terms (including reference rate modifications) typically requires remeasurement of the contract, or in the case of a hedging relationship, a dedesignation of the transaction.
4. The overall guidance in ASU 2020-04 is that a qualifying modification (as a result of reference rate reform) should not be considered an event that requires contract remeasurement at the modification date or reassessment of a previous accounting determination. FASB concluded that as reference rate changes are a market-wide initiative, one that is required primarily due to the discontinuance of LIBOR, it is outside the control of an entity and is the sole reason compelling an entity to make modifications to contracts or hedging strategies. As such, FASB

determined that the traditional financial reporting requirements of discontinuing such contracts and treating the modified contract as an entirely new contract or hedging relationship would 1) not provide decision-useful information to financial statement users and 2) require a reporting entity to incur significant costs in the financial statement preparation and potentially reflect an adverse financial statement impact, one of which may not accurately reflect the intent or economics of a modification to a contract or hedging transaction.

5. Guidance in ASU 2020-04 allows a method to ensure that the financial reporting results would continue to reflect the intended continuation of contracts and hedging relationships during the period of the market-wide transition to alternative reference rates – thus, generally not requiring remeasurement or dedesignation if certain criteria are met.

6. Guidance in ASU 2021-01 expanded the scope of ASU 2020-04 by permitting the optional, transitional, expedient guidance to also include derivative contracts that undergo a similar transition but do not specifically reference a rate that is expected to be discontinued. While these contract modifications do not reference LIBOR (or another reference rate expected to be discontinued), the changes are the direct result of reference rate reform and were deemed to be eligible for similar exception treatment. ASU 2021-01 allows for modifications in interest rates indexes used for margining, discounting or contract price alignment, as a result of reference rate reform initiatives (commonly referred to as a “discounting transition”) to be accounted for as a continuation of the existing contract and hedge accounting. [On August 13, 2023, the Working Group added the guidance in ASU 2022-06 which only acts to defer the sunset date of Topic 848 from December 31, 2022, to December 31, 2024, after which entities will no longer be permitted to apply the relief from the prior ASUs.](#)

7. The optional, expedient and exceptions guidance provided by the amendments in ASU 2020-04, ~~and~~ ASU 2021-01 [and ASU 2022-04](#) are applicable for all entities. However, they are only effective as of March 12, 2020 through December 31, ~~2022~~ [2024](#). This is because the amendments are intended to provide relief related to the accounting requirements in generally accepted accounting principles (GAAP) due to the effects of the market-wide transition away from IBORs. The relief provided by the amendments is temporary in its application in alignment with the expected market transition period. However, the FASB will monitor the market-wide IBOR transition to determine whether future developments warrant any changes, including changes to the end date of the application of the amendments in this ASU. If such an update occurs, the Working Group may also consider similar action. It is not expected that the Working Group will take action prior to or in the absence of a FASB amendment.

8. The accounting issues are:

- a. Issue 1: Should a reporting entity interpret the guidance in ASU 2020-04 as broadly accepted for statutory accounting?
- b. Issue 2: Should the optional, expedient and exception guidance in ASU 2020-04 apply to debt and other service agreements addressed in SSAP No. 15?
- c. Issue 3: Should the optional, expedient and exception guidance in ASU 2020-04 apply to lease transactions addressed in SSAP No. 22R?
- d. Issue 4: Should the optional, expedient and exception guidance in ASU 2020-04 apply to derivative transactions addressed in SSAP No. 86?
- e. Issue 5: Should the optional, expedient and exception guidance in ASU 2021-01 apply to derivative transactions addressed in SSAP No. 86?

INT 20-01 Discussion

9. For Issue 1, the Working Group came to the consensus that ASU 2020-04 shall be adopted, to include the same scope of applicable contracts or transactions for statutory accounting with the only modification related to a concept not utilized by statutory accounting, as noted below. The Working Group agreed the amendments provide appropriate temporary guidance that alleviate the following concerns due to reference rate reform:

- a. Simplifies accounting analyses under current GAAP and statutory accounting principles (SAP) for contract modifications.
 - i. All contracts within scope of ASU 2020-04, which allows for modifications due to reference rate reform and provides for the optional expedient to be accounted for as a continuation of the existing contract.
- b. Allows hedging relationships to continue without dedesignation upon a change in certain critical terms.
- c. Allows a change in the designated benchmark interest rate to a different eligible benchmark interest rate in a fair value hedging relationship.
- d. Suspends the assessment of certain qualifying conditions for fair value hedging relationships for which the shortcut method for assuming perfect hedge effectiveness is applied.
- e. Simplifies or temporarily suspends the assessment of hedge effectiveness for cash flow hedging relationships.
- f. The only SAP modification to this ASU is related to the option to sell debt currently classified held-to-maturity. This concept is not employed by statutory accounting and thus is not applicable.

10. For Issue 2, the Working Group came to the consensus that debt and service agreement modifications, as a result of reference rate reform, should not typically rise to the level of requiring a reversal and rebooking of the liability, as SSAP No. 15 states such liabilities should only be derecognized if extinguished. A reference rate modification should not generally require de-recognition and re-recognition under statutory accounting. Nonetheless, for clarity and consistency with ASU 2020-04, the Working Group came to the consensus that should an eligible contract be affected by reference rate reform, then the temporary guidance in ASU 2020-04 shall apply.

11. For Issue 3, the Working Group came to the consensus that lease modifications, solely caused by reference rate reform and ones eligible for optional expedience, likely do not rise to the level of a modification requiring re-recognition as a new lease under statutory accounting. SSAP No. 22R, paragraph 17 states only modifications in which grant the lessee additional rights shall be accounted for as a new lease. These changes are outside the scope allowed for optional expedience in ASU 2020-04. Nonetheless, for clarity and consistency with ASU 2020-04, the Working Group came to a consensus that if an eligible lease affected by reference rate reform, then the temporary guidance in ASU 2020-04 shall apply.

12. For Issue 4, the Working Group came to the consensus that ASU 2020-04 shall be applied to derivative transactions as the following considerations provided in the ASU are appropriate for statutory accounting:

- a. For any hedging relationship, upon a change to the critical terms of the hedging relationship, allow a reporting entity to continue hedge accounting rather than dedesignate the hedging relationship.

- b. For any hedging relationship, upon a change to the terms of the designated hedging instrument, allow an entity to change its systematic and rational method used to recognize the excluded component into earnings and adjust the fair value of the excluded component through earnings.
- c. For fair value hedges, allow a reporting entity to change the designated hedged benchmark interest rate and continue fair value hedge accounting.
- d. For cash flow hedges, adjust the guidance for assessment of hedge effectiveness to allow an entity to continue to apply cash flow hedge accounting.

13. For Issue 5, the Working Group came to a consensus on May 20, 2021, that ASU 2021-01 shall be applied to derivative transactions for statutory accounting. Accordingly, derivative instruments that are modified to change the reference rate used for margining, discounting, or contract price alignment that is a result of reference rate reform (regardless of whether the reference rate that is expected to be discontinued) are eligible for the exception guidance afforded in ASU 2020-04 in that such a modification is not considered a change in the critical terms that would require dedesignation of the hedging relationship. In addition, for all derivatives (those qualifying for hedge accounting, those that do not qualify for hedge accounting and replication (synthetic asset) transactions (RSAT)), a reporting entity may account for and report modifications (that are within the scope of INT 20-01) as a continuation of the existing contract even when the legal form of the modification is a termination of the original contract and its replacement with a new reference rate reform contract. This includes in-scope modifications of centrally cleared swap contracts whether they are automatically transitioned at a cessation date or voluntarily executed prior to cessation.

14. Additionally, for GAAP purposes, if an entity has not adopted the amendments in *ASU 2017-12, Derivatives and Hedging*, it is precluded from being able to utilize certain expedients for hedge accounting. For statutory accounting purposes, only the hedge documentation requirements were adopted from ASU 2017-12, while the remainder of the items are pending statutory accounting review. The Working Group concluded that all allowed expedient methods are permitted as elections for all reporting entities under statutory accounting. However, if a reporting entity is a U.S. GAAP filer, the reporting entity may only make elections under ASU 2017-12 if such elections were also made for their U.S. GAAP financials.

INT 20-01 Status

15. ~~No further~~ Further discussion is planned.

**Statutory Accounting Principles (E) Working Group
Maintenance Agenda Submission Form
Form A**

Issue: ASU 2019-08, Codification Improvements to Topic 718 and Topic 606

Check (applicable entity):

	P/C	Life	Health
Modification of existing SSAP	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
New Issue or SSAP	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Interpretation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Description of Issue: In November 2019, FASB issued *ASU 2019-08 Compensation—Stock Compensation (Topic 718) and Revenue from Contracts with Customers (Topic 606): Codification Improvements—Share-Based Consideration Payable to a Customer*, which includes amendments to Topics 718 and 606. The changes to Topic 718 include share-based payment transactions for acquiring goods and services from nonemployees and in doing so superseded guidance in Subtopic 505-50, *Equity—Equity-Based Payments to Non-Employees*. The changes to Topic 606 expand the scope of the codification to include share-based payment awards granted to a customer in conjunction with selling goods or services.

The amendments in ASU 2019-08 require that an entity measure and classify share-based payment awards granted to a customer by applying the guidance in Topic 718. The amount recorded as a reduction of the transaction price is required to be measured on the basis of the grant-date fair value of the share-based payment award in accordance with Topic 718. The grant date is the date at which a grantor (supplier) and a grantee (customer) reach a mutual understanding of the key terms and conditions of a share-based payment award. The classification and subsequent measurement of the award are subject to the guidance in Topic 718 unless the share-based payment award is subsequently modified and the grantee is no longer a customer.

For statutory accounting assessments, prior U.S. GAAP guidance related to share-based payments has been predominantly adopted with modification in *SSAP No. 104R—Share-Based Payments*. Statutory accounting modifications to the U.S. GAAP guidance have mostly pertained to statutory terms and concepts. (For example, statutory reporting lines, nonadmittance of prepaid assets, etc.)

Existing Authoritative Literature:

Stock Compensation is covered by *SSAP No. 104R—Share-Based Payments* and *SSAP No. 95—Nonmonetary Transactions*.

The ASUs related to ASC Topic 606 have been rejected in *SSAP No. 47—Uninsured Plans*.

Activity to Date (issues previously addressed by the Working Group, Emerging Accounting Issues (E) Working Group, SEC, FASB, other State Departments of Insurance or other NAIC groups):

Agenda item 2018-35 adopted with modification *ASU 2018-07, Improvements to Nonemployee Share-Based Payment Accounting* and incorporated the U.S. GAAP amendments from that project into SAP.

Agenda items 2016-19 and 2017-37 address the main ASUs related to *ASC Topic 606* and there have been several other agenda items for minor updates to revenue recognition guidance, all of which have been rejected in *SSAP No. 47*.

Per the comment letter received on June 9, 2023, interested parties had no comments on Agenda item 2023-07.

Information or issues (included in *Description of Issue*) not previously contemplated by the Working Group:
None.

Convergence with International Financial Reporting Standards (IFRS):
None.

Staff Recommendation:

Staff recommends that the Working Group move this item to the active listing, categorized as a SAP clarification, and expose revisions to adopt with modification *ASU 2019-08 Compensation—Stock Compensation (Topic 718) and Revenue from Contracts with Customers (Topic 606): Codification Improvements—Share-Based Consideration Payable to a Customer* for statutory accounting. These revisions would add language to include share-based consideration payable to customers under SSAP No. 104R guidance in the same manner as U.S. GAAP. With the revisions proposed to SSAP No. 104R, revisions are also proposed to *SSAP No. 95—Nonmonetary Transactions* to update previously adopted U.S. GAAP guidance. In addition, proposed revisions to *SSAP No. 47—Uninsured Plans*, reject Topic 606 guidance in ASU 2019-08. The proposed revisions to SSAP No. 95, SSAP No. 104R, and *SSAP No. 47—Uninsured Plans*, are illustrated in the Form A.

Proposed Revisions to SSAP No. 95—Nonmonetary Transactions

Accounting for a Convertible Instrument Granted or Issued to a Nonemployee for Goods or Services or Services and Cash (in combination or individually), or a ~~Combination of Goods or Services and Cash~~ as Consideration Payable to a Customer

17. The guidance in paragraph 18 addresses a convertible instrument that is issued or granted to a nonemployee in exchange for goods or services or a combination of goods or services and cash or consideration payable to a customer. The convertible instrument contains a nondetachable conversion option that permits the holder to convert the instrument into the issuer's stock.

19. To determine the fair value of a convertible instrument granted as part of a share-based payment transaction to a nonemployee in exchange for goods or services or as consideration payable to a customer that is equity in form or, if debt in form, that can be converted into equity instruments of the issuer, the entity shall first apply SSAP No. 104R.

Proposed Revisions to SSAP No. 104R—Share-Based Payments

SUMMARY OF ISSUE

2. The objective of accounting for transactions under share-based payment arrangements is to recognize in the financial statements the goods or services received in exchange for equity instruments granted or liabilities incurred and the related cost to the entity as those goods or services are received. This statement uses the terms “compensation” and “payment” in their broadest senses to refer to the consideration paid for goods, ~~or~~ services, or the consideration paid to a customer.

Scope and Scope Exceptions

4. This statement applies to all share-based payment transactions in which a grantor acquires goods or services to be used or consumed in the grantor’s own operations or provides consideration payable to a

[customer](#) by issuing (or offering to issue) its shares, share options, or other equity instruments or by incurring liabilities to an employee or nonemployee that meet either of the following conditions:

- a. The amounts are based, at least in part, on the price of the entity's shares or other equity instruments.
 - b. The awards require or may require settlement by issuing the entity's equity shares or other equity instruments.
5. Share-based payments awarded to a grantee by a related party or other holder of an economic interest in the entity as compensation for goods or services provided to the reporting entity are share-based payment transactions to be accounted for under this statement unless the transfer is clearly for a purpose other than compensation for goods or services to the reporting entity. The substance of such a transaction is that the economic interest holder makes a capital contribution to the reporting entity, and that entity makes a share-based payment to the grantee in exchange for services rendered or goods received. An example of a situation in which such a transfer is not compensation is a transfer to settle an obligation of the economic interest holder to the grantee that is unrelated to goods or services to be used or consumed in a grantor's own operations.
6. The guidance in this statement does not apply to:
- a. Equity instruments held by an employee stock ownership plan. Such equity instruments shall follow the guidance in SSAP No. 12—Employee Stock Ownership Plans.
 - b. Transactions involving equity instruments granted to a lender or investor that provides financing to the issuer.
 - c. Transactions involving equity instruments granted in conjunction with selling goods or services to customers as part of a contract (for example, sales incentives). If consideration payable to a customer is payment for a distinct good or service from the customer, then the entity shall account for the purchase of the good or service in the same way it accounts for other purchases from suppliers. Therefore, share-based payment awards granted to a customer for a distinct good or service to be used or consumed in the grantor's own operations are accounted for under this statement.

Recognition

11. This guidance does not address the period(s) or the manner (that is, capitalize versus expense) in which an entity granting the share-based payment award (the purchaser or grantor) to a nonemployee shall recognize the cost of the share-based payment award that will be issued, other than to require that a nonadmitted prepaid asset or expense be recognized (or previous recognition reversed) in the same period(s) and in the same manner as if the grantor had paid cash for the goods or services instead of paying with or using the share-based payment award.

Initial Measurement

35. An entity shall account for the compensation cost from share-based payment transactions in accordance with the fair-value-based method set forth in this statement. That is, the cost of goods obtained or services received in exchange for awards of share-based compensation generally shall be measured based on the grant-date fair value of the equity instruments issued or on the fair value of the liabilities incurred.

The cost of goods obtained or services received by an entity as consideration for equity instruments issued or liabilities incurred in share-based compensation transactions with employees shall be measured based on the fair value of the equity instruments issued or the liabilities settled. The portion of the fair value of an instrument attributed to goods obtained or services received is net of any amount that a grantee pays (or becomes obligated to pay) for that instrument when it is granted. For example, if a grantee pays \$5 at the grant date for an option with a grant-date fair value of \$50, the amount attributed to goods or services provided by the grantee is \$45.

Measurement Objective – Fair Value at Grant Date

38. The measurement objective for equity instruments awarded to grantees is to estimate the fair value at the grant date of the equity instruments that the entity is obligated to issue when grantees have delivered the good or rendered the service and satisfied any other conditions necessary to earn the right to benefit from the instruments (for example, to exercise share options). That estimate is based on the share price and other pertinent factors, such as expected volatility, at the grant date.

- a. Measurement Objective and Measurement Date for Awards Classified as Liabilities: At the grant date, the measurement objective for liabilities incurred under share-based compensation arrangements is the same as the measurement objective for equity instruments awarded to grantees as described in paragraph 38. However, the measurement date for liability instruments is the date of settlement.
- b. Intrinsic Value Option for Awards Classified as Liabilities: A reporting entity shall make a policy decision of whether to measure all of its liabilities incurred under share-based payment arrangements (for employee and nonemployee awards) issued in exchange for goods or services at fair value or ~~to measure all such liabilities~~ at intrinsic value. However, the reporting entity shall initially and subsequently measure awards determined to be consideration payable to a customer at fair value.

52. A reporting entity may not be able to reasonably estimate the fair value of its equity share options, nonemployee awards and similar instruments because it is not practicable for the reporting entity to estimate the expected volatility of its share price. In that situation, the entity shall account for its equity share options, nonemployee awards and similar instruments based on a value calculated using the historical volatility of an appropriate industry sector index instead of the expected volatility of the entity's share price (~~the calculated-permitted~~ value). A reporting entity's use of ~~calculated-permitted~~ value shall be consistent between employee share-based payment transactions and nonemployee share-based payment transactions. Throughout the remainder of this statement, provisions that apply to accounting for share options, nonemployee awards and similar instruments at fair value also apply to calculated value.

Staff Note: Paragraph 98 references "permitted value in accordance with paragraph 52", but terminology was not consistent between paragraphs. NAIC staff changed "calculated value" to "permitted value" to allow for easier cross-referencing.

54. A reporting entity that elects to apply the practical expedient in paragraph 53 shall apply the practical expedient to a share option or similar award that has all of the following characteristics:

- a. The share option or similar award is granted at the money.

- b. The grantee has only a limited time to exercise the award (typically 30-90 days) if the grantee no longer provides goods ~~or~~, terminates service after vesting, or ceases to be a customer.
- c. The grantee can only exercise the award. The grantee cannot sell or hedge the award.
- d. The award does not include a market condition.

Subsequent Measurement

68. The total amount of compensation cost recognized for share-based payment awards to nonemployees shall be based on the number of instruments for which a good has been delivered or a service has been rendered. To determine the amount of compensation cost to be recognized in each period, an entity shall make an entity-wide accounting policy election for all nonemployee share-based payment awards, including share-based payment awards granted to customers, to do either of the following:

- a. Estimate the number of forfeitures expected to occur. The entity shall base initial accruals of compensation cost on the estimated number of nonemployee share-based payment awards for which a good is expected to be delivered or service is expected to be rendered. The entity shall revise that estimate if subsequent information indicates that the actual number of instruments is likely to differ from previous estimates. The cumulative effect on current and prior periods of a change in the estimates shall be recognized in compensation cost in the period of the change.
- b. Recognize the effect of forfeitures in compensation cost when they occur. Previously recognized compensation cost for a nonemployee share-based payment award shall be reversed in the period that the award is forfeited.

80. A freestanding financial instrument issued to a grantee ~~in exchange for goods or services received (or to be received)~~ that is subject to initial recognition and measurement guidance within this statement shall continue to be subject to the recognition and measurement provisions of this statement throughout the life of the instrument, unless its terms are modified after a ~~nonemployee grantee~~ vests in the award and is no longer providing goods or services, a grantee vests in the award and is no longer a customer, or a grantee is no longer an employee. Only for purposes of this paragraph, a modification does not include a change to the terms of an award if that change is made solely to reflect an equity restructuring provided that both of the following conditions are met:

- a. There is no increase in fair value of the award (or the ratio of intrinsic value to the exercise price of the award is preserved, that is, the holder is made whole) or the antidilution provision is not added to the terms of the award in contemplation of an equity restructuring.
- b. All holders of the same class of equity instruments (for example, stock options) are treated in the same manner.

81. Other modifications of that instrument that take place after a ~~nonemployee grantee~~ vests in the award and is no longer providing goods or services, is no longer a customer, or ~~a grantee~~ is no longer an employee shall be subject to the modification guidance in paragraph 83. Following modification, recognition and measurement of the instrument shall be determined through reference to other applicable statutory accounting principles.

Subsequent Measurement - Awards Classified as Liabilities

97. Changes in the fair value (or intrinsic value for a reporting entity that elects that method) of a liability incurred under a share-based payment arrangement [issued in exchange for goods or services](#) that occur during the employee's requisite service period or the nonemployee's vesting period shall be recognized as compensation cost over that period. The percentage of the fair value (or intrinsic value) that is accrued as compensation cost at the end of each period shall equal the percentage of the requisite service that has been rendered for an employee award or the percentage that would have been recognized had the grantor paid cash for the goods or services instead of paying with a nonemployee award at that date. Changes in the fair value (or intrinsic value) of a liability [issued in exchange for goods or services](#) that occur after the end of the employee's requisite service period or the nonemployee's vesting period are compensation costs of the period in which the changes occur. Any difference between the amount for which a liability award [issued in exchange for goods or services](#) is settled and its fair value at the settlement date as estimated in accordance with the provisions of this statement is an adjustment of compensation cost in the period of settlement.

98. Reporting entities shall measure a liability award under a share-based payment arrangement based on the award's fair value (or permitted value in accordance with paragraph 52) remeasured at each reporting date until the date of settlement. Compensation costs for each period until settlement shall be based on the change (or a portion of the change, depending on the percentage of the requisite service that has been rendered for an employee award or the percentage that would have been recognized had the grantor paid cash for the goods and services instead of paying with a nonemployee award at the reporting date) in the fair value of the instrument for each reporting period. [A reporting entity shall subsequently measure awards determined to be consideration payable to a customer at fair value.](#)

Effective Date and Transition

132. Since the initial adoption of SSAP No. 104, subsequent revisions were effective as follows:

- b. [ASU 2019-08, Compensation—Stock Compensation \(Topic 718\) and Revenue from Contracts with Customers \(Topic 606\): Codification Improvements—Share-Based Consideration Payable to a Customer.](#)

REFERENCES**Other**

- *SSAP No. 12—Employee Stock Ownership Plans*

Proposed Revisions to SSAP No. 47—Uninsured Plans**RELEVANT LITERATURE**

15. This statement rejects *ASU 2014-09, Revenue from Contracts with Customers*; *ASU 2015-14, Revenue From Contracts With Customers*; *ASU 2016-08, Revenue From Contracts with Customers: Principal versus Agent Considerations (Reporting Revenue Gross versus Net)*; *ASU 2016-10, Revenue from Contracts with Customers: Identifying Performance Obligations and Licensing*; *ASU 2016-12, Revenue from Contracts with Customers: Narrow-Scope Improvements and Practical Expedients*; *ASU 2016-20,*

Technical Corrections and Improvements to Topic 606, Revenue from Contracts with Customers; ASU 2018-18, Collaborative Arrangements (Topic 808), Clarifying the Interaction between Topic 808 and Topic 606, [the Topic 606 guidance included in ASU 2019-08, Codification Improvements to Stock Compensation \(Topic 718\) and Share-Based Consideration Payable to a Customer \(Topic 606\)](#), ASU 2021-02, Franchisors—Revenue from Contracts with Customers, ASU 2021-08, Business Combinations, Accounting for Contract Assets and Contract Liabilities from Contracts with Customers

Staff Review Completed by:

NAIC Staff – William Oden, February 2023

Status:

On March 22, 2023, the Statutory Accounting Principles (E) Working Group moved this agenda item to the active listing, categorized as a SAP clarification, and exposed revisions to SSAP No. 95, SSAP No. 104R, and SSAP No. 47 to adopt, with modification, *ASU 2019-08 Compensation—Stock Compensation (Topic 718) and Revenue from Contracts with Customers (Topic 606): Codification Improvements—Share-Based Consideration Payable to a Customer*, as illustrated above.

On August 13, 2023, the Statutory Accounting Principles (E) Working Group adopted, as final, the exposed revisions, as illustrated above, to SSAP Nos. 47, 95, and 104R to adopt, with modification, ASU 2019-08 which expands the scope of stock compensation guidance to share-based consideration payable to customers.

[https://naiconline.sharepoint.com/sites/NAICSupportStaffHub/Member Meetings/E CMTE/APPTF/2023-2 Summer/Summary and Minutes/SAPWG/Attachments/Att1J-2023-07 ASU 2019-08.docx](https://naiconline.sharepoint.com/sites/NAICSupportStaffHub/Member%20Meetings/E%20CMTE/APPTF/2023-2%20Summer/Summary%20and%20Minutes/SAPWG/Attachments/Att1J-2023-07%20ASU%202019-08.docx)

**Statutory Accounting Principles (E) Working Group
 Maintenance Agenda Submission Form
 Form A**

Issue: ASU 2019-07, Codification Updates to SEC Sections

Check (applicable entity):

	P/C	Life	Health
Modification of Existing SSAP	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
New Issue or SSAP	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Interpretation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Description of Issue:

FASB issued *ASU 2019-07—Codification Updates to SEC Sections: Amendments to SEC Paragraphs Pursuant to SEC Final Rule Releases No. 33-10532, Disclosure Update and Simplification, and Nos. 33-10231 and 33-10442, Investment Company Reporting Modernization, and Miscellaneous Updates*, which primarily effects the codifications of Financial Services—Depository and Lending (Topic 942), Financial Services—Insurance (Topic 944), and Financial Services—Investment Companies (Topic 946). The update amends and supersedes certain SEC sections in Topic 942, 944, and 946 to align codification guidance with SEC Releases No. 33-10532, 33-10231, and 33-10442. These SEC Releases amend a wide range of disclosure requirements which were determined to be redundant, duplicative, overlapping, outdated, or superseded by other relevant literature. Additionally, the SEC Releases include several miscellaneous updates and corrections intended to clarify SEC guidance.

Existing Authoritative Literature:

Historically, SEC guidance from ASUs have been rejected as not applicable for statutory accounting in Appendix D. Regardless, all ASUs are reviewed for statutory accounting purposes to determine if the guidance should be considered for statutory accounting.

Debt is covered in *SSAP No. 15—Debt and Holding Company Obligations*, surplus is covered in *SSAP No. 72—Surplus and Quasi-Reorganizations*, and consolidation guidance is discussed in *SSAP No. 97—Investments in Subsidiary, Controlled and Affiliated Entities*.

Activity to Date (issues previously addressed by the Working Group, Emerging Accounting Issues (E) Working Group, SEC, FASB, other State Departments of Insurance or other NAIC groups): None.

Per the comment letter received on June 9, 2023, interested parties had no comments on Agenda item 2023-08.

Information or issues (included in *Description of Issue*) not previously contemplated by the Working Group: None.

Convergence with International Financial Reporting Standards (IFRS): None

Staff Recommendation:

NAIC staff recommends that the Working Group move this item to the active listing, categorized as a SAP clarification, and expose revisions to *Appendix D—Nonapplicable GAAP Pronouncements to reject ASU 2019-07—Codification Updates to SEC Sections: Amendments to SEC Paragraphs Pursuant to SEC Final Rule Releases No. 33-10532, Disclosure Update and Simplification, and Nos. 33-10231 and 33-10442, Investment Company Reporting Modernization, and Miscellaneous Updates* as not applicable to statutory accounting. This

item is proposed to be rejected as not applicable as ASU 2019-07 is specific to amendment of SEC paragraphs, which are not applicable for statutory accounting purposes.

Staff Review Completed by: William Oden – February 2023

Status:

On March 22, 2023, the Statutory Accounting Principles (E) Working Group moved this agenda item to the active listing, categorized as a SAP clarification, and exposed revisions to Appendix D to reject *ASU 2019-07—Codification Updates to SEC Sections: Amendments to SEC Paragraphs Pursuant to SEC Final Rule Releases No. 33-10532, Disclosure Update and Simplification, and Nos. 33-10231 and 33-10442, Investment Company Reporting Modernization, and Miscellaneous Updates* as not applicable to statutory accounting.

On August 13, 2023, the Statutory Accounting Principles (E) Working Group adopted, as final, the exposed revisions to *Appendix D—Nonapplicable GAAP Pronouncements* to reject ASU 2019-07 as not applicable to statutory accounting.

[https://naiconline.sharepoint.com/sites/NAICSupportStaffHub/Member Meetings/E CMTE/APPTF/2023-2 Summer/Summary and Minutes/SAPWG/Attachments/Att1K-2023-08 ASU 2019-07.docx](https://naiconline.sharepoint.com/sites/NAICSupportStaffHub/Member%20Meetings/E%20CMTE/APPTF/2023-2%20Summer/Summary%20and%20Minutes/SAPWG/Attachments/Att1K-2023-08%20ASU%202019-07.docx)

**Statutory Accounting Principles (E) Working Group
Maintenance Agenda Submission Form
Form A**

Issue: *ASU 2020-09—Amendments to SEC Paragraphs Pursuant to SEC Release No. 33-10762—Debt (Topic 470)*

Check (applicable entity):

	P/C	Life	Health
Modification of Existing SSAP	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
New Issue or SSAP	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Interpretation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Description of Issue:

FASB issued *ASU 2020-09, Amendments to SEC Paragraphs Pursuant to SEC Release No. 33-10762—Debt (Topic 470)*, which effects the codification in Debt (Topic 470). The update amends and supersedes certain SEC sections in Topic 470 to align codification guidance with SEC Release No. 33-10762. No. 33-10762 amends the SEC financial disclosure requirements for guarantors and issuers of guaranteed securities registered or being registered, and issuers' affiliates whose securities collateralize securities registered or being registered in Regulation S-X to improve those requirements for both investors and registrants. The changes are intended to provide investors with material information given the specific facts and circumstances, make the disclosures easier to understand, and reduce the costs and burdens to registrants.

Existing Authoritative Literature:

Historically, SEC guidance from ASUs have been rejected as not applicable for statutory accounting in Appendix D. Regardless, all ASUs are reviewed for statutory accounting purposes to determine if the guidance should be considered for statutory accounting.

Debt is covered in *SSAP No. 15— Debt and Holding Company Obligations*. Basic discussion of the nature of liabilities is covered in *SSAP No. 5R— Liabilities, Contingencies and Impairments of Assets*.

Activity to Date (issues previously addressed by the Working Group, Emerging Accounting Issues (E) Working Group, SEC, FASB, other State Departments of Insurance or other NAIC groups):

Per the comment letter received on June 9, 2023, interested parties had no comments on Agenda item 2023-09.

Information or issues (included in *Description of Issue*) not previously contemplated by the Working Group:

None

Convergence with International Financial Reporting Standards (IFRS): None

Staff Recommendation:

NAIC staff recommends that the Working Group move this item to the active listing, categorized as a SAP clarification, and expose revisions to *Appendix D—Nonapplicable GAAP Pronouncements* to reject *ASU 2020-09, Amendments to SEC Paragraphs Pursuant to SEC Release No. 33-10762—Debt (Topic 470)* as not applicable to statutory accounting. This guidance is not applicable as it pertains to an exception of issuers or guarantors filing financial statements with the SEC when the issuer or guarantor is included in filed consolidated financial statements and other conditions are met.

Staff Review Completed by: William Oden – February 2023

Status:

On March 22, 2023, the Statutory Accounting Principles (E) Working Group moved this agenda item to the active listing, categorized as a SAP clarification, and exposed revisions to Appendix D to reject *ASU 2020-09, Amendments to SEC Paragraphs Pursuant to SEC Release No. 33-10762—Debt (Topic 470)* as not applicable to statutory accounting.

On August 13, 2023, the Statutory Accounting Principles (E) Working Group adopted, as final, the exposed revisions to *Appendix D—Nonapplicable GAAP Pronouncements* to reject ASU 2020-09 as not applicable to statutory accounting.

[https://naiconline.sharepoint.com/sites/NAICSupportStaffHub/Member Meetings/E CMTE/APPTF/2023-2 Summer/Summary and Minutes/SAPWG/Attachments/Att1L-2023-09 ASU 2020-09.docx](https://naiconline.sharepoint.com/sites/NAICSupportStaffHub/Member%20Meetings/E%20CMTE/APPTF/2023-2%20Summer/Summary%20and%20Minutes/SAPWG/Attachments/Att1L-2023-09%20ASU%2020-09.docx)

**Statutory Accounting Principles (E) Working Group
 Maintenance Agenda Submission Form
 Form A**

Issue: *ASU 2022-05, Transition for Sold Contracts*

Check (applicable entity):

	P/C	Life	Health
Modification of existing SSAP	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
New Issue or SSAP	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Interpretation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Description of Issue: This agenda item has been drafted to consider *ASU 2022-05, Transition for Sold Contracts* (ASU) for statutory accounting. The FASB issued the ASU in December 2022 to amend specific sections of *ASU 2018-12, Targeted Improvements for Long-Durations Contracts* (LDTI). The amendments made by the ASU are intended to reduce implementation costs and complexity associated with the adoption of LDTI for contracts that have been derecognized in accordance with the ASU before the LDTI effective date. The revisions captured in the ASU are summarized as follows:

The amendments in the ASU amend the LDTI transition guidance to allow an insurance entity to make an accounting policy election on a transaction-by-transaction basis. An insurance entity may elect to exclude contracts that meet certain criteria from applying the amendments in the LDTI. To qualify for the accounting policy election, as of the LDTI effective date both of the following conditions must be met:

- a. The insurance contracts must have been derecognized because of a sale or disposal of individual or a group of contracts or legal entities.
- b. The entity has no significant continuing involvement with the derecognized contracts.

ASU 2018-12, as amended by 2022-05, is effective for public entities for fiscal years beginning after December 15, 2022, and interim periods within those fiscal years. For nonpublic entities, the LDTI is effective for fiscal years beginning after December 15, 2024, and interim periods within fiscal years beginning after December 15, 2025. The LDTI includes different transition provisions as follows:

- For the liability for future policyholder benefits and deferred acquisition costs, insurance entities should apply the amendments to contracts in force as of the beginning of the earliest period presented on the basis of their existing carrying amounts, adjusted for the removal of any related amounts in accumulated other comprehensive income. Insurance entities are permitted to apply the amendments retrospectively (with a cumulative catch-up adjustment to the opening balance of retained earnings), using actual historical experience information as of contract inception. (Estimates of historical experience may not be substituted for actual historical experience.) If electing retrospective application, it must be applied entity-wide for the same contract issue year, and all subsequent contract issue years. (Meaning, it must be used to all products and contracts issued in the first year in which retrospective application will be applied, and all subsequent products and contracts issued in later years.)
- For market risk benefits, insurance entities should apply the amendments retrospectively as of the beginning of the earliest year presented. An insurance entity may use hindsight in instances in which assumptions in a prior period are unobservable or otherwise unavailable and cannot be

independently substantiated. The difference between fair value and the carrying value at the transition date, excluding the effect of changes in the instrument-specific credit risk, requires an adjustment to the opening balance of retained earnings.

Existing Authoritative Literature:

The key changes reflected in ASU 2018-12 revised U.S. GAAP guidance previously rejected for statutory accounting. (In a couple instances, the prior U.S. GAAP guidance was not reviewed for SAP - as the guidance was not Board Directed or was still pending SAP review.)

References from Appendix D – Cross-Reference to SAP:

U.S. GAAP	SAP Accounting Provisions
<i>FAS 60, Accounting and Reporting by Insurance Entities</i>	Rejected in SSAP No. 40R, SSAP No. 50, SSAP No. 51R, SSAP No. 52, SSAP No. 53, SSAP No. 54R, SSAP No. 57, SSAP No. 59, and SSAP No. 71
<i>FAS 97, Accounting and Reporting by Insurance Enterprises for Certain Long-Duration Contracts and for Realized Gains and Losses from the Sale of Investments</i>	Rejected in SSAP No. 50, SSAP No. 51R, SSAP No. 52 and SSAP No. 71
<i>FSP FAS 97-1, Situations in Which Paragraphs 17(b) and 20 of FAS 97 Permit or Require Accrual of an Unearned Revenue Liability</i>	Not Board Directed
<i>SOP 95-1, Accounting for Certain Insurance Activities of Mutual Life Insurance Enterprises</i>	Rejected in SSAP No. 51R and SSAP No. 52
<i>SOP 03-1, Accounting and Reporting by Insurance Enterprises for Certain Nontraditional Long-Duration Contracts and for Separate Accounts</i>	Rejected in SSAP No. 56
<i>SOP 05-1, Accounting by Insurance Enterprises for Deferred Acquisition Costs in Connection with Modifications or Exchange of Insurance Contracts</i>	Rejected in SSAP No. 71
<i>SOP 00-3, Accounting by Insurance Enterprises for Demutualizations and Formations of Mutual Insurance Holding Companies and for Certain Long-Duration Participating Contracts</i>	Pending SAP
<i>AICPA Practice Bulletin 8, Application of FAS 97 to Insurance Enterprises</i>	Rejected in SSAP No. 51R and SSAP No. 52R
<u>ASU 2018-12, Financial Services—Insurance (Topic 944): Targeted Improvements to the Accounting for Long-Duration Contracts</u>	<u>Rejected in Preamble, SSAP No. 50, SSAP No. 51R, SSAP No. 52, SSAP No. 54R, SSAP No. 55, SSAP No. 56, SSAP No. 71, and SSAP No. 86</u>

Other U.S. GAAP revised as a result of the ASU include:

- *FAS 133, Accounting for Derivative Instruments and Hedging Activities* (and related DIGs) – The framework of FAS 133 was adopted with modification in *SSAP No. 86—Derivatives*. The revisions from ASU 2018-12 indicate that contracts with market risk benefits do not need to be bifurcated as

embedded derivatives, as the guidance in ASU 2018-12 requires market risk benefits to be measured at fair value. The ASU revisions also delete or revise related implementation guidance for assessing whether embedded derivatives shall be bifurcated under U.S. GAAP. **This guidance will not impact the FAS 133 guidance adopted with modification, as SSAP No. 86 specifies that embedded derivatives shall not be separated from the derivative instrument.**

- *FAS 130, Other Comprehensive Income* – FAS 130 was rejected as not applicable under statutory accounting. The revisions from ASU 2018-12 modify FAS 130 to specify the additional components (e.g., changes in discount rate assumptions) that are recognized through OCI. These modifications will not impact the prior statutory accounting decision to reject FAS 130 for statutory accounting.

The following relevant SAP guidance is noted:

- ***SSAP No. 51—Life Contracts:*** This SSAP establishes statutory accounting principles for income recognition and policy reserves for life contracts. This SSAP identifies that policy reserves shall be established as required in *Appendix A-820, Minimum Life and Annuity Reserves* and *Appendix A-822, Asset Adequacy Analysis Requirements* or the *Valuation Manual*.
- ***SSAP No. 55—Unpaid Claims, Losses and Loss Adjustment Expenses:*** This SSAP establishes statutory accounting principles for recording liabilities for unpaid claims and claim adjustment expenses for life insurance contracts and accident and health contracts. (It also addresses unpaid losses and LAE for property and casualty contracts.) Pursuant to the guidance in paragraph 12, for each line of business, and for all lines of business in the aggregate, management shall record its best estimate of its liabilities for unpaid claims, unpaid losses and loss/claim adjustment expenses. This guidance identifies that management shall follow the concept of conservatism when determining estimates, but there is not a specific requirement to include a provision for adverse deviation in claims. With the revisions reflected in ASU 2018-12, the U.S. GAAP guidance has been revised to specify that the assumptions used in determining a liability for future policy benefits shall not include a provision for the risk of adverse deviation. Prior to these revisions, the guidance in ASC 944-40-30-7 specifically stated that the assumptions shall include a provision for the risk of adverse deviation. (*Note, as detailed in the proposed statutory accounting modifications, reference to the old U.S. GAAP guidance for adverse deviation is included in the Preamble and is proposed to be deleted.*)
- ***SSAP No. 71—Policy Acquisition Costs and Commissions:*** This SSAP establishes statutory accounting principles for policy acquisition costs and commissions. Pursuant to SSAP No. 71, all policy acquisition costs and commissions shall be expensed when incurred. Although the ASU is streamlining the amortization of capitalized deferred acquisition costs, this revision will not impact statutory accounting. (*Note, as detailed in the proposed statutory accounting modifications, reference to the old U.S. GAAP guidance is included in the Preamble and is proposed to be modified to reflect the new guidance.*)

Activity to Date (issues previously addressed by the Working Group, Emerging Accounting Issues (E) Working Group, SEC, FASB, other State Departments of Insurance or other NAIC groups):

Per the comment letter received on June 9, 2023, interested parties support the conclusion reached on Agenda item 2023-07.

Information or issues (included in *Description of Issue*) not previously contemplated by the Working Group:

None

Convergence with International Financial Reporting Standards (IFRS):

In 2008, the FASB undertook an insurance contracts project jointly with the International Accounting Standards Board (IASB). In 2013, after considering comments from the exposure of a 2010 Discussion Draft and a 2013 Proposed Update, the FASB decided to separate from the IASB project, and instead focus on targeted improvements to existing U.S. GAAP concepts. The decision to focus on targeted improvements to existing U.S. GAAP guidance, with the continued limitation of the guidance to insurance companies, was strongly supported by commenters in lieu of introducing a completely new accounting model that would apply to all entities that issued “insurance contracts.”

Staff Recommendation:

NAIC staff recommends that the Working Group move this item to the active listing, categorized as a SAP clarification, and expose proposed revisions to reject *ASU 2022-05, Transition for Sold Contracts* as not applicable for statutory accounting in *SSAP No. 50—Classifications of Insurance or Managed Care Contracts*; *SSAP No. 51R—Life Contracts*; *SSAP No. 52—Deposit-Type Contracts*; *SSAP No. 56—Separate Accounts*; *SSAP No. 71—Policy Acquisition Costs and Commissions* and *SSAP No. 86—Derivatives*. The guidance in *ASU 2022-05* provides updated transition guidance for *ASU 2018-12*, which had previously been rejected for statutory accounting. The proposed revisions are illustrated below:

SSAP No. 50—Classifications of Insurance or Managed Care Contracts

46. This statement rejects the U.S. GAAP classifications (i.e., short-duration and long-duration) found in [ASU 2022-05 Transition for Sold Contracts](#), *ASU 2018-12, Targeted Improvements to the Accounting for Long-Duration Contracts*, *FASB Statement No. 60, Accounting and Reporting by Insurance Enterprises*, *FASB Statement No. 97, Accounting and Reporting by Insurance Enterprises for Certain Long-Duration Contracts and for Realized Gains and Losses from the Sale of Investments*, and *FASB Statement No. 120, Accounting and Reporting by Mutual Life Insurance Enterprises and by Insurance Enterprises for Certain Long Duration Participating Contracts*.

SSAP No. 51R—Life Contracts

56. This statement rejects [ASU 2022-05 Transition for Sold Contracts](#), *ASU 2018-12, Targeted Improvements to the Accounting for Long-Duration Contracts*, *FASB Statement No. 60, Accounting and Reporting by Insurance Enterprises*, *FASB Statement No. 97, Accounting and Reporting by Insurance Enterprises for Certain Long-Duration Contracts and for Realized Gains and Losses from the Sale of Investments*, *FASB Statement 120, Accounting and Reporting by Mutual Life Insurance Enterprises and by Insurance Enterprises for Certain Long-Duration Participating Contracts*, *AICPA Practice Bulletin No. 8, Application of FASB Statement No. 97, Accounting and Reporting by Insurance Enterprises for Certain Long-Duration Contracts and for Realized Gains and Losses From the Sale of Investments*, to *Insurance Enterprises*, the *AICPA Audit and Accounting Guide—Audits of Stock Life Insurance Companies*, *AICPA Statement of Position 95-1, Accounting for Certain Activities of Mutual Life Insurance Enterprises* relating to accounting and reporting for policy reserves for short and long duration contracts, and *FASB Interpretation No. 40, Applicability of Generally Accepted Accounting Principles to Mutual Life Insurance and Other Enterprises*, an interpretation of *FASB Statements No. 12, 60, 97, and 113*.

SSAP No. 52—Deposit-Type Contracts

25. This statement rejects [ASU 2022-05 Transition for Sold Contracts](#), *ASU 2018-12, Targeted Improvements to the Accounting for Long-Duration Contracts*, *FASB Statement No. 60, Accounting and Reporting by Insurance Enterprises*, *FASB Statement No. 97, Accounting and Reporting by Insurance Enterprises for Certain Long-Duration Contracts and for Realized Gains and Losses from the Sale of Investments*, *FASB Statement 120, Accounting and Reporting by Mutual Life Insurance Enterprises and by*

Insurance Enterprises for Certain Long-Duration Participating Contracts, AICPA Practice Bulletin No. 8, Application of FASB Statement No. 97, Accounting and Reporting by Insurance Enterprises for Certain Long-Duration Contracts and for Realized Gains and Losses From the Sale of Investments, to Insurance Enterprises, the AICPA Audit and Accounting Guide—Audits of Stock Life Insurance Companies, AICPA Statement of Position 95-1, Accounting for Certain Activities of Mutual Life Insurance Enterprises relating to accounting and reporting for policy reserves for short and long duration contracts, and FASB Interpretation No. 40, Applicability of Generally Accepted Accounting Principles to Mutual Life Insurance and Other Enterprises, an interpretation of FASB Statements No. 12, 60, 97, and 113.

SSAP No. 56—Separate Accounts

41. This statement rejects [ASU 2022-05 Transition for Sold Contracts](#), ASU 2018-12, *Targeted Improvements to the Accounting for Long-Duration Contracts*, AICPA *Statement of Position 03-1, Accounting and Reporting by Insurance Enterprises for Certain Nontraditional Long-Duration Contracts and for Separate Accounts* (SOP 03-1). The disclosure elements included within this SSAP are derived from the criteria for separate account reporting under SOP 03-1; however, this SSAP does not restrict separate account reporting pursuant to the criteria established in SOP 03-1.

SSAP No. 71—Policy Acquisition Costs and Commissions

6. This statement rejects [ASU 2022-05 Transition for Sold Contracts](#), ASU 2018-12, *Targeted Improvements to the Accounting for Long-Duration Contracts*, ASU 2010-26, *Accounting for Costs Associated with Acquiring or Renewing Insurance Contracts*, FASB *Statement No. 60, Accounting and Reporting by Insurance Enterprises*, FASB *Statement No. 97, Accounting and Reporting by Insurance Enterprises for Certain Long-Duration Contracts and for Realized Gains and Losses from the Sale of Investments*, and *Statement of Position 05-1, Accounting by Insurance Enterprises for Deferred Acquisition Costs in Connection with Modifications or Exchanges of Insurance Contracts*.

SSAP No. 86—Derivatives

73. This statement rejects [ASU 2022-05 Transition for Sold Contracts](#), 2020-06, *Debt—Debt with Conversion and Other Options (Subtopic 470-20) and Derivatives and Hedging—Contracts in Entity’s Own Equity (Subtopic 815-40)*, *Accounting for Convertible Instruments and Contracts in an Entity’s Own Equity*, ASU 2020-01, *Investments—Equity Securities (Topic 321)*, *Investments—Equity Method and Joint Ventures (Topic 323)*, and *Derivatives and Hedging (Topic 815)*, *Clarifying the Interactions between Topic 321, Topic 323 and Topic 815*, ASU 2018-03, *Recognition and Measurement of Financial Assets and Financial Liabilities*, and ASU 2016-03, *Intangibles—Goodwill and Other, Business Combinations, Consolidation, Derivatives and Hedging*.

Staff Review Completed by:

William Oden, NAIC Staff – December 2022

Status:

On March 22, 2023, the Statutory Accounting Principles (E) Working Group moved this agenda item to the active listing, categorized as a SAP clarification to reject *ASU 2022-05, Transition for Sold Contracts* in *SSAP No. 50—Classifications of Insurance or Managed Care Contracts*; *SSAP No. 51R—Life Contracts*; *SSAP No. 52—Deposit-Type Contracts*; *SSAP No. 56—Separate Accounts*; *SSAP No. 71—Policy Acquisition Costs and Commissions* and *SSAP No. 86—Derivatives*, which is consistent with prior agenda items related to this topic.

On August 13, 2023, the Statutory Accounting Principles (E) Working Group adopted, as final, the exposed revisions to reject ASU 2022-05 in SSAP Nos. 50, 51R, 52, 56, 71, and 86.

[https://naiconline.sharepoint.com/sites/NAICSupportStaffHub/Member Meetings/E CMTE/APPTF/2023-2 Summer/Summary and Minutes/SAPWG/Attachments/Att1M-2023-10 ASU 2022-05.docx](https://naiconline.sharepoint.com/sites/NAICSupportStaffHub/Member%20Meetings/E%20CMTE/APPTF/2023-2%20Summer/Summary%20and%20Minutes/SAPWG/Attachments/Att1M-2023-10%20ASU%2022-05.docx)

**Statutory Accounting Principles (E) Working Group
Maintenance Agenda Submission Form
Form A**

Issue: PIK Interest Disclosure Clarification

Check (applicable entity):

	P/C	Life	Health
Modification of Existing SSAP	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
New Issue or SSAP	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Interpretation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Description of Issue: This agenda item has been developed to further clarify, and incorporate a practical expedient, to the paid-in-kind (PIK) interest aggregate disclosure adopted in *SSAP No. 34—Investment Income Due and Accrued* for year-2023. In response to questions received on how paydowns / disposals would impact PIK interest included in the cumulative balance, it was noted that clarifying guidance would assist with consistent application. Furthermore, without clarification it was identified that companies and investment software vendors may interpret the need to detail the retrospective PIK allocations and paydowns / disposals as evidence for the resulting amount.

To eliminate the potential inconsistent application on how paydowns / disposals impact PIK interest included in cumulative principal / par balance, as well as to streamline the calculation, this agenda item proposes the following clarifications:

- Any decreasing amounts to principal balances (paydowns / disposals / sales, etc.) shall first be applied to any PIK interest included in the principal balance. For example, if original par was \$100, PIK interest received overtime was \$50 and paydowns received were \$30, the resulting PIK included in the cumulative balance would be \$20 - (\$50 less \$30). No reduction to the original principal would occur until the PIK interest had been fully eliminated from the balance. If in this scenario paydowns of \$70 had occurred, the company would report zero in the disclosure for cumulative PIK interest, as the amount received would have fully eliminated the \$50 in PIK interest.
- The determination of PIK interest in cumulative balance can be calculated through a practical expedient calculation of original par / principal value to current par / principal value, not to go less than zero. This calculation will determine the resulting balance from PIK interest over time as well as paydowns / disposals, etc. The intent of this calculation is to prevent companies and investment software vendors from creating a schedule that details PIK interest and paydowns received retroactively since the origination of the investment. The practical expedient calculation from the original to current par / principal value shall result with the same resulting PIK interest amount included in the cumulative balance without the retroactive scheduling required.

The adopted disclosure in SSAP No. 34 is not intended to change, but the proposed clarification and practical expedient guidance is intended to be captured in the annual statement instructions. This agenda item is being exposed at the SAPWG, as the source of the adopted disclosure, and will be used to subsequently provide a memo to blanks for year-end 2023 application and to revise the formal instructions for 2024.

Existing Authoritative Literature:

- **SSAP No. 34—Investment Income Due and Accrued**

Disclosures

7. The following disclosures shall be made for investment income due and accrued in the financial statements. (SSAP No. 37 captures disclosures for mortgage loans on nonaccrual status pursuant to paragraph 6.)

- a. The bases by category of investment income for excluding (nonadmitting) any investment income due and accrued;
- b. Disclose total amount excluded;
- c. Disclose the gross, nonadmitted and admitted amounts for interest income due and accrued;
- d. Disclose aggregate deferred interest;
- e. Disclose cumulative amounts of paid-in-kind (PIK) interest included in the current principal balance.

- **A/S Instructions – Life, Accident and Health / Fraternal Companies**

7. Investment Income Instruction:

Disclose the following for investment income due and accrued in the financial statements:

- A. The bases, by category of investment income, for excluding (nonadmitting) any investment income due and accrued,
- B. The total amount excluded.
- C. The gross, nonadmitted and admitted amounts for interest income due and accrued. (1) Gross amount for interest income due and accrued. (2) Nonadmitted amount for interest income due and accrued. (3) Admitted amount for interest income due and accrued.
- D. The aggregate deferred interest.
- E. The cumulative amounts of paid-in-kind (PIK) interest included in the current principal balance.

Activity to Date (issues previously addressed by the Working Group, Emerging Accounting Issues (E) Working Group, SEC, FASB, other State Departments of Insurance or other NAIC groups):

- Agenda item 2022-17: Interest Income Disclosure update was adopted March 22, 2023. This disclosure data-captured existing and incorporated new disclosures, to SSAP No. 34, which included the cumulative amount of paid-in-kind (PIK) interest included in the current principal balance. The revisions were adopted for year-end 2023 and are shown in the authoritative literature section above.

- Blanks Proposal 2023-11BWG intends to adopt instructions and illustrations for the revised disclosures in May 2023.

Information or issues (included in *Description of Issue*) not previously contemplated by the Working Group:
None

Convergence with International Financial Reporting Standards (IFRS): NA

Recommendation:

NAIC staff recommend that the Working Group include this item on their maintenance agenda as a SAP clarification and expose this agenda item to clarify and incorporate a practical expedient, to the paid-in-kind (PIK) interest aggregate disclosure for SSAP No. 34 and annual statement instruction purposes. For annual statement purposes, this instruction will be an editorial change only and can be provided by the SAPWG in a memo posted on the Blanks Working (E) Group page if adopted after the deadline to incorporate into the annual statement instructions for 2023. Comments on this exposure are requested by June 30, 2023, to allow for adoption consideration at the 2023 Summer National Meeting.

Proposed Revisions to SSAP No. 34

7. The following disclosures shall be made for investment income due and accrued in the financial statements. (SSAP No. 37 captures disclosures for mortgage loans on nonaccrual status pursuant to paragraph 6.)
- The bases by category of investment income for excluding (nonadmitting) any investment income due and accrued;
 - Disclose total amount excluded;
 - Disclose the gross, nonadmitted and admitted amounts for interest income due and accrued;
 - Disclose aggregate deferred interest;
 - Disclose cumulative amounts of paid-in-kind (PIK) interest included in the current principal balance: par value^{FN}.

New Footnote: In disclosing the cumulative amount of PIK interest, identify the specific amounts of PIK interest by lot and aggregate the amounts by CUSIP/PPN that have a net increase to the original par value. The net increase includes PIK interest added to the par value less disposals (i.e., repayments; sales) that are first applied to any PIK interest outstanding. As a practical expedient, an insurer may calculate the cumulative amount of PIK interest on a bond by subtracting the original principal / par value from the current principal / par value, but not less than \$0.

Proposed instruction for inclusion in the Annual Statement Instructions (or 2023 memo to Blanks):

7. Investment Income Instruction:
- Disclose the following for investment income due and accrued in the financial statements:
- The bases, by category of investment income, for excluding (nonadmitting) any investment income due and accrued,
 - The total amount excluded.

- C. The gross, nonadmitted and admitted amounts for interest income due and accrued. (1) Gross amount for interest income due and accrued. (2) Nonadmitted amount for interest income due and accrued. (3) Admitted amount for interest income due and accrued.
- D. The aggregate deferred interest.
- E. The cumulative amounts of paid-in-kind (PIK) interest included in the current principal balance.

For the PIK interest included in the current principal balance, include the amount of reported interest in which the terms permit "paid in kind" (PIK) instead of cash. The amount reported shall reflect the cumulative amount of PIK interest included in the current principal balance / par value. In disclosing the cumulative amount of PIK interest, identify the specific amounts of PIK interest by lot and aggregate the amounts by CUSIP/PPN that have a net increase to the original par value. The net increase includes PIK interest added to the par value less disposals (i.e., repayments; sales) that are first applied to any PIK interest outstanding. As a practical expedient, an insurer may calculate the cumulative amount of PIK interest on a bond by subtracting the original principal / par value from the current principal / par value, but not less than \$0.

Staff Review Completed by: Julie Gann - NAIC Staff, May 2023

Status:

On May 16, 2023, the Statutory Accounting Principles (E) Working Group moved this agenda item to the active listing, categorized as a SAP clarification, and exposed revisions to SSAP No. 34 and the Annual Statement Instructions to clarify and incorporate a practical expedient to the paid-in-kind (PIK) interest aggregate disclosure. These SSAP No. 34 revisions, when adopted, will also result in editorial changes to the annual statement instructions.

August 13, 2023, the Statutory Accounting Principles (E) Working Group adopted, as final, the exposed revisions, as illustrated above, to SSAP No. 34 and directed that the proposed updates to the Annual Statement Instructions be forwarded to the Blanks (E) Working Group. These revisions provide a practical expedient to the paid-in-kind (PIK) interest aggregate disclosure.

[https://naiconline.sharepoint.com/sites/NAICSupportStaffHub/Member Meetings/E CMTE/APPTF/2023-2 Summer/Summary and Minutes/SAPWG/Attachments/Att1N-2023-13 SSAP 34.docx](https://naiconline.sharepoint.com/sites/NAICSupportStaffHub/Member%20Meetings/E%20CMTE/APPTF/2023-2%20Summer/Summary%20and%20Minutes/SAPWG/Attachments/Att1N-2023-13%20SSAP%2034.docx)

The Guidance in this Statement is Effective January 1, 2025

Statement of Statutory Accounting Principles No. 26

Bonds

STATUS

Type of Issue.....	Common Area
Issued	August 13, 2023
Effective Date	January 1, 2025
Affects.....	Replaces SSAP No. 26R on January 1, 2025
Affected by.....	No other pronouncements
Interpreted by	INT 01-25; INT 06-02; INT 06-07; INT 07-01
Relevant Appendix A Guidance.....	None

STATUS.....	1
SCOPE OF STATEMENT	2
SUMMARY CONCLUSION	3
Principles-Based Bond Definition	3
Accounting and Reporting Guidance for Investments that Qualify as Issuer Credit Obligations.....	9
Acquisitions, Disposals and Changes in Unrealized Gains and Losses	9
Amortized Cost.....	10
Application of Yield-to-Worst.....	10
Balance Sheet Amount	11
Impairment	11
Income	12
Origination Fees	13
Origination, Acquisition and Commitment Costs.....	13
Commitment Fees.....	13
Exchanges and Conversions	13
SVO-Identified Bond Exchange-Traded Funds.....	13
Disclosures	16
Relevant Literature	18
Effective Date and Transition.....	19
Historical Adoption and Revisions to Original SSAP No. 26R.....	20
REFERENCES	22
Other	22
Relevant Issue Papers	22
EXHIBIT A - EXAMPLES OF ANALYSIS FOR ASSET-BACKED SECURITIES.....	23
EXHIBIT B – SYSTEMATIC VALUE CALCULATION.....	26
EXHIBIT C – AMORTIZATION TREATMENT FOR CALLABLE BONDS	27

The Guidance in this Statement is Effective January 1, 2025**SCOPE OF STATEMENT**

1. The principles-based definition of a bond within this statement shall be utilized to identify whether security structures should be reported as bonds. Investments that qualify within the principles-based definition as an issuer credit obligation shall follow the accounting guidance within this statement. Investments that qualify within the principles-based definition as an asset-backed security (ABS) shall follow the accounting guidance in *SSAP No. 43R—Asset-Backed Securities*.

2. In addition to security investments that qualify under the principles-based definition as issuer credit obligations, certain specific instruments are also captured in scope of this statement:

- a. Certificates of deposit that have a fixed schedule of payments and a maturity date in excess of one year from the date of acquisition;
- b. Bank loans that are obligations of operating entities issued directly by a reporting entity or acquired through a participation, syndication or assignment¹;
- c. Debt instruments in a certified capital company (CAPCO) ^(INT 06-02)
- d. Exchange Traded Funds (ETFs) that qualify for bond treatment as identified in the *Purposes and Procedures Manual of the NAIC Investment Analysis Office* and included in the 'SVO-Identified Bond ETF List' published on the SVO's webpage. (These instruments are referred to as SVO-Identified Bond ETFs.)
- e. Mortgage loans in scope of *SSAP No. 37—Mortgage Loans* that qualify under an SVO structural assessment and are identified as SVO-Identified Credit Tenant Loans.

3. Securities that qualify as issuer credit obligations with a maturity date of one year or less from date of acquisition that qualify as cash equivalents or short-term investments shall follow the accounting requirements of this statement. These investments are also captured in *SSAP No. 2R—Cash, Cash*

¹ **Bank Loan** – Fixed-income instruments, representing indebtedness of a borrower, made by a financial institution. Bank loans can be issued directly by a reporting entity or acquired through an assignment, participation or syndication:

- **Assignment** – A bank loan assignment is defined as a fixed-income instrument in which there is the sale and transfer of the rights and obligations of a lender (as assignor) under an existing loan agreement to a new lender (and as assignee) pursuant to an Assignment and Acceptance Agreement (or similar agreement) which effects a novation under contract law, so the new lender becomes the direct creditor of and is in contractual privity with the borrower having the sole right to enforce rights under the loan agreement.
- **Participation** – A bank loan participation is defined as a fixed-income investment in which a single lender makes a large loan to a borrower and subsequently transfers (sells) undivided interests in the loan to other entities. Transfers by the originating lender may take the legal form of either assignments or participations. The transfers are usually on a nonrecourse basis, and the originating lender continues to service the loan. The participating entity may or may not have the right to sell or transfer its participation during the term of the loan, depending on the terms of the participation agreement. Loan Participations can be made on a parri-passu basis (where each participant shares equally) or a senior subordinated basis (senior lenders get paid first and the subordinated participant gets paid if there are sufficient funds left to make a payment).
- **Syndication** – A bank loan syndication is defined as a fixed-income investment in which several lenders share in lending to a single borrower. Each lender loans a specific amount to the borrower and has the right to repayment from the borrower. Separate debt instruments exist between the debtor and the individual creditors participating in the syndication. Each lender in a syndication shall account for the amounts it is owed by the borrower. Repayments by the borrower may be made to a lead lender that then distributes the collections to the other lenders of the syndicate. In those circumstances, the lead lender is simply functioning as a servicer and shall not recognize the aggregate loan as an asset. A loan syndication arrangement may result in multiple loans to the same borrower by different lenders. Each of those loans is considered a separate instrument.

The Guidance in this Statement is Effective January 1, 2025

Equivalents, Drafts and Short-Term Investments and shall follow the reporting and disclosure requirements of that statement.

4. This statement excludes:
- a. Mortgage loans and other real estate lending activities made in the ordinary course of business. These investments are addressed in *SSAP No. 37—Mortgage Loans* and *SSAP No. 39—Reverse Mortgages*.
 - b. Investments that qualify within the principles-based definition as an ABS. These investments shall follow the guidance in *SSAP No. 43R—Asset-Backed Securities*
 - c. Securities that provide varying principal or interest based on underlying equity appreciation or depreciation, an equity-based derivative, real estate or other non-debt variable, as described in paragraph 6.d.
 - d. Securities that do not qualify as bonds pursuant to the principles-based bond definition, including first loss positions that lack contractual payments or substantive credit enhancement. These investments shall follow the appropriate guidance in *SSAP No. 21R—Other Admitted Assets*.
 - e. Replication (synthetic asset) transactions addressed in *SSAP No. 86—Derivatives*. The admissibility, classification and measurement of a replication (synthetic asset) transactions are not preemptively determined by the principles-based bond definition and should be evaluated in accordance with the guidance on replication (synthetic asset) transactions within SSAP No. 86.
 - f. Investments that are captured specifically within other SSAPs. For example, reporting entity acquired structured settlements are captured in scope of *SSAP No. 21R—Other Admitted Assets*, held surplus notes are captured in scope of *SSAP No. 41R—Surplus Notes* and working capital finance investments are captured in scope of *SSAP No. 105—Working Capital Finance Investments*. Investments captured in scope of other SSAPs are subject to the measurement and admittance provisions of those SSAPs. Furthermore, investments that have specific reporting lines on dedicated schedules (such as with both surplus notes and WCFI) shall be reported on their dedicated lines.

SUMMARY CONCLUSION

Principles-Based Bond Definition

5. A bond shall be defined as any security² representing a creditor relationship, whereby there is a fixed schedule for one or more future payments, and which qualifies as either an issuer credit obligation or

² This statement adopts the GAAP definition of a security as it is used in FASB Accounting Standards Codification Topics 320 and 860. Evaluation of an investment under this definition should consider the substance of the instrument rather than solely its legal form.

Security: A share, participation, or other interest in property or in an entity of the issuer or an obligation of the issuer that has all of the following characteristics:

- a. It is either represented by an instrument issued in bearer or registered form or, if not represented by an instrument, is registered in books maintained to record transfers by or on behalf of the issuer.
- b. It is of a type commonly dealt in on securities exchanges or markets or, when represented by an instrument, is commonly recognized in any area in which it is issued or dealt in as a medium for investment.
- c. It is either one of a class or series or by its terms is divisible into a class or series of shares, participations, interests or obligations.

The Guidance in this Statement is Effective January 1, 2025

an asset-backed security as described in this statement. Determining whether a security represents a creditor relationship should consider its substance, rather than solely the legal form of the instrument. The analysis of whether a security represents a creditor relationship should consider all other investments the reporting entity owns in the investee as well as any other contractual arrangements. A security that in substance possesses equity-like characteristics or represents an ownership interest in the issuer does not represent a creditor relationship. While not intended to be all-inclusive, paragraphs 6.a.-6.d. discuss specific elements that may introduce equity-like characteristics:

- a. Determining whether a debt instrument represents a creditor relationship in substance when the source of cash flows for repayment is derived from underlying equity interests inherently requires significant judgment and analysis. Unlike a debt instrument collateralized by assets with contractual cash flows, debt instruments collateralized by equity interests are dependent on cash flow distributions that are not contractually required to be made and are not controlled by the issuer of the debt. As a result, there is a rebuttable presumption that a debt instrument collateralized by equity interests does not represent a creditor relationship in substance. Notwithstanding this rebuttable presumption, it is possible for such a debt instrument to represent a creditor relationship if the characteristics of the underlying equity interests lend themselves to the production of predictable cash flows and the underlying equity risks have been sufficiently redistributed through the capital structure of the issuer. Factors to consider in making this determination include but are not limited to:
 - i. Number and diversification of the underlying equity interests
 - ii. Characteristics of the underlying equity interests (vintage, asset-types, etc.)
 - iii. Liquidity facilities
 - iv. Overcollateralization
 - v. Waiting period for distributions/paydowns to begin
 - vi. Capitalization of interest
 - vii. Covenants (e.g., loan-to-value trigger provisions)
 - viii. Reliance on ongoing sponsor commitments
- b. While reliance of the debt instrument on sale of underlying equity interests or refinancing at maturity does not preclude the rebuttable presumption from being overcome, it does require that the other characteristics mitigate the inherent reliance on equity valuation risk to support the transformation of underlying equity risk to bond risk. As reliance on sale or refinancing increases, the more compelling the other factors needed to overcome the rebuttable presumption become.
- c. Analysis of whether the rebuttable presumption for underlying equity interests is overcome shall be conducted and documented by a reporting entity at the time such an investment is acquired. The level of documentation and analysis required will vary based on the characteristics of the individual debt instrument, as well as the level of third-party and/or non-insurance company market validation to which the issuance has been subjected. For example, a debt instrument collateralized by fewer, less diversified equity interests would require more extensive and persuasive documented analysis than one collateralized by a larger diversified portfolio of equity interests. Likewise, a debt instrument that has been successfully marketed to unrelated and/or non-insurance company investors, may provide enhanced market validation of the structure compared to one held only by related party and/or insurance company investors where capital relief may be the primary motivation for the securitization.

The Guidance in this Statement is Effective January 1, 2025

- d. In order for a debt instrument to represent a creditor relationship in accordance with Paragraph 6, it must have pre-determined principal and interest payments (whether fixed interest or variable interest) with contractual amounts that do not vary based on the appreciation or depreciation (i.e., performance) of any underlying collateral value or other non-debt variable. For example, an issued security that has varying principal and interest payments based on the appreciation of referenced equity, real estate or other non-debt variable is precluded from bond treatment. This exclusion is not intended to restrict variables that are commonly related to debt instruments such as, but not limited to, plain-vanilla³ inflation or benchmark interest rate adjustments (such as with U.S. TIPs or SOFR-linked coupons, respectively), scheduled interest rate step-ups, or credit-quality related interest rate adjustments. This exclusion is also not intended to encompass nominal interest rate adjustments⁴. For clarification purposes, all returns from a debt instrument in excess of principal are required to be considered as interest. Therefore, investments with “stated” interest and then “additional returns” to which the holder of the debt instrument is entitled are collectively considered as interest and shall be assessed together in determining whether the investment has variable principal or interest due to underlying referenced non-debt variables. Examples of securities excluded from the bond definition under this guidance:
- i. Structured Notes, which are securities that otherwise meet the definition of a bond, but for which the contractual amount of the instrument to be paid at maturity (or the original investment) is at risk for other than the failure of the borrower to pay the principal amount due, are excluded from the bond definition. These investments, although in the form of a debt instrument, incorporate the risk of an underlying variable in the terms of the agreement, and the issuer obligation to return the full principal is contingent on the performance of the underlying variable. These investments are addressed in *SSAP No. 86—Derivatives*. Mortgage-referenced securities issued by a government sponsored enterprise are explicit inclusions in scope of *SSAP No. 43*. Foreign-denominated bonds subject to variation as a result of foreign currency fluctuations are not structured notes.
 - ii. Principal-protected securities, as defined in the *Purposes and Procedures Manual of the NAIC Investment Analysis Office* are excluded from the bond definition as they have a performance component whose payments originate from, or are determined by, non-fixed income securities. These investments shall follow the guidance for non-bond securities in *SSAP No. 21—Other Admitted Assets*.

³ Inflation or benchmark interest rate adjustment mechanisms are considered plain-vanilla if based on widely recognized measures of inflation or interest rate benchmarks and excludes those that involve either leverage (such as a multiplier) or an inverse adjustment relationship.

⁴ Nominal interest rate adjustments are those that are too small to be taken into consideration when assessing the investment’s substance as a bond. Nominal adjustments are not typically influential factors in an investors’ evaluation of investment return and are often included to incentivize certain behavior of the issuer. An example would include sustainability-linked bonds where failure to achieve performance metrics could cause interest rate adjustments. In general, interest rate adjustments that adjust the total return from interest by more than 10% (e.g., >0.4% for a 4% yielding bond), would not be considered nominal. Further, any such adjustments that cause an investment to meet the definition of a structured note would not be considered nominal.

The Guidance in this Statement is Effective January 1, 2025

6. An issuer credit obligation is a bond, for which the general creditworthiness of an operating entity or entities through direct or indirect recourse, is the primary⁵ source of repayment. Operating entity or entities includes holding companies with operating entity subsidiaries where the holding company has the ability to access the operating subsidiaries' cash flows through its ownership rights. An operating entity may be any sort of business entity, not-for-profit organization, governmental unit, or other provider of goods or services, but not a natural person or "ABS Issuer" (as defined in paragraph 8). Examples of issuer credit obligations include, but are not limited to:

- a. U.S. Treasury securities, including U.S. Treasury Inflation-Indexed Securities;^(INT 01-25)
- b. U.S. government agency securities;
- c. Municipal securities issued by the municipality or supported by cash flows generated by a municipally-owned asset or entity that provides goods or services (e.g., airport, toll roads, etc.);
- d. Corporate bonds issued by operating entities, including Yankee bonds and zero-coupon bonds;
- e. Corporate bonds, issued by holding companies that own operating entities;
- f. Project finance bonds issued by operating entities;
- g. Investments in the form of securities for which repayment is fully supported by an underlying contractual obligation of a single operating entity (e.g., Credit Tenant Loans (CTLs), Equipment trust certificates (ETCs), other lease backed securities, Funding Agreement Backed Notes (FABNs), etc.). For purposes of applying this principal concept, repayment is fully-supported by the underlying operating entity obligation if it provides cash flows for the repayment of all interest and at least 95% of the principal of the security.
- h. Bonds issued by real estate investment trusts (REITs) or similar property trusts;
- i. Bonds issued by business development corporations, closed-end funds, or similar operating entities, in each case registered under the 1940 Act.
- j. Convertible bonds issued by operating entities, including mandatory convertible bonds as defined in paragraph 20.b.

⁵ "Primary" refers to the first in order of repayment source, not to a majority of the sources of repayment. For example, an issuer obligation may have secondary recourse to collateral upon default of the operating entity but would otherwise be expected to be fully repaid with cash flows of the operating entity. This differs from an asset-backed security for which the primary source of repayment is from cash flows of the collateral.

The Guidance in this Statement is Effective January 1, 2025

7. An asset-backed security⁶ is a bond issued by an entity (an “ABS Issuer”) created for the primary purpose of raising debt capital backed by financial assets⁷ or cash generating non-financial assets owned by the ABS Issuer, for which the primary source of repayment is derived from the cash flows associated with the underlying defined collateral rather than the cash flows of an operating entity⁸. In most instances, the ABS Issuer is not expected to continue functioning beyond the final maturity of the debt initially raised by the ABS Issuer. Also, many ABS Issuers are in the form of a trust or special purpose vehicle (“SPV”), although the presence or lack of a trust or SPV is not a definitive criterion for determining that a security meets the definition of an asset-backed security. The provisions in paragraphs 9-10 detail the two defining characteristics that must be present for a security to meet the definition of an asset-backed security.

8. The assets owned by the ABS Issuer are either financial assets or cash-generating non-financial assets. Cash-generating non-financial assets are defined as assets that are expected to generate a meaningful level of cash flows toward repayment of the bond through use, licensing, leasing, servicing or management fees, or other similar cash flow generation. For the avoidance of doubt, there must be a meaningful level of cash flows to service the debt, other than through the sale or refinancing of the underlying assets held by the ABS Issuer. Reliance on cash flows from the sale or refinancing of cash generating non-financial assets does not preclude a security from being classified as an asset-backed security so long as the conditions in this paragraph are met.

- a. *Meaningful Level of Cash Flows*: Determining what constitutes a “meaningful” level of cash flows generated to service the debt from sources other than the sale or refinancing of the underlying collateral pursuant to paragraph 9 is specific to each transaction, determined at origination, and shall consider the following factors:
- i. The price volatility in the principal market for the underlying collateral;
 - ii. The liquidity in the principal market for the underlying collateral;
 - iii. The diversification characteristics of the underlying collateral (i.e., types of collateral, geographic location(s), source(s) of cash flows within the structure, etc.);
 - iv. The overcollateralization of the underlying collateral relative to the debt obligation; and
 - v. The variability of cash flows, from sources other than sale or refinancing, expected to be generated from the underlying collateral.

⁶ The underlying collateral supporting an asset-backed security shall meet the definition of an asset by the ABS Issuer. Certain forms of collateral, such as rights to future cash flows, may not be recognized as assets by the selling entity but may be recognized as assets when sold to an ABS Issuer. These assets are permitted as the collateral supporting an asset-backed security, although they may not represent an asset that can be liquidated to provide payment toward the issued debt obligations (i.e., if the future cash flows do not materialize). The limited ability to liquidate the underlying collateral supporting an asset-backed security does not impact the structural determination of whether an issued security meets the definition of an asset-backed security but may impact the recoverability of the investment, as well as the consideration of whether there is sufficient credit enhancement.

⁷ *SSAP No. 103R—Transfers and Servicing of Financial Assets and Extinguishments of Liabilities* defines a financial asset as cash, evidence of an ownership interest in an entity, or a contract that conveys to one entity a right (a) to receive cash or another financial instrument from a second entity or (b) to exchange other financial instruments on potentially favorable terms with the second entity. As a point of clarity, for the purposes of this standard, financial assets do not include assets for which the realization of the benefits conveyed by the above rights depends on the completion of a performance obligation (e.g., leases, mortgage servicing rights, royalty rights, etc.). These assets represent non-financial assets, or a means through which non-financial assets produce cash flows, until the performance obligation has been satisfied.

⁸ Dedicated cash flows from an operating entity can form the underlying defined collateral in an asset-backed security. This dynamic, perhaps noted in a whole-business securitization, still reflects an asset-backed security and is not an issuer credit obligation.

The Guidance in this Statement is Effective January 1, 2025

The factors for price variability and the variability of cash flows are directly related to the “meaningful” requirement. That is, as price volatility or variability of cash flows increase, the required percentage of cash flows generated to service the debt from sources other than the sale or refinancing of the underlying collateral must also increase. The factors for liquidity, diversification and overcollateralization are inversely related to the “meaningful” concept. That is, as liquidity, diversification or overcollateralization increase, the required percentage of cash flows generated to service the debt from sources other than the sale or refinancing of the underlying collateral may decrease.

- b. As a practical expedient to determining whether a cash generating non-financial asset is expected to produce meaningful cash flows, a reporting entity may consider an asset for which less than 50% of the original principal relies on sale or refinancing to meet the meaningful criteria. In applying this practical expedient, only contractual cash flows of the non-financial assets may be considered. This practical expedient should not be construed to mean that assets cannot meet the meaningful criteria if they rely on sale or refinancing to service greater than 50% of the original principal or if they rely on cash flows that are not contracted at origination. Rather, such instances would require a complete analysis of the considerations described within the meaningful level of cash flows definition in [paragraph 9](#).

9. The holder of a debt instrument issued by an ABS Issuer is in a different economic position than if the holder owned the ABS Issuer’s assets directly. The holder of the debt instrument is in a different economic position if such debt instrument benefits from substantive credit enhancement through guarantees (or other similar forms of recourse), subordination and/or overcollateralization.

- a. *Substantive Credit Enhancement:* The intent of the criteria requiring the holder to be in a different economic position is to distinguish qualifying bonds from instruments with equity-like characteristics or where the substance of the transaction is more closely aligned with that of the underlying collateral. To qualify as an ABS under this standard, there is a requirement that there are substantive credit enhancements within the structure that absorb losses before the debt instrument being evaluated would be expected to absorb losses. This is inherent in the context of an issuer credit obligation in scope of SSAP No. 26R as the owners of the equity in the operating entity are the first to absorb any variability in performance of the operating entity. The same concept applies to asset-backed securities. If substantive credit enhancement did not exist, the substance of the debt instrument being evaluated would be more closely aligned with that of the underlying collateral than that of a bond. Credit enhancement that is merely nominal or lacks economic substance does not put a holder in a different economic position. The substantive credit enhancement required to be in a different economic position is specific to each transaction; determined at origination; and refers to the level of credit enhancement a market participant (i.e., knowledgeable investor transacting at arm’s length) would conclude is substantive.
- b. The first loss position may be issued as part of a securitization in the form of a debt or equity interest, or it may be retained by the sponsor and not issued as part of the securitization. If the first loss position (or a more senior position(s), if the first loss position(s) lacks contractual payments along with a substantive credit enhancement) is issued as part of the securitization, and does not have contractual principal and interest payments along with substantive credit enhancement and is held by a reporting entity, the investment(s) does not qualify for reporting as a bond and shall be reported on Schedule BA: Other Long-Term Invested Assets at the lower of amortized cost or fair value

The Guidance in this Statement is Effective January 1, 2025

consistent with the treatment for residuals. (These items are further addressed in *SSAP No. 21R—Other Admitted Assets*.)

10. Whether an issuer of debt represents an operating entity or ABS Issuer is unambiguous in most instances, but certain instances may be less clear. For example, an entity may operate a single asset such as a toll road or power generation facility (e.g., project finance) which serves to collateralize a debt issuance, and the cash flows produced by the operation of the assets are pledged to service the debt. In many such instances, the entity is structured as a bankruptcy-remote entity that is separate from the municipality or project sponsor. Such entities have characteristics of operating entities as the operation of the asset constitutes a stand-alone business. They also have many common characteristics of ABS Issuers as they are formed for the purpose of raising debt capital backed by the cash flows from collateral held by a bankruptcy-remote entity. When viewed more holistically, these issuing entities are typically being used to facilitate the financing of an operating component of a project sponsor or municipality. The use of a bankruptcy-remote entity facilitates the efficient raising of debt to finance the operating project, but the primary purpose is to finance an operating project. Therefore, structures in which the issuing entity represents a stand-alone business producing its own operating revenues and expenses, where the primary purpose is to finance an operating project, shall be considered operating entities despite certain characteristics they may share with ABS Issuers.

11. The definition of a creditor relationship, per **paragraph 6**, does not include equity/fund investments (such as mutual funds or exchanged-traded funds), or securities that possess equity-like characteristics or that represent an ownership interest in the issuer. However, as identified in **paragraph 2**, exchange traded funds (ETFs), which qualify for bond treatment, as identified in Part Three of the *Purposes and Procedures Manual of the NAIC Investment Analysis Office* and included in the ‘SVO-Identified Bond ETF List’ published on the SVO’s webpage are provided special statutory accounting treatment and are included within the scope of this statement. These investments shall follow the guidance within this statement, as if they were issuer credit obligations, unless different treatment is specifically identified in **paragraphs 32-38**.

12. Investments within the scope of this statement issued by a related party, or acquired through a related party transaction, are also subject to the provisions, admittance assessments and disclosure requirements of *SSAP No. 25—Affiliates and Other Related Parties*.

13. Investments within the scope of this statement meet the definition of assets as defined in *SSAP No. 4—Assets and Nonadmitted Assets* and are admitted assets to the extent they conform to the requirements of this statement and *SSAP No. 25*.

Accounting and Reporting Guidance for Investments that Qualify as Issuer Credit Obligations⁹

Acquisitions, Disposals and Changes in Unrealized Gains and Losses

14. A bond acquisition or disposal shall be recorded on the trade date (not the settlement date) except for the acquisition of private placement bonds which shall be recorded on the funding date. At acquisition, bonds shall be reported at their cost, including brokerage and other related fees. The reported cost of a bond received as a property dividend or capital contribution shall be the initial recognized value. *SSAP No. 25* shall be used to determine whether a transfer is economic or noneconomic for initial recognition.

15. For reporting entities required to maintain an interest maintenance reserve (IMR), the accounting for realized capital gains and losses on sales of bonds shall be in accordance with *SSAP No. 7—Asset*

⁹ For all references to “bond” investments beginning in **paragraph 15**, this term intends to refer to investments that are permitted accounting and reporting treatment within scope of this standard.

The Guidance in this Statement is Effective January 1, 2025

Valuation Reserve and Interest Maintenance Reserve. For reporting entities required to maintain an asset valuation reserve (AVR), the accounting for unrealized gains and losses shall be in accordance with SSAP No. 7.

16. For reporting entities not required to maintain an IMR, realized gains and losses on sales of bonds shall be reported as net realized capital gains or losses in the statement of income. For reporting entities not required to maintain an AVR, unrealized gains and losses shall be recorded as a direct credit or charge to unassigned funds (surplus).

Amortized Cost

17. Amortization of bond premium or discount shall be calculated using the scientific (constant yield) interest method taking into consideration specified interest and principal provisions over the life of the bond.¹⁰ (INT 07-01) Bonds containing call provisions (where the issue can be called away from the reporting entity at the issuer's discretion), except "make-whole" call provisions, shall be amortized to the call or maturity value/date which produces the lowest asset value (yield-to-worst). Although the concept for yield-to-worst shall be followed for all callable bonds, make-whole call provisions, which allow the bond to be callable at any time, shall not be considered in determining the timeframe for amortizing bond premium or discount unless information is known by the reporting entity indicating that the issuer is expected to invoke the make-whole call provision.

Application of Yield-to-Worst

18. For callable bonds¹¹, the first call date after the lockout period (or the date of acquisition if no lockout period exists) shall be used as the "effective date of maturity." Depending on the characteristics of the callable bonds, the yield-to-worst concept in [paragraph 18](#) shall be applied as follows:

- a. For callable bonds with a lockout period, premium in excess of the next call price¹² (subsequent to acquisition¹³ and lockout period) shall be amortized proportionally over the length of the lockout period. After each lockout period (if more than one), remaining premium shall be amortized to the call or maturity value/date which produces the lowest asset value.
- b. For callable bonds without a lockout period, the book adjusted carrying value (at the time of acquisition) of the callable bonds shall equal the lesser of the next call price (subsequent to acquisition) or cost. Remaining premium shall then be amortized to the call or maturity value/date which produces the lowest asset value.
- c. For callable bonds that do not have a stated call price, all premiums over par shall be immediately expensed. For callable bonds with a call price at par in advance of the maturity date, all premiums shall be amortized to the call date.

¹⁰ For perpetual bonds with an effective call option, any applicable premium shall be amortized utilizing the yield-to-worst method.

¹¹ Callable bonds within the scope of [paragraph 19](#) excludes bonds with make-whole call provisions unless information is known by the reporting entity indicating that the issuer is expected to invoke the make-whole call provision. [Exhibit C](#) includes illustrations for the amortization of callable bonds.

¹² Reference to the "next call price" indicates that the reporting entity shall continuously review the call dates/prices to ensure that the amortization (and resulting BACV) follows the yield-to-worst concept throughout the time the reporting entity holds the bond.

¹³ The reporting entity shall only consider call dates/prices that occur after the reporting entity acquires the bond. If all of the call dates had expired prior to the reporting entity acquiring the bond, the reporting entity would consider the bond continuously callable without a lockout period.

The Guidance in this Statement is Effective January 1, 2025

Balance Sheet Amount

19. Bonds shall be valued and reported in accordance with this statement, the *Purposes and Procedures Manual of the NAIC Investment Analysis Office*, and the designation assigned in the NAIC *Valuations of Securities* product prepared by the NAIC Securities Valuation Office (SVO).

- a. Bonds, except for mandatory convertible bonds: For reporting entities that maintain an asset valuation reserve (AVR), the bonds shall be reported at amortized cost, except for those with an NAIC designation of 6, which shall be reported at the lower of amortized cost or fair value. For reporting entities that do not maintain an AVR, bonds that are designated highest-quality and high-quality (NAIC designations 1 and 2, respectively) shall be reported at amortized cost; all other bonds (NAIC designations 3 to 6) shall be reported at the lower of amortized cost or fair value. For perpetual bonds which do not possess or no longer possess an effective call option, the bond shall be reported at fair value regardless of NAIC designation.
- b. Mandatory convertible bonds: Mandatory convertible bonds are subject to special reporting instructions and are not assigned NAIC designations or unit prices by the SVO. The balance sheet amount for mandatory convertible bonds shall be reported at the lower of amortized cost or fair value during the period prior to conversion. This reporting method is not impacted by NAIC designation or information received from credit rating providers (CRPs). Upon conversion, these securities will be subject to the accounting guidance of the statement that reflects their revised characteristics. (For example, if converted to common stock, the security will be in scope of *SSAP No. 30R—Unaffiliated Common Stock*, if converted to preferred stock, the security will be in scope of *SSAP No. 32R—Preferred Stocks*.)

20. The premium paid on a zero coupon convertible bond that produces a negative yield as a result of the value of a warrant exceeding the bond discount shall be written off immediately so that a negative yield is not produced. The full amount of the premium should be recorded as amortization within investment income on the date of purchase.

Impairment

21. An other-than-temporary^(INT 06-07) impairment shall be considered to have occurred if it is probable that the reporting entity will be unable to collect all amounts due according to the contractual terms of a debt security in effect at the date of acquisition.¹⁴ A decline in fair value which is other-than-temporary includes situations where a reporting entity has made a decision to sell a security prior to its maturity at an amount below its carrying value. If it is determined that a decline in the fair value of a bond is other-than-temporary, an impairment loss shall be recognized as a realized loss equal to the entire difference between the bond's carrying value and its fair value at the balance sheet date of the reporting period for which the assessment is made. The measurement of the impairment loss shall not include partial recoveries of fair value subsequent to the balance sheet date. For reporting entities required to maintain an AVR/IMR, the accounting for the entire amount of the realized capital loss shall be in accordance with SSAP No. 7. The other-than-temporary impairment loss shall be recorded entirely to either AVR or IMR (and not bifurcated between credit and non-credit components) in accordance with the annual statement instructions.

¹⁴ If a bond has been modified from original acquisition, the guidance in *SSAP No. 36—Troubled Debt Restructuring* and paragraph 22 of *SSAP No. 103R—Transfers and Servicing of Financial Assets and Extinguishments of Liabilities* shall be followed, as applicable. After modification of original terms, future assessments to determine other-than-temporary impairment shall be based on the modified contractual terms of the debt instrument.

The Guidance in this Statement is Effective January 1, 2025

22. In periods subsequent to the recognition of an other-than-temporary impairment loss for a bond, the reporting entity shall account for the other-than-temporarily impaired security as if the security had been purchased on the measurement date of the other-than-temporary impairment. The fair value of the bond on the measurement date shall become the new cost basis of the bond and the new cost basis shall not be adjusted for subsequent recoveries in fair value. The discount or reduced premium recorded for the security, based on the new cost basis, shall be amortized over the remaining life of the security in the prospective manner based on the amount and timing of future estimated cash flows. The security shall continue to be subject to impairment analysis for each subsequent reporting period. Future declines in fair value which are determined to be other-than temporary shall be recorded as realized losses.

Income

23. Interest income for any period consists of interest collected during the period, the change in the due and accrued interest between the beginning and end of the period as well as reductions for premium amortization and interest paid on acquisition of bonds, and the addition of discount accrual. In accordance with *SSAP No. 34—Investment Income Due and Accrued*, investment income shall be reduced for amounts which have been determined to be uncollectible. Contingent interest may be accrued if the applicable provisions of the underlying contract and the prerequisite conditions have been met.

24. A bond may provide for a prepayment penalty or acceleration fee in the event the bond is liquidated prior to its scheduled termination date. Such fees shall be reported as investment income when received.

25. The amount of prepayment penalty and/or acceleration fee to be reported as investment income or loss shall be calculated as follows:

- a. For called or tendered bonds in which the total proceeds (consideration) received exceeds par:
 - i. The amount of investment income reported is equal to the consideration received less the par value of the investment; and
 - ii. Any difference between the book adjusted carrying value (BACV) and the par value at the time of disposal shall be reported as realized capital gains and losses, subject to the authoritative literature in SSAP No. 7.
- b. For called or tendered bonds in which the consideration received is less than par¹⁵:
 - i. To the extent an entity has in place a process to identify an explicit prepayment penalty or acceleration fee, these should be reported as investment income. (An entity shall consistently apply their process. Once a process is in place, an entity is required to maintain a process to identify prepayment penalties for called bonds in which consideration received is less than par.)
 - ii. After determining any explicit prepayment penalty or acceleration fee, the reporting entity shall calculate the resulting realized gain as the difference between

¹⁵ This guidance applies to situations in which consideration received is less than par but greater than the book adjusted carrying value (BACV). Pursuant to the yield-to-worst concept, bonds shall be amortized to the call or maturity date that produces the lowest asset value. In the event a bond has not been amortized to the lowest value prior to the call, or in cases of an accepted tender bond offer (BACV is greater than the consideration received), the entire difference between consideration received and the BACV shall be reported to investment income.

The Guidance in this Statement is Effective January 1, 2025

the remaining consideration and the BACV, which shall be reported as realized capital gain, subject to the authoritative literature in SSAP No. 7.

Origination Fees

26. Origination fees represent fees charged to the borrower in connection with the process of originating or restructuring a transaction such as the private placement of bonds. The fees include, but are not limited to, points, management, arrangement, placement, application, underwriting and other fees pursuant to such a transaction. Origination fees shall not be recorded until received in cash. Origination fees intended to compensate the reporting entity for interest rate risks (e.g., points) shall be amortized into income over the term of the bond consistent with paragraph 18 of this statement. Other origination fees shall be recorded as income upon receipt.

Origination, Acquisition and Commitment Costs

27. Costs related to origination when paid in the form of brokerage and other related fees shall be capitalized as part of the cost of the bond, consistent with paragraph 15 of this statement. All other costs, including internal costs or costs paid to an affiliated entity related to origination, purchase or commitment to purchase bonds shall be charged to expense when incurred.

Commitment Fees

28. Commitment fees are fees paid to the reporting entity that obligate the reporting entity to make available funds for future borrowing under a specified condition. A fee paid to the reporting entity to obtain a commitment to make funds available at some time in the future, generally, is refundable only if the bond is issued. If the bond is not issued, then the fees shall be recorded as investment income by the reporting entity when the commitment expires.

29. A fee paid to the reporting entity to obtain a commitment to be able to borrow funds at a specified rate and with specified terms quoted in the commitment agreement, generally, is not refundable unless the commitment is refused by the reporting entity. This type of fee shall be deferred, and amortization shall depend on whether or not the commitment is exercised. If the commitment is exercised, then the fee shall be amortized in accordance with paragraph 18 of this statement over the life of the bond as an adjustment to the investment income on the bond. If the commitment expires unexercised, the commitment fee shall be recognized in income on the commitment expiration date.

Exchanges and Conversions

30. If a bond is exchanged or converted into other securities (including conversions of mandatory convertible securities addressed in paragraph 20.b.), the fair value of the bond surrendered at the date of the exchange or conversion shall become the cost basis for the new securities with any gain or loss realized at the time of the exchange or conversion. However, if the fair value of the securities received in an exchange or conversion is more clearly evident than the fair value of the bond surrendered, then it shall become the cost basis for the new securities.

SVO-Identified Bond Exchange –Traded Funds

31. SVO-identified bond exchange-traded fund (ETF) investments, as discussed in paragraph 2.d., are captured within the scope of this statement for accounting and reporting¹⁶ purposes only. The inclusion of these investments within this statement is not intended to contradict state law regarding the classification

¹⁶ With the inclusion of these SVO-identified investments as bonds, specific guidelines are detailed in the annual statement instructions for reporting purposes.

The Guidance in this Statement is Effective January 1, 2025

of these investments and does not intend to provide exceptions to state investment limitations involving types of financial instruments (e.g., equity/fund interests), or with regards to concentration risk (e.g., issuer).

32. SVO-identified bond ETF investments shall be initially reported at cost, including brokerage and other related fees. Subsequently, SVO-identified bond ETF investments shall be reported at fair value,¹⁷ with changes in fair value recorded as unrealized gains or losses) unless the reporting entity has elected use¹⁸ of a documented systematic approach to amortize or accrete the investment in a manner that represents the expected cash flows from the underlying bond holdings. This special measurement approach is referred to as the “systematic value” measurement method and shall only be used for the SVO-identified bond ETF investments within the scope of this statement.

33. Use of the systematic value for SVO-identified bond ETF investments is limited as follows:

- a. Systematic value is only permitted to be designated as the measurement method for AVR filers acquiring qualifying investments that have an NAIC designation of 1 to 5, and for non-AVR filers acquiring qualifying investments with an NAIC designation of 1 or 2. SVO-identified investments that have an NAIC designation of 6 for AVR filers or 3-6 for non AVR filers shall be measured at fair value.
- b. Designated use of a systematic value is an irrevocable election per qualifying investment (by CUSIP) at the time investment is originally acquired¹⁹. Investments owned prior to being identified by the SVO as a qualifying SSAP No. 26R investment are permitted to be subsequently designated to the systematic value measurement method. This designation shall be applied as a change in accounting principle pursuant to *SSAP No. 3—Accounting Changes and Corrections of Errors*, which requires the reporting entity to recognize a cumulative effect to adjust capital and surplus as if the systematic value measurement method had been applied retroactively for all prior periods in which the investment was held. The election to use systematic value for investments shall be made before the year-end reporting of the investment in the year in which the SVO first identifies the investment as a qualifying SSAP No. 26R investment.
- c. Once designated for a particular investment, the systematic value measurement method must be retained as long as the qualifying investment is held by the reporting entity and the investment remains within the scope of this statement with an allowable NAIC designation per paragraph 34.a. Upon a full sale/disposal of an SVO-identified investment (elimination of the entire CUSIP investment), after 90 days the reporting entity can reacquire the SVO-identified investment and designate a different measurement method. If the reporting entity was to reacquire the same investment within 90 days after it was sold/disposed, the reporting entity must utilize the measurement method previously designated for the investment. Subsequent/additional purchases of the same SVO-identified investment (same CUSIP) already held by a reporting entity must follow the election previously made by the reporting entity. If an investment no longer qualifies for a systematic value

¹⁷ For these investments, net asset value (NAV) is allowed as a practical expedient to fair value.

¹⁸ The election to use systematic value is not a permitted or prescribed practice as it is an accounting provision allowed within this SSAP. Similarly, this election does not override state statutes, and if a state does not permit reporting entities the election to use systematic value as the measurement method, this is also not considered a permitted or prescribed practice. SVO-identified investments reported at fair value (NAV) or systematic value, if in accordance with the provisions of this standard, are considered in line with SSAP No. 26R and do not require permitted or prescribed disclosures under *SSAP No. 1—Accounting Policies, Risks & Uncertainties and Other Disclosures*.

¹⁹ This guidance requires investments purchased in lots to follow the measurement method established at the time the investment was first acquired.

The Guidance in this Statement is Effective January 1, 2025

measurement because the NAIC designation has declined, then the security must be subsequently reported at the lower of “systematic value” or fair value. If the security has been removed from the SVO-identified listings, and is no longer in scope of this statement, then the security shall be measured and reported in accordance with the applicable SSAP.

- d. Determination of the designated systematic value must follow the established²⁰ approach, which is consistently applied for all SVO-identified bond ETF investments designated for a systematic value. In all situations, an approach that continuously reflects “original” or “historical cost” is not an acceptable measurement method. The designated approach shall result with systematic amortization or accretion of the equity/fund investment in a manner that represents the expected cash flows from the underlying bond holdings.

34. Income distributions received from SVO-identified bond ETF investments (cash or shares) shall be reported as interest income in the period in which it is earned. For those SVO-identified bond ETF investments where the systematic value method is applied, interest income shall be recognized based on the book yield applied to the carrying value each period, similar to bonds.

35. For reporting entities required to hold an IMR and AVR reserve, realized and unrealized gains and losses for the SVO-identified bond ETF investments shall be consistent with bonds within the scope of this standard. With this guidance, recognition of gains/losses (and corresponding AVR/IMR impacts) will be based on the ETF, and not activity that occurs within the ETF (e.g., such as changes in the underlying bonds held within the ETF). Also consistent with the guidance for bonds, recognized losses from other-than-temporary impairments shall be recorded entirely to either AVR or IMR (and not bifurcated between credit and non-credit components) in accordance with the annual statement instructions.

36. SVO-identified bond ETF investments reported at systematic value shall recognize other-than-temporary impairments in accordance with the following guidance:

- a. A decision to sell an SVO-identified bond ETF investment that has a fair value less than systematic value results in an other-than-temporary impairment that shall be recognized.
- b. In situations in which an SVO-identified bond ETF investment has a fair value that is less than systematic value, the reporting entity must assess for other-than-temporary impairment. For these investments, a key determinant, along with other impairment indicators in *INT 06-07: Definition of Phrase “Other Than Temporary,”* shall be whether the net present value of the projected cash flows for the underlying bonds in the SVO-identified investment have materially²¹ declined from the prior reporting period (most recent issued financial statements) or from the date of acquisition. In calculating the net present value of the projected cash flows for each reporting period, entities shall discount cash flows using a constant purchase yield, which is the initial book yield at acquisition. Consistent with INT 06-07, a predefined threshold to determine whether the decline in projected cash flows (e.g., percentage change) shall result in an other than temporary impairment has not been set, as exclusive reliance on such thresholds removes the ability of management to apply its judgement.

²⁰ Exhibit B details the established systematic value approach.

²¹ The net present value of cash flows will decline in a declining interest rate environment. Reporting entities shall use judgment when assessing whether the decline in cash flows is related to a decline in interest rates or the result of a non-interest related decline, and determine whether the decline represents an OTTI pursuant to INT 06-07.

The Guidance in this Statement is Effective January 1, 2025

- c. Upon identification of an SVO-identified investment as OTTI, the reporting entity shall recognize a realized loss equal to the difference between systematic value and the current fair value. (Although the determination of OTTI is likely based on projected cash flows, the realized loss recognized for the OTTI is based on the difference between systematic value and fair value.) The fair value of the SVO-identified investment on the date of the OTTI shall become the new cost basis of the investment.
- d. Subsequent to recognition of an OTTI, the SVO-identified bond ETF investment is required to be reported at the lower of the then-current period systematic value or fair value. As the underlying bonds can be replaced within an ETF, it is possible for a subsequent period systematic value and fair value to recover above the fair value that existed at the time an OTTI was recognized. As such, the requirement for subsequent reporting at the lower of systematic value or fair value is intended to be a current period assessment. For example, in reporting periods after an OTTI, the systematic value for an SVO-identified investment may exceed the fair value at the time of the OTTI, but in no event shall the reported systematic value exceed the then-current period fair value. If current calculated systematic value is lower than the current fair value, systematic value is required.

37. Impairment guidance for SVO-identified bond ETF investments reported at fair value is consistent with impairment guidance for investments captured under SSAP No. 30R. Pursuant to this guidance, realized losses are required to be recognized when a decline in fair value is considered to be other-than-temporary. Subsequent fluctuations in fair value shall be recorded as unrealized gains or losses. Future declines in fair value which are determined to be other-than-temporary shall be recorded as realized losses. A decision to sell an impaired security results with an other-than-temporary impairment that shall be recognized.

Disclosures

38. The financial statements shall include the following disclosures:
- a. Fair value in accordance with *SSAP No. 100R—Fair Value*;
 - b. Concentrations of credit risk in accordance with *SSAP No. 27—Off-Balance-Sheet and Credit Risk Disclosures*;
 - c. The basis at which the bonds, mandatory convertible securities, and SVO-identified bond ETF investments identified in **paragraph 2.d.**, are stated;
 - d. Amortization method for bonds and mandatory convertible securities, and if elected by the reporting entity, the approach for determining the systematic value for SVO-identified securities per **paragraph 33**. If utilizing systematic value measurement method approach for SVO-identified investments, the reporting entity must include the following information:
 - i. Whether the reporting entity consistently utilizes the same measurement method for all SVO-identified investments²² (e.g., fair value or systematic value). If

²² As identified in **paragraph 34.d.**, a consistent approach must be followed for all investments designated to use the systematic value method. As such, this disclosure is limited to situations in which a reporting entity uses both fair value and systematic value for reported SVO-identified investments.

The Guidance in this Statement is Effective January 1, 2025

different measurement methods are used²³, information on why the reporting entity has elected to use fair value for some SVO-identified investments and systematic value for others.

- ii. Whether SVO-identified investments are being reported at a different measurement method from what was used in an earlier current-year interim and/or in a prior annual statement. (For example, if reported at systematic value prior to the sale, and then reacquired and reported at fair value.) This disclosure is required in all interim reporting periods and in the year-end financial statements for the year in which an SVO-identified investment has been reacquired and reported using a different measurement method from what was previously used for the investment. (This disclosure is required regardless of the length of time between the sale/reacquisition of the investments, but is only required in the year in which the investment is reacquired.)
- iii. Identification of securities still held that no longer qualify for the systematic value method. This should separately identify those securities that are still within the scope of SSAP No. 26R and those that are being reported under a different SSAP.
- e. For each balance sheet presented, the book/adjusted carrying values, fair values, excess of book/carrying value over fair value or fair value over book/adjusted carrying values for each pertinent bond or assets in scope of this statement.
- f. For the most recent balance sheet, the book/adjusted carrying values and the fair values of bonds and assets in scope of this statement, reported in statutory Annual Statement Schedule D – **Part 1A** due:
 - i. In one year or less (including items without a maturity date which are payable on demand and in good standing);
 - ii. After one year through five years;
 - iii. After five years through ten years;
 - iv. After ten years (including items without a maturity date which are either not payable on demand or not in good standing).
- g. For each period for which results of operations are presented, the proceeds from sales of bonds and assets in scope of this Statement and gross realized gains and gross realized losses on such sales.
- h. For each balance sheet presented, all items in scope of this Statement in an unrealized loss position for which other-than-temporary declines in value have not been recognized:
 - i. The aggregate amount of unrealized losses (that is, the amount by which cost or amortized cost exceeds fair value) and
 - ii. The aggregate related fair value of bonds with unrealized losses.

²³ The guidance in this statement allows different measurement methods by qualifying investment (CUSIP), but it is anticipated that companies will generally utilize a consistent approach for all qualifying investments.

The Guidance in this Statement is Effective January 1, 2025

- i. The disclosures in paragraphs 39.h.i. and 39.h.ii. should be segregated by items that have been in a continuous unrealized loss position for less than 12 months and those that have been in a continuous unrealized loss position for 12 months or longer using fair values determined in accordance with SSAP No. 100R.
- j. As of the most recent balance sheet date presented, additional information should be included describing the general categories of information that the investor considered in reaching the conclusion that the impairments are not other-than-temporary.
- k. When it is not practicable to estimate fair value in accordance with SSAP No. 100R, the investor should disclose the following additional information, if applicable, as of each date for which a statement of financial position is presented in its annual financial statements:
 - i. The aggregate carrying value of the investments not evaluated for impairment, and
 - ii. The circumstances that may have a significant adverse effect on the fair value.
- l. For securities sold, redeemed or otherwise disposed as a result of a call or tender offer feature (including make-whole call provisions), disclose the number of CUSIPs sold, disposed or otherwise redeemed and the aggregate amount of investment income generated as a result of a prepayment penalty and/or acceleration fee.

39. Refer to the Preamble for further discussion regarding disclosure requirements. The disclosures in paragraphs 39.b., 39.e., 39.f., 39.g., 39.h., 39.i., 39.j. and 39.k. shall be included in the annual audited statutory financial reports only.

Relevant Literature

40. This statement adopts *AICPA Statement of Position 90-11, Disclosure of Certain Information by Financial Institutions About Debt Securities Held as Assets*, and *AICPA Practice Bulletin No. 4, Accounting for Foreign Debt/Equity Swaps*. This statement also adopts *FASB Staff Position 115-1/124-1, The Meaning of Other-Than-Temporary Impairment and Its Application to Certain Investments*, paragraph 16, with modification to be consistent with statutory language in the respective statutory accounting statements. This statement adopts the GAAP definition of “security” as it is used in FASB Codification Topic 320 and 860. This statement refers to the definition of “financial assets” captured in SSAP No. 103R adopted from U.S. GAAP. As noted in footnote 7, for purposes of this statement, and in applying the principles-based bond definition, financial assets do not include assets that depend on the completion of a performance obligation. When there is a performance obligation, the asset represents non-financial assets, or a means through which non-financial assets produce cash flows, until the performance obligation has been satisfied.

41. This statement rejects the GAAP guidance for debt securities, which is contained in *ASU 2020-08, Codification Improvements to Subtopic 310-20, Receivables – Nonrefundable Fees and Other Costs*, *ASU 2018-03, Recognition and Measurement of Financial Assets and Financial Liabilities*, *ASU 2017-08, Premium Amortization on Purchased Callable Debt Securities*, *ASU 2016-01, Financial Instruments – Overall*, *FASB Statement No. 115, Accounting for Certain Investments in Debt and Equity Securities*, *FASB Statement No. 91, Accounting for Nonrefundable Fees and Costs Associated with Originating or Acquiring Loans and Initial Direct Costs of Leases*, *FASB Emerging Issues Task Force No. 89-18, Divestitures of Certain Investment Securities to an Unregulated Commonly Controlled Entity under FIRREA*, and *FASB Emerging Issues Task Force No. 96-10, Impact of Certain Transactions on Held-to-Maturity Classifications Under FASB Statement No. 115*.

The Guidance in this Statement is Effective January 1, 2025

Effective Date and Transition

42. Revisions to SSAP No. 26R, adopted August 2023, to incorporate the principle-based bond concepts are effective January 1, 2025. These revisions incorporate principle concepts on what should be reported as a long-term bond. Securities that qualify as issuer credit obligations within the principle concepts are captured within scope of SSAP No. 26R. Securities that qualify as asset-backed securities within the principle concepts are captured within scope of SSAP No. 43R. Securities that do not qualify as issuer credit obligations or ABS, unless specifically permitted in scope of these statements, are not permitted to be reported as a bond.

43. At the time of transition, reporting entities shall make their best efforts to assess investments to determine whether they qualify within the bond definition for reporting on Schedule D-1. The bond definition requires assessments at the time of acquisition (as of the origination date), and it is recognized that reporting entities may not have the means to complete historical assessments for securities held at the time of transition. For these instances, if information is not readily available for reporting entities to assess a security as of the date at origination, reporting entities may utilize current or acquisition information in concluding that a security qualifies for reporting as a bond as either an issuer obligation or asset-backed security.

44. Investments that were reported as a bond on Schedule D-1: Long-Term Bonds as of December 31, 2024, that do not qualify under the principle-based bond concepts shall be reported as a disposal from that schedule, with a reacquisition on the appropriate reporting schedule as of January 1, 2025. These investments shall be accounted for in accordance with the resulting SSAP that addresses the specific investment structure. For securities that are reported at the lower of amortized cost or fair value under the new applicable guidance, this could result with an unrealized loss in the measurement of the investment at the time of the reclassification. Although the adoption of this guidance is considered a change in accounting principle under SSAP No. 3, the following transition guidance shall be applied on January 1, 2025, to ensure consistency in reporting and to allow investment schedules to roll appropriately:

- a. Securities reclassified from Schedule D-1 as they no longer qualify under the bond definition shall be reported as a disposal from Schedule D-1 at amortized cost. Although no proceeds are received, amortized cost at the time of disposal shall be reported as consideration on Schedule D-4.
 - i. For securities held at amortized cost at the time of disposal, book adjusted carrying value and amortized cost shall agree, preventing gain or loss recognition at the time of reclassification.
 - ii. For securities held at fair value under the lower of amortized cost or fair value measurement method, previously reported unrealized losses shall be reversed on Jan. 1, 2025, prior to disposal, resulting with a reported value that mirrors amortized cost at the time of disposal. This action prevents realized loss recognition at time of reclassification.
- b. Securities reclassified from Schedule D-1 shall be recognized on the subsequent schedule (e.g., Schedule BA) with an actual cost that agrees to the disposal value (amortized cost). Immediately subsequent to recognition on the resulting schedule, the securities shall be reported in accordance with the measurement method prescribed by the applicable SSAP:
 - i. For securities previously reported at fair value on Schedule D-1 (under a lower of amortized cost or fair value measurement method), the reporting entity will

The Guidance in this Statement is Effective January 1, 2025

recognize an unrealized loss to match the previously reported book adjusted carrying value. Subsequently, the security will continue to reflect a lower of amortized cost or fair value measurement method.

- ii. For securities previously reported at amortized cost on Schedule D-1, if the subsequent statement requires a lower of amortized cost or fair value measurement method, then the reporting entity shall recognize an unrealized loss to the extent fair value is less than amortized cost.
- iii. After application of paragraph 45.b.i. and 45.b.ii. all securities shall reflect either the same reported value as of December 31, 2024 (amortized cost or fair value) or a lower reported value (if the security is subject to the lower of amortized cost or fair value measurement method). There should be no instances that result with a security having a greater reported value than what was presented on December 31, 2024. Subsequent to transition, securities reported at fair value may incur unrealized gains or losses due to fair value fluctuations, but should never have unrealized gains that result with a book adjusted carrying value that exceeds amortized cost.

45. With this transition guidance, changes in measurement for securities reclassified under the bond definition will be reported as a change in unrealized capital gains (losses) in the first quarter 2025 financial statements (unless sold in the interim with a realized gain or loss) and not as a change in accounting principle. To enable regulators the ability to identify the impact of securities reclassified under the bond definition, the following disclosure for the 2025 first quarter financial statement is required:

- a. Aggregate book adjusted carrying value for all securities reclassified off Schedule D-1.
- b. Aggregate book adjusted carrying value after transition for all securities reclassified off Schedule D-1 that resulted with a change in measurement basis. (This shall be a subset of paragraph 46.a. and captures the securities that moved from an amortized cost to a fair value measurement method under the lower of amortized cost or fair value approach.)
- c. Aggregate surplus impact for securities reclassified off Schedule D-1. This shall include the difference between book adjusted carrying value as of December 31, 2024, and book adjusted carrying value after transition for those securities that moved from an amortized cost to a fair value measurement method under the lower of amortized cost or fair value approach.

46. For clarification purposes, the transition guidance shall be applied prospectively beginning with the first year of adoption (Jan. 1, 2025). For disclosures that provide comparative information, reporting entities shall not restate the prior year's information in the 2025 disclosure.

Historical Adoption and Revisions to Original SSAP No. 26R

47. For historical reference, the original adoption, and subsequent revisions to SSAP No. 26R prior to the adoption of the principles-based bond definition are detailed below:

- a. SSAP No. 26R was originally effective for years beginning January 1, 2001.
- b. Guidance for the accounting of securities subsequent to other than temporary impairments was originally effective for reporting periods beginning on January 1, 2009, with early

The Guidance in this Statement is Effective January 1, 2025

adoption permitted. This guidance was incorporated from *SSAP No. 99—Accounting for Securities Subsequent to an Other-Than-Temporary Impairment* in 2010. The original impairment guidance included in this standard, and the substantive revisions reflected in SSAP No. 99 are retained for historical purposes in Issue Paper No. 131.

- c. Guidance pertaining to the accounting for zero-coupon convertible bonds was originally effective December 8, 2002, and was subsequently incorporated into this statement from *INT 02-05: Accounting for Zero Coupon Convertible Bonds*.
- d. Guidance adopted in December 2013 clarifying the ‘yield-to-worst’ concept for bonds with make-whole call provisions was initially effective January 1, 2014, unless the company had previously been following the guidance. (Companies that have previously been following the original intent, as clarified in the revisions, were not impacted by these changes.)
- e. The guidance on the calculation of investment income for prepayment penalties and/or acceleration fees was effective January 1, 2017, on a prospective basis and was required for interim and annual reporting periods thereafter, with early application permitted.
- f. In April 2017, revisions were incorporated in accordance with the investment classification project. These revisions are detailed in Issue Paper No. 156 and were effective December 31, 2017. These revisions clarified the scope of the bond definition as well as incorporated new guidance for SVO-Identified Bond ETFs identified in scope of this statement. Retained transition / application guidance is captured as follows:
 - i. For situations in which there is an interval of time between when a company purchases an investment and when the investment is designated as an SVO-identified investment eligible for systematic value, the book yield should be calculated by equating the book/adjusted carrying value at that time to the portfolio’s aggregate cash flows (ACF). For these situations, the ETF shall be reported as a disposed security on the prior reporting schedule and reported as an acquisition.
 - ii. In accordance with the systematic value methodology, at the next reporting period date, the reporting entity shall amortize or accrete the carrying value by the difference between the effective interest using the initial book yield, and the distributions received, and shall recalculate the new effective book yield using the new carrying value and ACF as of the last day of the reporting period.
 - iii. As the necessary historical ACF data is not available for calculating the initial book yield at acquisition for the net present value constant purchase yield (NPV-CPY) method for impairment recognition, reporting entities shall use recently published yield-to-maturity (YTM) as their constant purchase yield to be applied for NPV-CPY impairment recognition.
 - iv. If the investment no longer qualifies as an SVO-Identified Bond ETF in scope of statement, this change shall be reflected prospectively from the effective date. Investments previously captured in this statement, that will move within the scope of another SSAP and reporting schedule shall be shown as dispositions on and shown as an acquisition on the schedule for which it will be subsequently reported.

The Guidance in this Statement is Effective January 1, 2025

- g. The guidance to explicitly exclude securities for which the contract amount of the instrument to be paid at maturity (or the original investment) is at risk for other than failure of the borrower to pay the contractual amount due, were effective December 31, 2019.
- h. Revisions to clarify existing guidance that all prepayment penalties and acceleration fees for when a bond is liquidated prior to its scheduled maturity date, including those from tendered bonds, shall follow the guidance in SSAP No. 26R was effective January 1, 2021. Reporting entities that have historically applied this guidance shall not change historical practices, but the effective date of January 1, 2021, with early application permitted, was allowed for reporting entities to make systems changes to capture tendered bonds in scope of this guidance.

REFERENCES**Other**

- *Purposes and Procedures Manual of the NAIC Investment Analysis Office*
- NAIC Valuation of Securities product prepared by the Securities Valuation Office

Relevant Issue Papers

- *Issue Paper No. 26—Bonds, Excluding Loan-Backed and Structured Securities*
- *Issue Paper No. 131—Accounting for Certain Securities Subsequent to an Other-Than-Temporary Impairment*
- *Issue Paper No. 156—Bonds*
- *Issue Paper No. XX—Principles-Based Bond Definition*

The Guidance in this Statement is Effective January 1, 2025

EXHIBIT A - EXAMPLES OF ANALYSIS FOR ASSET-BACKED SECURITIES

1. As detailed in paragraphs 9-10, the holder of an asset-backed securities is 1) required to be in a different economic position than if the holder owned the ABS Issuer's assets directly, and 2) if the assets owned by the ABS Issuer are cash generating non-financial assets, then the assets are expected to generate a meaningful level of cash flows towards repayment of the bond through use, licensing, leasing servicing or management fees, or other similar cash flow generation. (This guidance requires a meaningful level of cash flows to service the debt other than through the sale or refinancing of the assets.) This appendix details example analysis for these meaningful cash flow and substantive credit enhancements.

2. **Example 1:** A reporting entity invests in debt instruments issued from a SPV sponsored by the Government National Mortgage Association (GNMA), the Federal National Mortgage Association (FNMA) and the Federal Home Loan Mortgage Corporation (Freddie Mac) (collectively, "Agency or Agencies"). These debt instruments pass through principal and interest payments received from underlying mortgage loans held by the SPV to the debtholders proportionally, with principal and interest guaranteed by the Agencies. While there is prepayment and extension risk associated with the repayment of the underlying mortgage loans, the credit risk associated with the mortgage loans is assumed by the Agencies.

3. **Example 1 Rationale:** Although the reporting entity participates on a proportional basis in the cash flows from the underlying mortgage loans held by the SPV, the reporting entity is in a different economic position than if it owned the underlying mortgage loans directly because the credit risk has been redistributed and assumed by the Agencies. This is a substantive credit enhancement because a market participant (i.e., a knowledgeable investor transacting at arm's length) would conclude the Agency guarantee is expected to absorb all losses before the debt instrument being evaluated. Therefore, the holder of the debt instrument is in a substantively different economic position than if the holder owned the ABS Issuer's unguaranteed assets directly, in accordance with the requirements in paragraph 10. When guarantees do not cover 100% of principal and interest as the Agency guarantees do in this example, it is still appropriate to determine if the guarantee is substantive in accordance with the requirements in paragraph 10, to determine if the holder is in a substantively different economic position than if the holder held the ABS Issuer's assets directly.

4. **Example 2:** A reporting entity invested in a debt instrument issued by a SPV. Payments under the instrument are secured by a note, a legal assignment from the borrower of a lease for real property and an assignment of the lease payments from an operating entity tenant. Additional security is provided by a mortgage on the leased property (the "underlying collateral"). The leased property is owned by the borrower under the note -- the SPV does not have any ownership interest in the underlying collateral, though it has legal recourse to it through the mortgage. The tenant makes contractually-fixed payments over the life of the lease to the borrower, who has assigned both the lease and the lease payments to the SPV as security for the debt. While the debt is outstanding, the lease, the lease payments, and the mortgage all serve as security for the debtholders. Should a default occur, the debtholders can foreclose on and liquidate the real property as well as submit an unsecured lease claim in the lessee's bankruptcy for all or a portion of the defaulted lease payments. The loan-to-value (as a percentage of property value) at origination is 100%.

5. The existing lease payments are sufficient to cover all interest payments and all scheduled debt amortization payments over the life of the debt instrument. However, at debt maturity, there is a balloon payment due, totaling 50% of the original outstanding debt principal amount. The corresponding lease has no balloon payment due at lease maturity, so the SPV will either need to refinance the debt or sell the underlying collateral to service the final debt balloon payment. The property has a high probability of appreciating in value over the term, however ignoring any potential for appreciation, the 50% loan-to-value at maturity is the expected figure at the end of the debt term based solely on scheduled amortization payments. The real property is expected to be subject to some market value volatility and periods of lower

The Guidance in this Statement is Effective January 1, 2025

liquidity at certain points in time but has a predictable value range and ready market over a longer period of time, such that the property could be liquidated over a reasonable period of time, if necessary.

6. **Example 2 Rationale:** The reporting entity determined that the debtholder was in a fundamentally different position than if the real estate was owned directly. The lease is a cash generating non-financial asset which is expected to generate a meaningful level of cash flows for the repayment of the bonds which covers all interest payments and 50% of the principal payments. The level of reliance on the collateral value for sale or refinancing is just over the cutoff for using the practical expedient (<50%), so a full analysis is required. In reaching its determination, the reporting entity considered the predictable nature of the cash flows, which are contractually fixed for the life of the debt instrument, as well as the ability of the underlying collateral value to provide for the balloon payment through sale or refinancing in light of its characteristics. While the real property may have some market value volatility and periods of lower liquidity at points in time, the cash flows produced by the lease were concluded to reduce the loan balance to a level (50% loan-to-value) that would be able to be recovered by sale or refinancing at the maturity of the loan.

7. The reporting entity also determined that the structure provides substantive credit enhancement in the form of overcollateralization to conclude that investors are in a different economic position than holding the real property directly, in accordance with the requirements in paragraph 10. In reaching this conclusion, the reporting entity noted that although the debt instrument starts with a 100% loan-to-value (not including the value of the contractually required lease payments), contractual fixed payments from the lease provide additional security such that the reporting entity is in a different economic position than owning the property directly. Lease cash flows are sufficient to cover the payment of all interest and 50% of the outstanding principal over the term of the lease. In the context of the predictable nature of the cash flows and collateral value range over time, the reporting entity concluded that a market participant (i.e., knowledgeable investor transacting at arm's length) would consider this level of overcollateralization to put the investor in a substantively different economic position than owning the underlying property directly.

8. For the purposes of determining whether there is substantive overcollateralization, it is appropriate to consider any expected economic depreciation, if it is reasonably expected, but it is not appropriate to consider any expected economic appreciation. Note that a debt instrument with a loan-to-value that is expected to decrease over time is not necessarily deemed to have substantive overcollateralization.

9. **Example 3:** A reporting entity invested in a debt instrument with the same characteristics as described in Example 2, except that the existing lease at the time of origination has a contractual term that is shorter than that of the debt instrument. It is expected with a high degree of probability that the lease will be renewed, and a substantial leasing market exists to replace the lessee should they not renew. However, in the unlikely circumstance that the property cannot be re-leased, there would not be enough cash flows to service the scheduled principal and interest payments, and the property would have to be liquidated to pay off the debt upon default.

10. **Example 3 Rationale:** All details of Example 3, including the expected collateral cash flows, are consistent with those in Example 2, except that the cash flows in Example 2 are contractually fixed for the duration of the debt while the cash flows in Example 3 are subject to re-leasing risk. Notwithstanding the involvement of re-leasing risk, the reporting entity concluded that the ability to re-lease the property was highly predictable and supported the conclusion that the underlying collateral was expected to produce meaningful cash flows to service the debt.

11. This distinction is to highlight that the expected cash flows of a cash-generating non-financial asset may or may not be contractually fixed for the term of the bond. Certain securitized cash flow streams may not by their nature lend themselves to long-term contracts (e.g., single-family home rentals), but may nevertheless lend themselves to the production of predictable cash flows. While the non-contractual nature of the cash flows is an important consideration in determining whether a non-financial asset is expected to

The Guidance in this Statement is Effective January 1, 2025

produce meaningful cash flows to service the debt, it does not, in and of itself, preclude a reporting entity from concluding that the assets are expected to produce meaningful cash flows.

12. **Example 4:** A reporting entity invested in a debt instrument issued by a SPV that owns equipment which is leased to an equipment operator. The equipment operator makes lease payments to the SPV, which are passed through to service the SPV's debt obligation. While the debt is outstanding, the equipment and lease are held in trust and pledged as collateral for the debtholders. Should a default occur, the debtholders can foreclose on and liquidate the equipment as well as submit an unsecured lease claim in the lessee's bankruptcy for any defaulted lease payments. The loan-to-value at origination is 70%.

13. The existing lease payments are sufficient to cover all interest payments and all scheduled debt amortization payments over the life of the debt instrument. However, at maturity, there is a balloon payment due, totaling 80% of the original outstanding principal amount. The corresponding lease has no balloon payment due at lease maturity, so the SPV will either need to refinance the debt or sell the underlying equipment to service the final debt balloon payment. The loan-to-value at maturity is expected to increase to 95% considering the scheduled principal amortization payments net of the expected economic depreciation in the equipment value over the term of the debt. The equipment is expected to be subject to some market value volatility and periods of lower liquidity at certain points in time, but has a predictable value range and ready market over a longer period of time, such that the equipment could be liquidated over a reasonable period of time, if necessary.

14. **Example 4 Rationale:** The equipment is a cash generating non-financial asset which is not expected to generate a meaningful level of cash flows for the repayment of the bonds via the existing lease that covers all interest payments and 20% of principal payments. In reaching this determination, the reporting entity considered that, while the cash flows being produced are predictable, the ability to recover the principal of the debt investment is almost entirely reliant on the equipment retaining sufficient value to sell or refinance to satisfy the debt.

15. The reporting entity also determined that the structure lacks substantive credit enhancement to conclude that investors are in a different economic position than holding the equipment directly, in accordance with the requirements in [paragraph 10](#). In reaching this conclusion, the reporting entity noted that the debt starts with a 70% loan-to-value, but the overcollateralization is expected to deteriorate over the term of the debt as the equipment economically depreciates more quickly than the debt amortizes. This results in a high loan-to-value (i.e., 95%) at maturity, relative to the market value volatility of the underlying collateral. Despite the predictable nature of the cash flows, the reporting entity concluded that the debt instrument lacked a substantive level of overcollateralization to conclude that the investor is in a different economic position than owning the underlying equipment directly. It was determined that the level of overcollateralization, as determined by a market participant (i.e., a knowledgeable investor transacting at arm's length), is nominal. Therefore, the reporting entity concluded that it was in a substantively similar position as if it owned the equipment directly.

16. For the purposes of determining whether there is substantive overcollateralization, it is appropriate to consider any expected economic depreciation, if it is reasonably expected, but it is not appropriate to factor in any expected economic appreciation. Note that a debt instrument with a loan-to-value that is expected to increase over time is not necessarily deemed to have nominal overcollateralization.

The Guidance in this Statement is Effective January 1, 2025

EXHIBIT B – SYSTEMATIC VALUE CALCULATION

The established systematic value method is considered an “aggregated cash flow” (ACF) method in which the cash flow streams from the individual bond holdings are aggregated into a single cash flow stream. These cash flows are scaled such that, when equated with the market price at which the ETF was purchased or sold, an internal rate of return is calculated, representing the investor’s initial book yield for the ETF. Although the initial book yield is utilized to determine the current period effective yield, and the resulting adjustments to the ETF’s reported (systematic) value, the book yield is recalculated at least quarterly in order to adjust the investor’s book yield to reflect current cash flow projections of the current bond holdings within the ETF.

The following calculation shall be followed by reporting entities electing systematic value:

1. Download cash flows file from <u>ETF provider website</u> .	
NAV:	\$115.07 (Official end-of-day NAV found on <u>ETF provider website</u>)
Maturity:	12/8/2027 = SUMPRODUCT (CASHFLOW_DATE column, PRINCIPAL column)/SUM (PRINCIPAL column)
When Paid:	Monthly
Par Value:	2,500 # shares purchased
Monthly Effective Interest:	\$0.40 = (Recalculated Effective Book Yield from prior month x Prior Month Ending Book Value /12)
Distribution:	\$0.34 Found on <u>provider website</u>
Net Amortization/Accretion:	\$0.06 = (Monthly Effective Interest) – (Distribution)
Prior Month Ending Book Value:	\$115.35
NPV Constant Yield Method:	\$117.10 = XNPV (Initial Book Yield, CASHFLOW column, CASHFLOW_DATE column) / 1000000
Initial Book Yield:	4.15%
Book (Systematic) Value:	\$115.41 = (Prior Period Ending Book Value) + (Net “amortization/ accretion”)
Expense Ratio:	0.1500%
Recalculated Effective Book Yield:	4.1639% =XIRR(CASHFLOW column, CASHFLOW_DATE column, 0.05)

All formulas on the left are at a per share level (excepting “Par Value” which represents the number of shares purchased for this lot).

The resulting values calculated on the left are aggregated to reflect the total number of shares held on the previous tabs reflecting how one might populate the reporting schedule with these values.

Additionally, the cash flows in the data file are based on 1 million shares. This was done in order to make the cash flows easier to observe and work with (i.e., at a single share level, cash flows would be at fractional dollar levels). Therefore, in order to calculate the yield, investors must multiply the price of the ETF by 1 million shares and then use that value as a cash outflow against the positive cash inflows from the bond portfolio in order to calculate the IRR.

CUSIP	ASOF_DATE	CALL_TYPE	CASHFLOW_DATE	INTEREST	PRINCIPAL	CASHFLOW
2. Insert a row in between the column headings and the cash flow data.						
		3. Filter for “Call Type” is WORST. (Click “Data” at the top of Excel sheet, then click “Filter” and click the new dropdown box in the “Call Type” cell and select only “WORST.”)				5. Under the column “CASHFLOW” enter the following formula in Excel: =(-Ending Book Value)*1000000
			8/31/20X1			(115,414,059.56)
“Ticker”	8/31/20X1	WORST	9/8/20X1	136,538.564	81,472.372	218,010.937
“Ticker”	8/31/20X1	WORST	9/9/20X1	5,990.106	0	5,990.106
“Ticker”	8/31/20X1	WORST	9/10/20X1	9,706.324	0	9,706.324

The Guidance in this Statement is Effective January 1, 2025

EXHIBIT C – AMORTIZATION TREATMENT FOR CALLABLE BONDS

Example 1: Call Price Less Than BACV Throughout the Life of the Bond

12/31/2008 – Issuance of Bond. Par = 100/10-Year Bond (Matures 12/31/2018)

01/01/2009 – Call Date/Call Price 107

12/15/2010 – Reporting Entity Acquires Bond. Cost = 106

01/01/2012 – Scheduled Call Date Subsequent to Reporting Entity Acquisition. Call Price 104

01/01/2014 – Scheduled Call Date Subsequent to Reporting Entity Acquisition. Call Price 103

01/01/2016 – Scheduled Call Date Subsequent to Reporting Entity Acquisition. Call Price 102

General Note for Examples: The reporting entity purchased the bond at a premium (cost was greater than par). The 1/1/2009 call date and price is ignored as it occurred prior to the reporting entity acquiring the bond. The bolded numbers represent the lowest asset value at each reporting period. The bond is amortized to the lowest asset value, which in this scenario is amortizing to the call dates and prices. (The standard amortization to the maturity date is shown as it should be compared to the amortization to the call date/price to verify that the BACV at any given reporting date reflects the lowest asset value.)

Date	Action	Cost	Call Price	BACV (Under Call Date/Price)	Amortization to the Lowest Value	BACV Under Standard Amortization
12/15/2010	Acquired	106		106		106
12/31/2011	Lockout Period			104	2	105.25
01/01/2012	Call Date		104	104		
12/31/2012	Year-End Reporting			103.5	0.5	104.50
12/31/2013	Year-End Reporting			103	0.5	103.75
01/01/2014	Call Date		103	103		
12/31/2014	Year-End Reporting			102.5	0.5	103
12/31/2015	Year-End Reporting			102	0.5	102.25
01/01/2016	Call Date Exercised		102	102		

Standard Amortization

This table shows the amortization with a purchase date of 12/15/2010 at \$106 through the maturity date of 12/31/2018.

	12/15/2010	12/31/2011	12/31/2012	12/31/2013	12/31/2014	12/31/2015	12/31/2016	12/31/2017	12/31/2018
Amortization		.75	.75	.75	.75	.75	.75	.75	.75
BACV		105.25	104.50	103.75	103	102.25	101.50	100.75	100

	Consideration	Par Value	BACV at Disposal Date	Realized Gain/Loss*
01/01/2016 Call Exercised	102	100	102	(2)

* Per paragraph 26, the entity would recognize a \$(2) loss (BACV less par), and investment income of \$2 (consideration less par).

The Guidance in this Statement is Effective January 1, 2025**Example 2: Call Price Could be Greater Than BACV**

12/31/2008 – Issuance of Bond. Par = 100/10-Year Bond (Matures 12/31/2018)

01/01/2009 – Call Date/Call Price 107

12/15/2010 – Reporting Entity Acquires Bond. Cost = 104

01/01/2012 – Scheduled Call Date Subsequent to Reporting Entity Acquisition. Call Price 106

01/01/2014 – Scheduled Call Date Subsequent to Reporting Entity Acquisition. Call Price 103

01/01/2016 – Scheduled Call Date Subsequent to Reporting Entity Acquisition. Call Price 102

The bolded numbers represent the lowest asset value:

Date	Action	Cost	Call Price	BACV (Under Call Date / Price)	Amortization To the Lowest Asset Value	BACV Under Standard Amortization
12/15/2010	Acquired	104		104		104
12/31/2011	Lockout Period		106	104	0.5	103.50
01/01/2012	Call Date		106	104		103.50
12/31/2012	Year-End Reporting			103.5	0.5	103
12/31/2013	Year-End Reporting			103	0.5	102.50
01/01/2014	Call Date		103	103		102.50
12/31/2014	Year-End Reporting			102.5	0.5	102
12/31/2015	Year-End Reporting			102	0.5	101.50
01/01/2016	Call Date Exercised		102	102		101.50

Standard Amortization

This table shows the amortization with a purchase date of 12/15/2010 at \$104 through the maturity date of 12/31/2018.

	12/15/2010	12/31/2011	12/31/2012	12/31/2013	12/31/2014	12/31/2015	12/31/2016	12/31/2017	12/31/2018
Amortization		0.50	0.50	0.50	0.50	0.50	0.50	0.50	0.50
BACV		103.50	103	102.50	102	101.50	101	100.50	100

	Consideration	Par Value	BACV at Disposal Date	Realized Gain/Loss*
01/01/2016 Call Exercised	102	100	101.50	(1.50)

* Per paragraph 26, the entity would recognize a \$(1.50) loss (BACV less par), and investment income of \$2 (consideration less par).

The Guidance in this Statement is Effective January 1, 2025**Example 3: Call Price Could be Greater Than BACV**

12/31/2008 – Issuance of Bond. Par = 100/10-Year Bond (Matures 12/31/2018)

01/01/2009 – Call Date/Call Price 107

12/15/2010 – Reporting Entity Acquires Bond. Cost = 104

01/01/2012 – Scheduled Call Date Subsequent to Reporting Entity Acquisition. Call Price 106

01/01/2014 – Scheduled Call Date Subsequent to Reporting Entity Acquisition. Call Price 102

01/01/2016 – Scheduled Call Date Subsequent to Reporting Entity Acquisition. Call Price 101

Note – This illustration shows that the evaluation of whether standard amortization (to the maturity date) or the call date price may change over the time. The bolded numbers represent the lowest asset value:

Date	Action	Cost	Call Price	BACV (Under Call Date / Price)	Amortization To the Lowest Asset Value	BACV Under Standard Amortization
12/15/2010	Acquired	104		104		
12/31/2011	Lockout Period		106	104	0.5	103.50
01/01/2012	Call Date		106	104		103.50
12/31/2012	Year-End Reporting			103	0.5	103
12/31/2013	Year-End Reporting			102	1	102.50
01/01/2014	Call Date		102	102		102.50
12/31/2014	Year-End Reporting			101.5	0.5	102
12/31/2015	Year-End Reporting			101	0.5	101.50
01/01/2016	Call Date Exercised		101	101		101.50

Standard Amortization

This table shows the amortization with a purchase date of 12/15/2010 at \$104 through the maturity date of 12/31/2018.

12/15/2010	12/31/2011	12/31/2012	12/31/2013	12/31/2014	12/31/2015	12/31/2016	12/31/2017	12/31/2018
Amortization	0.50	0.50	0.50	0.50	0.50	0.50	0.50	0.50
BACV	103.50	103	102.50	102	101.50	101	100.50	100

	Consideration	Par Value	BACV at Disposal Date	Realized Gain/Loss*
01/01/2016 Call Exercised	101	100	101	(1)

* Per paragraph 26, the entity would recognize a \$(1) loss (BACV less par), and investment income of \$1 (consideration less par).

The Guidance in this Statement is Effective January 1, 2025

Example 4: Continuously Callable Bond – Callable at Par After Initial Lockout Period

12/31/2008 – Issuance of Bond. Par = 100/10-Year Bond (Matures 12/31/2018)
 01/01/2009 – Call Date / Call Price 107 – Continuously Callable Thereafter at Par
 12/15/2010 – Reporting Entity Acquires Bond. Cost = 104

The bolded numbers represent the lowest asset value:

Date	Action	Cost	Call Price	BACV (Under Call Date/Price)	Amortization To the Lowest Asset Value	BACV Under Standard Amortization
12/15/2010	Acquired	104		100	4	
12/31/2010	Year-End Reporting		100	100	There is no subsequent amortization as the premium was fully expensed at acquisition.	104
12/31/2011	Year-End Reporting		100	100		103.50
12/31/2012	Year-End Reporting		100	100		103
12/31/2013	Year-End Reporting		100	100		102.50
12/31/2014	Year-End Reporting		100	100		102
12/31/2015	Year-End Reporting		100	100		101.50
01/01/2016	Year-End Reporting		100	100		101.50

Standard Amortization								
This table shows the amortization with a purchase date of 12/15/2010 at \$104 through the maturity date of 12/31/2018.								
12/15/2010	12/31/2011	12/31/2012	12/31/2013	12/31/2014	12/31/2015	12/31/2016	12/31/2017	12/31/2018
Amortization	0.50	0.50	0.50	0.50	0.50	0.50	0.50	0.50
BACV	103.50	103	102.50	102	101.50	101	100.50	100

	Consideration	Par Value	BACV at Disposal Date	Realized Gain/Loss*
01/01/2016 Call Exercised	100	100	100	0

* Since the call price is par and could occur immediately after acquisition, the premium is immediately expensed. When the bond is called, there is no gain or loss as the consideration received equals the BACV.

The Guidance in this Statement is Effective January 1, 2025

Example 5: Determination of Prepayment Penalty When Call Price is Less Than Par

Call Price Less than Par				
Entity 1			Entity 2	
Par	100		Par	100
BACV	24		BACV	25
Consideration	26		Consideration	26
Explicit fee	1		Explicit fee	1
Remaining consideration	25		Remaining consideration	25
Gain	2		Gain	0
Income*	0		Income**	1

*Entity 1 does not have in place a process to identify explicit an prepayment penalty or acceleration fee.

**Entity 2 has in place a process to identify an explicit prepayment penalty or acceleration fee.

[https://naiconline.sharepoint.com/sites/NAICSupportStaffHub/Member Meetings/E CMTE/APPTF/2023-2 Summer/Summary and Minutes/SAPWG/Attachments/Att1O-2019-21 SSAP 26R.docx](https://naiconline.sharepoint.com/sites/NAICSupportStaffHub/Member%20Meetings/E%20CMTE/APPTF/2023-2%20Summer/Summary%20and%20Minutes/SAPWG/Attachments/Att1O-2019-21%20SSAP%2026R.docx)

The Guidance in this Statement is Effective January 1, 2025

Statement of Statutory Accounting Principles No. 43

Asset-Backed Securities

STATUS

Type of Issue.....	Common Area
Issued	August 13, 2023
Effective Date	January 1, 2025
Affects.....	Replaces SSAP No. 43R on January 1, 2025
Affected by	No other pronouncements
Interpreted by	INT 06-07; INT 07-01; INT 22-01
Relevant Appendix A Guidance	None

STATUS.....	1
SCOPE OF STATEMENT.....	1
SUMMARY CONCLUSION	3
Principles-Based Bond Definition - Asset-Backed Security.....	3
Initial Reporting Value and Recognition of Origination and Commitment Fees & Costs	3
Subsequent Carrying Value Method, Amortization, Accruals and Prepayment Penalties	5
Assessment of Cash Flows and Impact of Prepayments.....	6
Accretable Yield and Changes to Effective Yield for Application of Prospective Method.....	7
Recognition of Realized and Unrealized Gains and Losses and Impairment Guidance	8
Designation Guidance.....	12
Giantization/Megatization of FHLMC or FNMA Mortgage-Backed Securities	13
Disclosures.....	14
Relevant Literature.....	15
Effective Date and Transition	15
REFERENCES.....	17
Other	17
Relevant Issue Papers	17
EXHIBIT A – QUESTION AND ANSWER IMPLEMENTATION GUIDE	18

SCOPE OF STATEMENT

1. This statement establishes statutory accounting principles for each security investment that qualifies as an asset-backed security (ABS) under the principles-based bond definition detailed in *SSAP No. 26R—Bonds*. Each security shall be individually assessed under the bond definition to determine applicability as an asset-backed security and reported separately regardless of whether the security was issued in combination or as a unit with other investments. Items captured in scope of this statement are collectively referred to as asset-backed securities.

The Guidance in this Statement is Effective January 1, 2025

2. In addition to security investments that qualify under the principles-based definition as an asset-backed security, certain specific investments are also captured in scope of this statement:

- a. Mortgage Referenced Securities that do not meet the definition of an asset-backed security. In order to qualify as a mortgage-referenced security, the security must be issued by a government sponsored enterprise¹ or by a special purpose trust in a transaction sponsored by a government sponsored enterprise in the form of a “credit risk transfer.” In these situations, the issued security is tied to a referenced pool of mortgages and the payments received are linked to the credit and principal payment risk of the underlying mortgage loan borrowers captured in the referenced pool of mortgages. For these instruments, reporting entity holders may not receive a return of their full principal as principal repayment is contingent on repayment by the mortgage loan borrowers in the referenced pool of mortgages. Unless specifically noted, the provisions within this standard apply to mortgage-referenced securities.
- b. Freddie-Mac When Issued K-Deal (WI Trust) Certificates fully guaranteed by Freddie Mac are included in scope of this statement from original acquisition, and not initially reported as a derivative forward contract. ^(INT 22-01)

3. Securities captured in scope of this statement are not permitted to be reported as cash equivalents or short-term investments in scope of *SSAP No. 2R—Cash, Cash Equivalents, Drafts and Short-Term Investments* even if acquired within one year or less from the maturity date. Investments captured in scope of SSAP No. 2R are intended to reflect situations in which limited risk remains, either from changes in credit quality or interest rates, due to the short-duration until maturity. As ultimate cash flows from asset-backed securities may have other risks beyond default risk or interest rate risk (such as performance factors, balloon payments, collateral quality) reporting as a cash equivalent or short-term investment is not permitted to prevent inappropriate assumptions of the investment’s remaining potential risk.

4. This statement excludes:

- a. Securities captured in scope of *SSAP No. 26R—Bonds*.
- b. Mortgage loans in scope of *SSAP No. 37—Mortgage Loans* that qualify under an SVO structural assessment as SVO-Identified Credit Tenant Loans. These investments are excluded as these are captured as issuer credit obligations under SSAP No. 26R.
- c. Securities that do not qualify as Asset-Backed Securities per the bond definition in *SSAP No. 26R—Bonds*. This exclusion includes residual or interests, as well as first loss positions, that do not have contractual payments or substantive credit enhancement. Debt securities that do not qualify and residual interests shall follow guidance in *SSAP No. 21R—Other Admitted Assets*.

¹ Currently, only Fannie Mae and Freddie Mac are the government sponsored entities that either directly issue qualifying mortgage-referenced securities or sponsor transactions in which a special purpose trust issues qualifying mortgage-reference securities. However, this guidance would apply to mortgage-referenced securities issued by any other government sponsored entity that subsequently engages in the transfer of mortgage credit risk.

The Guidance in this Statement is Effective January 1, 2025

SUMMARY CONCLUSION

Principles-Based Bond Definition - Asset-Backed Security

5. Investments within the scope of this statement issued by a related party or acquired through a related party transaction or arrangement are also subject to the provisions, admittance assessments and disclosure requirements of *SSAP No. 25—Affiliates and Other Related Parties*. In determining whether a security is a related party investment, consideration should be given to the substance of the transaction, and the parties whose action or performance materially impacts the insurance reporting entity holding the security. Asset-backed securities meet the definition of assets as defined in *SSAP No. 4—Assets and Nonadmitted Assets* and are admitted assets to the extent they conform to the requirements of this statement and *SSAP No. 25*.

- a. Although an asset-backed security may be acquired from a non-related issuer, if the assets held in trust predominantly² reflect assets issued by affiliates of the insurance reporting entity, and the insurance reporting entity only has direct recourse to the assets held in trust, the transaction shall be considered an affiliated investment. In such situations where the underlying collateral assets are issued by related parties that do not qualify as affiliates, these securities shall be identified as related party investments in the investment schedules.
- b. An asset-backed security may involve a relationship with a related party but not be considered an affiliated investment. This may be because the relationship does not result in direct or indirect control of the issuer or because there is an approved disclaimer of control or affiliation. Regardless of whether investments involving a related party relationship are captured in the affiliated investment reporting lines, these securities shall be identified as related party investments in the investment schedules. Examples of related party relationships would include involvement of a related party in sponsoring or originating the asset-backed security or any type of underlying servicing arrangement. For the avoidance of doubt, investments from any arrangement that results in direct or indirect control, including control through a servicer or other controlling arrangement, shall be reported as affiliated in accordance with *SSAP No. 25—Affiliates and Other Related Parties*.

Initial Reporting Value and Recognition of Origination and Commitment Fees & Costs

6. Items in scope of this statement shall initially be reported at cost, including brokerage and related fees, unless otherwise detailed in [paragraph 8](#). Acquisitions and dispositions shall be recorded on the trade date, not the settlement date, except for the acquisition of private placement asset-backed securities which shall be recorded on the funding date. For securities where all information is not known as of the trade date (e.g., actual payment factors and specific pools), a reporting entity shall make its best estimate based on known facts.

² In applying this guidance, a reporting entity is not required to complete a detailed review of the assets held in trust to determine the extent, if any, the assets were issued by related parties. Rather, this guidance is a principle concept intended to prevent situations in which related party transactions (particularly those involving affiliates) is knowingly captured in a *SSAP No. 43R* structure and not identified as a related party transaction (or not reported as an affiliated investment on the investment schedule) because of the involvement of a non-related trustee or *SSAP No. 43R* security issuer. As identified in *SSAP No. 25—Affiliates and Other Related Parties*, it is erroneous to conclude that the inclusion of a non-related intermediary, or the presence of non-related assets in a structure predominantly comprised of related party investments, eliminates the requirement to identify and assess the investment transaction as a related party arrangement.

The Guidance in this Statement is Effective January 1, 2025

7. For assets that qualify in scope of this statement that result from a securitization or transfer of assets by the reporting entity captured in SSAP No. 103R, the guidance in that SSAP determines the initial reporting value:

- a. For asset-backed securities resulting from transfers of participating interests that qualify as a sale, the participating interests in financial assets that continue to be held by the reporting entity transferor shall be measured and reported at the date of transfer by allocating the previous carrying amount between the participating interests transferred and sold, and the participating interests that are not transferred and continue to be held by the reporting entity, based on their relative fair values.
- b. For asset-backed securities resulting from transfers of an entire financial asset or group of entire financial assets that qualify as a sale, assets obtained, including beneficial interests, shall be initially recognized at fair value.
- c. For asset-backed securities resulting from the transfer of assets that do not qualify as sales, the reporting entity transferor shall continue to report the transferred financial assets with no change in measurement.

8. Costs related to origination when paid in the form of brokerage and other related fees shall be capitalized as part of the cost of the asset-backed security. All other costs, including internal costs or costs paid to an affiliated entity related to origination, purchase, or commitment to purchase asset-backed securities, shall be charged to expense when incurred.

9. Origination fees represent fees charged to the borrower (paid to the reporting entity) in connection with the process of originating or restructuring a transaction. The fees include, but are not limited to, points, management, arrangement, placement, application, underwriting, and other fees pursuant to such a transaction. Origination fees shall not be recorded until received in cash. Origination fees intended to compensate the reporting entity for interest rate risks (e.g., points), shall be amortized into income over the term of the asset-backed security consistent with **paragraph 12** of this statement. Other origination fees shall be recorded as income upon receipt.

10. Commitment fees are fees paid to the reporting entity that obligate the reporting entity to make available funds for future borrowing under a specified condition:

- a. A fee paid to the reporting entity to obtain a commitment to make funds available at some time in the future is generally refundable only if the asset-backed security is issued. If the security is not issued, then the fees shall be recorded as investment income by the reporting entity when the commitment expires.
- b. A fee paid to the reporting entity to obtain a commitment to borrow funds at a specified rate and with specified terms quoted in the commitment agreement is generally not refundable unless the commitment is refused by the reporting entity. This type of fee shall be deferred, and amortization shall depend on whether or not the commitment is exercised. If the commitment is exercised, then the fee shall be amortized in accordance with **paragraph 12** of this statement over the life of the asset-backed security as an adjustment to the investment income on the security. If the commitment expires unexercised, the commitment fee shall be recognized in income on the commitment expiration date.

The Guidance in this Statement is Effective January 1, 2025

Subsequent Carrying Value Method, Amortization, Accruals and Prepayment Penalties

11. After initial recognition, the carrying value shall be determined in accordance with the reported NAIC designation. The determination of NAIC designations shall be in accordance with the requirements detailed in the *Purposes and Procedures Manual of the NAIC Investment Analysis Office (P&P Manual)*³:

- a. For reporting entities that maintain an Asset Valuation Reserve (AVR), asset-backed securities, excluding residual tranches or interests, shall be reported at amortized cost, except for those with an NAIC designation of 6, which shall be reported at the lower of amortized cost or fair value.
- b. For reporting entities that do not maintain an AVR, asset-backed securities designated highest-quality and high-quality (NAIC designations 1 and 2, respectively), excluding residual tranches or interests, shall be reported at amortized cost; loan-backed and structured securities that are designated medium quality, low quality, lowest quality and in or near default (NAIC designations 3 to 6, respectively) shall be reported at the lower of amortized cost or fair value.
- c. For residual tranches or interests⁴, all reporting entities shall report the item on Schedule BA: Other Long-Term Invested Assets at the lower of amortized cost or fair value. Changes in the reported value from the prior period shall be recorded as unrealized gains or losses. For reporting entities that maintain an AVR, the accounting for unrealized gains and losses shall be in accordance with *SSAP No. 7—Asset Valuation Reserve and Interest Maintenance Reserve*. These items are captured in *SSAP No. 21R—Other Admitted Assets* and subject to admittance restrictions detailed in that statement.

12. Amortization of premium or discount shall be calculated using the scientific (constant yield) interest method and shall be recorded as an adjustment to investment income.^(INT 07-01) The interest method results in a constant effective yield equal to the prevailing rate at the time of purchase or at the time of subsequent adjustments to book value. The amortization period shall reflect estimates of the period over which repayment of principal of the asset-backed securities is expected to occur, not the stated maturity period. (P9)

13. Interest shall be accrued using the effective-yield method using the redemption prices and redemption dates used for amortizing premiums and discounts. Interest income consists of interest collected during the period, the change in the due and accrued interest between the beginning and end of the period as well as reductions for premium amortization and interest paid on acquisition of asset-backed securities, and the addition of discount accrual. Contingent interest may be accrued if the applicable provisions of the underlying contract and the prerequisite conditions have been met.

³ Paragraphs 39-40 provide guidance on the NAIC financial modeling approach applicable to certain securities in determining NAIC designations.

⁴ Reference to “residual tranches or interests” intends to capture securitization tranches and beneficial interests as well as other structures that reflect loss layers without any contractual payments, whether principal or interest, or both. Payments to holders of these investments occur after contractual interest and principal payments have been made to other tranches or interests and are based on the remaining available funds. Although payments to holders can occur throughout an investment’s duration (and not just at maturity), such instances still reflect the residual amount permitted to be distributed after other holders have received contractual interest and principal payments.

The Guidance in this Statement is Effective January 1, 2025

14. An asset-backed security may provide for a prepayment penalty or acceleration fee in the event the investment is liquidated prior to its scheduled termination date. These fees shall be reported as investment income when received.

15. The amount of prepayment penalty and/or acceleration fees to be reported as investment income shall be calculated as follows:

- a. The amount of investment income reported is equal to the total proceeds (consideration) received less the par value of the investment; and
- b. Any difference between the book adjusted carrying value (BACV) and the par value at the time of disposal shall be reported as realized capital gains and losses subject to the authoritative literature in SSAP No. 7.

Assessment of Cash Flows and Impact of Prepayments

16. Prepayments can be a significant variable element in the cash flows received from asset-backed securities because they may affect the yield and determine the expected maturity against which the yield is evaluated. For example, with a mortgage-backed security, falling interest rates generate faster prepayment of the mortgages underlying the security, shortening its duration. This causes the reporting entity to reinvest assets sooner than expected at potentially less advantageous rates. This is called prepayment risk. Extension risk is created when rising interest rates slow repayment and can significantly lengthen the duration of the security. In addition to interest rate risk, other factors can influence the cash flows generated from an asset-backed securities. These factors include, but are not limited to, defaults of the underlying payors as well as performance requirements that must occur before cash flows can be generated from the underlying assets (such as with leases or royalty rights). If the underlying assets are delinquent or otherwise not generating expected cash flows, such items should be reflected in the cash flow analysis through diminishing security cash flows. Updated cash flow assessments shall continue to occur even if the underlying assets have not been liquidated and regardless of whether an other-than-temporary loss has been recognized.

17. Changes in currently estimated cash flows, including the effect of prepayment assumptions, on all asset-backed securities shall be reviewed periodically, at least quarterly. The prepayment rates of the underlying assets shall be used to determine prepayment assumptions. Prepayment assumptions shall be applied consistently across portfolios to all asset-backed securities backed by similar collateral (similar with respect to coupon, issuer, and age of collateral). Reporting entities shall use consistent assumptions across portfolios for similar collateral within controlled affiliated groups. Since each reporting entity may have a unique method for determining the prepayment assumptions, it is impractical to set standard assumptions for the industry. Relevant sources and rationale used to determine each prepayment assumption shall be documented by the reporting entity.

18. Asset-backed securities shall be revalued using the currently estimated cash flows, including new prepayment assumptions. Reporting entities may utilize the prospective adjustment method for all asset-backed securities, or they may elect to utilize the retrospective adjustment methodology to specific asset-backed securities that are reported with NAIC designations that are of high credit quality⁵ at the time of acquisition by the reporting entity. That is, the reporting entity shall determine if it will apply the retrospective or prospective method at the time of acquisition depending on the NAIC designation at that time and can only apply retrospective (as a policy election) to securities that of high credit. Subsequently,

⁵ Under U.S. GAAP, application of the retrospective method for beneficial interests in securitized financial assets, which would generally encompass most asset backed securities defined within SSAP 43R, is limited to “high quality” investments. This has been interpreted to be investments with AA or better ratings.

The Guidance in this Statement is Effective January 1, 2025

if an investment is downgraded below high credit quality, the reporting entity may continue to apply the retrospective method unless the security is other-than-temporarily impaired.

19. The prospective approach recognizes, through the recalculation of the effective yield to be applied to future periods, the effects of all cash flows whose amounts differ from those estimated earlier and the effects and changes in projected cash flows. Under the prospective method, the recalculated effective yield will equate the amortized cost of the investment to the present value of the anticipated future cash flows. The recalculated yield is then used to accrue income on the investment balance for subsequent accounting periods. There are no accounting changes in the current period unless the security is determined to be other than temporarily impaired.

20. The retrospective methodology changes both the yield and the amortized cost so that expected future cash flows produce a return on the investment equal to the return now expected over the life of the investment as measured from the date of acquisition. Under the retrospective method, the recalculated effective yield will equate the present value of the actual and anticipated cash flows with the original cost of the investment. The current amortized cost basis for the asset-backed security is then increased or decreased to the amount that would have resulted had the revised yield been applied since inception, and investment income is correspondingly decreased or increased.

Accretable Yield and Changes to Effective Yield for Application of Prospective Method

21. At initial acquisition of an asset-backed security, the reporting entity shall determine the accretable yield. The accretable yield is the excess of cash flows expected to be collected over the reporting entity's initial investment in the asset-backed security. The accretable yield shall be recognized as interest income on an effective-yield basis over the life of the asset-backed security⁶. The nonaccretable difference is the contractually required payments in excess of the cash flows expected to be collected. The nonaccretable difference shall not be recognized as an adjustment to yield, a loss accrual or a valuation allowance for credit risk. For transactions initially captured in SSAP No. 103R resulting from a reporting entity's transfer of assets, all cash flows estimated at the transaction date are defined as the holder's estimate of the amount and timing of estimated future principal and interest cash flows used in determining the purchase price or the holder's fair value for purposes of determining a gain or loss under SSAP No. 103R.

22. After the transaction date, cash flows expected to be collected are defined as the holder's estimate of the amount and timing of the estimated principal and interest cash flows based on the holder's best estimate of current considerations and reasonable and supportable forecasts. Expected cash flows are re-evaluated each quarter to determine if there has been a favorable (or an adverse) change in cash flows versus the previous estimate.

23. If upon evaluation there is a favorable (or an adverse) change in cash flows expected to be collected from the cash flows previously projected, the reporting entity shall recalculate the amount of accretable yield for the asset-backed security on the date of evaluation as the excess of cash flows expected to be collected over the asset-backed security's current amortized cost. The amortized cost is equal to the initial investment minus cash received to date, minus write-offs of the amortized cost basis (e.g., recognized other than temporary impairments) plus the yield accreted to date. If the security is in an impaired state (meaning, fair value is less than amortized cost, regardless if an unrealized loss has been recognized because the security is reported at amortized cost) and there is an adverse change in cash flows expected to be collected, an other-than-temporary impairment shall be considered to have occurred as described in [paragraph 30](#) and

⁶ An asset-backed security may be acquired at a discount because of a change in credit quality or rate or both. When a security is acquired at a discount that relates, at least in part, to the security's credit quality, the effective interest rate is the discount rate that equates the present value of the investor's estimate of the security's future cash flows with the purchase price of the security.

The Guidance in this Statement is Effective January 1, 2025

requires recognition of a realized loss pursuant to paragraph 35. However, an adverse change in cash flows due solely to changes in the interest rate of a “plain-vanilla”, variable-rate asset-backed security generally shall not result in the recognition of an other-than-temporary impairment (a plain-vanilla, variable-rate asset-backed investment does not include those variable-rate investments with interest rate reset formulas that involve either leverage or an inverse floater).

24. A favorable (or an adverse) change in cash flows expected to be collected is considered in the context of both timing and amount of the cash flows expected to be collected. Based on cash flows expected to be collected, interest income may be recognized on an asset-backed security even if the net investment in the asset-backed security is accreted to an amount greater than the amount at which the asset-backed security could be settled if prepaid immediately in its entirety. The adjustment shall be accounted for prospectively as a change in estimate in conformity with SSAP No. 3, with the amount of periodic accretion adjusted over the remaining life of the asset-backed security.

25. Determining whether there has been a favorable (or an adverse) change in cash flows expected to be collected from the cash flows previously projected (taking into consideration both the timing and amount of the cash flows expected to be collected) involves comparing the present value of the remaining cash flows expected to be collected at the initial transaction date (or at the last date previously revised) against the present value of the cash flows expected to be collected at the current financial reporting date. Both the current and previous sets of cash flows shall be discounted at a rate equal to the current yield used to accrete the asset-backed security.

Recognition of Realized and Unrealized Gains and Losses and Impairment Guidance

26. Asset-backed securities required to be reported at the lower of amortized cost or fair value shall report changes from the prior reporting period as unrealized gains or losses unless an other-than-temporary impairment has occurred. For reporting entities required to maintain an AVR, the accounting for unrealized gains and losses shall be reported through the AVR. For reporting entities not required to maintain an AVR, unrealized gains and losses shall be recorded as a direct credit or charge to unassigned funds (surplus). (P29)

27. Assessment of an other-than-temporary impairment is required for all asset-backed securities when fair value is less than the amortized cost basis. The amortized cost basis includes adjustments made to the cost of an investment for accretion, amortization, collection of cash, and previous other-than-temporary impairments recognized as a realized loss. Reporting a security at the lower of amortized cost or fair value is not a substitute for other-than-temporary impairment recognition. For securities reported at fair value where an other-than-temporary impairment has been determined, the loss recognized reflects the realization of unrealized losses previously recorded from fluctuations in fair value. (The extent to which unrealized losses are realized depends on whether the other-than-temporary impairment is considered a full impairment or a bifurcated impairment pursuant to paragraphs 34 and 35.) After the recognition of an other-than-temporary impairment, securities reported at the lower of amortized cost or fair value shall continue to report unrealized gains and losses from fluctuations in fair value.

28. If an entity intends to sell the asset-backed security (that is, it has decided to sell the security), an other-than-temporary impairment shall be considered to have occurred.

29. If an entity does not intend to sell the asset-backed security, the entity shall assess whether it has the intent and ability⁷ to retain the investment in the security for a period of time sufficient to recover the

⁷ This assessment shall be considered a high standard due to the accounting measurement method established for the securities within the scope of this statement (amortized cost).

The Guidance in this Statement is Effective January 1, 2025

amortized cost basis. If the entity does not have the intent and ability to retain the investment for the time sufficient to recover the amortized cost basis, an other-than-temporary impairment shall be considered to have occurred.

30. If the entity does not expect to recover the entire amortized cost basis of the security, the entity would be unable to assert that it will recover its amortized cost basis even if it does not intend to sell the security and the entity has the intent and ability to hold. (This includes situations in which an entity has an adverse change in cash flows expected to be collected for a security that is an impaired position (meaning, fair value is less than amortized cost, regardless of if an unrealized loss has been recognized.) In such situations, an other-than temporary impairment shall be considered to have occurred. (For mortgage-referenced securities, an OTTI is considered to have occurred when there has been a delinquency or other credit event in the referenced pool of mortgages such that the entity does not expect to recover the entire amortized cost basis of the security.) In assessing whether the entire amortized cost basis of the security will be recovered, an entity shall compare the present value of cash flows expected to be collected from the security with the amortized cost basis of the security. If present value of cash flows expected to be collected is less than the amortized cost basis of the security, the entire amortized cost basis of the security will not be recovered, and an other-than-temporary impairment shall be considered to have occurred. A decrease in the present value of cashflows expected to be collected on an asset-backed security that results from an increase or decrease in expected prepayments on the underlying assets shall be considered in the estimate of the present value of cashflows expected to be collected.

31. In determining whether an other than-temporary impairment has occurred, an entity shall calculate the present value of cash flows expected to be collected based on an estimate of the expected future cash flows of the impaired asset-backed security, discounted at the security's effective interest rate. For securities in which there was no nonaccretable yield and for which there has been no changes to estimated cash flows since acquisition, the effective interest rate is the rate of return implicit in the security (that is, the contractual interest rate adjusted for any net deferred fees or costs, premium, or discount existing at the origination or acquisition of the security).⁸ For all other securities, the effective interest rate is the rate implicit immediately prior to the recognition of the other-than-temporary impairment. (Meaning, the effective interest rate as adjusted to reflect the last revised assessment of expected cash flows.)

32. It is inappropriate to automatically conclude that a security is not other-than-temporarily impaired because all of the scheduled payments to date have been received. However, it also is inappropriate to automatically conclude that every decline in fair value represents an other-than-temporary impairment. Further analysis and judgment are required to assess whether a decline in fair value indicates that it is probable that the holder will not collect all of the contractual or estimated cash flows from the security. In addition, the length of time and extent to which the fair value has been less than cost can indicate a decline is other than temporary. The longer and/or the more severe the decline in fair value, the more persuasive the evidence that is needed to overcome the premise that it is probable that the holder will not collect all of the contractual or estimated cash flows from the issuer of the security.

33. In making its other-than-temporary impairment assessment, the holder shall consider all available information relevant to the collectibility of the security, including information about past events, current conditions, and reasonable and supportable forecasts, when developing the estimate of future cash flows. Such information generally shall include the remaining payment terms of the security, prepayment speeds, the financial condition of the issuer(s), expected defaults, and the value of any underlying collateral. To achieve that objective, the holder shall consider, for example, industry analyst reports and forecasts, sector

⁸ An asset-backed security may be acquired at a discount because of a change in credit quality or rate or both. When a security is acquired at a discount that relates, at least in part, to the security's credit quality, the effective interest rate is the discount rate that equates the present value of the investor's estimate of the security's future cash flows with the purchase price of the security.

The Guidance in this Statement is Effective January 1, 2025

credit ratings, and other market data that are relevant to the collectibility of the security. The holder also shall consider how other credit enhancements affect the expected performance of the security, including consideration of the current financial condition of the guarantor of a security (if the guarantee is not a separate contract) and/or whether any subordinated interests are capable of absorbing estimated losses on the loans underlying the security. The remaining payment terms of the security could be significantly different from the payment terms in prior periods (such as for some securities backed by “nontraditional loans”⁹). Thus, the holder shall consider whether a security backed by currently performing loans will continue to perform when required payments increase in the future (including “balloon” payments). The holder also shall consider how the value of any collateral would affect the expected performance of the security. If the fair value of the collateral has declined, the holder needs to assess the effect of that decline on the ability of the holder to collect the balloon payment.

34. When an other-than-temporary impairment has occurred because the entity intends to sell the security or has assessed that they do not have the intent and ability to retain the investments in the security for a period of time sufficient to recover the amortized cost basis, the amount of the other-than-temporary impairment recognized in earnings as a realized loss shall equal the entire difference between the investment’s amortized cost basis and its fair value at the balance sheet date (full impairment). For asset-backed securities held at lower of amortized cost or fair value, upon recognition of an other-than-temporary impairment, all unrealized losses would be considered realized and the current fair value becomes the new cost basis.)

35. When an other-than-temporary impairment has occurred because the entity does not expect to recover the entire amortized cost basis of the security even if the entity has no intent to sell and the entity has the intent and ability to hold, the amount of the other-than-temporary impairment recognized as a realized loss shall equal the difference between the investment’s amortized cost basis and the present value of cash flows expected to be collected, discounted at the security’s effective interest rate in accordance with [paragraph 31](#) (bifurcated impairment). For asset-backed securities held at lower of cost or fair value, unrealized losses would be realized for the non-interest related decline. Hence, unrealized losses could continue to be reflected for these securities based on the difference between the current fair value and the present value of cash flows expected to be collected. (After recognizing an OTTI in these situations, the present value of cash flows expected to be collected becomes the new cost basis of the security.)

36. For reporting entities required to maintain an AVR or IMR, all unrealized gains and losses shall be reported through the AVR. For realized gains and losses, an analysis is required on whether the realized loss reflects an interest or non-interest related decline¹⁰. The analysis required is the same regardless of whether a realized loss results from an impairment write-down or whether there was a gain or loss upon sale. Guidance on specific scenarios resulting in realized gains and losses are as follows:

⁹ A nontraditional loan may have features such as (a) terms that permit principal payment deferral or payments smaller than interest accruals (negative amortization), (b) a high loan-to-value ratio, (c) multiple loans on the same collateral that when combined result in a high loan-to value ratio, (d) option adjustable-rate mortgages (option ARMs) or similar products that may expose the borrower to future increases in repayments in excess of increases that result solely from increases in the market interest rate (for example, once negative amortization results in the loan reaching a maximum principal accrual limit), (e) an initial interest rate that is below the market interest rate for the initial period of the loan term and that may increase significantly when that period ends, and (f) interest-only loans that should be considered in developing an estimate of future cash flows.

¹⁰ Pursuant to INT 06-07, the term interest-related includes a declining value due to both increases in the risk free interest rate and general credit spread widening. Credit spreads can widen or contract for a variety of reasons, including supply/demand imbalances in the marketplace or the perceived higher/lower risk of an entire sector. If the declining value is caused, in whole or in part, due to credit spreads widening, but not due to fundamental credit problems of the issuer, the change in credit spreads is deemed to be interest-related.

The Guidance in this Statement is Effective January 1, 2025

- a. Unrealized Gains and Losses – Record all unrealized gains and losses through AVR. At the time an unrealized gain or loss is realized, allocation between AVR or IMR will depend on the analysis and bifurcation between interest or non-interest related declines. Unrealized gains or losses that are realized shall be reversed from AVR before the recognition of the realized gain or loss within AVR and IMR.
- b. Other-Than-Temporary Impairment – Non-interest related other-than-temporary impairment losses shall be recorded through the AVR and interest-related OTTI losses shall be recorded through the IMR. If the reporting entity wrote the security down to fair value due to the intent to sell or because the entity does not have the intent and ability to retain the investment for a period of time sufficient to recover the amortized cost basis, the entity shall bifurcate the realized loss between non-interest related (AVR) and interest related (IMR). The analysis for bifurcating impairment losses between AVR and IMR shall be completed as of the date when the other-than-temporary impairment is determined. Entities that recognized an OTTI based on the difference between amortized cost and the present value of expected cash flows shall recognize the full realized loss through AVR.
- c. Security Sold at a Loss Without Prior OTTI – An entity shall bifurcate the loss into AVR and IMR portions depending on interest and non-interest related declines in accordance with the analysis performed as of the date of sale.
- d. Security Sold at a Loss With Prior OTTI – An entity shall bifurcate the current realized loss into AVR and IMR portions depending on interest and non-interest related declines in accordance with the analysis performed as of the date of sale. An entity shall not adjust previous allocations to AVR and IMR that resulted from previous recognition of other-than-temporary impairments.
- e. Security Sold at a Gain With Prior OTTI – An entity shall bifurcate the gain into AVR and IMR portions depending on interest and non-interest factors in accordance with the analysis performed as of the date of sale. The bifurcation between AVR and IMR that occurs as of the date of sale may be different from the AVR and IMR allocation that occurred at the time of previous other-than-temporary impairments. An entity shall not adjust previous allocations to AVR and IMR that resulted from previous recognition of other-than-temporary impairments.
- f. Security Sold at a Gain Without Prior OTTI – An entity shall bifurcate the gain into AVR and IMR portions depending on interest and non-interest factors in accordance with the analysis performed as of the date of sale.

37. This statement does not permit reversals of recognized other-than-temporary impairments based on subsequent recoveries of fair value. If there are subsequent changes to the cash flows expected to be collected, the prospective adjustment method shall be used to adjust the effective yield in future periods to reflect those changes.

38. In periods subsequent to the recognition of an other than temporary impairment loss for an asset-backed security, the reporting entity shall account for the other-than-temporarily impaired security as if the security had been purchased on the measurement date of the other-than-temporary impairment at an amortized cost basis equal to the previous amortized cost basis less the other-than-temporary impairment recognized as a realized loss. The difference between the new amortized cost basis and the cash flows expected to be collected shall be accreted as interest income. A reporting entity shall continue to estimate the present value of cash flows expected to be collected over the life of the asset-backed security.

The Guidance in this Statement is Effective January 1, 2025**Designation Guidance**

39. For Residential Mortgage-Backed Securities (RMBS), Commercial Mortgage-Backed Securities (CMBS) and Collateralized Loan Obligations (CLOs) securities within the scope of this statement, the initial NAIC designation used to determine the carrying value method and the final NAIC designation for reporting purposes is determined using a multi-step process or the NAIC designation assigned by the NAIC Securities Valuation Office. The P&P Manual provides detailed guidance. A general description of the processes is as follows:

- a. Financial Modeling: Pursuant to the P&P Manual, the NAIC identifies select securities where financial modeling must be used to determine the NAIC designation. For a modeled RMBS/CMBS legacy security, meaning one which closed prior to January 1, 2013, the NAIC designation is based on financial modeling incorporating the insurers' carrying value. For a modeled RMBS/CMBS non-legacy security, meaning one which closed after December 31, 2012, or modeled CLO, the NAIC designation and NAIC designation category assigned by the NAIC Securities Valuation Office must be used. For those RMBS/CMBS legacy securities that are financially modeled, the insurer must use NAIC CUSIP specific modeled breakpoints provided by the modelers in determining initial and final designation for these identified securities. As specified in the P&P Manual, a modeled legacy security RMBS or CMBS tranche that has no expected loss, as compiled and published by the NAIC Securities Valuation Office, under any of the selected modeling scenarios would be assigned an NAIC 1 designation and NAIC 1.A designation category regardless of the insurer's book/adjusted carrying value. The three-step process for modeled RMBS/CMBS legacy securities is as follows:
 - i. Step 1: Determine Initial Designation – The current amortized cost (divided by remaining par amount) of an asset-backed security is compared to the modeled breakpoint values assigned to each NAIC designation and NAIC designation category for each CUSIP to establish the **initial** NAIC designation.
 - ii. Step 2: Determine Carrying Value Method – The carrying value method, either the amortized cost method or the lower of amortized cost or fair value method, is then determined as described in paragraph 11 based upon the initial NAIC designation from Step 1.
 - iii. Step 3: Determine Final Designation – The final NAIC designation is determined by comparing the carrying value (divided by remaining par amount) of a security (based on paragraph 39.a.ii.) to the NAIC CUSIP specific modeled breakpoint values assigned to the NAIC designation and NAIC designation category for each CUSIP or is mapped to an NAIC designation category, according to the instructions in the P&P Manual. This final NAIC designation shall be applicable for statutory accounting and reporting purposes and the NAIC designation category will be used for investment schedule reporting and establishing RBC and AVR charges. The final NAIC designation is not used for establishing the appropriate carrying value method in Step 2 (paragraph 39.a.ii.).
- b. All Other Asset-Backed Securities: For securities not subject to paragraph 39.a. (financial modeling) follow the established designation procedures according to the appropriate section of the P&P Manual. The NAIC designation shall be applicable for statutory accounting and reporting purposes (including determining the carrying value method and

The Guidance in this Statement is Effective January 1, 2025

establishing the AVR charges). The carrying value method is established as described in paragraph 11.

40. For securities that will be financially modeled under paragraph 39, the guidance in this paragraph shall be applied in determining the reporting method for such securities acquired in the current year for quarterly financial statements. Securities reported as of the prior-year end shall continue to be reported under the prior-year end methodology for the current-year quarterly financial statements. For year-end reporting, securities shall be reported in accordance with paragraph 39, regardless of the quarterly methodology used. (P28)

- a. Reporting entities that acquired the entire financial modeling database for the prior-year end are required to follow the financial modeling methodology (paragraph 39.a.) for all securities acquired in the subsequent year that were included in the financial modeling data acquired for the prior year-end.
- b. Reporting entities that acquired identical securities (identical CUSIP) to those held and financially modeled for the prior year-end are required to follow the prior year-end financial modeling methodology (paragraph 39.a.) for these securities acquired subsequent to year-end.
- c. Reporting entities that do not acquire the prior-year financial modeling information for current-year acquired individual CUSIPS, and are not captured within paragraphs 40.a. or 40.b., are required to follow the analytical procedures for non-financially modeled securities (paragraph 39.b. as appropriate) until the current year financial modeling information becomes available and then follow the procedures for financially modeled securities (paragraph 27.a., as appropriate). Reporting entities that do acquire the individual CUSIP information from the prior-year financial modeling database shall use that information for interim reporting.
- d. Reporting entities that acquire securities not previously modeled at the prior year-end are required to follow the analytical procedures for non-financially modeled securities (paragraph 39.b. as appropriate) until the current year financial modeling information becomes available and then follow the procedures for financially modeled securities (paragraph 27.a., as appropriate).

Giantization/Megatization of FHLMC or FNMA Mortgage-Backed Securities

41. Giantization/megatization of mortgage-backed securities is defined as existing pools of FHLMC or FNMA mortgage-backed securities (MBS) with like coupon and prefix which are repooled together by the issuing agency creating a new larger security. The new Fannie Mae “Mega” or Freddie Mac “Giant” is a guaranteed MBS pass-through representing an undivided interest in the underlying pools of loans.

42. Repooled FHLMC and FNMA securities meet the definition of substantially the same as defined in *SSAP No. 103R—Transfers and Servicing of Financial Assets and Extinguishments of Liabilities*. The transaction shall not be considered a sale/purchase and no gain or loss shall be recognized. To properly document the repooling, the transaction shall be reported through Schedule D of the annual statement as a disposition and an acquisition.

43. Transaction fees charged by the issuing agencies shall be capitalized and amortized over the life of the repooled security.

The Guidance in this Statement is Effective January 1, 2025**Disclosures**

44. In addition to the disclosures required for invested assets in general, the following disclosures regarding asset-backed securities shall be made in the financial statements. Regardless of the allowances within paragraph 63 of the Preamble, the disclosures in paragraph 44.f., 44.g. and 44.h. of this statement are required in separate, distinct notes to the financial statements:

- a. Fair values in accordance with *SSAP No. 100R—Fair Value*.
- b. Concentrations of credit risk in accordance with *SSAP No. 27*;
- c. Basis at which the asset-backed securities are stated;
- d. The adjustment methodology used for each type of security (prospective or retrospective);
- e. Descriptions of sources used to determine prepayment assumptions.
- f. All securities within the scope of this statement with a recognized other-than-temporary impairment, disclosed in the aggregate, classified on the basis for the other-than-temporary impairment: (1) intent to sell, (2) inability or lack of intent to retain the investment in the security for a period of time sufficient to recover the amortized cost basis, or (3) present value of cash flows expected to be collected is less than the amortized cost basis of the security.
- g. For each security with an other-than-temporary impairment, recognized in the current reporting period by the reporting entity, as the present value of cash flows expected to be collected is less than the amortized cost basis of the securities:
 - i. The amortized cost basis, prior to any current-period other-than-temporary impairment.
 - ii. The other-than-temporary impairment recognized in earnings as a realized loss.
 - iii. The fair value of the security.
 - iv. The amortized cost basis after the current-period other-than-temporary impairment.
- h. All impaired securities (fair value is less than cost or amortized cost) for which an other-than-temporary impairment has not been recognized in earnings as a realized loss (including securities with a recognized other-than-temporary impairment for non-interest related declines when a non-recognized interest related impairment remains):
 - i. The aggregate amount of unrealized losses (that is, the amount by which cost or amortized cost exceeds fair value) and
 - ii. The aggregate related fair value of securities with unrealized losses.
- i. The disclosures in (i) and (ii) above should be segregated by those securities that have been in a continuous unrealized loss position for less than 12 months and those that have been in a continuous unrealized loss position for 12 months or longer using fair values determined in accordance with *SSAP No. 100R*.

The Guidance in this Statement is Effective January 1, 2025

- j. Additional information should be included describing the general categories of information that the investor considered in reaching the conclusion that the impairments are not other-than-temporary.
- k. When it is not practicable to estimate fair value, the investor should disclose the following additional information, if applicable:
 - i. The aggregate carrying value of the investments not evaluated for impairment, and
 - ii. The circumstances that may have a significant adverse effect on the fair value.
- l. For securities sold, redeemed or otherwise disposed as a result of a callable feature (including make whole call provisions), disclose the number of CUSIPs sold, disposed or otherwise redeemed and the aggregate amount of investment income generated as a result of a prepayment penalty and/or acceleration fee.
- m. The items in the scope of this statement are also subject to the annual audited disclosures in *SSAP No. 26R—Bonds*, paragraphs 39.e., 39.f. and 39.g.

45. Refer to the Preamble for further discussion regarding disclosure requirements. All disclosures within this statement, except disclosures included in paragraphs 44.b., 44.k. and 44.m., shall be included within the interim and annual statutory financial statements. Disclosure requirements in paragraphs 44.b., 44.k. and 44.m. are required in the annual audited statutory financial statements only.

Relevant Literature

46. This statement reflects specific statutory accounting guidance for assets that qualify as asset-backed securities under the statutory accounting principles-based bond definition. The classification of investments as ‘bonds’ for statutory accounting and reporting purposes differs from the U.S. GAAP determination of a “debt instrument” and this statement reflects statutory specific measurement and impairment guidance for investments captured in scope. This statement does incorporate limited U.S. GAAP concepts, particularly with the determination of accretable yield and consideration of changes in expected cash flows using the retrospective or prospective method. However, due to the statutory accounting specifications on scope, measurement method and impairment, no U.S. GAAP standards are considered adopted within this statement. Concepts that converge with U.S. GAAP are limited to the extent they are detailed in this statement.

Effective Date and Transition

47. This statement adopted August 13, 2023, is effective for years beginning January 1, 2025. The revisions to this statement, and *SSAP No. 26R—Bonds*, incorporate principal concepts on what should be reported as a long-term bond. Securities that qualify as issuer credit obligations within the principal concepts are captured within scope of *SSAP No. 26R*. Securities that qualify as asset-backed securities within the principal concepts are captured within scope of *SSAP No. 43R*. Securities that do not qualify as issuer credit obligations or ABS, unless specifically permitted in scope of these statements, are not permitted to be reported as a bond.

48. At the time of transition, reporting entities shall make their best efforts to assess investments to determine whether they qualify within the bond definition for reporting as issuer credit obligations on Schedule D-1-1 or asset-backed securities on Schedule D-1-2. The bond definition requires assessments at the time of acquisition (as of the origination date), and it is recognized that reporting entities may not have the means to complete historical assessments for securities held at the time of transition. For these instances,

The Guidance in this Statement is Effective January 1, 2025

if information is not readily available for reporting entities to assess a security as of the date at origination, reporting entities may utilize current or acquisition information in concluding that a security qualifies for reporting as a bond as either an issuer obligation or asset-backed security.

49. Investments that were reported as a bond on Schedule D-1: Long-Term Bonds as of December 31, 2024, that do not qualify under the principle-based bond concepts shall be reported as a disposal from that schedule, with a reacquisition on the appropriate reporting schedule as of January 1, 2025. These investments shall be accounted for in accordance with the resulting SSAP that addresses the specific investment structure. For securities that are reported at the lower of amortized cost or fair value under the new applicable guidance, this could result with an unrealized loss in the measurement of the investment at the time of the reclassification. Although the adoption of this guidance is considered a change in accounting principle under SSAP No. 3, the following transition guidance shall be applied on January 1, 2025, to ensure consistency in reporting and to allow investment schedules to roll appropriately:

- a. Securities reclassified from Schedule D-1 as they no longer qualify under the bond definition shall be reported as a disposal from Schedule D-1 at amortized cost. Although no proceeds are received, amortized cost at the time of disposal shall be reported as consideration on Schedule D-4.
 - i. For securities held at amortized cost at the time of disposal, book adjusted carrying value and amortized cost shall agree, preventing gain or loss recognition at the time of reclassification.
 - ii. For securities held at fair value under the lower of amortized cost or fair value measurement method, previously reported unrealized losses shall be reversed on Jan. 1, 2025, prior to disposal, resulting with a reported value that mirrors amortized cost at the time of disposal. This action prevents realized loss recognition at time of reclassification.
- b. Securities reclassified from Schedule D-1 shall be recognized on the subsequent schedule (e.g., Schedule BA) with an actual cost that agrees to the disposal value (amortized cost). Immediately subsequent to recognition on the resulting schedule, the securities shall be reported in accordance with the measurement method prescribed by the applicable SSAP:
 - i. For securities previously reported at fair value on Schedule D-1 (under a lower of amortized cost or fair value measurement method), the reporting entity will recognize an unrealized loss to match the previously reported book adjusted carrying value. Subsequently, the security will continue to reflect a lower of amortized cost or fair value measurement method.
 - ii. For securities previously reported at amortized cost on Schedule D-1, if the subsequent statement requires a lower of amortized cost or fair value measurement method, then the reporting entity shall recognize an unrealized loss to the extent fair value is less than amortized cost.
 - iii. After application of **paragraph 49.b.i. and 49.b.ii.** all securities shall reflect either the same reported value as of December 31, 2024 (amortized cost or fair value) or a lower reported value (if the security is subject to the lower of amortized cost or fair value measurement method). There should be no instances that result with a

The Guidance in this Statement is Effective January 1, 2025

security having a greater reported value than what was presented on December 31, 2024. Subsequent to transition, securities reported at fair value may incur unrealized gains or losses due to fair value fluctuations, but should never have unrealized gains that result with a book adjusted carrying value that exceeds amortized cost.

50. With this transition guidance, changes in measurement for securities reclassified under the bond definition will be reported as a change in unrealized capital gains (losses) in the first quarter 2025 financial statements (unless sold in the interim with a realized gain or loss) and not as a change in accounting principle. To enable regulators the ability to identify the impact of securities reclassified under the bond definition, the following disclosure for the 2025 first quarter financial statement is required:

- a. Aggregate book adjusted carrying value for all securities reclassified off Schedule D-1.
- b. Aggregate book adjusted carrying value after transition for all securities reclassified off Schedule D-1 that resulted with a change in measurement basis. (This shall be a subset of paragraph 50.a. and captures the securities that moved from an amortized cost to a fair value measurement method under the lower of amortized cost or fair value approach.)
- c. Aggregate surplus impact for securities reclassified off Schedule D-1. This shall include the difference between book adjusted carrying value as of December 31, 2024, and book adjusted carrying value after transition for those securities that moved from an amortized cost to a fair value measurement method under the lower of amortized cost or fair value approach.

51. Asset-backed securities that were previously reported as short-term (Schedule DA) or as a cash equivalent (Schedule E2) shall be reclassified to be reported on Schedule D-1-2 on Jan. 1, 2025. Similar to the process detailed in paragraph 49, the securities shall be removed from DA and E2 at amortized cost, with reversal of any unrealized loss prior to the reclassification. The amortized cost shall be reported as “consideration received on disposals” on Schedule DA – Verification Between Years or Schedule E-2 – Verification Between Years, as applicable based on the prior reporting location. The security shall be recognized as an ABS acquired on Schedule D-3 at amortized cost. Immediately after initial recognition, if the security was required to be held at fair value, under the lower of amortized cost or fair value measurement method, the reporting entity shall recognize an unrealized loss.

52. For clarification purposes, the transition guidance shall be applied prospectively beginning with the first year of adoption (Jan. 1, 2025). For disclosures that provide comparative information, reporting entities shall not restate the prior year’s information in the 2025 disclosure.

REFERENCES**Other**

- *Purposes and Procedures Manual of the NAIC Investment Analysis Office*
- NAIC Valuation of Securities product prepared by the Securities Valuation Office

Relevant Issue Papers

- *Issue Paper No. XX—Principles Based Bond Definition*

The Guidance in this Statement is Effective January 1, 2025

EXHIBIT A – QUESTION AND ANSWER IMPLEMENTATION GUIDE

This exhibit addresses common questions regarding the valuation and impairment guidance detailed in SSAP No. 43R.

Index to Questions

No.	Question
1	Are reporting entities permitted to establish an accounting policy to write down a SSAP No. 43R other-than-temporarily impaired security, for which a “non-interest” related decline exists, to fair-value regardless of whether the reporting entity intends to sell, or has the intent and ability to hold?
2	Can a reporting entity avoid completing a cash-flow assessment or testing for a specific other-than-temporarily impaired security when the entity believes there is a clear cash-flow shortage (i.e., non-interest related impairment) and elect to recognize a full impairment for the SSAP No. 43R security (no impairment bifurcation), with fair value becoming the new amortized cost basis, and recognition of the full other-than-temporary impairment as a realized loss?
3	Can reporting entities change their “intend to sell” or “unable to hold” assertions and recover previously recognized other-than-temporary impairments?
4	How do the regulators intend the phrase “intent and ability to hold” as used within SSAP No. 43R to be interpreted?
5	How do contractual prepayments affect the determination of credit losses?
6	Are the disclosure requirements within paragraphs 44.f. and 44.g. of SSAP No. 43R required to be completed for the current reporting quarter only, or as a year-to-date cumulative disclosure?
7	If an impairment loss is recognized based on the "present value of projected cash flows" in one period is the entity required to get new cash flows every reporting period subsequent or just in the periods where there has been a significant change in the actual cash flows from projected cash flows?
Questions 8-10 are specific to securities subject to the financial modeling process. (This process is limited to qualifying RMBS/CMBS securities reviewed by the NAIC Structured Securities Group.) The guidance in questions 8-10 shall not be inferred to other securities in scope of SSAP No. 43R.	
8	Do ABS purchased in different lots result in a different NAIC designation for the same CUSIP? Can reporting entities use a weighted average method determined on a legal entity basis?
9	The NAIC Designation process for ABS may incorporate loss expectations that differ from the reporting entity’s expectations related to OTTI conclusions. Should the reporting entities be required to incorporate recovery values obtained from data provided by the service provider used for the NAIC Designation process for impairment analysis as required by SSAP No. 43R?

The Guidance in this Statement is Effective January 1, 2025

No.	Question
10	For companies that have separate accounts, can the NAIC designation be assigned based upon the total legal entity or whether it needs to be calculated separately for the general account and the total separate account?

Questions 8-10 are specific to securities subject to the financial modeling process. (This process is limited to qualifying RMBS/CMBS securities reviewed by the NAIC Structured Securities Group.) The guidance in questions 8-10 shall not be inferred to other securities in scope of SSAP No. 43R.

1. Question - Are reporting entities permitted to establish an accounting policy to write down a SSAP No. 43R other-than-temporarily impaired security, for which a “non-interest” related decline exists, to fair value regardless of whether the reporting entity intends to sell, or has the intent and ability to hold?

1.1 Pursuant to the guidance in SSAP No. 43R, optionality is not permitted. As such, an accounting policy that differs from SSAP No. 43R would be considered a departure from statutory accounting principles as prescribed by the NAIC *Accounting Practices and Procedures Manual*.

2. Question – Can a reporting entity avoid completing a cash-flow assessment or testing for a specific other-than-temporarily impaired security when the entity believes there is a clear cash-flow shortage (i.e., non-interest related impairment) and elect to recognize a full impairment for the SSAP No. 43R security (no impairment bifurcation), with fair value becoming the new amortized cost basis, and recognition of the full other-than-temporary impairment as a realized loss?

2.1 Under the basis of SSAP No. 43R, an entity is not permitted to elect a write-down to fair value in lieu of assessing cash flows and bifurcating “interest” and “non-interest” impairment components. As noted in [paragraph 30](#), if the entity does not have the intent to sell, and has the intent and ability to hold, but does not expect to recover the entire amortized cost basis of the security, the entity shall compare the present value of cash flows expected to be collected with the amortized cost basis of the security. If present value of cash flows expected to be collected is less than the amortized cost basis of the security, the entire amortized cost basis of the security will not be recovered (a non-interest decline exists) and an other-than-temporary impairment shall be considered to have occurred. Pursuant to [paragraph 35](#), when an other-than-temporary impairment has occurred because the entity does not expect to recover the entire amortized cost basis of the security even if the entity has no intent to sell and the entity has the intent and ability to hold, the amount of the other-than-temporary impairment recognized as a realized loss shall equal the difference between the investment’s amortized cost basis and the present value of cash flows expected to be collected, discounted at the asset-backed security’s effective interest rate.

2.2 If the entity does not want to assess cash flows of an impaired security (fair value is less than amortized cost), the entity can designate the security as one the entity intends to sell, or one that the entity does not have the intent and ability to hold, providing it is reflective of the true intent and assessment of the ability of the entity. Once an impaired security has this designation, pursuant to [paragraphs 28 or 29](#), an other-than-temporary impairment shall be considered to have occurred. As detailed in [paragraph 34](#), the amount of the other-than-temporary impairment recognized in earnings as a realized loss shall equal the entire difference between the investment’s amortized cost basis and its fair value at the balance sheet date.

The Guidance in this Statement is Effective January 1, 2025

- 2.3 As addressed in question 3 of this Question and Answer Guide, reporting entities are not permitted to change assertions regarding their intent to sell or their lack of intent and ability to hold. Once the security has been identified as one the entity intends to sell, or as a security that the entity does not have the intent and ability to hold, that assertion shall not change as long as the entity continues to hold the security.
- 3. Question - Can reporting entities change their “intend to sell” or “unable to hold” assertions and recover previously recognized other-than-temporary impairments?**
- 3.1 No, a reporting entity is not permitted to change assertions and reverse previously recognized SSAP No. 43R other-than-temporary impairments. Although an entity may elect to hold a security due to a favorable change in the security’s fair value, once the security has been identified as one the entity intends to sell, or as a security that the entity does not have the intent and ability to hold for purposes of initially recognizing an other-than-temporary impairment, that assertion shall not change as long as the entity continues to hold the security.
- 3.2 Reporting entities that have recognized an other-than-temporary impairment on a SSAP No. 43R security in a manner corresponding with an assertion on the intent to sell or the lack of the intent and ability to hold, for which a subsequent other-than-temporary impairment has been identified, shall recognize a realized loss for the difference between the current amortized cost (reflecting the previously recognized SSAP No. 43R other-than-temporary impairment) and the fair value at the balance sheet date of the subsequent impairment. Thus, bifurcation of impairment between interest and non-interest related declines is not permitted for securities in which an other-than-temporary impairment was previously recognized on the basis that the reporting entity had the intent to sell, or lacked the intent and ability to hold, regardless if the entity has subsequently decided to hold the security.
- 3.3 Reporting entities shall reclassify a security as one for which there is an intent to sell, or for which there is not an intent or ability to hold, regardless if a bifurcated other-than-temporary impairment had previously been recognized, as soon as the entity realizes that they can no longer support a previous assertion to hold the security. In making such reclassifications, if the security is impaired, the difference between the amortized cost (reflecting the initial non-interest other-than-temporary impairment recognized) and fair value at the balance sheet date of the reclassification shall be recognized as a realized loss, with fair value reflecting the new amortized cost basis. Once such a reclassification occurs, and the security is classified as one for which there is an intent to sell, or for which there is not an intent and ability to hold, the security must continue to carry that assertion until it is no longer held by the reporting entity.
- 4. Question – How do the regulators intend the phrase “intent and ability to hold” as used within SSAP No. 43R to be interpreted?**
- 4.1 SSAP No. 43R paragraph 29 states in part “...the entity shall assess whether it has the intent and ability to retain the investment in the security for a period of time sufficient to recover the amortized cost basis. If the entity does not have the intent and ability to retain the investment for the time sufficient to recover the amortized cost basis, an other-than-temporary impairment shall be considered to have occurred.”

The Guidance in this Statement is Effective January 1, 2025

- 4.2 The intent of this language within SSAP No. 43R is focused on ensuring that, as of the balance sheet date, after considering the entity’s own cash or working capital requirements and contractual or regulatory obligations and all known facts and circumstances related to the impaired security, the entity does not have the intention of selling the impaired security and has the current intent and ability to hold the security to recovery. Due to impairment bifurcation provisions provided within SSAP No. 43R, and the amortized cost measurement method generally permitted for asset-backed securities, the assessment of “intent and ability” is intended to be a high standard. Despite the intent of paragraph 29, it is identified that information not known to the entity may become known in subsequent periods and/or facts and circumstances related to an individual holding or group of holdings may change thereby influencing the entity’s subsequent determination of intent and ability with respect to a security or securities.
- 4.3 If a reporting entity asserts that it has the intent and ability to hold a security, or group of securities, until recovery of the amortized cost, but sells or otherwise disposes the security or securities prior to such recovery, the reporting entity shall be prepared to justify this departure from their original assertion to examiners and auditors. SSAP No. 43R purposely does not identify specific circumstances in which a change in assertion would be justifiable, but requires judgment from management, examiners and auditors on whether future assertions warrant closer review.
- 4.4 Delaying recognition of other-than-temporary impairments is a cause of serious concern by the regulators, and entities that habitually delay such recognition through false assertions on the “intent and ability to hold” may face increased scrutiny and regulatory action by their domiciliary state. It is imperative that a reporting entity recognize the full other-than-temporary impairment as soon as the entity realizes that they will no longer be able to hold the security until recovery of the amortized cost basis. Greater scrutiny shall be placed on securities sold or otherwise disposed shortly after a financial statement reporting date if such securities had been excluded from the full other-than-temporary impairment recognition on the basis of the reporting entity’s intent and ability to hold.
- 4.5 As noted in paragraph 3.3 of this question and answer guide, once a security is classified as one for which there is an intent to sell, or for which there is not an intent and ability to hold, the security must continue to carry that assertion until the security is no longer held by the reporting entity.
- 5. Question** – How do contractual prepayments affect the determination of credit losses?
- 5.1 Paragraph 30 of SSAP No. 43R states that "A decrease in cash flows expected to be collected on asset-backed security that results from an increase in prepayments on the underlying assets shall be considered in the estimate of present value of cash flows expected to be collected." Paragraph 18 states that "Asset-backed securities shall be revalued using the currently estimated cash flows, including new prepayment assumptions. Reporting entities may utilize the prospective adjustment method for all asset-backed securities that are reported with NAIC designations that are of high credit at the of acquisition by the reporting entity."
- 6. Question** – Are the disclosure requirements within paragraphs 44.f. and 44.g. of SSAP No. 43R required to be completed for the current reporting quarter only, or as a year-to-date cumulative disclosure?
- 6.1 The disclosures should reflect the year-to-date other-than-temporary impairments. The “fair value” reported within the disclosure is intended to reflect the fair value at the date of

The Guidance in this Statement is Effective January 1, 2025

the other-than-temporary impairment and shall not be updated due to the fluctuations identified at subsequent reporting dates. If a security has more than one other-than-temporary impairment identified during a fiscal reporting year, the security shall be included on the disclosure listing separately for each identified other-than-temporary impairment. Notation shall be included in the disclosure identifying the other-than-temporary impairments that were recognized for each respective reporting period.

7. Question – If an impairment loss is recognized based on the "present value of projected cash flows" in one period is the entity required to get new cash flows every reporting period subsequent or just in the periods where there has been a significant change in the actual cash flows from projected cash flows?

7.1 The guidance in **paragraph 38** of SSAP No. 43R indicates that a reporting entity shall continue to estimate the present value of cash flows expected to be collected over the life of the asset-backed security. This guidance is explicit that the reporting entity shall continue to estimate the present value of cash flows expected to be collected over the life of the loan-backed or structured security.

7.2 As provided in paragraph 2.2 of this Q&A, if the entity does not want to assess cash flows of an impaired security (fair value is less than amortized cost), the entity can designate the security as one the entity intends to sell, or one that the entity does not have the intent and ability to hold, providing it is reflective of the true intent and assessment of the ability of the entity. Reporting entities subject to the requirements of AVR and IMR should allocate the impairment loss between AVR and IMR accordingly.

8. Question – Do ABS purchased in different lots result in a different NAIC designation for the same CUSIP? Can reporting entities use a weighted average method determined on a legal entity basis?

8.1 Under the financial modeling process (applicable to qualifying RMBS/CMBS reviewed by the NAIC Structured Securities Group), the amortized cost of the security impacts the "final" NAIC designation used for reporting and RBC purposes. As such, securities subject to the financial modeling process acquired in different lots can result in a different NAIC designation for the same CUSIP. In accordance with the current instructions for calculating AVR and IMR, reporting entities are required to keep track of the different lots separately, which means reporting the different designations. For reporting purposes, if a SSAP No. 43R security (by CUSIP) has different NAIC designations by lot, the reporting entity shall either 1) report the aggregate investment with the lowest applicable NAIC designation or 2) report the investment separately by purchase lot on the investment schedule. If reporting separately, the investment may be aggregated by NAIC designation. (For example, all acquisitions of the identical CUSIP resulting with an NAIC 1 designation may be aggregated, and all acquisitions of the identical CUSIP resulting with an NAIC 3 designation may be aggregated.)

9. Question – The NAIC Designation process for ABS subject to the financial modeling process may incorporate loss expectations that differ from the reporting entity's expectations related to OTTI conclusions. Should the reporting entities be required to incorporate recovery values obtained from data provided by the service provider used for the NAIC Designation process for impairment analysis as required by SSAP No. 43R?

9.1 In accordance with *INT 06-07: Definition of Phrase "Other Than Temporary,"* reporting entities are expected to "consider all available evidence" at their disposal, including the information that can be derived from the NAIC designation.

The Guidance in this Statement is Effective January 1, 2025

10. Question - For companies that have separate accounts, can the NAIC designation be assigned based upon the total legal entity or whether it needs to be calculated separately for the general account and the total separate account?

10.1 The financial modeling process for qualifying RMBS/CMBS securities is required for applicable securities held in either the general or separate account.

[https://naiconline.sharepoint.com/sites/NAICSupportStaffHub/Member Meetings/E CMTE/APPTF/2023-2 Summer/Summary and Minutes/SAPWG/Attachments/Att1P-2019-21 SSAP 43R.docx](https://naiconline.sharepoint.com/sites/NAICSupportStaffHub/Member%20Meetings/E%20CMTE/APPTF/2023-2%20Summer/Summary%20and%20Minutes/SAPWG/Attachments/Att1P-2019-21%20SSAP%2043R.docx)

The Revisions Shown in this Document are Effective January 1, 2025

Bond Definition - Revisions to other SSAPs Adopted Aug. 13, 2023

SSAP Reference Revisions

1. ***SSAP No. 2R—Cash, Cash Equivalents, Drafts and Short-Term Investments***

SSAP No. 26R: Updated reference in paragraph 18. No revisions needed to paragraph 7 or 15.

SSAP No. 43R: Adjusted title references in paragraphs 7 and 15.

2. ***SSAP No. 7—Asset Valuation Reserve and Interest Maintenance Reserve***

SSAP No. 43R: Adjusted reference in paragraph 3.

3. ***SSAP No. 15—Debt and Holding Company Obligations***

SSAP No. 26R: No revisions needed to paragraph 13.

4. ***SSAP No. 21—Other Admitted Assets***

SSAP No. 26R: Updated footnote 1 and clarified guidance for GICs in paragraphs 14-17.

SSAP No. 43R: Adjusted reference in paragraph 6 to asset-backed securities that qualify.

5. ***SSAP No. 36—Troubled Debt Restructuring***

SSAP No. 26R: No revisions needed to paragraph 29.

6. ***SSAP No. 43R—Asset-Backed Securities***

SSAP No. 26R: Updated disclosure reference that link to SSAP No. 26R, paragraph 51.m.

7. ***SSAP No. 86—Derivatives***

SSAP No. 26R and SSAP No. 43R: Updated the guidance for structured notes in paragraph 5.g. and replication (synthetic assets) in Footnote 5.

8. ***SSAP No. 95—Nonmonetary Transactions***

SSAP No. 26R: No revisions needed to paragraph 6.

SSAP No. 43R: Adjusted the citation to SSAP No. 43R in paragraph 6.

9. ***SSAP No. 100R—Fair Value***

SSAP No. 26R: No revisions needed to Footnote 3.

The Revisions Shown in this Document are Effective January 1, 2025

10. SSAP No. 103R—Transfers and Servicing of Financial Assets and Extinguishments of Liabilities

SSAP No. 43R: Revisions remove the direct pointer of beneficial interests as in scope of SSAP No. 43R and incorporate guidance for reporting under the applicable SSAP in paragraphs 2, 11 and 18.

11. INT 01-25: Accounting for U.S. Treasury Inflation-Indexed Securities

SSAP No. 26: No revisions needed.

12. 06-02: Accounting and Reporting for Investments in a Certified Capital Company (CAPCO)

SSAP No. 26: Updated paragraph reference in paragraph 5.a.

13. 06-07: Definition of Phrase “Other Than Temporary”

SSAP No. 26: No revisions needed.

SSAP No. 43R: Updated reference in list of applicable SSAPs.

14. INT 07-01: Application of the Scientific (Constant Yield) Method in Situations of Reverse Amortization

SSAP No. 26R: Removed quoted guidance.

SSAP No. 43R: Updated reference in list of applicable SSAPs and removed quoted guidance.

15. INT 19-02: Freddie Mac Single Security Initiative

SSAP No. 26R: No revisions needed.

SSAP No. 43R: Updated reference in list of applicable SSAPs and in paragraph 1.

16. INT 22-01: Freddie Mac When Issued K-Deal (WI Trust) Certificates

SSAP No. 43R: Updated reference in list of applicable SSAPs and in paragraph 1.

Summary of SAP Guidance Revisions

17. SSAP No. 2R—Cash, Cash Equivalents, Drafts and Short-Term Investments

Revisions preclude asset-backed securities that are in scope of SSAP No. 43R from being reported as cash equivalents or short-term investments. The revisions also identify items captured on Schedule BA as non-bond securities. (These revisions also add reference to working capital finance investments, but that is not new guidance, but was not explicitly stated in SSAP No. 2R.)

The Revisions Shown in this Document are Effective January 1, 2025

Summary of SAP Reference Revisions:

SSAP No. 2R—Cash, Cash Equivalents, Drafts and Short-Term Investments

7. Regardless of maturity date, related party or affiliated investments that would be in scope of *SSAP No. 26R—Bonds*, *SSAP No. 43R—~~Loan-Backed and Structured~~Asset-Backed Securities*, or that would be reported as “Other Invested Assets” shall be reported as long-term investments if any of the following conditions apply,¹ unless the reporting entity has re-underwritten the investment, maintained appropriate re-underwriting documentation, and each participating party had the ability to independently review the terms and can terminate the transaction prior to renewal.

- a. The reporting entity does not reasonably expect the investment to terminate on the maturity date. This provision includes investments that are expected to be renewed (or rolled) with a maturity date that ends subsequent to the initial 90-day timeframe.
- b. The investment was previously reported as a cash equivalent investment and the initial maturity timeframe has passed. If an investment is reported as a cash equivalent and it is unexpectedly renewed/rolled, the reporting entity is not permitted to continue to report the held security as a cash equivalent, regardless of the updated maturity date, and shall report the security as a long-term investment. An investment is only permitted to be reported as a cash equivalent for one quarter reporting period. Meaning, if an investment was reported as a cash equivalent in the first quarter, it is not permitted to be reported as a cash equivalent in the second quarter.
- c. The reporting entity reacquired the investment (or a substantially similar investment) within one year after the original security matured or was terminated. These reacquired securities shall be reported as long-term investments. (These securities are also not permitted to be reported as short-term investments, regardless of the maturity date of the reacquired investment.)

Footnote 1: Cash equivalents subject to the provisions of paragraph 7 are not permitted to be subsequently reported as short-term investments, even if the updated/reacquired maturity date is within one year. These investments shall be reported as long-term investments. To avoid changes in reporting schedules, reporting entities are permitted to report securities as long-term investments at initial acquisition, regardless of the initial maturity date.

15. Regardless of maturity date, related party or affiliated investments in scope of *SSAP No. 26R—Bonds*, *SSAP No. 43R—~~Loan-Backed and Structured~~Asset-Backed Securities*, or that would be reported as “Other Invested Assets” shall be reported as long-term investments if any of the following conditions apply,^{2, 3} unless the reporting entity has re-underwritten the investment, maintained appropriate re-underwriting documentation, and each participating party had the ability to independently review the terms and can terminate the transaction prior to renewal.

- a. The reporting entity does not reasonably expect the investment to terminate on the maturity date. This provision includes investments that are expected to be renewed (or rolled) with a maturity date that ends subsequent to the initial “less than one year” timeframe.
- b. The investment was previously reported as a short-term investment and the initial maturity timeframe has passed. If an investment is reported as a short-term investment and it is unexpectedly renewed/rolled, the reporting entity is not permitted to continue to report the held security as a short-term investment (or as a cash equivalent) regardless of the updated maturity date and shall report the security as a long-term investment. An investment is only permitted to be reported as a short-term investment for one annual reporting period.

The Revisions Shown in this Document are Effective January 1, 2025

Meaning, if an investment was reported as a short-term investment as of December 31, 2018, it is not permitted to be reported as short-term investment as of December 31, 2019.

- c. The reporting entity reacquired the investment (or a substantially similar investment) within one year after the original security matured or was terminated. These reacquired securities shall be reported as long-term investments. (These securities are also not permitted to be reported as cash equivalent investments regardless of the maturity date of the reacquired investment.)

Footnote 2: Reverse repurchase transactions are excluded from these provisions if admitted in accordance with collateral requirements pursuant to *SSAP No. 103R—Transfers and Servicing of Financial Assets and Extinguishments of Liabilities*.

Footnote 3: Short-term investments subject to the provisions of paragraph 15 are not permitted to be subsequently reported as cash equivalents, even if the updated/reacquired maturity date is within 90 days. These investments shall be reported as long-term investments. To avoid changes in reporting schedules, reporting entities are permitted to report securities as long-term investments at initial acquisition, regardless of the initial maturity date.

Disclosures

18. The following disclosures shall be made for short-term investments in the financial statements:
 - a. Fair values in accordance with *SSAP No. 100R—Fair Value*;
 - b. Concentrations of credit risk in accordance with *SSAP No. 27—Off-Balance-Sheet and Credit Risk Disclosures*;
 - c. Basis at which the short-term investments are stated.
 - d. The items in the scope of this statement are also subject to the annual audited disclosures in *SSAP No. 26R—Bonds*, paragraph ~~39.f.30.f.~~
 - e. Identification of cash equivalents (excluding money market mutual funds as detailed in paragraph 8) and short-term investments (or substantially similar investments), which remain on the same reporting schedule for more than one consecutive reporting period. This disclosure is satisfied by use of a designated code in the investment schedules of the statutory financial statements.

SSAP No. 7—Asset Valuation Reserve and Interest Maintenance Reserve

3. The IMR and AVR shall be calculated and reported as determined per guidance in the SSAP for the specific type of investment (e.g., SSAP No. 43R for ~~loan-backed and structured~~ asset-backed securities), or if not specifically stated in the respective SSAP, in accordance with the NAIC *Annual Statement Instructions* for Life and Accident and Health Insurance Companies.

SSAP No. 15—Debt and Holding Company Obligations - (No Changes)

13. Convertible debt securities and convertible preferred stock with beneficial conversion features are to be valued according to the appropriate statutory accounting statement; *SSAP No. 26R—Bonds* or *SSAP No. 32R—Preferred Stock*.

The Revisions Shown in this Document are Effective January 1, 2025

SSAP No. 21R—Other Admitted Assets

Collateral Loans

4. Collateral loans are unconditional obligations¹ for the payment of money secured by the pledge of an investment² and meet the definition of assets as defined in SSAP No. 4, and are admitted assets to the extent they conform to the requirements of this statement. The outstanding principal balance on the loan and any related accrued interest shall be recorded as an admitted asset subject to the following limitations:

Footnote 1: For purposes of determining a collateral loan in scope of this statement, a collateral loan does not include investments captured in scope of other statements. For example, *SSAP No. 26R—Bonds* includes securities [that qualify as issuer creditor obligations and SSAP No. 43—Asset-Backed Securities includes securities that qualify as asset-backed securities under the bond definition.](#) ~~(as defined in that statement) representing a creditor relationship whereby there is a fixed schedule for one or more future payments.~~ Investments captured in SSAP No. 26R [or SSAP No. 43R](#) that are also secured with collateral shall continue to be captured within scope of ~~SSAP No. 26R~~ [those statements](#).

Footnote 2: Investment defined as those assets listed in Section 3 of *Appendix A-001—Investments of Reporting Entities*.

6. A reporting entity that acquires (directly or indirectly) structured settlement payment rights³ through a factoring company, excluding securitizations [that qualify as asset-backed securities captured in scope of SSAP No. 43R](#), shall report the acquisition as follows:

- a. Period-certain (non-life contingent) structured settlement income streams shall be reported as other long-term invested assets⁴, and are admitted assets if the rights to the future payments from a structured settlement have been legally acquired in accordance with all state and federal requirements. If the structured settlement has not met all legal requirements, including the court-approved transfer from the original recipient, then the reporting entity shall recognize the appropriate excise tax obligation and the structured settlement shall be nonadmitted.
- b. Life-contingent structured settlement income streams shall be reported as other long-term invested assets on Schedule BA and shall be nonadmitted. (Nonadmittance is required regardless if the right to future payments has been legally transferred.)

Footnote 3: This guidance is specific to acquired structured settlement income streams (legal right to receive future payments from a structured settlement) and does not capture accounting and reporting guidance for the acquisition of any insurance product (e.g., life settlement, annuities, etc.).

Footnote 4: Reporting entities that hold qualifying structured settlement payment rights shall report the security on Schedule BA either as an “any other class of asset” or as a “fixed or variable interest rate investment with underlying characteristics of other fixed income instruments” if the structured settlement payment right qualifies for reporting within that reporting line (e.g., NAIC designation).

Guaranteed Investment Contracts

14. Guaranteed Investment Contracts (GICs) purchased for investment purposes meet the definition of assets as defined in SSAP No. 4, and are admitted assets to the extent they conform to the requirements of this statement. [This includes an investment in a GIC payment stream which can be created when an intermediary purchases individual GICs, pools them, and sells the rights to the payment stream.](#)

[15. GICs acquired in a security structure that qualify under the bond definition as an issuer obligation or asset-backed security shall follow the accounting guidance within SSAP No. 26R or SSAP No. 43R as applicable.](#)

The Revisions Shown in this Document are Effective January 1, 2025

~~15.16.~~ Purchases of GIC investments that do not meet the definition of a security, but for which all contractual rights and ownership of the GIC result in an investment similar to a corporate bond, shall be reported at amortized cost and accounted for in accordance with the guidance in SSAP No. 26R—Bonds included on Schedule BA: Other Long-Term Invested Assets. If, in accordance with SSAP No. 5R, it is probable that the carrying value of a GIC is not fully recoverable the investment shall be considered impaired. Accordingly, the cost basis of the investment shall be written down to the undiscounted estimated cash flows and the amount of the write down shall be accounted for as a realized loss. The new cost basis shall not be changed for subsequent recoveries in fair value.

~~16.— An investment in a GIC payment stream is created when an intermediary purchases individual GICs, pools them, and sells the rights to the payment stream. These investments shall be reported as other long-term invested assets and shall be carried at amortized cost.~~

~~17.— If, in accordance with SSAP No. 5R, it is probable that the carrying value of a GIC is not fully recoverable the investment shall be considered impaired. Accordingly, the cost basis of the investment shall be written down to the undiscounted estimated cash flows and the amount of the write down shall be accounted for as a capital loss. The new cost basis shall not be changed for subsequent recoveries in fair value.~~

SSAP No. 36—Troubled Debt Restructuring (No Changes)

29. Although FASB Statement No. 91, *Accounting for Nonrefundable Fees and Costs Associated with Originating or Acquiring Loans and Initial Direct Costs of Leases* (FAS 91) was rejected in SSAP No. 26R—Bonds, this statement is consistent with paragraph 14 of FAS No. 91.

SSAP No. 43R—Asset-Backed Securities**Disclosures**

51. In addition to the disclosures required for invested assets in general, the following disclosures regarding loan-backed and structured securities shall be made in the financial statements. Regardless of the allowances within paragraph 63 of the Preamble, the disclosures in paragraph 51.f., 51.g. and 51.h. of this statement are required in separate, distinct notes to the financial statements:

- m. The items in the scope of this statement are also subject to the annual audited disclosures in SSAP No. 26R—Bonds, paragraphs ~~39.e., 30.e., 39.f., 30.f.~~ and ~~39.g., 30.g.~~

SSAP No. 86—Derivatives

5. Derivative instruments include, but are not limited to; options, warrants used in a hedging transaction and not attached to another financial instrument, caps, floors, collars, swaps, forwards, futures, structured notes with risk of principal/original investment loss based on the terms of the agreement (in addition to default risk), and any other agreements or instruments substantially similar thereto or any series or combination thereof.

- g. ~~“Structured Notes” in scope of this statement are instruments defined in SSAP No. 26R—Bonds (often in the form of debt instruments),~~ in scope of this statement are instruments in which the amount of principal repayment or return of original investment is contingent on an underlying variable/interest⁵ where the terms of the agreement make it possible that the reporting entity could lose all or a portion of its original investment amount (for other than failure of the issuer to pay the contractual amounts due). ~~Structured notes that are~~

The Revisions Shown in this Document are Effective January 1, 2025

~~“mMortgage-referenced securities”~~ issued by a government sponsored enterprise in the form of credit-risk transfers where an issue security is tied to a referenced pool are mortgages are captured in *SSAP No. 43R—Loan-Backed and Structured Securities*.

Footnote 5 - ~~The “structured notes” captured within scope of this statement is specific to instruments in which the terms of the agreement make it possible that the reporting entity could lose all or a portion of its original investment amount (for other than failure of the issuer to pay the contractual amounts due).~~ These instruments incorporate both the credit risk of the issuer, as well as the risk of an underlying variable/interest (such as the performance of an equity index or the performance of an unrelated security). Securities that are labeled “principal-protected notes” are captured within scope of this statement if the “principal protection” involves only a portion of the principal and/or if the principal protection requires the reporting entity to meet qualifying conditions in order to be safeguarded from the risk of loss from the underlying linked variable. Securities that may have changing positive interest rates in response to a linked underlying variable or the passage of time, or that have the potential for increased principal repayments in response to a linked variable (such as U.S. Treasury Inflation-Indexed Securities) that do not incorporate risk of original investment/principal loss (outside of default risk) are not captured as structured notes in scope of this statement. A replication (synthetic asset) transaction addressed within this standard may reproduce the investment characteristics of an otherwise permissible investment that would not meet the principles-based bond definition (e.g., is distinct from a “structured note” as defined here); the admissibility, classification and measurement of a replication (synthetic asset) transaction are not preemptively determined by the principles-based bond definition, and should be evaluated in accordance with the guidance on replication (synthetic asset) transactions within this standard.

SSAP No. 95—Nonmonetary Transactions

6. Fair value of assets received or transferred in a nonreciprocal transfer shall be measured based on statutory accounting principles for the type of asset transferred. Accordingly, the value shall be determined in accordance with *SSAP No. 26R—Bonds*, *SSAP No. 30R—Unaffiliated Common Stock*, *SSAP No. 32R—Preferred Stock*, *SSAP No. 37—Mortgage Loans*, *SSAP No. 39—Reverse Mortgages*, *SSAP No. 40R—Real Estate Investments*, *SSAP No. 43R—~~Loan-Backed and Structured~~Asset-Backed Securities*, *SSAP No. 90—Impairment or Disposal of Real Estate Investments* or other applicable statements. The guidance provided in *SSAP No. 25* shall be followed in accounting for nonreciprocal transactions with affiliates and other related parties as defined in that statement.

SSAP No. 100—Fair Value (No Changes)

48. For each class of assets and liabilities measured and reported³ at fair value or NAV in the statement of financial position after initial recognition. The reporting entity shall determine appropriate classes of assets and liabilities in accordance with the annual statement instructions.

Footnote 3: The term “reported” is intended to reflect the measurement basis for which the asset or liability is classified within its underlying SSAP. For example, a bond with an NAIC designation of 2 is considered an amortized cost measurement and is not included within this disclosure even if the amortized cost and fair value measurement are the same. An example of when such a situation may occur includes a bond that is written down as other-than-temporarily impaired as of the date of financial position. The amortized cost of the bond after the recognition of the other-than-temporary impairment may agree to fair value, but under *SSAP No. 26R* this security is considered to still be reported at amortized cost.

SSAP No. 103R—Transfers and Servicing of Financial Assets and Extinguishments of Liabilities

2. This statement focuses on the issues of accounting for transfers and servicing of financial assets and extinguishments of liabilities. This statement establishes statutory accounting principles for transfers and servicing of financial assets, including asset securitizations and securitizations of policy acquisition costs, extinguishments of liabilities, repurchase agreements, repurchase financing and reverse repurchase agreements, including dollar repurchase and dollar reverse repurchase agreements that are consistent with the Statutory Accounting Principles Statement of Concepts and Statutory Hierarchy (Statement of Concepts). This statement discusses generalized situations. Facts and circumstances and specific contracts need to be considered carefully in applying this statement. Securitizations of nonfinancial assets are outside

The Revisions Shown in this Document are Effective January 1, 2025

the scope of this statement. Transfers of financial assets that are in substance real estate shall be accounted for in accordance with *SSAP No. 40R—Real Estate Investments*. Additionally, retained beneficial interests from the sale of ~~loan-backed or structured~~ asset-backed securities are to be accounted for in accordance with the statutory accounting statement that is applicable to the investment retained ~~with~~ SSAP No. 43R—Loan-Backed and Structured Securities, Revised. If the retained security does not qualify for reporting as a bond under the bond definition detailed in SSAP No. 26R, it shall be reported as a debt security that does not qualify as a bond in scope of SSAP No. 21R—Other Admitted Assets.

11. Upon completion of a transfer of an entire financial asset or a group of entire financial assets that satisfies the conditions to be accounted for as a sale (see paragraph 8), the transferor (seller) shall:
- a. Derecognize the transferred financial assets;
 - b. Recognize and initially measure at fair value servicing assets, servicing liabilities, and any other assets obtained (including a transferor's beneficial interest in the transferred financial assets) and liabilities incurred¹ in the sale (paragraphs 60 and 62-66).
 - c. For reporting entities required to maintain an Interest Maintenance Reserve (IMR), the accounting for realized and unrealized capital gains and losses shall be determined per the guidance in the SSAP for the specific type of investment ~~(e.g., SSAP No. 43R for loan-backed and structured securities)~~, or if not specifically stated in the related SSAP, in accordance with *SSAP No. 7—Asset Valuation Reserve and Interest Maintenance Reserve*. For reporting entities not required to maintain an IMR, realized capital gains and losses shall be reported as net realized capital gains or losses in the statement of income, and unrealized capital gains and losses shall be reported as net unrealized gains and losses in unassigned funds (surplus).

The transferee shall recognize all assets obtained and any liabilities incurred, and initially measure them at fair value.

Footnote 1: Some assets that might be obtained and liabilities that might be incurred include cash, put or call options that are held or written (for example, guarantee or recourse obligations), forward commitments (for example, commitments to deliver additional receivables during the revolving periods of some securitizations) and swaps (for example, provisions that convert interest rates from fixed to variable).

Financial Assets Subject to Prepayment

18. Financial assets, except for instruments that are within the scope of *SSAP No. 86—Derivatives*, that can contractually be prepaid or otherwise settled in such a way that the holder would not recover substantially all of its recorded investment shall be assessed in accordance with the bond definition captured in SSAP No. 26R—Bonds to determine appropriate accounting and reporting. Securities that do not qualify for bond reporting shall be captured as debt securities that do not qualify as bonds in scope of SSAP No. 21R—Other Admitted Assets. ~~subsequently measured in accordance with the statutory accounting statement that is applicable to the financial asset. subsequently measured like investments in debt securities and loan-backed and structured securities in accordance with SSAP No. 43R. Examples of such financial assets include, but are not limited to, interest-only strips, other beneficial interests, loans, or other receivables.~~

INT 01-25: Accounting for U.S. Treasury Inflation-Indexed Securities

- No Change – Applies to SSAP No. 26R.

The Revisions Shown in this Document are Effective January 1, 2025

INT 06-02: Accounting and Reporting for Investments in a Certified Capital Company (CAPCO)

5. For Issue 1, the Working Group came to a consensus that reporting entities should account and report for investments in CAPCO's consistent with the agreement structure within the guidance provided below:

- h. Investment in a debt instrument of a CAPCO shall be reported as a bond in accordance with the *Purposes and Procedures Manual of the NAIC Investment Analysis Office* and the designation assigned in the *NAIC Valuations of Securities* product prepared by the NAIC Securities Valuation Office (Valuations of Securities manual) as stated in SSAP No. 26R, paragraph ~~20~~¹¹.
- i. Investment in an equity interest of a CAPCO shall be reported as common stock and reported at fair value as stated in SSAP No. 30R, paragraph 8.
- j. Investment in preferred stock interest of a CAPCO shall be reported as preferred stock in accordance with the *Purposes and Procedures Manual of the NAIC Investment Analysis Office* and the designation assigned in the *NAIC Valuations of Securities* product prepared by the NAIC Securities Valuation Office (Valuations of Securities manual) as stated in SSAP No. 32R, paragraphs 19-22.
- k. Investment in a Joint Venture, Partnership and Limited Liability Company (LLC) shall be reported in accordance with SSAP No. 48, paragraphs 5-6. The reported value of the investment shall be decreased in proportion to the premium tax credits utilized.
- l. The tax credits shall be recognized as a reduction of the tax liabilities as they are utilized. Tax credits received are not to be included in investment income.

INT 06-07: Definition of Phrase "Other Than Temporary"

- Update interpreted SSAP list to reference to *SSAP No. 43R—Asset-Backed Securities*

INT 07-01: Application of the Scientific (Constant) Yield Method in Situations of Reverse Amortizations

1. SSAP No. 26R and SSAP No. 43R both reference the use of the scientific or constant yield method of amortization of a premium or a discount. ~~SSAP No. 26R—Bonds provides the following (bolding added for emphasis):~~

~~Amortized Cost~~

~~9. Amortization of bond premium or discount shall be calculated using the scientific (constant yield) interest method taking into consideration specified interest and principal provisions over the life of the bond. Bonds containing call provisions (where the issue can be called away from the reporting entity at the issuer's discretion) shall be amortized to the call or maturity value/date which produces the lowest asset value (yield to worst).~~

~~SSAP No. 43R—Loan-Backed and Structured Securities provides the following (bolding added for emphasis):~~

The Revisions Shown in this Document are Effective January 1, 2025

Amortization

~~8.— Amortization of premium or discount shall be calculated using the scientific (constant yield) interest method and shall be recorded as an adjustment to investment income. The interest method results in a constant effective yield equal to the prevailing rate at the time of purchase or at the time of subsequent adjustments to book value. The amortization period shall reflect estimates of the period over which repayment of principal of the loan-backed securities is expected to occur, not the stated maturity period.~~

Collection of All Contractual Cashflows is Probable

~~12.— The following guidance applies to loan-backed and structured securities for which it is probable that the investor will be able to collect all contractually required payments receivable. (Paragraphs 17-19 provide guidance for securities in which collection of all contractual cash flows is not probable and paragraphs 20-24 provide guidance for beneficial interests.) Prepayments are a significant variable element in the cash flow of loan-backed securities because they affect the yield and determine the expected maturity against which the yield is evaluated. Falling interest rates generate faster prepayment of the mortgages underlying the security, shortening its duration. This causes the reporting entity to reinvest assets sooner than expected at potentially less advantageous rates. This is called prepayment risk. Extension risk is created by rising interest rates which slow repayment and can significantly lengthen the duration of the security. Differences in cash flows can also result from other changes in the cash flows from the underlying assets. If assets are delinquent or otherwise not generating cash flow, which should be reflected in the cash flow analysis through diminishing security cash flows, even if assets have not been liquidated and gain/losses have not been booked.~~

~~13.— Changes in currently estimated cash flows, including the effect of prepayment assumptions, on loan-backed securities shall be reviewed periodically, at least quarterly. The prepayment rates of the underlying loans shall be used to determine prepayment assumptions. Prepayment assumptions shall be applied consistently across portfolios to all securities backed by similar collateral (similar with respect to coupon, issuer, and age of collateral). Reporting entities shall use consistent assumptions across portfolios for similar collateral within controlled-affiliated groups. Since each reporting entity may have a unique method for determining the prepayment assumptions, it is impractical to set standard assumptions for the industry. Relevant sources and rationale used to determine each prepayment assumption shall be documented by the reporting entity.~~

~~14.— Loan-backed securities shall be revalued using the currently estimated cash flows, including new prepayment assumptions, using either the prospective or retrospective adjustment methodologies, consistently applied by type of securities. However, if at any time during the holding period, the reporting entity determines it is no longer probable that they will collect all contractual cashflows, the reporting entity shall apply the accounting requirements in paragraphs 17-19.~~

~~15.— The prospective approach recognizes, through the recalculation of the **effective yield** to be applied to future periods, the effects of all cash flows whose amounts differ from those estimated earlier and the effects and changes in projected cash flows. Under the prospective method, the recalculated effective yield will equate the carrying amount of the investment to the present value of the anticipated future cash flows. The recalculated yield is then used to accrue income on the investment balance for subsequent accounting periods. There are no accounting changes in the current period unless the security is determined to be other than temporarily impaired.~~

~~16.— The retrospective methodology changes both the yield and the asset balance so that expected future cash flows produce a return on the investment equal to the return now expected over the life of the investment as measured from the date of acquisition. Under the retrospective method, the recalculated **effective yield** will equate the present value of the actual and anticipated cash flows with the original cost of the investment. The current balance is then increased or~~

The Revisions Shown in this Document are Effective January 1, 2025

~~decreased to the amount that would have resulted had the revised yield been applied since inception, and investment income is correspondingly decreased or increased.~~

2. This interpretation~~The following~~ identifies three situations where, using a constant yield methodology for determining amortization or accretion, changes in amortized value move in the opposite direction of what is expected. That is, if a security is purchased at a premium, the constant yield methodology will, in certain cases, cause the amortized value to move to a discount during the life of the security. Conversely, if the security were purchased at a discount, the constant yield methodology will, in certain cases, cause the amortized value to move to a premium during the life of the security.

INT 19-02: Freddie Mac Single Security Initiative

- Update interpreted SSAP list to reference to *SSAP No. 43R—Asset-Backed Securities*
 1. This interpretation has been issued to provide a limited-scope exception to the exchange and conversion guidance in *SSAP No. 26R—Bonds* as well as prescribe guidance in *SSAP No. 43R—Asset-Backed ~~Loan-Backed and Structured~~ Securities* (SSAP No. 43R) for instruments converted in accordance with the Freddie Mac Single Security Initiative. Under this initiative, reporting entities will be permitted to exchange “45-day securities” for “55-day securities” without any material change to the securities, or to the loans that back the securities. (With the exchange, there would be a 10-day delay in payment cycle.)

INT 22-01: Freddie Mac When Issued K-Deal (WI Trust) Certificates

- Update interpreted SSAP list to reference to *SSAP No. 43R—Asset-Backed Securities*
 1. This interpretation is to address questions on the accounting and reporting for Freddie Mac “When-Issued K-Deal (WI Trust) Certificates” (WI Program). Ultimately, the question is whether the structure should be initially captured in scope of *SSAP No. 43R—~~Loan-Backed and Structured~~Asset-Backed Securities* or as a forward contract in scope of *SSAP No. 86—Derivatives*.

Summary of SAP Guidance Revisions:***SSAP No. 2R—Cash, Cash Equivalents, Drafts and Short-Term Investments*****Cash Equivalents**

6. Cash equivalents are short-term, highly liquid investments that are both (a) readily convertible to known amounts of cash, and (b) so near their maturity that they present insignificant risk of changes in value because of changes in interest rates. Only investments with original maturities¹ of three months or less can qualify under this definition, with the exception of money market mutual funds, as detailed in paragraph 8, and cash pooling, as detailed in paragraph 9. Regardless of maturity date, the following investments are not permitted to be reported as cash equivalents and shall be reported on the investment schedule that corresponds to the SSAP for which the investment is applicable:

¹ Original maturity means original maturity to the entity holding the investment. For example, both a three-month U.S. Treasury bill and a three-year Treasury note purchased three months from maturity qualify as cash equivalents. However, a Treasury note purchased three years ago does not become a cash equivalent when its remaining maturity is three months.

The Revisions Shown in this Document are Effective January 1, 2025

- a. Asset-backed securities captured in scope of SSAP No. 43R.
- b. All debt securities that do not qualify as bonds which are in scope of SSAP No. 21R.
- ~~a.c. , d~~ Derivative instruments in scope of SSAP No. 86 or SSAP No. 108 shall not be reported as cash equivalents and shall be reported as derivatives on Schedule DB.
- d. Working capital finance investments in scope of SSAP No. 105R.
- ~~b.c.~~ Securities with terms that are reset at predefined dates (e.g., an auction-rate security that has a long-term maturity and an interest rate that is regularly reset through a Dutch auction) or have other features an investor may believe results in a different term than the related contractual maturity shall be accounted for based on the contractual maturity at the date of acquisition, except where other specific rules within the statutory accounting framework currently exist.

Short-Term Investments

14. Short-term investments are investments that do not qualify as cash equivalents with remaining maturities (or repurchase dates under reverse repurchase agreements) of one year or less at the time of acquisition. Short-term investments can include, but are not limited to bonds, commercial paper, reverse repurchase agreements, and collateral and mortgage loans which meet the noted criteria. Short-term investments shall not include investments specifically classified as cash equivalents as defined in this statement, certificates of deposit, or derivatives. Regardless of maturity date, the following investments are not permitted to be reported as cash equivalents and shall be reported on the investment schedule that corresponds to the SSAP for which the investment is applicable:

- a. Asset-backed securities captured in scope of SSAP No. 43R.
- b. All debt securities that do not qualify as bonds which are in scope of SSAP No. 21R.
- ~~c. , d~~ Derivative instruments in scope of SSAP No. 86 or SSAP No. 108 shall not be reported as short term investments and shall be reported as derivatives on Schedule DB.
- ~~a.d.~~ Working capital finance investments in scope of SSAP No. 105R.

https://naiconline.sharepoint.com/sites/naicsupportstaffhub/member_meetings/e_cmte/apptf/2023-2_summer/summary_and_minutes/sapwg/attachments/att1q-2019-21_other_ssap_changes.docx

**Statutory Accounting Principles (E) Working Group
Maintenance Agenda Submission Form
Form A**

Issue: Conceptual Framework – Updates

Check (applicable entity):

	P/C	Life	Health
Modification of Existing SSAP	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
New Issue or SSAP	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Interpretation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Description of Issue: In December 2021, the Financial Accounting Standards Board (FASB) issued two new chapters of its conceptual framework. The conceptual framework is a body of interrelated objectives and fundamentals that provides the FASB with a foundation for setting standards and concepts to consider when it resolves questions or develops/modifies accounting and reporting guidance.

It is important to note that the Statements of Financial Accounting Concepts are not authoritative and do not establish new or change existing U.S. GAAP. Per the FASB chair, these concepts are “a tool for the Board to use in setting standards that improve the understandability of information entities provide to existing and potential investors, lenders, donors, and other resource providers.”

This agenda item reviews and summarizes each of the two newly issued concept chapters and reviews their potential impact on statutory accounting. Again, while the conceptual framework statements are not authoritative, they are the guiding principles for standard setting and these new updates have superseded chapters currently referenced in the *Accounting Practices and Procedures Manual (AP&P Manual)*. In addition, and most notably, in the case of one of these chapters, FASB changed certain key fundamental definitions, specifically the definition of an asset and a liability, which have historically been mirrored by statutory accounting.

Update 1:

FASB Concepts Statement No. 8, *Conceptual Framework for Financial Reporting—Chapter 4, Elements of Financial Statements* introduced updated definitions of certain key elements used in financial reporting – the definition of an asset and liability. The chapter states that assets and liabilities have conceptual and definitional primacy because assets and liabilities (and changes in those elements) are foundational to all the other items reported in the financial statements. To correctly identify and represent an asset or liability is the beginning basis for all financial reporting and due to their importance, updates to both financial statement elements have been adopted. A summary of each, comparing the historical and current definitions, is provided below:

Changes regarding the definition of an ASSET:

- **Historical definition:** a probable future economic benefit obtained or controlled by a particular entity as a result of past transactions or events.
- **Historical Characteristics: Three essential characteristics:**
 1. it embodies a probable future benefit that involves a capacity, singly or in combination with other assets, to contribute directly or indirectly to future net cash inflows,
 2. a particular enterprise can obtain the benefit and control others' access to it, and
 3. the transaction or other event giving rise to the enterprise's right to or control of the benefit has already occurred.

- **New Definition:** a present right of an entity to an economic benefit.
- **Current Characteristics: Two essential characteristics:**
 1. it is a present right, and
 2. the right is to an economic benefit.

The combination of these two characteristics allows an entity to obtain the economic benefit and control others' access to the benefit. A present right of an entity to an economic benefit entitles the entity to the economic benefit and the ability to restrict others' access to the benefit to which the entity is entitled. For clarity, an "economic benefit" represents services or other items of economic value and generally result in net cash inflows to the entity.

Commentary regarding definitional changes:

The current definition of an asset no longer includes the term *probable* or the phrases *future economic benefit* and *past transactions or events*. The FASB concluded that the term *probable* has historically been misunderstood as implying that a future benefit must be probable to a certain threshold before the definition of an asset was met. Thus, if the probability of a future benefit was low, an asset could not be recognized. FASB also struck the phrase *future economic benefit* as this phrase often was interpreted that the asset must represent a certain future economic benefit (such as eventual cash inflows), however with this update, FASB clarified that the asset represents the rights to the benefit, not the actual benefit itself – nor the probability of realization.

Finally, FASB struck the phrase as the result of *past transactions or events*. It was concluded that if the asset represents a *present right*, by default, the right must have occurred as the result of a past transaction or event and thus this phraseology was deemed redundant and unnecessary.

Changes regarding **the definition of a LIABILITY:**

- **Historical definition:** are [certain or] probable future sacrifices of economic benefits arising from present obligations of a particular entity to transfer assets or provide services to other entities in the future as a result of past transactions or events.
- **Historical Characteristics: Three essential characteristics:**
 1. it embodies a present duty or responsibility to one or more other entities that entails settlement by probable future transfer or use of assets at a specified or determinable date, on occurrence of a specified event, or on demand,
 2. the duty or responsibility obligates a particular enterprise, leaving it little or no discretion to avoid the future sacrifice, and
 3. the transaction or other event obligating the enterprise has already happened.
- **New Definition:** a present obligation of an entity to transfer an economic benefit.
- **Current Characteristics: Two essential characteristics:**
 1. it is a present obligation, and
 2. the obligation requires an entity to transfer or otherwise provide economic benefit to others. (For the purposes of this characteristic, *transfer* is typically used to describe obligations to pay cash or convey assets, while the term *provide* is used to describe obligations to provide services or stand by to do so).

Commentary regarding definitional changes:

The current definition of a liability no longer includes the term *probable* or the phrase *in the future as a result of past transactions or events*. The FASB concluded that the term *probable* has historically been understood as implying that a future obligation must meet a probability to a certain threshold before the definition of a liability was met. Thus, if the probability of a future transfer of an asset (or the requirement to provide a service) was low, a liability would likely not be recognized. In removing the term *probable* (and replacing it with “present obligation”), FASB concluded that in almost all situations, the presence of an obligation will be apparent. It stated that most present obligations are legally enforceable, including obligations arising from binding contracts, agreements, statutes, or other legal or contractual means. Chapter 4 also discusses the prevalence of certain business risks and how to assess if they result in the recognition of a liability. It concluded that while certain businesses pose risk of future events occurring that will cause them to transfer an economic benefit (an asset), the risk itself does not represent a present obligation because exposure to a potential negative consequence does not constitute a present obligation.

However, FASB also stated situations lacking clear legal or contractual evidence of a present obligation may pose particular challenges that may make it difficult to discern whether a present obligation exists. In these settings, the FASB stated that constructive obligations or other noncontractual obligations are created by circumstance rather than by explicit agreement. In the absence of an explicit agreement, sufficient information to distinguish a present obligation is likely only available at the specific standards level. Thus, the FASB concluded that the specific facts and circumstances at the standards level (or in the case of statutory accounting, at the SAP level) must be utilized to determine whether the entity has created a constructive obligation and must recognize a liability.

FASB also struck the phrase as the result of *past transactions or events*. It was concluded that if the liability represents a *present right*, by default, the right must have occurred as the result of a past transaction or event and thus this phraseology was deemed redundant and unnecessary.

Update 2:

FASB Concepts Statement No. 8, *Conceptual Framework for Financial Reporting—Chapter 7, Presentation* identifies factors that the FASB will consider when deciding **how** items should be displayed on the financial statements. Chapter 7 describes the information to be included in the financial statements and how appropriate presentation can contribute to the objective of financial reporting – to communicate financial information about an entity that is useful to existing and potential investors, lenders, and other creditors in making decisions about providing resources (goods and services) to the entity. These decisions typically involve buying or selling of goods/services or holding equity and debt instruments as well as providing or settling loans or other forms of credit. This chapter articulates that the financial statements meet a “general purpose” and should not be considered to meet all purposes for possible users – and thus a common set of conceptual standards is appropriate.

Chapter 7 also describes the importance of financial statement notes, or supplementary information so that financial statement users are provided with a more complete picture of an entity’s accounting policy or any particular unique circumstance or event. In terms of general reporting, the conceptual statement relays that a distinction between nonhomogeneous items should be depicted in the financial statements with different reporting line items and subtotals and that the information should be provided based on recognition and measurement standards. In essence, reporting should be sufficiently aggregated, but not aggregated to a level in which the information is too consolidated for general use and understanding. Once reported, then any significant accounting policy or circumstance would further be defined with accompanying notes.

The chapter broadly states that to meet the objectives of financial reporting, line items should be distinct based on the information being provided – as the information should distinguish between various types of transactions/events

and should assist users in their estimates in the amounts and timing of future cash flows or the entity's ability to provide other economic value. The financial statements should depict the results of different types of transactions, including changes in events or other circumstances that may vary the frequency or predictability of performance based on many items, including changes in economic conditions.

In summary, while Chapter 7 does supersede sections of *Statement of Financial Accounting Concept 5*, it did not result in fundamental changes to the principal concepts of financial reporting. The chapter articulates the need for complete financial reporting, describes the interconnectedness of a 'complete set of financial statements' and relays the importance of these documents as the information in the financial statements is the primary (and typically the sole) source for analyzing current and potential future performance of an organization and its ability to meet its long-term financial objectives. At a high level, the chapter discusses what information should broadly be categorized as revenues, expenses, gains, and losses and to the extent equity is impacted by operations as well as changes in owners' equity through investments or distributions.

In terms of the impact to statutory accounting, the updated concepts in this chapter are not expected to modify current guidance, other than to update references to superseded accounting concepts.

Existing Authoritative Literature:

NAIC Staff Note – the Preamble contains reference to certain concept statements in footnotes 2 and 4 and have been bolded below for ease of identification. It is important to note that while these footnotes currently reference superseded conceptual statements, the conceptual statements noted do not represent adopted guidance - they are noted as reference for overarching guiding principles regarding financial reporting.

Preamble

IV. Statutory Accounting Principles Statement of Concepts

25. This document states the fundamental concepts on which statutory financial accounting and reporting standards are based. These concepts provide a framework to guide the National Association of Insurance Commissioners (NAIC) in the continued development and maintenance of statutory accounting principles ("SAP" or "statutory basis") and, as such, these concepts and principles constitute an accounting basis for the preparation and issuance of statutory financial statements by insurance companies in the absence of state statutes and/or regulations.

26. The NAIC and state insurance departments are primarily concerned with statutory accounting principles that differ from GAAP reflective of the varying objectives of regulation. Recodification of areas where SAP and GAAP are parallel is an inefficient use of limited resources.

27. SAP utilizes the framework established by GAAP. **FN2** This document integrates that framework with objectives exclusive to statutory accounting. The NAIC's guidance on SAP is comprehensive for those principles that differ from GAAP based on the concepts of statutory accounting outlined herein. Those GAAP pronouncements that are not applicable to insurance companies will not be adopted by the NAIC. For those principles that do not differ from GAAP, the NAIC must specifically adopt those GAAP Pronouncements to be included in statutory accounting. GAAP Pronouncements do not become part of SAP until and unless adopted by the NAIC.

28. The body of statutory accounting principles is prescribed in the statutory hierarchy of accounting guidance. This hierarchy provides the framework for judging the presentation of statutory financial statements in conformance with statutory accounting principles.

29. Statutory requirements vary from state to state. While it is desirable to minimize these variations, to the extent that they exist it is the objective of NAIC statutory accounting principles to provide the standard against which the exceptions will be measured and disclosed if material.

FN 2 - The GAAP framework applicable to insurance accounting is set forth in *Statements of Financial Accounting Concepts One, Two, Five, and Six*. These documents, promulgated by the Financial Accounting Standards Board, set forth the objectives and concepts which are used in developing accounting and reporting standards.

V. Statutory Hierarchy

42. The following Hierarchy is not intended to preempt state legislative and regulatory authority.

Level 1

SSAPs, including U.S. GAAP reference material to the extent adopted by the NAIC from the FASB Accounting Standards Codification (FASB Codification or GAAP guidance)

Level 2

Consensus positions of the Emerging Accounting Issues (E) Working Group as adopted by the NAIC (INTs adopted before 2016)

Interpretations of existing SSAPs as adopted by the Statutory Accounting Principles (E) Working Group (INTs adopted in 2016 or beyond)

Level 3

NAIC Annual Statement Instructions

Purposes and Procedures Manual of the NAIC Investment Analysis Office

Level 4

Statutory Accounting Principles Preamble and Statement of Concepts FN4

Level 5

Sources of nonauthoritative GAAP accounting guidance and literature, including: (a) practices that are widely recognized and prevalent either generally or in the industry, (b) FASB Concept Statements, (c) AICPA guidance not included in FASB Codification, (d) International Financial Reporting Standards, (e) Pronouncements of professional associations or regulatory agencies, (f) Technical Information Service Inquiries and Replies included in the AICPA Technical Practice Aids, and (g) Accounting textbooks, handbooks and articles

43. If the accounting treatment of a transaction or event is not specified by the SSAPs, preparers, regulators and auditors of statutory financial statements should consider whether the accounting treatment is specified by another source of established statutory accounting principles. If an established statutory accounting principle from one or more sources in Level 2 or 3 is relevant to the circumstances, the preparer, regulator or auditor should apply such principle. If there is a conflict between statutory accounting principles from one or more sources in Level 2 or 3, the preparer, regulator or auditor should follow the treatment specified by the source in the higher level—that is, follow Level 2 treatment over Level 3. Revisions to guidance in accordance with additions or revisions to the NAIC statutory hierarchy should be accounted for as a change in accounting principle in accordance with SSAP No. 3—*Accounting Changes and Corrections of Errors*.

44. Because of developments such as new legislation or the evolution of a new type of business transaction, there sometimes are no established statutory accounting principles for reporting a specific transaction or event. In those instances, it might be possible to report the event or transaction on the basis of its substance by selecting a statutory accounting principle that appears appropriate when applied in a manner similar to the application of an established statutory principle to an analogous transaction or event. In the absence of a SSAP or another source of established statutory accounting principles, the preparer, regulator or auditor of statutory financial statements may consider other accounting literature, depending on its relevance in the circumstances. Other accounting literature includes the Statutory Accounting Principles Statement of Concepts and GAAP reference material and accounting literature identified in Level 5. The appropriateness of other accounting literature depends on its relevance to the particular circumstances, the specificity of the guidance, and the general recognition of the issuer or author as an authority. For example, the Statutory Accounting Principles Statement of Concepts would be more authoritative than any other sources of accounting literature. Similarly, FASB Concepts Statements would normally be more influential than other sources of nonauthoritative GAAP pronouncements.

FN 4 - The Statutory Accounting Principles Statement of Concepts incorporates by reference FASB Concepts Statements One, Two, Five and Six to the extent they do not conflict with the concepts outlined in the statement. However, for purposes of applying this hierarchy the FASB Concepts Statements shall be included in Level 5 and only those concepts unique to statutory accounting as stated in the statement are included in Level 4.

SSAP No. 4—Assets and Nonadmitted Assets

NAIC Staff Note – this SAP contains the definition of the financial statement element of an **Asset**. Relevant items have been bolded below for ease of identification.

2. For purposes of statutory accounting, **an asset shall be defined as: probable future economic benefits obtained or controlled by a particular entity as a result of past transactions or events. An asset has three essential characteristics: (a) it embodies a probable future benefit that involves a capacity, singly or in combination with other assets, to contribute directly or indirectly to future net cash inflows, (b) a particular entity can obtain the benefit and control others' access to it, and (c) the transaction or other event giving rise to the entity's right to or control of the benefit has already occurred.** These assets shall then be evaluated to determine whether they are admitted. The criteria used is outlined in paragraph 3.

3. As stated in the Statement of Concepts, "The ability to meet policyholder obligations is predicated on the existence of readily marketable assets available when both current and future obligations are due. Assets having economic value other than those which can be used to fulfill policyholder obligations, or those assets which are unavailable due to encumbrances or other third-party interests should not be recognized on the balance sheet," and are, therefore, considered nonadmitted. For purposes of statutory accounting principles, a nonadmitted asset shall be defined as an asset meeting the criteria in paragraph 2, which is accorded limited or no value in statutory reporting, and is one which is:

- a. Specifically identified within the *Accounting Practices and Procedures Manual* as a nonadmitted asset; or
- b. Not specifically identified as an admitted asset within the *Accounting Practices and Procedures Manual*.

If an asset meets one of these criteria, the asset shall be reported as a nonadmitted asset and charged against surplus unless otherwise specifically addressed within the *Accounting Practices and Procedures Manual*. The asset shall be depreciated or amortized against net income as the estimated economic benefit expires. In accordance with the reporting entity's written capitalization policy, amounts less than a predefined threshold of furniture, fixtures, equipment, or supplies, shall be expensed when purchased.

4. Transactions which do not give rise to assets as defined in paragraph 2 shall be charged to operations in the period the transactions occur. Those transactions which result in amounts which may meet the definition of assets, but are specifically identified within the *Accounting Practices and Procedures Manual* as not giving rise to assets (e.g., policy acquisition costs), shall also be charged to operations in the period the transactions occur.

5. The reporting entity shall maintain a capitalization policy containing the predefined thresholds for each asset class to be made available for the department(s) of insurance.

FN1 - FASB Statement of Financial Accounting Concepts No. 6, Elements of Financial Statements, states: Probable is used with its usual general meaning, rather than in a specific accounting or technical sense (such as that in FASB Statement No. 5, Accounting for Contingencies, paragraph 3), and refers to that which can reasonably be expected or believed on the basis of available evidence or logic but is neither certain nor proved.

FN2 - If assets of an insurance entity are pledged or otherwise restricted by the action of a related party, the assets are not under the exclusive control of the insurance entity and are not available to satisfy policyholder obligations due to these encumbrances or other third-party interests. Thus, pursuant to paragraph 2(c), such assets shall not be recognized as an admitted asset on the balance sheet. Additional guidance for assets pledged as collateral is included in INT 01-31.

SSAP No. 5—Liabilities, Contingencies and Impairments of Assets

NAIC Staff Note – this SAP contains the definition of the financial statement element of a **Liability**. Relevant items have been bolded below for ease of identification.

2. A liability is defined as certain or probable FN1 future sacrifices of economic benefits arising from present obligations of a particular entity to transfer assets or to provide services to other entities in the future as a result of a past transaction(s) or event(s).

3. A liability has three essential characteristics: (a) it embodies a present duty or responsibility to one or more other entities that entails settlement by probable FN1 future transfer or use of assets at a specified or determinable date, on occurrence of a specified event, or on demand, (b) the duty or responsibility obligates a particular entity, leaving it little or no discretion to avoid the future sacrifice, and (c) the transaction or other event obligating the entity has already happened. This includes, but is not limited to, liabilities arising from policyholder obligations (e.g., policyholder benefits, reported claims and reserves for incurred but not reported claims). Liabilities shall be recorded on a reporting entity's financial statements when incurred.

4. Estimates (e.g., loss reserves) are required in financial statements for many ongoing and recurring activities of a reporting entity. The mere fact that an estimate is involved does not of itself constitute a loss contingency. For example, estimates of losses utilizing appropriate actuarial methodologies meet the definition of liabilities as outlined above and are not loss contingencies.

FN1 - FASB Statement of Financial Accounting Concepts No. 6, Elements of Financial Statements, states: Probable is used with its usual general meaning, rather than in a specific accounting or technical sense (such as that in FASB Statement 5, Accounting for Contingencies, paragraph 3), and refers to that which can reasonably be expected or believed on the basis of available evidence or logic but is neither certain nor proved.

Activity to Date (issues previously addressed by the Working Group, Emerging Accounting Issues (E) Working Group, SEC, FASB, other State Departments of Insurance or other NAIC groups): None.

Information or issues (included in *Description of Issue*) not previously contemplated by the Working Group:
None

Convergence with International Financial Reporting Standards (IFRS): While slightly different, the updated FASB asset & liability definitions closely align with IFRS definitions. While IFRS retains the phrase “as a result of past events,” it also explicitly retains the term “control,” which is now implicit with the FASB updates. The elimination of the explicit term “control” was a deliberate action of the FASB as they noted that the notion of control has been historically misunderstood (control is to the right that gives rise to the economic benefit rather than to the economic benefits themselves). For reference *IFRS Chapter 4 – The Elements of Financial Statements*, defines an **asset** as a present economic resource controlled by the entity as a result of past events; with the economic resource representing a right that has the potential to produce economic benefits. Additionally, the chapter defines a **liability** as a present obligation of an entity to transfer an economic resource as a result of past events.

Staff Recommendation: NAIC staff recommends that the Working Group move this item to the active listing, categorized as a SAP clarification, and expose revisions to the Preamble, *SSAP No. 4—Assets and Nonadmitted Assets* and *SSAP No. 5R—Liabilities, Contingencies and Impairment of Assets*, as illustrated below and in the issue papers, to incorporate updates from *Chapter 4, Elements of Financial Statements* and *Chapter 7, Presentation of the FASB’s Conceptual Framework for Financial Reporting*.

Proposed edits to the Preamble: proposed modifications reflect updates for superseded FASB Financial Accounting Concepts.

IV. Statutory Accounting Principles Statement of Concepts

25. This document states the fundamental concepts on which statutory financial accounting and reporting standards are based. These concepts provide a framework to guide the National Association of Insurance Commissioners (NAIC) in the continued development and maintenance of statutory accounting principles (“SAP” or “statutory basis”) and, as such, these concepts and principles constitute an accounting basis for the preparation and issuance of statutory financial statements by insurance companies in the absence of state statutes and/or regulations.

26. The NAIC and state insurance departments are primarily concerned with statutory accounting principles that differ from GAAP reflective of the varying objectives of regulation. Recodification of areas where SAP and GAAP are parallel is an inefficient use of limited resources.

27. SAP utilizes the framework established by GAAP. **FN2** This document integrates that framework with objectives exclusive to statutory accounting. The NAIC’s guidance on SAP is comprehensive for those principles that differ from GAAP based on the concepts of statutory accounting outlined herein. Those GAAP pronouncements that are not applicable to insurance companies will not be adopted by the NAIC. For those principles that do not differ from GAAP, the NAIC must specifically adopt those GAAP Pronouncements to be included in statutory accounting. GAAP Pronouncements do not become part of SAP until and unless adopted by the NAIC.

28. The body of statutory accounting principles is prescribed in the statutory hierarchy of accounting guidance. This hierarchy provides the framework for judging the presentation of statutory financial statements in conformance with statutory accounting principles.

29. Statutory requirements vary from state to state. While it is desirable to minimize these variations, to the extent that they exist it is the objective of NAIC statutory accounting principles to provide the standard against which the exceptions will be measured and disclosed if material.

FN 2 - The GAAP framework applicable to insurance accounting is set forth in *Statements of Financial Accounting Concepts ~~One, Two, Five, and Six~~Eight*. These documents, promulgated by the Financial Accounting Standards Board, set forth the objectives and concepts which are used in developing accounting and reporting standards.

V. Statutory Hierarchy

42. The following Hierarchy is not intended to preempt state legislative and regulatory authority.

Level 1

SSAPs, including U.S. GAAP reference material to the extent adopted by the NAIC from the FASB Accounting Standards Codification (FASB Codification or GAAP guidance)

Level 2

Consensus positions of the Emerging Accounting Issues (E) Working Group as adopted by the NAIC (INTs adopted before 2016)

Interpretations of existing SSAPs as adopted by the Statutory Accounting Principles (E) Working Group (INTs adopted in 2016 or beyond)

Level 3

NAIC Annual Statement Instructions

Purposes and Procedures Manual of the NAIC Investment Analysis Office

Level 4

*Statutory Accounting Principles Preamble and Statement of Concepts **FN4***

Level 5

Sources of nonauthoritative GAAP accounting guidance and literature, including: (a) practices that are widely recognized and prevalent either generally or in the industry, (b) FASB Concept Statements, (c) AICPA guidance not included in FASB Codification, (d) International Financial Reporting Standards, (e) Pronouncements of professional associations or regulatory agencies, (f) Technical Information Service Inquiries and Replies included in the AICPA Technical Practice Aids, and (g) Accounting textbooks, handbooks and articles

FN 4 - The Statutory Accounting Principles Statement of Concepts incorporates by reference FASB Concepts Statements ~~One, Two, Five and Six~~Eight to the extent they do not conflict with the concepts outlined in the statement. However, for purposes of applying this hierarchy the FASB Concepts Statements shall be included in Level 5 and only those concepts unique to statutory accounting as stated in the statement are included in Level 4.

Proposed edits SSAP No. 4—Assets and Nonadmitted Assets: proposed modifications reflect an updated definition of the term **Asset** – to match the newly issued definition in FASB Statement of Financial Accounting Concepts No. 8

2. For purposes of statutory accounting, an asset shall be defined as: [a present right of an entity to an economic benefit](#), ~~probable **FN1** future economic benefits obtained or controlled by a particular entity as a result of past transactions or events~~. An asset has ~~two~~three essential characteristics: (a) it [is a present right](#) ~~embodies a probable future benefit that involves a capacity, singly or in combination with other assets,~~

~~to contribute directly or indirectly to future net cash inflows, and (b) the right is to an economic benefit, a particular entity can obtain the benefit and control others' access to it **FN1 FN2**, and (c) the transaction or other event giving rise to the entity's right to or control of the benefit has already occurred.~~ These assets shall then be evaluated to determine whether they are admitted. The criteria used is outlined in paragraph 3.

3. As stated in the Statement of Concepts, "The ability to meet policyholder obligations is predicated on the existence of readily marketable assets available when both current and future obligations are due. Assets having economic value other than those which can be used to fulfill policyholder obligations, or those assets which are unavailable due to encumbrances or other third-party interests should not be recognized on the balance sheet," and are, therefore, considered nonadmitted. For purposes of statutory accounting principles, a nonadmitted asset shall be defined as an asset meeting the criteria in paragraph 2, which is accorded limited or no value in statutory reporting, and is one which is:

- a. Specifically identified within the *Accounting Practices and Procedures Manual* as a nonadmitted asset; or
- b. Not specifically identified as an admitted asset within the *Accounting Practices and Procedures Manual*.

If an asset meets one of these criteria, the asset shall be reported as a nonadmitted asset and charged against surplus unless otherwise specifically addressed within the *Accounting Practices and Procedures Manual*. The asset shall be depreciated or amortized against net income as the estimated economic benefit expires. In accordance with the reporting entity's written capitalization policy, amounts less than a predefined threshold of furniture, fixtures, equipment, or supplies, shall be expensed when purchased.

4. Transactions which do not give rise to assets as defined in paragraph 2 shall be charged to operations in the period the transactions occur. Those transactions which result in amounts which may meet the definition of assets, but are specifically identified within the *Accounting Practices and Procedures Manual* as not giving rise to assets (e.g., policy acquisition costs), shall also be charged to operations in the period the transactions occur.

5. The reporting entity shall maintain a capitalization policy containing the predefined thresholds for each asset class to be made available for the department(s) of insurance.

FN1 - *FASB Statement of Financial Accounting Concepts No. 86, Elements of Financial Statements*, states that the combination of these two characteristics allows an entity to obtain the economic benefit and control others' access to the benefit. A present right of an entity to an economic benefit entitles the entity to the economic benefit and the ability to restrict others' access to the benefit to which the entity is entitled. Probable is used with its usual general meaning, rather than in a specific accounting or technical sense (such as that in *FASB Statement No. 5, Accounting for Contingencies*, paragraph 3), and refers to that which can reasonably be expected or believed on the basis of available evidence or logic but is neither certain nor proved.

FN2 - If assets of an insurance entity are pledged or otherwise restricted by the action of a related party, the assets are not under the exclusive control of the insurance entity and are not available to satisfy policyholder obligations due to these encumbrances or other third-party interests. Thus, pursuant to paragraph 2(c), such assets shall not be recognized as an admitted asset on the balance sheet. Additional guidance for assets pledged as collateral is included in INT 01-31.

Relevant Literature

9. This statement incorporates the definition of an asset from ~~adopts~~ *FASB Statement of Financial Accounting Concepts No. 86, Chapter 4, Elements of Financial Statements*, paragraphs E16-E18~~25-33~~.

References**Relevant Issue Papers**

Issue Paper No. 4—Definition of Assets and Nonadmitted Assets

Issue Paper No. 119—Capitalization Policy, An Amendment to SSAP Nos. 4, 19, 29, 73, 79 and 82

Issue Paper No. 166—Updates to the Definition of an Asset

SSAP No. 5—Liabilities, Contingencies and Impairments of Assets: proposed modifications reflect an updated definition of the term **Liability** – to match the newly issued definition in FASB Statement of Financial Accounting Concepts No. 8

2. A liability is defined as a present obligation of an entity to transfer an economic benefit. ~~certain or probable FN1 future sacrifices of economic benefits arising from present obligations of a particular entity to transfer assets or to provide services to other entities in the future as a result of a past transaction(s) or event(s).~~

3. A liability has ~~three~~ two essential characteristics: (a) it is a present obligation ~~embodies a present duty or responsibility to one or more other entities that entails settlement by probable FN1 future transfer or use of assets at a specified or determinable date, on occurrence of a specified event, or on demand, and~~ (b) the obligation requires an entity to transfer or otherwise provide economic benefit to others ~~duty or responsibility obligates a particular entity, leaving it little or no discretion to avoid the future sacrifice, and~~ (c) ~~the transaction or other event obligating the entity has already happened.~~ This includes, but is not limited to, liabilities arising from policyholder obligations (e.g., policyholder benefits, reported claims and reserves for incurred but not reported claims). Liabilities shall be recorded on a reporting entity's financial statements when incurred.

4. Estimates (e.g., loss reserves) are required in financial statements for many ongoing and recurring activities of a reporting entity. The mere fact that an estimate is involved does not of itself constitute a loss contingency. For example, estimates of losses utilizing appropriate actuarial methodologies meet the definition of liabilities as outlined above and are not loss contingencies.

~~FN1—FASB Statement of Financial Accounting Concepts No. 6, Elements of Financial Statements, states: Probable is used with its usual general meaning, rather than in a specific accounting or technical sense (such as that in FASB Statement 5, Accounting for Contingencies, paragraph 3), and refers to that which can reasonably be expected or believed on the basis of available evidence or logic but is neither certain nor proved.~~

Relevant Literature

39. This statement adopts *FASB Statement No. 5, Accounting for Contingencies* (FAS 5), *FASB Statement 114, Accounting by Creditors for Impairment of a Loan* only as it amends in part FAS 5 ~~and paragraphs 35 and 36 of FASB Statement of Financial Accounting Concepts No. 6—Elements of Financial Statements~~. *FASB Interpretation No. 14, Reasonable Estimation of the Amount of a Loss, An Interpretation of FASB Statement No. 5* (FIN No. 14) is adopted with the modification to accrue the loss amount as the midpoint of the range rather than the minimum as discussed in paragraph 3 of FIN No. 14.

This statement adopts with modification ASU 2013-04, *Obligations Resulting from Joint and Several Liability Arrangements for Which the Total Amount of the Obligation is Fixed at the Reporting Date* with the same statutory modification adopted for FIN 14. [This statement incorporates the definition of a liability from FASB Statement of Financial Accounting Concepts No. 8, Chapter 4, Elements of Financial Statements, paragraphs E37 and E38.](#)

References

Relevant Issue Papers

Issue Paper No. 5—Definition of Liabilities, Loss Contingencies and Impairments of Assets

Issue Paper No. 20—Gain Contingencies

Issue Paper No. 135—Guarantor’s Accounting and Disclosure Requirements for Guarantees, Including Indirect Guarantees of Indebtedness of Others

[Issue Paper No. 166—Updates to the Definition of an Asset](#)

Recommendation:

NAIC staff recommends that the Working Group move this item to the active listing, categorized as a SAP clarification, and expose revisions to the Preamble, SSAP No. 4—Assets and Nonadmitted Assets and SSAP No. 5R—Liabilities, Contingencies and Impairment of Assets, as illustrated in the agenda item and in the draft issue papers, to incorporate updates from Chapter 4, Elements of Financial Statements and Chapter 7, Presentation of the FASB’s Conceptual Framework for Financial Reporting.

Staff Review Completed by: Jim Pinegar– NAIC Staff, January – 2022; Robin Marcotte, NAIC Staff, December – 2022

Status:

On April 4, 2022, the Statutory Accounting Principles (E) Working Group moved this agenda item to the active listing, categorized as a SAP clarification, and exposed revisions to the Preamble, SSAP No. 4—Assets and Nonadmitted Assets and SSAP No. 5R—Liabilities, Contingencies and Impairment of Assets to incorporate 1) updates from FASB Concepts Statement No. 8, *Conceptual Framework for Financial Reporting—Chapter 7, Presentation* which identifies factors to consider when deciding how items should be displayed on the financial statements, and 2) Concepts Statement No. 8, *Conceptual Framework for Financial Reporting—Chapter 4, Elements of Financial Statements*, which updates the definitions of an asset and a liability. The Working Group also exposed two draft issue papers for historical documentation of these SAP clarifications.

On August 10, 2022, the Statutory Accounting Principles (E) Working Group adopted, as final, the exposed revisions, as illustrated above, to the Preamble and SSAP No. 4—Assets and Nonadmitted Assets. The revisions incorporate updates from FASB Concepts Statement No. 8, *Conceptual Framework for Financial Reporting—Chapter 7, Presentation*, which identifies factors to consider when deciding how items should be displayed on the financial statements, and Concepts Statement No. 8, *Conceptual Framework for Financial Reporting—Chapter 4, Elements of Financial Statements*, which updates the definition of an asset. In addition, the Working Group adopted *Issue Paper No. 166—Updates to the Definition of an Asset*, which documents the revisions to SSAP No. 4.

Additionally, on August 10, 2022, the Working Group re-exposed the proposed revisions and draft issue paper related to the definition change of a liability in SSAP No. 5R—Liabilities, Contingencies and Impairment of Assets. This exposure intends to provide additional time for industry to review the changes in accordance with statutory accounting statements. These revisions are also shown above under the SSAP No. 5R heading.

On December 13, 2022, the Working Group re-exposed the proposed revisions and draft *Issue Paper No. 16X—Updates to the Definition of a Liability* related to the definition change of a liability in *SSAP No. 5R—Liabilities, Contingencies and Impairment of Assets*. This exposure intends to provide additional time for industry to review the changes in accordance with statutory accounting statements. NAIC staff were directed to collaborate with interested parties on proposed clarifying language.

On March 22, 2023, the Working Group exposed additional revisions to *Issue Paper No. 16X—Updates to the Definition of a Liability* related to the definition change of a liability in *SSAP No. 5R—Liabilities, Contingencies and Impairment of Assets*. The revisions to: 1) add an additional footnote to the definition of a liability in *SSAP No. 5R* which defers to more topic specific contradictory guidance 2) revise the relevant literature section of *SSAP No. 5R* to note the modification and 3) note the additional exposure action in the Issue Paper paragraph 18.

These clarifications were because of the authoritative treatment that statutory accounting provides to the definition of an asset and a liability in *SSAP No. 4* and *SSAP No. 5R*. For GAAP, the FASB Conceptual statements definitions are not authoritative, but rather are concepts to consider when developing and applying guidance. The FASB basis for conclusions noted that some existing authoritative FASB literature regarding liabilities is inconsistent with the updates to Concepts Statement No. 8. Therefore, a modification regarding topic specific liabilities guidance was incorporated to address variations from the definition of a liability. Examples of existing SAP variations from the definition of a liability include but are not limited to:

- a. *SSAP No. 7—Asset Valuation Reserves and Interest Maintenance Reserves – AVR and IMR* establish liabilities for regulatory objectives.
- b. *SSAP No. 62R—Property and Casualty Reinsurance* – contains the provision for reinsurance liability guidance which results in a liability that is a regulatory valuation allowance for overdue and slow paying reinsurance and also enforces Credit for Reinsurance (Model No. 785) collateral requirements.
- c. *SSAP No. 92—Post Retirement Benefits Other than Pensions*, provides liability recognition, which adopts several GAAP standards with modifications.

The additional exposed revisions to *SSAP No. 168* and *SSAP No. 5R* are reflected in the Issue Paper and also shown below.

- **Exposed revisions – Topic Specific Footnote** - This language is proposed for incorporation as a footnote to the liability definition in *SSAP No. 5R* and its related and *Issue Paper No. 16X—Updates to the Definition of a Liability*.

New Footnote to paragraph 3 of *SSAP No. 5R*:

The guidance in this Statement regarding the definition of a liability is applicable unless another authoritative statement of statutory accounting principles (SSAP) provides more topic specific contradictory guidance. In such cases the topic specific guidance shall apply.

- Exposed revisions to *SSAP No. 5R—Liabilities, Contingencies and Impairment of Assets* and *Issue Paper No. 16X—Updates to the Definition of a Liability* (New language shaded):

Relevant Literature

39. This statement adopts *FASB Statement No. 5, Accounting for Contingencies* (FAS 5), *FASB Statement 114, Accounting by Creditors for Impairment of a Loan* only as it amends in part FAS 5 and

~~paragraphs 35 and 36 of FASB Statement of Financial Accounting Concepts No. 6—Elements of Financial Statements.~~ FASB Interpretation No. 14, *Reasonable Estimation of the Amount of a Loss, An Interpretation of FASB Statement No. 5* (FIN No. 14) is adopted with the modification to accrue the loss amount as the midpoint of the range rather than the minimum as discussed in paragraph 3 of FIN No. 14. This statement adopts with modification ASU 2013-04, *Obligations Resulting from Joint and Several Liability Arrangements for Which the Total Amount of the Obligation is Fixed at the Reporting Date* with the same statutory modification adopted for FIN 14. This statement incorporates the definition of a liability from FASB Statement of Financial Accounting Concepts No. 8, Chapter 4, Elements of Financial Statements, paragraphs E37 and E38 with modification reflected in this Statement regarding topic specific guidance.

On August 13, 2023, the Statutory Accounting Principles (E) Working Group adopted, as final, the exposed revisions, as illustrated in *Issue Paper No. 168—Updates to the Definition of a Liability*, to the Preamble and SSAP No. 5R which revises the definition of a liability under statutory accounting.

[https://naiconline.sharepoint.com/sites/NAICSupportStaffHub/MemberMinutes/SAPWG/Attachments/-2022-01 SSAP 5R.docx](https://naiconline.sharepoint.com/sites/NAICSupportStaffHub/MemberMinutes/SAPWG/Attachments/-2022-01%20SSAP%205R.docx)

Meetings/E

CMTE/APPTF/2023-2

Summer/Summary

and

Statutory Issue Paper No. 168

Updates to the Definition of a Liability

STATUS

Finalized August 13, 2023

Original and Current Authoritative Guidance: SSAP No. 5R

Type of Issue:

Common Area

SUMMARY OF ISSUE

1. This issue paper documents the SAP clarification revisions to *SSAP No. 5R—Liabilities, Contingencies and Impairment of Assets*. The intent of the revisions is to align current statutory accounting guidance, specifically the definition of a “liability,” with the term utilized by the Financial Accounting Standards Board (FASB).

SUMMARY CONCLUSION

2. The statutory accounting principle clarifications to SSAP No. 5R (illustrated in Exhibit A), reflect that for the purposes of statutory accounting, a liability shall be defined as: a present obligation of an entity to transfer an economic benefit. A liability has two essential characteristics: (1) it is a present obligation, and (2) the obligation requires an entity to transfer or otherwise provide economic benefit to others. For the purposes of these characteristics, *transfer* is typically used to describe obligations to pay cash or convey assets, while the term *provide* is used to describe obligations to provide services or stand by to do so. This includes, but is not limited to, liabilities arising from policyholder obligations (e.g., policyholder benefits, reported claims and reserves for incurred but not reported claims). Liabilities shall be recorded on a reporting entity’s financial statements when incurred.

3. Estimates (e.g., loss reserves) are required in financial statements for many ongoing and recurring activities of a reporting entity. The mere fact that an estimate is involved does not of itself constitute a loss contingency. For example, estimates of losses utilizing appropriate actuarial methodologies meet the definition of liabilities as outlined above and are not loss contingencies. (The definition and recognition requirements of loss contingencies under SSAP No. 5R are not proposed to be revised and will continue as statutory accounting guidance.)

DISCUSSION

4. In December 2021, FASB issued *Concepts Statement No. 8, Conceptual Framework for Financial Reporting—Chapter 4, Elements of Financial Statements*, which introduced updated definitions of certain key elements used in financial reporting – most notably updating the fundamental definition of a liability. Through the FASB’s adoption of Concept Statement No. 8, the original Concept Statement No. 6 has been superseded. As statutory accounting currently reflects FASB’s historical definition, this issue paper is to review the prior concept definition (currently utilized by statutory accounting) and compare it to FASB’s updated concept definition and assess whether the revised concept definition shall be reflected in statutory accounting.

5. FASB concept statements do not reflect authoritative U.S. GAAP guidance. Rather concept statements are intended to set forth objectives and fundamental concepts that will be the basis for development of financial accounting and reporting guidance. The term “liability” is not captured or defined in the FASB Accounting Standards Codification (which is the source of authoritative U.S. GAAP.) Furthermore, although the concept statement is intended to be used as a guide in establishing authoritative U.S. GAAP, the FASB is not restricted to the concepts when developing guidance, and the FASB may issue U.S. GAAP which may be inconsistent with the

objectives and fundamental concepts set forth in Concept Statements. A change in a FASB Concept Statement does not 1) require a change in existing U.S. GAAP, 2) amend, modify or interpret the Accounting Standards Codification, or 3) justify either changing existing generally accepted accounting and reporting practices or interpreting the Accounting Standards Codification based on personal interpretations of the objectives and concepts in the concepts statement.

6. Under the prior FASB concept statement, which was reflected in SSAP No. 5R, a liability was defined as a probable future sacrifice of economic benefits arising from present obligations of a particular entity to transfer assets or to provide services to other entities in the future as a result of past transactions or events. In addition, the historical definition possessed three essential characteristics in that (1) it embodies a present duty or responsibility to one or more other entities that entails settlement by probable future transfer or use of assets at a specified or determinable date, on occurrence of a specified event, or on demand, (2) the duty or responsibility obligates a particular entity, leaving it little or no discretion to avoid the future sacrifice, and (3) the transaction or other event obligating the entity has already happened.

7. Pursuant to the prior concept statement, and as incorporated in SSAP No. 5R, *probable*, as referenced both in the definition and essential characters, was used in a usual general meaning, rather than in a specific accounting or technical sense and referred to which can reasonably be expected or believed on the basis of available evidence or logic but is neither certain nor proved.

8. With the new FASB conceptual framework chapter, a liability is now defined as a present obligation of an entity to transfer an economic benefit. In addition, the current definition has two essential characteristics in that the liability is (1) a present obligation, and (2) the obligation requires an entity to transfer or otherwise provide economic benefits to others.

9. The updated liability definition from Concept Statement No. 8 no longer includes the term *probable* or the phrase *in the future* and *as a result of past transactions or events*. The FASB concluded that the term *probable* has historically been misunderstood as implying that a future obligation must meet a probability to a certain threshold before the definition of a liability was met. Thus, if the probability of a future transfer of an asset (or the requirement to provide a service) was low, a liability would likely not be recognized. In removing the term *probable* (and replacing it with “present obligation”), FASB concluded that in almost all situations, the presence of an obligation will be apparent. It stated that most present obligations are legally enforceable, including obligations arising from binding contracts, agreements, statutes, or other legal or contractual means. Chapter 4 also discusses the prevalence of certain business risks and how to assess if they result in the recognition of a liability. The FASB concluded that while certain businesses have a risk that a future event will cause them to transfer an economic benefit (an asset), the risk itself does not represent a present obligation because exposure to a potential negative consequence does not constitute a present obligation.

10. However, the FASB also stated that situations lacking clear legal or contractual evidence of a present obligation may pose particular challenges that may make it difficult to discern whether a present obligation exists. In these settings, the FASB stated that constructive obligations or other noncontractual obligations are created by circumstance rather than by explicit agreement. In the absence of an explicit agreement, sufficient information to distinguish a present obligation is likely only available at the specific standards level. Thus, the FASB concluded that the specific facts and circumstances at the standards level (or in the case of statutory accounting, at the SSAP level) must be utilized to determine whether the entity has created a constructive obligation and must recognize a liability.

11. The FASB also struck the phrase *as the result of past transactions or events*. With this action, the FASB clarified that if the liability represents a *present obligation*, by default, the obligation must have occurred as the result of a past transaction or event and thus this phraseology was deemed redundant and unnecessary.

12. When reviewing the substance of the revisions, the FASB concluded that the updated definition resulted in a clearer and more precise definition. Furthermore, while it did not fundamentally change the historical concept of a liability, the revised definition potentially expands the population of liabilities to include certain obligations to issue or potentially issue an entity's own shares rather than settle an obligation exclusively with assets. In essence, clarifying that instruments with characteristics of both liabilities and equity may in fact be classified as liabilities in certain situations.

13. In general, the FASB did not anticipate that the liability definition revisions would result in any material changes in instrument reclassification (e.g., items now being classified as a liability when previously they were not considered liabilities). Again, FASB Concept Statements are not authoritative and thus the guidance in any specific standard will still be utilized for instrument measurement and classification. For statutory accounting purposes, the updated definition should be viewed similarly, that is it does not change fundamental concepts, change current practices, or introduce a new, original or a modified accounting principle. The revisions to the definition of a liability clarify the definitional language and do not modify the original intent of SSAP No. 5R and thus the changes are deemed to be a statutory accounting principle clarification.

14. The remaining concepts and guidance articulated in SSAP No. 5R (e.g., contingencies, impairments, guarantees, etc.) were not proposed for revision and thus are not further discussed in this issue paper.

Actions of the Statutory Accounting Principles (E) Working Group

15. During the 2022 Spring National Meeting, the Working Group exposed this issue paper for public comment.

16. During the 2022 Summer National Meeting, the Working Group re-exposed this issue paper for public comment.

17. At the 2022 Fall National Meeting, the Working Group re-exposed this issue paper related to the definition change of a liability in *SSAP No. 5R—Liabilities, Contingencies and Impairment of Assets*. This exposure intends to provide additional time for industry to review the changes in accordance with statutory accounting statements. NAIC staff were directed to collaborate with interested parties on proposed clarifying language.

18. At the 2023 Spring National Meeting, the Working Group exposed this issue paper with revisions to: 1) add an additional footnote to the definition of a liability in SSAP No. 5R which defers to more topic specific contradictory guidance and 2) revise the relevant literature section of SSAP No. 5R to note the modification. These clarifications were because of the authoritative treatment that statutory accounting provides to the definition of an asset and a liability in SSAP No. 4 and SSAP No. 5R. For U.S. GAAP, the FASB Conceptual statements definitions are not authoritative, but rather are concepts to consider when developing and applying guidance. The FASB basis for conclusions noted that some existing authoritative FASB literature regarding liabilities is inconsistent with the updates to Concepts Statement No. 8. Therefore, a modification regarding topic specific liabilities guidance was incorporated to address variations from the definition of a liability. Examples of existing SAP variations from the definition of a liability include but are not limited to:

- a. *SSAP No. 7—Asset Valuation Reserves and Interest Maintenance Reserves – AVR and IMR* establish liabilities for regulatory objectives.
- b. *SSAP No. 62R—Property and Casualty Reinsurance* – contains the provision for reinsurance liability guidance which results in a liability that is a regulatory valuation allowance for overdue and slow paying reinsurance and also enforces credit for reinsurance (*Credit for Reinsurance Model Law (#785)*) collateral requirements.

- c. *SSAP No. 92—Post Retirement Benefits Other than Pensions*, provides liability recognition, which adopts several U.S. GAAP standards with modifications.

19. At the 2023 Summer National Meeting, the Working Group adopted the exposed revisions to SSAP No. 5R as documented in this issue paper and adopted this issue paper.

RELEVANT STATUTORY ACCOUNTING AND GAAP GUIDANCE

Statutory Accounting

20. Relevant excerpts of SSAP No. 5R, paragraphs 2-3 regarding the definition of a liability accounting are as follows:

2. A liability is defined as certain or probable¹ future sacrifices of economic benefits arising from present obligations of a particular entity to transfer assets or to provide services to other entities in the future as a result of a past transaction(s) or event(s).

3. A liability has three essential characteristics: (a) it embodies a present duty or responsibility to one or more other entities that entails settlement by probable¹ future transfer or use of assets at a specified or determinable date, on occurrence of a specified event, or on demand, (b) the duty or responsibility obligates a particular entity, leaving it little or no discretion to avoid the future sacrifice, and (c) the transaction or other event obligating the entity has already happened. This includes, but is not limited to, liabilities arising from policyholder obligations (e.g., policyholder benefits, reported claims and reserves for incurred but not reported claims). Liabilities shall be recorded on a reporting entity's financial statements when incurred.

Generally Accepted Accounting Principles

21. Relevant paragraphs from *Concepts Statement No. 8, Conceptual Framework for Financial Reporting—Chapter 4, Elements of Financial Statements* have been included below:

Liabilities

E37. A liability is a present obligation of an entity to transfer an economic benefit

Characteristics of Liabilities

E38. A liability has the following two essential characteristics: a. It is a present obligation. b. The obligation requires an entity to transfer or otherwise provide economic benefits to others.²

E39. Liabilities commonly have features that help identify them. For example, many liabilities require the obligated entity to pay cash to one or more identified other entities. Liabilities may not require an entity to pay cash but may require the entity to convey other assets, provide services, or transfer other economic benefits or to be ready to do so. Liabilities are based on a foundation of legal rights and duties.

¹ *FASB Statement of Financial Accounting Concepts No. 6, Elements of Financial Statements*, states: Probable is used with its usual general meaning, rather than in a specific accounting or technical sense (such as that in *FASB Statement 5, Accounting for Contingencies*, paragraph 3), and refers to that which can reasonably be expected or believed on the basis of available evidence or logic but is neither certain nor proved.

² This chapter continues the practice of describing liabilities as an obligation either to transfer or to provide economic benefits. For example, the term transfer has typically been used to describe obligations to pay cash or convey assets, and the term provide has typically been used to describe obligations to perform services or stand ready to do so.

E40. Entities routinely incur liabilities in exchange transactions to acquire the funds, goods, and services they need to operate. For example, borrowing cash (acquiring funds) obligates an entity to repay the amount borrowed, acquiring assets on credit obligates an entity to pay for the assets, and selling products with a warranty or guarantee obligates an entity to either pay cash or repair or replace any products that prove defective. Often, obligations incurred in exchange transactions are contractual based on written or oral agreements to pay cash or to provide goods or services to specified or determinable entities on demand at specified or determinable dates or on the occurrence of specified events.

Present obligation

E41. A liability requires that an entity be obligated to perform or act in a certain manner. In most cases it is apparent that liabilities are legally enforceable. Legally enforceable obligations include those arising from binding contracts, agreements, rules, statutes, or other requirements that would be upheld by a judicial system or government. Judicial systems vary in type and form, and the term judicial systems includes any such system that would enforce laws, statutes, and regulations. In the context most relevant to financial reporting, an obligation is any condition that binds an entity to some performance or action. In a financial reporting context, something is binding on an entity if it requires performance. Performance is what the entity is required to do to satisfy the obligation.

E42. Many obligations that qualify as liabilities stem from contracts and other agreements that are enforceable by courts or from governmental actions that have the force of law. Agreements, contracts, or statutory requirements often will specify or imply how an obligation was incurred and when and how the obligation is to be settled. For example, borrowing and lease agreements specify the amount of charges and the dates when the payments are due. The absence of a specified maturity date or event to require settlement may cast doubt that an obligation exists.

E43. Liabilities necessarily involve other parties, society, or law. The identity of the other party or recipient need not be known to the obligated entity before the time of settlement. An obligation of an entity to itself cannot be a liability. For example, in the absence of external requirements an entity is not obligated to repair the roof of its building or maintain its plant and equipment. Although those actions may be wise business moves, the entity may forgo or defer such activities because there is no present obligation to perform the activity.

E44. Certain obligations require nonreciprocal transfers from an entity to one or more other entities. Such obligations include taxes imposed by governments, donations pledged to charitable entities, and cash dividends declared but not yet paid.

E45. To have a liability, an entity must have a present obligation, that is, the obligation exists at the financial statement date. The settlement date of the liability may occur in the future, but the obligation must be present at the financial statement date. Transactions or other events or circumstances expected to occur in the future do not in and of themselves give rise to obligations today.

E46. An intention to purchase an item, for example, an asset, does not in and of itself create a liability. However, a contractual obligation that requires an entity to pay more than the fair value of the asset at the transaction date may create a liability before the asset is received, reflecting what the entity might have to pay to undo the unfavorable contract.

E47. Business risks result from the conduct of an entity's business activities. A business risk is not a present obligation, though at some point in the future an event may occur that creates a present obligation. Some businesses have the potential of carrying out activities and creating present obligations as a result of those activities. However, no present obligation exists even if it is virtually certain that an obligating event will occur, though at present no such event has occurred. The essence of distinguishing business risks from liabilities is determining the point in time when an entity has a present obligation.

E48. Some business risks result from an entity's transactions, for example, selling goods in overseas markets might expose an entity to the risk of future cash flow fluctuations because of changes in foreign exchange rates. Other business risks result from an entity's operating environment, for example, operating in a highly specialized industry might expose an entity to the risk that it will be unable to attract sufficient skilled staff to sustain its operating activities. Those risks are not liabilities.

E49. To be presently obligated, an entity must be bound, either legally or in some other way, to perform or act in a certain way. Most liabilities are legally enforceable, including those arising from contracts, agreements, rules, and statutes. An entity also can become obligated by other means that would be expected to be upheld by a judicial process. However, the existence of a present obligation may be less clear in those circumstances.

E50. Some liabilities rest on constructive obligations, including some that arise in exchange transactions. A constructive obligation is created, inferred, or construed from the facts in a particular situation rather than contracted by agreement with another entity or imposed by government. An entity may become constructively obligated through customary business practice. In the normal course of business, an entity conducting certain activities may not create a clear contractual obligation but may nonetheless cause the entity to become presently obligated. For example, policies and practices for sales returns and those for warranties in the absence of a contract may create a present obligation because the pattern of behavior may create an enforceable claim for performance that would be upheld in the ultimate conclusion of a judiciary process.

E51. An entity's past behavior also may give rise to a present obligation. Repeated engagement in a certain behavior may obligate the entity to perform or act in a certain way on the basis of that pattern of behavior. For example, the entity may create a constructive obligation to employees for vacation pay or year-end bonuses by paying them every year even though it is not contractually bound to do so and has not announced a policy to do so.

22. The most notable changes regarding the definition of a liability included removal of the term *probable* and the phrase *as a result of past transactions or events*. Rationale for these changes were documented in *Chapter 4, Elements of Financial Statements* commentary as follows:

BC4.11. The definitions of both an asset and a liability in Concepts Statement 6 include the term *probable* and the phrases *future economic benefit* and *past transactions or events*. The term *probable* in the definitions in Concepts Statement 6 has been misunderstood as implying that a future economic benefit or a future sacrifice of economic benefit must be probable to a certain threshold before the definition of an asset or a liability is met. In other words, if the probability of future economic benefit is low, the asset definition is not met under that interpretation. A similar interpretation could be made for liabilities. The footnotes to the Concepts Statement 6 definition of assets and liabilities also were not helpful in clarifying the application of the term *probable* as used in the definitions of assets and liabilities. Accordingly, the Board decided to eliminate that term from the definitions of both assets and liabilities.

BC4.12. The term *future* in the definitions in Concepts Statement 6 focused on identifying a future flow of economic benefits to demonstrate that an asset exists or identifying a future transfer of economic benefits to demonstrate that a liability exists. The definitions in Concepts Statement 6 were often misunderstood as meaning that the asset (liability) is the ultimate future inflow (outflow). For example, in the instance of trade receivables, the definition in Concepts Statement 6 could be misunderstood to indicate that the asset is the successful collection of the receivable in the future. When applied appropriately, however, the definition would conclude that the asset is the present right to collection. Similar misunderstandings occurred in applying the liability definition. As a result, the Board concluded that a focus on the term *present* would appropriately shift the focus from identifying a future occurrence. Therefore, the Board decided to include the term *present right* to demonstrate that an asset exists and emphasize the term *present obligation* to demonstrate that a liability exists.

BC4.13. The definitions of assets and liabilities in Concepts Statement 6 both include the phrase past transactions or events. The Board concluded that if an entity has a present right or a present obligation, one can reasonably assume that it was obtained from some past transaction or event. Therefore, that phrase is considered redundant and has been eliminated from the definitions.

23. The other significant change to the definition of a liability included changing *future sacrifices* to a *present obligation*. Rationale for these changes were documented in *Chapter 4, Elements of Financial Statements* commentary as follows:

BC4.25. The term present obligation is included in the definition of a liability, both in this chapter and in Concepts Statement 6. Because the application of the liability definition under Concepts Statement 6 did not give sufficient emphasis to the term present obligation, the definition in this chapter more appropriately emphasizes that term. Assessing whether a present obligation exists is the primary criterion in the definition of a liability in this chapter. The primacy of the term present obligation is made more evident through the removal of many of the problematic terms in the definition of a liability in Concepts Statement 6, as discussed in paragraphs BC4.11–BC4.13.

BC4.26. Almost always, the existence of a present obligation will be apparent. Most present obligations are legally enforceable, including obligations arising from binding contracts, agreements, statutes, or other legal or contractual means. However, situations lacking clear legal or contractual evidence of a present obligation pose particular challenges that may make it difficult to discern whether a present obligation exists.

BC4.27. Determining when a present obligation exists has caused confusion with the existence of business risks. Business risks result from the nature of the business and where, when, and how an entity conducts its business. While certain businesses pose risks of future events occurring that will cause a transfer of economic benefits, the Board decided that the risks themselves are not present obligations because exposure to a potential negative consequence does not constitute a present obligation. Rather than viewing all business risks as liabilities, the Board decided that an entity has a present obligation only after an event occurs that demonstrates that the inherent business risk has created a present obligation. Thus, distinguishing when a business risk makes an entity presently obligated requires analysis of the facts and circumstances at the standards level.

BC4.28. Determining the existence of a present obligation is particularly challenging in evaluating constructive obligations. Interpreting constructive obligations too narrowly will tend to exclude significant actual obligations of an entity, while interpreting them too broadly will effectively nullify the definition by including items that lack an essential characteristic of liabilities.

BC4.29. Given that constructive obligations and other noncontractual obligations are created by circumstance rather than explicit agreement, it can be unclear whether a present obligation exists. In the absence of an explicit agreement, sufficient information to distinguish a present obligation is likely only available at the specific standards level. Thus, the Board decided that specific facts and circumstances at the standards level must be assessed to determine whether an entity has created a constructive obligation.

RELEVANT LITERATURE

Statutory Accounting

- Statutory Accounting Principles Statement of Concepts and Statutory Hierarchy

Generally Accepted Accounting Principles

- FASB Statement of Financial Accounting Concepts No. 8, Conceptual Framework for Financial Reporting – Chapter 4, Elements of Financial Statements

Effective Date

24. As issue papers are not authoritative and are not represented in the Statutory Hierarchy (see Section V of the Preamble), the consideration and adoption of this issue paper will not have any impact on the SAP clarifications adopted to SSAP No. 5R by the Working Group on August 13, 2023.

EXHIBIT A – SAP Clarification Revisions to SSAP No. 5R—Liabilities, Contingencies and Impairments of Assets the other paragraphs of SSAP No. 5R are unchanged.

Statement of Statutory Accounting Principles No. 5 - Revised**Liabilities, Contingencies and Impairments of Assets**

SCOPE OF STATEMENT

1. This statement defines and establishes statutory accounting principles for liabilities, contingencies and impairments of assets.

SUMMARY CONCLUSION**Liabilities**

2. A liability is defined as a present obligation of an entity to transfer an economic benefit. ~~certain or probable FNI future sacrifices of economic benefits arising from present obligations of a particular entity to transfer assets or to provide services to other entities in the future as a result of a past transaction(s) or event(s).~~

3. A liability¹ has ~~three~~ two essential characteristics: (a) it is a present obligation ~~embodies a present duty or responsibility to one or more other entities that entails settlement by probable FNI future transfer or use of assets at a specified or determinable date, on occurrence of a specified event, or on demand, and~~ (b) the obligation required an entity to transfer or otherwise provide economic benefit to others ~~duty or responsibility obligates a particular entity, leaving it little or no discretion to avoid the future sacrifice, and~~ (c) ~~the transaction or other event obligating the entity has already happened~~. This includes, but is not limited to, liabilities arising from policyholder obligations (e.g., policyholder benefits, reported claims and reserves for incurred but not reported claims). Liabilities shall be recorded on a reporting entity's financial statements when incurred.

4. Estimates (e.g., loss reserves) are required in financial statements for many ongoing and recurring activities of a reporting entity. The mere fact that an estimate is involved does not of itself constitute a loss contingency. For example, estimates of losses utilizing appropriate actuarial methodologies meet the definition of liabilities as outlined above and are not loss contingencies.

¹ The guidance in this statement regarding the definition of a liability is applicable unless another authoritative statement of statutory accounting principles (SSAP) provides more topic specific contradictory guidance. In such cases the topic specific guidance shall apply.

~~FN1—FASB Statement of Financial Accounting Concepts No. 6, Elements of Financial Statements, states: Probable is used with its usual general meaning, rather than in a specific accounting or technical sense (such as that in FASB Statement 5, Accounting for Contingencies, paragraph 3), and refers to that which can reasonably be expected or believed on the basis of available evidence or logic but is neither certain nor proved.~~

Relevant Literature

39. This statement adopts *FASB Statement No. 5, Accounting for Contingencies* (FAS 5), *FASB Statement 114, Accounting by Creditors for Impairment of a Loan* only as it amends in part FAS 5 ~~and paragraphs 35 and 36 of FASB Statement of Financial Accounting Concepts No. 6—Elements of Financial Statements~~. *FASB Interpretation No. 14, Reasonable Estimation of the Amount of a Loss, An Interpretation of FASB Statement No. 5* (FIN No. 14) is adopted with the modification to accrue the loss amount as the midpoint of the range rather than the minimum as discussed in paragraph 3 of FIN No. 14. This statement adopts with modification *ASU 2013-04, Obligations Resulting from Joint and Several Liability Arrangements for Which the Total Amount of the Obligation is Fixed at the Reporting Date* with the same statutory modification adopted for FIN 14. [This statement incorporates the definition of a liability from FASB Statement of Financial Accounting Concepts No. 8, Chapter 4, Elements of Financial Statements, paragraphs E37 and E38 with modification reflected in this Statement regarding topic specific guidance.](#)

REFERENCES

Relevant Issue Papers

- *Issue Paper No. 5—Definition of Liabilities, Loss Contingencies and Impairments of Assets*
- *Issue Paper No. 20—Gain Contingencies*
- *Issue Paper No. 135—Guarantor’s Accounting and Disclosure Requirements for Guarantees, Including Indirect Guarantees of Indebtedness of Others*
- [Issue Paper No. 168—Updates to the Definition of a Liability](#)

[https://naiconline.sharepoint.com/sites/NAICSupportStaffHub/Member Meetings/E CMTE/APPTF/2023-2 Summer/Summary and Minutes/SAPWG/Attachments/ IP 168.docx](https://naiconline.sharepoint.com/sites/NAICSupportStaffHub/Member%20Meetings/E%20CMTE/APPTF/2023-2%20Summer/Summary%20and%20Minutes/SAPWG/Attachments/IP%20168.docx)

**Statutory Accounting Principles (E) Working Group
 Maintenance Agenda Submission Form
 Form A**

Issue: Negative IMR

Check (applicable entity):

	P/C	Life	Health
Modification of Existing SSAP	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
New Issue or SSAP	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Interpretation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Description of Issue: This agenda item has been developed to discuss the interest maintenance reserve (IMR) within statutory accounting, specifically the current guidance for the nonadmittance of disallowed negative IMR. Although the statutory accounting guidance has been in place for several years, the rising interest rate environment has created an increased likelihood for reporting entities to move to a negative IMR position. This agenda item intends to provide information on the background of IMR, current accounting guidance, recent discussions of the Life Actuarial (A) Task Force and some broad financial results from year-end 2021 and interim 2022 financial statements. The intent is to provide this information to facilitate Working Group discussion.

The following provides a high-level overview of the use of the terms positive IMR and negative IMR for entities filing the Life, Accident & Health / Fraternal annual statement blank:

- A positive IMR means that the net realized interest related gains which are amortized in the IMR calculation are greater than net realized interest related losses which are being amortized in the IMR calculation. A positive IMR is reported as a statutory liability and amortized to income over time.
- A negative IMR means that net realized interest related losses which are amortized in the IMR calculation are greater than net realized interested related gains which are amortized in the IMR calculation. A disallowed negative IMR is reported as a nonadmitted asset and amortized to income as a loss over time.

As IMR occurs in the general and separate account, there are specific guidelines in determining whether the IMR reflects a net disallowed negative or position in the annual statement instructions. These are on page 5.

A letter from the American Council of Life Insurers (ACLI) dated Oct. 31, 2022, raised concerns with existing statutory accounting requirements on the nonadmittance of disallowed negative IMR noting negative ramifications for insurers. Key summarized positions from this ACLI letter include:

- In general, rising interest rates are favorable to the financial health of the insurance industry and policyholders. However, with negative IMR, there is an inappropriate perception of decreased financial strength through lower surplus and risk-based capital.
- Negative IMR could impact the rating agency view of the industry or incentivize companies to avoid prudent investment transactions that are necessary to avoid mismatches between assets and liabilities. In either scenario, negative IMR encourages short-term non-economic activity that is not in the best long-term interest of a reporting entity’s financial health or its policyholders.

Background of IMR

The IMR was first effective in statutory accounting in 1992 and requires that a realized fixed income gains or losses attributable to changes in interest rates (excluding gains/losses that are credit related), be amortized into income over the remaining term to maturity of the fixed-income investments (and related hedging programs) sold rather than being reflected in income immediately.

Minutes, including adopted materials – in the Blue Book (Life Statement), from the 2002 4th Quarter NAIC Proceedings discussing IMR are provided below. Please note the last section that includes “Future Directions” which identifies recognition of negative IMR as a major area of effort.

Description and other components of IMR from the Blue Book, captured in the 2002 4th Quarter NAIC Proceedings, provides the following definition and other details: (*Only key excerpts included.*)

The Interest Maintenance Reserve (IMR): captures for all types of fixed income investments, all of the realized capital gains and losses which result from changes in the overall level of interest rates as they occur. Once captured, these capital gains or losses are amortized into income over the remaining life (period to maturity) of the investments sold. Realized gains and losses on derivative investments, which alter the interest rate characteristics of assets/liabilities, also are allocated to the IMR and are to be amortized into income over the life of the associated assets/liabilities. Note: certain significant unusual transactions may require immediate recognition of any realized capital gains or losses, as described in a later section. This reserve is not subject to any maximum.

VII. IMR MINIMUMS/MAXIMUMS: A. Minimums: **The IMR can be negative for any line of business as long as the aggregate IMR for the Company is not less than zero. Any otherwise negative IMR value is carried over to subsequent years.** B. Maximums: There is no maximum of the IMR

VIII. BACKGROUND/PERSPECTIVE: To insure solvency of a company, its assets should be invested so that the company has a very high probability of paying its contractual liabilities when they become due. In order to assess whether a company is able to fulfill its obligations, it must present its liabilities and assets on a financially integrated basis. Since the accounting practices prescribed for the life insurance annual statement are an important element in this discipline, it is imperative that the accounting practices be consistent for assets and liabilities. If they are inconsistent, then the annual statement will not reveal whether assets exceed liabilities; more importantly, neither regulators nor management can determine the risk of insolvency for the company.

The Valuation Actuary’s Opinion includes a statement that the assets backing the liabilities make adequate provision for the company’s liabilities. That is, the Actuary must look beyond the statutory valuation formulas and satisfy himself that the cash flows generated by the assets will probably be sufficient to discharge the liabilities. Prior to the AVR and IMR, there were many circumstances under which the statutory formula valuation methods gave rise to inappropriate results. Some examples were:

- Changes in values due to interest rate swings were recognized inconsistently on the asset and liability sides of the balance sheet. Liabilities are valued using interest rates fixed at issue while some assets may be valued using current interest rates through trading activity.
- When the assets are poorly matched to the liabilities, a significant adverse swing in the interest rates will reduce financial strength and could lead to insolvency even though the balance sheet value of the assets exceeds the balance sheet value of the liabilities. Using long term assets to back demand liabilities is dangerous if there is a significant upswing in interest rates. In addition, individual insurance premiums are received and invested for many years after the issue date on which the reserve interest rate is determined, creating a potential for inadequate yields that is not reflected in standard accounting procedures.

- The potential for future asset losses was not well reflected in the balance sheet or earnings statement.

It is desirable that the valuation of the assets and liabilities be made as consistent as possible to 1) minimize the instances where, in order to render a clean opinion, the actuary must establish extra reserves due to interest rate gains or potential for defaults and 2) increase the likelihood that assets supporting liabilities are sufficient even in the absence of an Actuarial Opinion. The development of an AVR and IMR will correct many of these deficiencies in consistency.

XII. AVR AND IMR BUILT ON AND COMPLEMENT EXISTING VALUATION PRACTICES: The existing framework of asset and liability valuation practices, as augmented by the NAIC Model Standard Valuation Law, played a key role in designing the AVR and IMR, including:

A. Reserve valuation standards should contain a provision for future losses. Although it is well understood that in cash flow testing provision must be made for future asset losses, it may not be as well understood that historically the minimum valuation standards implicitly contained such a provision.

B. Interest assumptions in reserve valuation generally recognize the potential for mismatch. Dynamic valuation rates are lower for ordinary life than for guaranteed investment contracts, for example, because the mismatch is almost inevitable on the former. In addition, it is required in other regulations, and in the NAIC Model Standard Valuation Law, that cash flow testing should be used and may result in the adoption of lower than the dynamic valuation rates if mismatch exists. Hence, with the one exception noted in section (c), there is no need for the IMR reserves to make provision for the risk of mismatch.

C. Asset valuations for fixed interest securities usually reflect the outlook at the time of purchase of an asset. In particular, bond amortization tends to reflect the yields available at time of purchase and the expected cash flow. Liabilities are established at the same time, and the interest rate assumptions on them are those appropriate to the outlook at that time. **But if securities are traded, a new amortization schedule is established that may be based on an entirely different yield environment, which may not be consistent with the liabilities that have been established. Using the IMR to absorb trading gains is desirable and appropriate to eliminate this subsequently created mismatch.**

D. Equities present special valuation problems. Common stocks are valued at market rather than amortized value; hence they require different treatment. Real estate and similar investments, although usually valued at depreciated value, require special consideration because of the great likelihood of major changes in yield and yield expectation after purchase.

XXII. RESERVE MAXIMUM AND MINIMUM LEVELS: No maximum is placed on the Interest Maintenance Reserve. The aggregate minimum value for the IMR for the Company is zero. The IMR may be negative for any Line of Business as long as the aggregate for all lines equals zero. Provision is made in the accounting rules that if an aggregate negative IMR is developed in the absence of the zero minimum, that negative value is carried over to subsequent years.

The basic rationale for the IMR would conclude that neither a maximum nor a minimum is appropriate. If the liability values are based on the assumption that the assets were purchased at about the same time as the liabilities were established, then there should be no bounds to the reserve which corrects for departures from that assumption; if a company has to set up a large reserve because of trading gains, it is in no worse position than if it had held the original assets. As for negative values of the IMR, the same rationale applies. However, the concept of a negative reserve in the aggregate has not been adopted.

XXVIII. EXCESSIVE WITHDRAWALS:

- A. Background: Major book-value withdrawals or increases in policy loans can occur at a time of elevated interest rates. If these withdrawals or increases are far in excess of the withdrawals provided for in the company's reserving and cash flow testing, and **if asset sales at this point are, in effect, forced sales to fund liabilities that are no longer on the books, the allocation of a negative amount to the IMR is not correct.**

A company may also experience a "run on the bank" due to adverse publicity. This could occur even during a period of low interest rates, and the sale of assets to meet a run would conceivably produce gains. It is appropriate to register the gains immediately.

If the withdrawals were scheduled payments under a GIC, then there is a presumption that any gains or losses that might occur at the time of withdrawal should be added to the IMR since the gains or losses would be spurious if the company has followed a policy of matching its assets to its liabilities. Note that many of the situations where an upsurge in withdrawal activity generates real losses arise when a company has a severe mismatch between its assets and its liabilities. Such losses can be present even in the absence of any realized gains or losses. The primary protection as to the adequacy of reserves in these circumstances is the requirement for an actuary's opinion.

- B. IMR Exclusions: All realized interest-related gains or losses which arise from the sale of investments required to meet "Excess Withdrawal Activity" as defined below will be excluded from the IMR and will be reflected in net income.

STANDARDS FOR ACTUARIAL RESERVES WITH AN IMR AND AN AVR

LXX. IMR RESERVE STANDARD The Interest Maintenance Reserve is a true actuarial reserve, and actuaries should use the assets supporting the Interest Maintenance Reserve when opining that the assets supporting the company's reserves make adequate provision for the company's obligations. **In the case of a negative IMR, the actuarial opinion should include an explicit statement that the impact of the negative IMR on reserve adequacy has been considered and that the reserves after deduction of the negative IMR still make adequate provision for the liabilities.**

LXXI. GENERAL EXPLANATION The IMR is designed to work with minimum statutory reserves based on formulas contained in laws or regulations. Where, for example, the valuation rate is based on the interest rate conditions prevailing in the year of deposit, the assets supporting the liabilities will be consistent with the liability assumptions. Disposal of the assets during a period of declining interest rates will produce interest-related gains, but these gains will be needed to support the liabilities that are still valued at the interest rate levels prevailing at time of deposit. Thus, it is appropriate in the case of positive IMR to treat the IMR as an additional reserve requirement above and beyond formula minimums.

In cash-flow-testing actuaries take future cash flows into account from existing assets. In an example such as described above, existing assets may well have been purchased at rates below those prevailing at the time reserves were established. The positive IMR that has been built up has captured the gains and not allowed them to be available for distribution. The IMR is recognized as part of the reserves available to meet future obligation cash flows.

Thus from either point of view a positive IMR is treated as a true actuarial reserve. The same arguments should apply equally well in the case of a negative IMR, but some concern has been expressed that in this case the net reserves are in effect lower than statutory formulas minimums, and therefore special considerations are required.

FUTURE DIRECTIONS

In late 2002, the interested persons (as its name had become) considered refinements of the AVR/IMR for the next several years, from that vantage point, some of the major areas of effort appear to be as follows:

1. **There should be recognition of negative values of the IMR. The group had long recognized that the philosophical basis for the IMR supports negative values of the reserve as well as positive. There is a need to have investment return match the liabilities associated with the investment; and a need to remove the incentive for a company to make investment decisions based on the short term balance sheet effect; and these needs exist also on the negative side of the IMR.**

No doubt there are concerns that a negative reserve of this type could somehow lead to an unsound condition, so there has been appended to this report a discussion entitled “Why Are Negative Values For the IMR Necessary?” It also seems as though there should be additional safeguards in the case of a negative IMR. Rather than put arbitrary limits on the amount of the negative reserve, however, consideration is being given to an actuary’s statement that an asset adequacy analysis has been carried out that demonstrates the soundness of the reserves.

(Staff Note: The NAIC library does not have a record of the report noted in the above paragraph.)

Current Accounting Guidance

The statutory accounting guidance for IMR (and the Asset Valuation Reserve – AVR) is within *SSAP No. 7—Asset Valuation Reserve and Interest Maintenance Reserve*, but the guidance within that SSAP is very limited. It provides a general description, identifies that IMR/AVR shall be calculated and reported per the guidance in the applicable SSAP, and if not explicit in the SSAP, in accordance with the Annual Statement Instructions. The SSAPs most often simply direct allocation to (or between) IMR and AVR, with the bulk of the guidance within the Annual Statement Instructions.

The guidance in the Annual Statement instructions provides information on the net IMR balance, which takes into consideration both the positive and negative balances in the general and separate accounts. As detailed, disallowed negative IMR is reported so that it is a direct reduction to surplus on the Summary of Operations, page 4, line 41 change in nonadmitted assets:

Line 6 – Reserve as of December 31, Current Year

Record any positive or allowable negative balance in the liability line captioned “Interest Maintenance Reserve” on Page 3, Line 9.4 of the General Account Statement and Line 3 of the Separate Accounts Statement. A negative IMR balance may be recorded as a negative liability in either the General Account or the Separate Accounts Statement of a company only to the extent that it is covered or offset by a positive IMR liability in the other statement.

If there is any disallowed negative IMR balance in the General Account Statement, include the change in the disallowed portion in Page 4, Line 41 so that the change will be appropriately charged or credited to the Capital and Surplus Account on Page 4. If there is any disallowed negative IMR balance in the Separate Accounts Statement, determine the change in the disallowed portion (prior year less current year disallowed portions), and make a direct charge or credit to the surplus account for the “Change in Disallowed Interest Maintenance Reserve” in the write-in line, in the Surplus Account on Page 4 of the Separate Accounts Statement.

The following information is presented to assist in determining the proper accounting:

General Account IMR Balance	Separate Account IMR Balance	Net IMR Balance
Positive	Positive	Positive (See rule a)
Negative	Negative	Negative (See rule b)
Positive	Negative	Positive (See rule c)
Positive	Negative	Negative (See rule d)
Negative	Positive	Positive (See rule e)
Negative	Positive	Negative (See rule f)

Rules:

- a. If both balances are positive, then report each as a liability in its respective statement.
- b. If both balances are negative, then no portion of the negative balances is allowable as a negative liability in either statement. Report a zero for the IMR liability in each statement and follow the above instructions for handling disallowed negative IMR balances in each statement.
- c. If the general account balance is positive, the separate accounts balance is negative and the combined net balance is positive, then all of the negative IMR balance is allowable as a negative liability in the Separate Accounts Statement.
- d. If the general account balance is positive, the separate account balance is negative, and the combined net balance is negative, then the negative amount not covered by the positive amount is not allowable. Report only the allowable portion as a negative liability in the Separate Accounts Statement and follow the above instructions for handling the disallowed portion of negative IMR balances in the Separate Accounts Statement.
- e. If the general account balance is negative, the separate account balance is positive, and the combined net balance is positive, then all of the negative IMR balance is allowable as a negative liability in the General Account Statement.
- f. If the general account balance is negative, the separate account balance is positive, and the combined net balance is negative, then the negative amount not covered by the positive amount is not allowable. Report only the allowable portion as a negative liability in the General Account Statement and follow the above instructions for handling the disallowed portion of negative IMR balances in the General Account Statement.

The Statutory Accounting Statement of Concepts in the Preamble to the AP&P provides the following on Recognition:

Recognition

35. The principal focus of solvency measurement is determination of financial condition through analysis of the balance sheet. However, protection of the policyholders can only be maintained through continued monitoring of the financial condition of the insurance enterprise. Operating performance is another indicator of an enterprise's ability to maintain itself as a going concern. Accordingly, the income statement is a secondary focus of statutory accounting and should not be diminished in importance to the extent contemplated by a liquidation basis of accounting.

36. The ability to meet policyholder obligations is predicated on the existence of readily marketable assets available when both current and future obligations are due. Assets having economic value other

than those which can be used to fulfill policyholder obligations, or those assets which are unavailable due to encumbrances or other third party interests should not be recognized on the balance sheet but rather should be charged against surplus when acquired or when availability otherwise becomes questionable.

37. Liabilities require recognition as they are incurred. Certain statutorily mandated liabilities may also be required to arrive at conservative estimates of liabilities and probable loss contingencies (e.g., interest maintenance reserves, asset valuation reserves, and others).

Life Actuarial (A) Task Force 2022 Guidance

The Life Actuarial (A) Task Force considered comments from the ACLI that the inclusion of a negative IMR balance in asset adequacy testing, the disallowance of a negative IMR could result in double counting of losses (i.e., through the disallowance on the balance sheet and the potential AAT-related reserve deficiency). The Task Force identified that VM-20 Section 7.D.7.b notes that "...the company shall use a reasonable approach to allocate any portion of the total company balance that is disallowable under statutory accounting procedures (i.e., when the total company balance is an asset rather than a liability)." Question 22 of the AAA's Asset Adequacy Practice Note (Attachment 2) states that "... a negative IMR is not an admitted asset in the annual statement. So, some actuaries do not reflect a negative value of IMR in the liabilities used for asset adequacy analysis." However, Question 22 also notes a 2012 survey data that showed varying practices across companies, including some companies that allocated negative IMR.

On Nov. 17, 2022, in order to assist state regulators in achieving uniform outcomes for year-end 2022, the Task Force exposed guidance until November 30, 2022:

Recommendation In order to assist state regulators in achieving uniform outcomes for year-end 2022, we have the following recommendation: the allocation of IMR in VM-20, VM-21, and VM-30 should be principle-based, "appropriate", and "reasonable". Companies are not required to allocate any non-admitted portion of IMR (or PIMR, as applicable) for purposes of VM-20, VM-21, and VM-30, as being consistent with the asset handling for the nonadmitted portion of IMR would be part of a principle-based, reasonable and appropriate allocation. However, if a company was granted a permitted practice to admit negative IMR as an asset, the company should allocate the formerly non-admitted portion of negative IMR, as again a principle-based, reasonable and appropriate IMR allocation would be consistent with the handling of the IMR asset. This recommended guidance is for year-end 2022, to address the current uncertainty and concerns with the "double-counting" of losses. This recommended guidance will help ensure consistency between states and between life insurers in this volatile rate environment. Refinement of this guidance may be considered beyond year-end 2022.

The Oct. 31, 2022 ACLI Letter also identified the following references to IMR in the valuation manual and Risk-Based Capital Calculations:

Regulation	Use	IMR references
Actuarial Opinion and Memorandum Regulation (VM-30)	Asset adequacy analysis for annual reserve opinion	An appropriate allocation of assets in the amount of the IMR, whether positive or negative, shall be used in any asset adequacy analysis.
Life principle-based reserves (VM-20)	Calculation of deterministic reserve	Calculate the deterministic reserve equal to the actuarial present value of benefits, expenses, and related amounts less the actuarial present value of premiums and

		related amounts, less the positive or negative pre-tax IMR balance at the valuation date allocated to the group of one or more policies being modeled
Life principle-based reserves (VM-20)	Calculation of stochastic reserve	Add the CTE amount (D) plus any additional amount (E) less the positive or negative pre-tax IMR balance allocated to the group of one or more policies being modeled
Variable annuities principle-based reserves (VM-21)	Reserving for variable annuities	The IMR shall be handled consistently with the treatment in the company's cash-flow testing, and the amounts should be adjusted to a pre-tax basis.
C3 Phase 1 (Interest rate risk capital)	RBC for fixed annuities and single premium life	IMR assets should be used for C3 modeling.

Assessment of 2020-2022 IMR Balances:

Note – The following amounts reflect the general account IMR Reserve balance. (This is the amount shown as a liability and shows the decrease in the positive IMR reported since 2020.) This detail does not show the disallowed negative IMR reported as an asset and nonadmitted. Also, information on the separate account IMR, which is a factor in determining in disallowed negative IMR, will not be known until the year-end financial statements are filed (March 1, 2023).

	GA 2022 – Q3	GA 2022 – Q2	GA 2022 – Q1	GA YE – 2021	GA YE – 2020
Aggregate IMR	27,601,001,445	31,859,274,989	37,697,176,149	40,598,068,038	35,229,578,726
Change from Prior	(4,258,273,544)	(5,837,901,160)	(2,900,891,889)	5,368,489,312	
% Change	(13.4%)	(21.5%)	(7.1%)	15.2%	

Review of GA IMR Reserve Decrease:

- From the first quarter (Q1) to second quarter (Q2), 25 companies had decreases in the IMR reserve balance over \$50M totaling \$4,717,657,986, representing 80% of the overall change. 13 of these companies had decreases of IMR over \$100M, totaling \$3,959,569,339, representing 68% of the change. Four of these companies had decreases of IMR over \$400M. One of these companies reported a zero IMR liability and reported a disallowed IMR on the asset page of approx. \$570M.
- From the first quarter (Q1) to second quarter (Q2), 49 companies increased their prior reported positive IMR by \$61,390,564. From the second quarter (Q2) to third quarter (Q3), 56 companies increase their prior reported positive IMR by \$60,316,403
- From the second quarter (Q2) to third quarter (Q3), 16 companies had decreases in the IMR reserve balance over \$50M totaling \$3,161,570,362, representing 74% of the change. 8 of these companies had decreases of IMR over \$100M, totaling \$2,580,832,015, representing 60% of the change. All of these companies were still in a net positive IMR position.
- For the 30 companies that reflected the largest decline in reported IMR between the first to second quarter and then the second to third quarter, the following key details are noted.
 - From the first (Q1) to second quarter (Q2), the top 30 companies reflected a decrease in \$4,923,166,733, which is 84% of the total decrease.
 - From the second (Q2) to third quarter (Q3), the top 30 companies reflected a decrease in \$3,642,088,165, which is 85.5% of the total decrease.
 - 19 companies were noted as being in the population for both periods. 29 of the 30 companies reported a net positive IMR in the third quarter. One company reported a zero IMR in Q3.
- For the 15 companies that had the largest declines between the first quarter (Q1) to second quarter (Q2), eight of those companies also had the largest declines from second quarter (Q2) to third quarter (Q3).
- A limited number of companies are reporting a negative IMR on the liabilities side. Seven companies reported a net negative IMR balance in the third quarter (Q3) for a total of 11,031,998. One company made up \$10.5M of the aggregate balance and this company initially went negative in the second quarter (Q2). Six companies reported a net negative IMR balance for Q2 for a total of \$9,815,594. (The other companies

with negative IMR were immaterial amounts.) *(Under the guidance in the A/S instructions, these companies should stop at zero and report the negative as disallowed nonadmitted asset.)*

Review of Disallowed IMR:

Although the assessment of the liability balance shows the decrease in positive IMR, it no longer tracks the decline for companies that go negative, as the reserve balance on the liability page should stop at zero. (This info may be identifiable from the IMR schedule, but not within the quarterly financials from a review of the IMR reported on the liability page.) As such, NAIC staff completed a review of the data to identify the companies that moved to a zero balance (from a prior positive balance) at year-end 2021 or in the 2022 quarters:

Companies that moved from a positive IMR (liability) to a zero balance:

- Initially went to zero in 2022 – Q3: 20 companies
- Initially went to zero in 2022 – Q2: 20 companies
- Initially went to zero in 2022 – Q1: 11 companies
- Initially went to zero YE 2021 – 20 companies (This is a comparison to YE 2020.)

For these 71 companies, NAIC staff has completed a manual review to the 2022 third quarter financial statements to determine if a disallowed IMR was reported as an aggregate write-in on the asset page. For these companies, 60 were identified with a disallowed IMR for a total of \$1 Billion as of the third quarter 2022.

Existing Authoritative Literature:

SSAP Authoritative Guidance:

- *SSAP No. 7—Asset Valuation Reserve and Interest Maintenance Reserve*
- Life Annual Statement Instructions

(Guidance included as part of discussion.)

Activity to Date (issues previously addressed by the Working Group, Emerging Accounting Issues (E) Working Group, SEC, FASB, other State Departments of Insurance or other NAIC groups):

- Nov. 17, 2022, Discussion by Life Actuarial (A) Task Force as discussed above.

Information or issues (included in *Description of Issue*) not previously contemplated by the Working Group:

None

Convergence with International Financial Reporting Standards (IFRS): NA

Recommendation:

NAIC staff recommend that the Working Group include this item on their maintenance agenda as a New SAP Concept for discussion to assess the current guidance for disallowed negative IMR. NAIC staff recommend that at the Working Group's conclusion, documentation of the discussion, and resulting decisions, be captured for historical purposes in an Issue Paper.

Staff Review Completed by: Julie Gann - NAIC Staff, November 2022

Status:

On December 13, 2022, the Statutory Accounting Principles (E) Working Group moved this agenda item to the active listing, categorized as a New SAP Concept and exposed the agenda item with a request for comments by

industry on potential guardrails and details on unique considerations. The Working Group directed NAIC staff to coordinate with the Life Actuarial (A) Task Force and request regulator-only sessions with industry to receive specific company information.

On March 22, 2023, the Statutory Accounting Principles (E) Working Group directed NAIC staff regarding the consideration of negative interest maintenance reserve (IMR) with an intent to work on both a 2023 solution and a long-term solution as follows:

- a. Draft a referral to the Life Actuarial (A) Task Force on further consideration of the asset adequacy implications of negative IMR. Items to include: 1) developing a template for reporting within asset adequacy testing (AAT); 2) considering the actual amount of negative IMR that is admitted to be used in the AAT; 3) better consideration of cash flows within AAT (and documentation), as well as any liquidity stress test (LST) considerations; 4) ensuring that excessive withdrawal considerations are consistent with actual data (sales of bonds because of excess withdrawals should not use the IMR process); and 5) ensuring that any guardrails for assumptions in the AAT are reasonable and consistent with other aspects.
- b. Draft a referral to the Capital Adequacy (E) Task Force for the consideration of eliminating any admitted net negative IMR from total adjusted capital (TAC) and the consideration of sensitivity testing with and without negative IMR.
- c. Develop guidance for future Working Group consideration that would allow the admission of negative IMR up to 5% of surplus using the type of limitation calculation similar to that used for goodwill admittance. The guidance should also provide for a downward adjustment if RBC ratio is less than 300.
- d. Review and provide updates on any annual statement instructions for excess withdraws, related bond gains/losses and non-effective hedge gains/losses to clarify that those related gains/losses are through asset valuation reserve (AVR), not IMR.
- e. Develop accounting and reporting guidance to require the use of a special surplus (account or line) for net negative IMR.
- f. Develop governance related documentation to ensure sales of bonds are reinvested in other bonds.
- g. Develop a footnote disclosure for quarterly and annual reporting.

On April 10, 2023, the Working Group exposed a limited-time, optional INT to allow admittance of net negative (disallowed) IMR in the general account up to 5% of adjusted capital and surplus. The exposed INT proposed restrictions on what is permitted to be captured in the net negative IMR balance eligible for admittance as well as reporting and disclosure requirements.

On June 28, 2023, the Working Group discussed comments received on the exposed INT and directed NAIC staff to incorporate several revisions to the INT. The revised INT reflects the following:

- Requirement for RBC over 300% after adjustment to remove admitted positive goodwill, EDP equipment and operating system software, DTAs and admitted IMR.

- Allowance to admit up to 10% of adjusted capital and surplus – first in the GA, and then if all disallowed IMR in the GA is admitted and the percentage limit is not reached, then to the SA account proportionately between insulated and non-insulated accounts. *(The adjustments are the same that occur for the RBC adjustment and reduce capital and surplus before applying the 10% percentage limit.)*
- There is no exclusion for derivatives losses included in negative IMR if the company can demonstrate historical practice in which realized gains from derivatives were also reversed to IMR (as liabilities) and amortized.
- Inclusion of a new reporting entity attestation.
- Effective date through Dec. 31, 2025, with a note that it could be nullified earlier or extended based on WG actions to establish specific guidance on net negative (disallowed) IMR.
- Application guidance for admitting / recognizing IMR in both the general and separate accounts.

On July 5, 2023, the Working Group exposed via evote the revised INT for a shortened comment period ending July 21, 2023.

On August 13, 2023, the Statutory Accounting Principles (E) Working Group adopted, as final, the exposed INT 23-01 which provides optional, limited-time guidance, which allows the admittance of net negative (disallowed) interest maintenance reserve (IMR) up to 10% of adjusted capital and surplus. INT 23-01 is effective through December 31, 2025.

[https://naiconline.sharepoint.com/sites/NAICSupportStaffHub/Member Meetings/E CMTE/APPTF/2023-2 Summer/Summary and Minutes/SAPWG/Attachments/Att1T-2022-19 Negative IMR.docx](https://naiconline.sharepoint.com/sites/NAICSupportStaffHub/Member%20Meetings/E%20CMTE/APPTF/2023-2%20Summer/Summary%20and%20Minutes/SAPWG/Attachments/Att1T-2022-19%20Negative%20IMR.docx)

Interpretation of the Statutory Accounting Principles (E) Working Group Net Negative (Disallowed) Interest Maintenance Reserve

INT 23-01 Dates Discussed

April 10, 2023, June 28, 2023, August 13, 2023

INT 23-01 References

Current:

*SSAP No. 7—Asset Valuation Reserve and Interest Maintenance Reserve
Annual Statement Instructions*

INT 23-01 Issue

1. The statutory accounting guidance for interest maintenance reserve (IMR) and the asset valuation reserve (AVR) is within *SSAP No. 7—Asset Valuation Reserve and Interest Maintenance Reserve*, but the guidance within *SSAP No. 7* is very limited. It provides a general description, identifies that IMR/AVR shall be calculated and reported per the guidance in the applicable SSAP, and if not explicit in the SSAP, in accordance with the annual statement instructions. The SSAPs most often simply direct allocation to (or between) IMR and AVR, with the bulk of the guidance residing within the annual statement instructions.

2. As detailed in *SSAP No. 7*, paragraph 2, the guidance for IMR and AVR applies to life and accident and health insurance companies and focuses on IMR and AVR liability recognition and distinguishing between IMR and AVR:

2. Life and accident and health insurance companies shall recognize liabilities for an AVR and an IMR. The AVR is intended to establish a reserve to offset potential credit-related investment losses on all invested asset categories excluding cash, policy loans, premium notes, collateral notes and income receivable. The IMR defers recognition of the realized capital gains and losses resulting from changes in the general level of interest rates. These gains and losses shall be amortized into investment income over the expected remaining life of the investments sold. The IMR also applies to certain liability gains/losses related to changes in interest rates. These gains and losses shall be amortized into investment income over the expected remaining life of the liability released.

3. The IMR guidance in the annual statement instructions provides information on the net balance. A positive IMR represents net interest rate realized gains and is reported as a liability on a dedicated reporting line. A negative disallowed IMR represents net interest rate realized losses and is reported as a miscellaneous other-than-invested write-in asset in the general account and nonadmitted.

4. IMR balances between the general account and separate accounts are separate and distinct. Meaning, a net negative IMR in the general account only represents activity that occurred in the general account that was allocated to IMR. However, the net positive or negative balance of the general account influences how the net positive or negative balances are reported in separate account statements (and vice versa). (A net negative IMR balance in the general account may not be disallowed if there is a covering net positive IMR in the separate account. Negative IMR that is not disallowed is reported as a contra-liability.) The instructions for reporting the net negative and positive balances are detailed in the annual statement instructions:

Line 6 – Reserve as of December 31, Current Year

Record any positive or allowable negative balance in the liability line captioned “Interest Maintenance Reserve” on Page 3, Line 9.4 of the General Account Statement and Line 3 of the Separate Accounts Statement. A negative IMR balance may be recorded as a negative liability in either the General Account or the Separate Accounts Statement of a company only to the extent that it is covered or offset by a positive IMR liability in the other statement.

If there is any disallowed negative IMR balance in the General Account Statement, include the change in the disallowed portion in Page 4, Line 41 so that the change will be appropriately charged or credited to the Capital and Surplus Account on Page 4. If there is any disallowed negative IMR balance in the Separate Accounts Statement, determine the change in the disallowed portion (prior year less current year disallowed portions), and make a direct charge or credit to the surplus account for the “Change in Disallowed Interest Maintenance Reserve” in the write-in line, in the Surplus Account on Page 4 of the Separate Accounts Statement. The following information is presented to assist in determining the proper accounting:

General Account IMR Balance	Separate Account IMR Balance	Net IMR Balance
Positive	Positive	Positive (See rule a)
Negative	Negative	Negative (See rule b)
Positive	Negative	Positive (See rule c)
Positive	Negative	Negative (See rule d)
Negative	Positive	Positive (See rule e)
Negative	Positive	Negative (See rule f)

Rules:

- a. If both balances are positive, then report each as a liability in its respective statement.
- b. If both balances are negative, then no portion of the negative balances is allowable as a negative liability in either statement. Report a zero for the IMR liability in each statement and follow the above instructions for handling disallowed negative IMR balances in each statement.
- c. If the general account balance is positive, the separate accounts balance is negative and the combined net balance is positive, then all of the negative IMR balance is allowable as a negative liability in the Separate Accounts Statement.
- d. If the general account balance is positive, the separate account balance is negative, and the combined net balance is negative, then the negative amount not covered by the positive amount is not allowable. Report only the allowable portion as a negative liability in the Separate Accounts Statement and follow the above instructions for handling the disallowed portion of negative IMR balances in the Separate Accounts Statement.
- e. If the general account balance is negative, the separate account balance is positive, and the combined net balance is positive, then all of the negative IMR balance is allowable as a negative liability in the General Account Statement.
- f. If the general account balance is negative, the separate account balance is positive, and the combined net balance is negative, then the negative amount not covered by the positive amount is not allowable. Report only the allowable portion as a negative liability in the General Account Statement and follow the above instructions for handling the disallowed portion of negative IMR balances in the General Account Statement.

5. In October 2022, the ACLI requested the Statutory Accounting Principles (E) Working Group to reassess the guidance for net negative (disallowed) IMR, with a request to consider admittance of those amounts. The ACLI noted that the nonadmittance of disallowed negative IMR can have adverse negative ramifications for insurers with two key themes:

- a. In general, rising interest rates are favorable to the financial health of the insurance industry and policyholders. However, with negative IMR, there is an inappropriate perception of decreased financial strength through lower surplus and risk-based capital.
- b. Negative IMR could impact the rating agency view of the industry or incentivize companies to avoid prudent investment transactions that are necessary to avoid mismatches between assets and liabilities. In either scenario, negative IMR encourages short-term non-economic activity that is not in the best long-term interest of a reporting entity's financial health or its policyholders.

6. In considering the request, the Working Group concluded that, for year-end 2022, there would be no change to statutory accounting guidance and deviations from statutory accounting principles would need to be approved via a permitted or prescribed practice. The Working Group then held company-specific educational sessions in January 2023 to receive detailed information regarding negative IMR and received a subsequent comment letter from the ACLI.

7. During the 2023 Spring National Meeting, the Working Group further discussed the topic of negative IMR and directed NAIC staff to proceed with drafting guidance for a 2023 solution and to begin work towards a long-term solution.

INT 23-01 Discussion

8. This interpretation prescribes limited-time, optional, statutory accounting guidance, as an exception to the existing guidance detailed in SSAP No. 7 and the annual statement instructions that requires nonadmittance of net negative (disallowed) IMR as a short-term solution. Specifically, this interpretation impacts the annual statement instruction rules regarding disallowed negative IMR detailed in rules 'b,' 'd' and 'f' shown in paragraph 4.

9. Reporting entities are permitted to admit net negative (disallowed) IMR with the following restrictions:

- a. Reporting entities that qualify pursuant to paragraph 9.b., are permitted to admit net negative (disallowed) IMR up to 10% of the reporting entity's adjusted general account¹ capital and surplus as required to be shown on the statutory balance sheet of the reporting entity for its most recently filed statement with the domiciliary state commissioner. The capital and surplus shall be adjusted to exclude any net positive goodwill, EDP equipment and operating system software, net deferred tax assets and admitted² net negative (disallowed) IMR.
- b. Reporting entities applying this interpretation are required to have a risk-based capital (RBC) greater than 300% authorized control level (ACL) after an adjustment to total adjusted capital (TAC) that reflects a reduction to remove any net positive goodwill, EDP equipment and operating

¹ The general account capital and surplus includes surplus reflected in the separate account; therefore, an aggregation of general account and separate account surplus is not necessary.

² As the separate account does not have "admitted" assets, broad reference to "admitted net negative (disallowed) IMR" throughout this interpretation includes what is admitted in the general account and what is recognized as an asset in the separate accounts.

system software, net deferred tax assets and admitted net negative (disallowed) IMR. Compliance with this adjusted RBC calculation shall be affirmed for all quarterly and annual financial statements for which net negative (disallowed) IMR is reported as an admitted asset in the general account or recognized as an asset in the separate accounts. Reporting entities shall provide documentation to illustrate compliance with this requirement upon state regulator request. Reporting entities with an adjusted RBC calculation of 300% ACL or lower are not permitted to admit net negative (disallowed) IMR in the general account or recognize IMR assets in the separate accounts.

- c. The net negative (disallowed) IMR permitted for admittance shall not include losses from derivatives that were reported at fair value prior to derivative termination³ unless the reporting entity has historically followed the same process for interest-rate hedging derivatives that were terminated in a gain position. In other words, there is a requirement for documented, historical evidence illustrating that unrealized gains from derivatives reported at fair value were reversed to IMR (as a liability) and amortized as part of IMR. Reporting entities that do not have evidence of this past application are required to remove realized losses from derivatives held at fair value from the net negative (disallowed) IMR balance to determine the amount permitted to be admitted. Reporting entities that begin a new process for the use of hedging derivatives, perhaps with a theoretical process to treat derivative losses and derivative gains similarly, but do not have evidence illustrating the historical treatment of derivative gains through IMR are not permitted to include derivative losses in the net negative (disallowed) IMR permitted to be admitted. This evidence is required separately for the general account, insulated separate account and non-insulated separate account if losses from derivatives previously reported at fair value are currently being allocated to IMR in those accounts.

10. Reporting entities that admit net negative (disallowed) IMR shall follow the following process:

- a. All net negative (disallowed) IMR in the general account shall first be admitted until the capital and surplus percentage limit, as detailed in paragraph 9.a., is reached.
- b. If all general account net negative (disallowed) IMR has been fully admitted, and the reporting entity is still below the paragraph 9.a. capital and surplus limit, then the reporting entity can report net negative (disallowed) IMR as an asset in the separate accounts. Reporting entities that have both insulated and non-insulated separate accounts shall recognize IMR assets proportionately between the insulated and non-insulated statements until the aggregated amount recognized as an admitted asset in the general account and as an asset in the insulated and non-insulated statements reaches the percentage limit of capital and surplus detailed in paragraph 9.a.

11. Reporting entities that admit net negative (disallowed) IMR in the general account shall report the admittance in the balance sheet as follows:

- a. Reporting entities shall report the net negative (disallowed) IMR as an aggregate write-in to miscellaneous other-than-invested assets (line 25) (named as “Admitted Disallowed IMR”) on the asset page. The net negative (disallowed) IMR shall be admitted to the extent permitted per paragraph 9.a., with the remaining net negative (disallowed) IMR balance nonadmitted.

³ Reference to derivative termination throughout this interpretation includes all actions that close out a derivative, including, but not limited to, termination, expiration, settlement, or sale.

- b. Reporting entities shall allocate an amount equal to the general account admitted net negative (disallowed) IMR from unassigned funds to an aggregate write-in for special surplus funds (line 34) (named as “Admitted Disallowed IMR”). Although dividends are contingent on state specific statutes and laws, the intent of this reporting is to provide transparency and preclude the ability for admitted negative IMR to be reported as funds available to dividend.

12. Reporting entities that record net negative (disallowed) IMR as an asset in the separate account shall report the recognition in the balance sheet as follows:

- a. Reporting entities shall report the permitted net negative (disallowed) IMR as an aggregate write-in to miscellaneous other-than-invested assets (line 15) (named as “Recognized Disallowed IMR”) on the asset page.
- b. Reporting entities shall allocate an amount from surplus equal to the asset recognized as disallowed IMR as an aggregate write-in for special surplus funds (line 19) (named as “Recognized Disallowed IMR”) on the liabilities and surplus page.

13. Reporting entities admitting net negative (disallowed) IMR are required to complete the following disclosures in the annual and quarterly financial statements for IMR:

- a. Reporting entities that have allocated gains/losses to IMR from derivatives that were reported at fair value prior to the termination of the derivative shall disclose the unamortized balances in IMR from these allocations separately between gains and losses.
- b. Reporting entities shall complete a note disclosure that details the following:
 - i. Net negative (disallowed) IMR in aggregate and allocated between the general account, insulated separate account and non-insulated account,
 - ii. Amounts of negative IMR admitted in the general account and reported as an asset in the separate account insulated and non-insulated blank,
 - iii. The calculated adjusted capital and surplus per paragraph 9.a., and
 - iv. Percentage of adjusted capital and surplus for which the admitted net negative (disallowed) IMR represents (including what is admitted in the general account and what is recognized as an asset in the separate account).
- c. Reporting entities shall include a note disclosure that attests to the following statements:
 - i. Fixed income investments generating IMR losses comply with the reporting entity’s documented investment or liability management policies,
 - ii. IMR losses for fixed income related derivatives are all in accordance with prudent and documented risk management procedures, in accordance with a reporting entity’s derivative use plans and reflect symmetry with historical treatment in which unrealized derivative gains were reversed to IMR and amortized in lieu of being recognized as realized gains upon derivative termination.

- iii. Any deviation to 13.c.i was either because of a temporary and transitory timing issue or related to a specific event, such as a reinsurance transaction, that mechanically made the cause of IMR losses not reflective of reinvestment activities.
- iv. Asset sales that were generating admitted negative IMR were not compelled by liquidity pressures (e.g., to fund significant cash outflows including, but not limited to excess withdrawals and collateral calls).

INT 23-01 Status

14. The consensuses in this interpretation were adopted on August 13, 2023, to provide limited-time exception guidance to SSAP No. 7 and the annual statement instruction for the reporting of net negative (disallowed) IMR. The provisions within this interpretation are permitted as a short-term solution until December 31, 2025, and will be automatically nullified on January 1, 2026.

15. The effective date of this interpretation may be adjusted (nullified earlier or with an extended effective date timeframe) in response to Statutory Accounting Principles (E) Working Group actions to establish statutory accounting guidance specific to net negative (disallowed) IMR.

16. No further discussion is planned.

Application Guidance for Admitting / Recognizing Net Negative (Disallowed) IMRGeneral Account:

1. Net negative IMR in the general account that exceeds net positive IMR in the separate accounts is considered “disallowed” general account IMR. (Determination of the disallowed IMR in the general account shall be compared against the aggregate IMR balance in all separate accounts.)
2. Net negative disallowed IMR in the general account shall be reported as an aggregate write-in for other-than-invested assets as “Admitted Disallowed IMR” on line 25 of the asset page and nonadmitted. The change in nonadmittance shall be reported on line 41 in the summary of operations.
3. To the extent the reporting entity is permitted to admit net negative disallowed IMR pursuant to the provisions in this interpretation, the reporting entity shall admit the disallowed IMR reported on line 25 of the asset page to the extent permitted, with the change in nonadmittance reflected on line 41 in the summary of operations.
4. Reporting entities shall report an amount equal to the general account admitted net negative (disallowed) IMR as an aggregate write-in for special surplus funds (line 34 of the Liabilities, Surplus and Other Funds page) named as “Admitted Disallowed IMR.”
5. Reporting entities shall include note disclosures in the quarterly and annual financial statements as required in paragraph 13 of the interpretation.

Separate Account:

6. Net negative IMR in the separate account (aggregated IMR in both insulated and non-insulated separate accounts) that exceeds net positive IMR in the general account is considered “disallowed” separate account IMR. If the aggregate separate account IMR is positive, with a negative IMR in the insulated separate account and positive IMR in non-insulated separate account (or vice versa), then the negative IMR in the insulated separate account is not permitted to be reported as an asset. In those situations, the separate account has an aggregate positive IMR balance.
7. Net negative (disallowed) IMR in the separate account permitted to be recognized as an asset, as the admittance in the general account did not utilize the full percentage of adjusted capital and surplus permitted within this interpretation, shall be proportionately divided between insulated and non-insulated separate accounts if both separate accounts are in a negative position. If the separate account IMR is an aggregate net negative, but only one separate account blank is in a negative position, then only the separate account blank with a net negative position can recognize disallowed IMR as an asset.
8. If negative IMR in the separate account has previously been recognized as a direct charge to surplus, the reporting entity shall recognize an asset as an aggregate write-in for other-than-invested assets as “Recognized Disallowed IMR” on line 15 of the separate account asset page, with an offsetting credit to surplus. This credit to surplus shall reverse the charge previously recognized. This process shall continue in subsequent quarters if additional separate account IMR is permitted as an asset to the extent IMR was previously taken as a direct charge to surplus. Once prior surplus impacts have been fully eliminated, then the entity shall follow the guidance for new net negative (disallowed) IMR as detailed in the following paragraph. If subsequent quarters result with a decline in the permitted IMR asset in the separate account, then the asset shall be credited with an offsetting charge to surplus.

9. If the reporting entity enters a net negative (disallowed) IMR position (meaning, there has not been a prior charge to surplus for net negative (disallowed) IMR), then the entity shall recognize the asset as an aggregate write-in for other-than-invested assets as “Disallowed IMR” on line 15 of the separate account balance sheet, with an offsetting credit to IMR (line 3 of the liability page) until the IMR liability equals zero. This process shall continue in subsequent quarters if additional net negative IMR is generated from operations and is permitted as an asset under the provisions of this interpretation. If subsequent quarters result with a decline in the permitted IMR asset in the separate account, then the asset shall be credited with an offsetting charge to surplus.
10. Reporting entities shall report an amount equal to the asset recognized reflecting net negative (disallowed) IMR as an aggregate write-in for special surplus funds (line 19) (named as “Recognized Disallowed IMR.” This shall be included in each separate account statement (insulated and non-insulated) if net negative disallowed IMR is recognized as an asset in that statement.
11. Reporting entities shall include note disclosures in the quarterly and annual financial statements as required in paragraph 13 of the interpretation.

[https://naiconline.sharepoint.com/sites/naicsupportstaffhub/member meetings/e cmte/apptf/2023-2 summer/summary and minutes/sapwg/attachments/att1u-2022-19 int 23-01.docx](https://naiconline.sharepoint.com/sites/naicsupportstaffhub/member%20meetings/e%20cmte/apptf/2023-2%20summer/summary%20and%20minutes/sapwg/attachments/att1u-2022-19%20int%2023-01.docx)

**Statutory Accounting Principles (E) Working Group
 Maintenance Agenda Submission Form
 Form A**

Issue: Additional Updates on ASU 2021-10, Government Assistance

Check (applicable entity):

	P/C	Life	Health
Modification of Existing SSAP	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
New Issue or SSAP	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Interpretation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Description of Issue:

On August 10, 2022, the Statutory Accounting Principles (E) Working Group adopted, revisions to *SSAP No. 24—Discontinued Operations and Unusual or Infrequent Items* in agenda item 2022-04: ASU 2021-10, Government Assistance. The revisions incorporate certain disclosures, adopted with modification from ASU 2021-10, to supplement existing disclosures regarding unusual or infrequent items.

This agenda item is to provide additional clarifications to SSAP No. 24, regarding follow-up questions, that NAIC staff received regarding the adoption of the disclosures about government assistance in ASU 2021-10. The primary questions were regarding whether the adoption with modification of the ASU disclosures intended to allow insurers to use the grant and contribution model. If the intent was not to allow for the use of the grant and contribution model, then the question becomes in what situation would these disclosures be required. Because NAIC staff understanding is that the grant and contribution model is not intended to be permitted for statutory accounting, additional modifications to clarify this point have been proposed which reject ASU 2021-10 but still incorporate government assistance disclosures.

In November 2021, the Financial Accounting Standards Board (FASB) issued *Accounting Standards Update (ASU) 2021-10, Government Assistance, Disclosures by Business Entities about Government Assistance* to increase financial statement transparency regarding certain types of government assistance by increasing the disclosure of such information in the notes to the financial statements.

The new disclosure aims to increase transparency by enhancing the identification of 1) the types of assistance received, 2) an entity’s accounting for said assistance, and 3) the effects of the assistance in an entity’s financial statements. The disclosures will contain information about the nature of the transactions, which includes a general description of the transaction and identification of the form (cash or other) in which the assistance was received. In terms of the effects on the financial statement, disclosure will include identification of the specific line items in both the balance sheet and income statement and a description of the extent to which they have been impacted by any government assistance. In addition, an entity will be required to disclose information about any significant terms of the transaction with a government entity, with items including durations of such agreements and any provisions for potential recapture.

ASU 2021-10 defines “government assistance,” in a comprehensive manner to capture most types of assistance from governmental entities and includes examples of tax credits, cash grants, or grants of other assets. ASU 2021-10 does not apply to not-for-profit entities or benefit plans, and only applies to government assistance transactions analogizing either a grant or contribution model.

With the specificity of these additional disclosures only applying in certain circumstances (only applicable in cases where the government assistance is not accounted for in accordance with other accounting standards – i.e., revenue

in the normal course of business or debt), NAIC staff believe the occurrence of such items requiring disclosure per ASU 2021-10 will likely be relatively infrequent.

NAIC Staff Note – as mentioned above, NAIC staff believe that as these additional disclosures are not applicable for transactions that are in scope of other accounting standards, and only apply when the transaction is accounted for by analogy using the grant or contribution model, the prevalence of such items will be infrequent. As such, the most appropriate location for these items is reflected in SSAP No. 24.

Existing Authoritative Literature:

The following revisions were adopted to *SSAP No. 24—Discontinued Operations and Unusual or Infrequent Items* in agenda item 2022-04

Disclosures [Unusual/Infrequent Items]

16. The nature, [including a general description of the transactions](#), and financial effects of each unusual or infrequent event or transaction shall be disclosed in the notes to the financial statements. Gains or losses of a similar nature that are not individually material shall be aggregated. This disclosure shall include the line items which have been affected by the event or transaction considered to be unusual and/or infrequent. [If the unusual or infrequent item is as the result of government assistance \(as defined in ASU 2021-10, Government Assistance, Disclosures by Business Entities about Government Assistance\) disclosure shall additionally include the form in which the assistance has been received \(for example, cash or other assets\), and information regarding significant terms and conditions of the transaction, with items including, to the extent applicable, the duration or period of the agreement, and commitments made by the reporting entity, provisions for recapture, or other contingencies.](#)

Relevant Literature

24. [This statement adopts ASU 2021-10, Government Assistance: Disclosure by Business Entities about Government Assistance, with modification to require disclosure by all entity types.](#)

Activity to Date (issues previously addressed by the Working Group, Emerging Accounting Issues (E) Working Group, SEC, FASB, other State Departments of Insurance or other NAIC groups):

Agenda item 2022-04: ASU 2021-10, Government Assistance was adopted on August 10, 2022.

Information or issues (included in *Description of Issue*) not previously contemplated by the Working Group:

None.

Convergence with International Financial Reporting Standards (IFRS): None.

Staff Review Completed by: Robin Marcotte – NAIC Staff

Staff Recommendation: NAIC staff recommends that the Working Group move this item to the active listing, categorized as a SAP clarification, and expose revisions to SSAP No. 24 as illustrated below. These revisions will clarify the rejection of ASU 2021-10, Government Assistance and the incorporation of disclosures regarding government assistance.

17. The nature, including a general description of the transactions, and financial effects of each unusual or infrequent event or transaction shall be disclosed in the notes to the financial statements. Gains or losses of a similar nature that are not individually material shall be aggregated. This disclosure shall include the line items

which have been affected by the event or transaction considered to be unusual and/or infrequent. If the unusual or infrequent item is as the result of government assistance, ~~(as defined in ASU 2021-10, Government Assistance, Disclosures by Business Entities about Government Assistance)~~ disclosure shall additionally include the form in which the assistance has been received (for example, cash or other assets), and information regarding significant terms and conditions of the transaction, with items including, to the extent applicable, the duration or period of the agreement, and commitments made by the reporting entity, provisions for recapture, or other contingencies.

Relevant Literature

24. This statement ~~adopts~~ rejects ASU 2021-10, *Government Assistance: Disclosure by Business Entities about Government Assistance*. However, it does incorporate general disclosures about government assistance for all reporting entity types. ~~with modification to require disclosure by all entity types.~~

Status:

On March 22, 2023, the Statutory Accounting Principles (E) Working Group moved this agenda item to the active listing, categorized as a SAP clarification, and exposed revisions to SSAP No. 24 to specify rejection of *ASU 2021-10, Government Assistance* but that the statutory guidance does incorporate general disclosures regarding government assistance for all entity types.

On August 13, 2023, the Statutory Accounting Principles (E) Working Group adopted, as final, the exposed revisions, as illustrated above, to SSAP No. 24 which specifies the rejection of ASU 2021-10 but incorporates general disclosures regarding government assistance for all entity types.

[https://naiconline.sharepoint.com/sites/NAICSupportStaffHub/Member Meetings/E CMTE/APPTF/2023-2 Summer/Summary and Minutes/SAPWG/Attachments/Att1V-2023-06 SSAP 24.docx](https://naiconline.sharepoint.com/sites/NAICSupportStaffHub/Member%20Meetings/E%20CMTE/APPTF/2023-2%20Summer/Summary%20and%20Minutes/SAPWG/Attachments/Att1V-2023-06%20SSAP%2024.docx)

Summer National Meeting - Review of GAAP Exposures for Statutory Accounting:

Pursuant to a 2014 direction from the SAPWG chair, there is a desire for the Statutory Accounting Principles (E) Working Group to be more proactive in considering FASB exposures that may be significant to statutory accounting and reporting. Historically, the SAPWG has commented on limited, key FASB exposures – mostly pertaining to insurance contracts and financial instruments. To ensure consideration of all FASB exposures, staff has prepared this memorandum to highlight the current exposures, comment deadlines, and to provide a high-level summary of the exposed item’s potential impact to statutory accounting. It is anticipated that this information would assist the Working Group in determining whether a comment letter should be submitted to the FASB on the issues. Regardless of the Working Group’s election to submit comments to the FASB on proposed accounting standards, under the NAIC Policy Statement on Statutory Accounting Principles Maintenance Agenda Process, issued US GAAP guidance noted in the hierarchy within Section V of the Preamble to the *Accounting Practices and Procedures Manual* must be considered by the Statutory Accounting Principles (E) Working Group.

FASB Exposures: [Exposure Documents and Public Comment Documents \(fasb.org\)](https://www.fasb.org/exposure-documents-and-public-comment-documents)

Exposed FASB Guidance	Comment Deadline & Initial Staff Comments
Proposed Accounting Standards Update— Compensation— <i>Stock Compensation (Topic 718): Scope Application of Profits Interest Awards</i>	July 10, 2023
Proposed Accounting Standards Update—Financial Instruments— <i>Credit Losses (Topic 326): Purchased Financial Assets</i>	August 28, 2023

Proposed Accounting Standards Update—Compensation—*Stock Compensation (Topic 718): Scope Application of Profits Interest Awards*

The FASB is issuing the amendments in this proposed Update to improve generally accepted accounting principles (GAAP) by adding an illustrative example to demonstrate how an entity would apply the scope guidance in paragraph 718- 10-15-3 to determine whether profits interest and similar awards (“profits interest awards”) should be accounted for in accordance with Topic 718, Compensation— Stock Compensation.

Certain entities provide employees or other service providers with profits interest awards to align compensation with an entity’s operating performance and provide those holders with the opportunity to participate in future profits and/or equity appreciation of the entity. The term profits interest is not defined in GAAP but differentiates those interests from capital interests held by investors that provide those holders with rights to the existing net assets in a partnership. Because profits interest holders only participate in future profits and/or equity appreciation and have no rights to the existing net assets of the partnership, stakeholders have indicated that it can be complex to determine whether a profits interest award should be accounted for as a share-based payment arrangement (Topic 718) or similar to a cash bonus or profit-sharing arrangement (Topic 710, Compensation— General, or other Topics). As a result, stakeholders have highlighted existing diversity in practice.

Currently, entities evaluate the terms, conditions, and characteristics of a profits interest award and apply judgment to determine whether to account for the award under Topic 718 or Topic 710. However, stakeholders have indicated that there is diversity in practice even when evaluating similar fact patterns. Therefore, stakeholders requested examples to clarify when the guidance in Topic 718 should be applied to profits interest awards (referred to herein

as the “scope application issue”). In addition, entities accounting for economically similar awards consistently would benefit investors and other allocators of capital.

The scope application issue, along with other related issues, was identified and discussed by the Private Company Council (PCC) because of the prevalence of profits interest awards among private companies. However, given that the PCC research indicated that certain public business entities (PBEs) also may be required to account for profits interest awards, the PCC recommended that the Board add a project to address the scope application issue for PBEs and entities other than PBEs (that is, all reporting entities). The Board added that project, Scope Application of Profits Interests Awards: Compensation—Stock Compensation (Topic 718), to its technical agenda in December 2022.

The amendments in this proposed Update would apply to all reporting entities that account for profits interest awards as compensation to employees in return for goods or services.

The amendments in this proposed Update would improve GAAP by adding an illustrative example that includes four fact patterns to demonstrate how an entity would apply the scope guidance in paragraph 718-10-15-3 to determine whether a profits interest award should be accounted for in accordance with Topic 718. The fact patterns in the proposed illustrative example focus on the scope conditions in paragraph 718-10-15-3. The proposed illustrative example is intended to reduce (1) complexity in determining whether a profits interest award is subject to the guidance in Topic 718 and (2) existing diversity in practice.

The amendments in this proposed Update would be applied either (1) retrospectively to all prior periods presented in the financial statements or (2) prospectively to profits interest awards granted or modified on or after the effective date. If the proposed amendments are applied prospectively, an entity would be required to disclose the nature of and reason for the change in accounting principle. The effective date and whether early adoption of the proposed amendments should be permitted will be determined after the Board considers stakeholder feedback on the proposed amendments.

The Board invites individuals and organizations to comment on all matters in this proposed Update, particularly on the issues and questions below. Comments are requested from those who agree with the proposed guidance as well as from those who do not agree. Comments are most helpful if they identify and clearly explain the issue or question to which they relate. Those who disagree with the proposed guidance are asked to describe their suggested alternatives, supported by specific reasoning.

Question 1: Do you agree that the amendments in this proposed Update should apply to all reporting entities (including PBEs and entities other than PBEs)? Please explain why or why not.

Question 2: Is the proposed illustrative example included in paragraphs 718-10- 55-138 through 55-148 to determine whether a profits interest award should be accounted for in accordance with Topic 718 clear and operable? Please explain why or why not. Should the illustrative example include other considerations or exclude any considerations? If yes, please explain how you would change the proposed illustrative example.

Question 3: An entity would be required to apply the proposed amendments either (a) retrospectively to all prior periods presented in the financial statements or (b) prospectively to awards granted or modified on or after the effective date with an associated disclosure that describes the nature of and reason for the change in accounting principle. Do you agree with the proposed transition provisions? If not, why not, and what basis would be more appropriate and why?

Question 4: Regarding the effective date, how much time would be needed to implement the proposed amendments? Should the amount of time needed to implement the proposed amendments by entities other than PBEs be different from the amount of time needed by PBEs? Should early adoption be permitted? Please explain your response.

Staff Review and Commentary:

Comment deadline was July 10, 2023

NAIC staff recommend that ASU be reviewed under the SAP Maintenance Process as detail in *Appendix F—Policy Statements*.

Proposed Accounting Standards Update—Financial Instruments—*Credit Losses (Topic 326): Purchased Financial Assets*

Since the issuance of Accounting Standards Update No. 2016-13, Financial Instruments—Credit Losses (Topic 326): Measurement of Credit Losses on Financial Instruments, the Board has monitored and assisted stakeholders with the implementation of Topic 326. Post-Implementation Review (PIR) activities included forming a Credit Losses Transition Resource Group (TRG); conducting outreach with a broad range of stakeholders on costs, benefits, and operability; developing educational materials and staff guidance; conducting educational workshops; and performing an archival review of financial reports.

One area that stakeholders have highlighted in connection with the PIR of Topic 326 is the accounting for acquired financial assets. Financial assets acquired through (1) a business combination, (2) an asset acquisition, and (3) the consolidation of a variable interest entity (VIE) that is not a business are initially recorded at fair value, and an allowance for expected credit losses (ACL or allowance) is separately recognized in accordance with Topic 326. Any purchase discount or premium (the difference between the purchase price and the par value of an acquired financial asset) is subsequently accreted or amortized to interest income in accordance with Topic 310, Receivables.

Topic 326 provides criteria for identifying purchased financial assets with credit deterioration (PCD or PCD assets). PCD assets have experienced a more-than insignificant deterioration in credit quality since origination based on an assessment by the acquirer as of the date of acquisition. That assessment is subjective because Topic 326 does not define what constitutes a “more-than insignificant” deterioration in credit quality. However, the Board clarified in Update 2016-13 its intent that a broad population of purchased financial assets should be eligible for PCD classification—not limited to nonaccrual loans or other “impaired” assets. Acquired financial assets that do not meet the PCD criteria (non-PCD) are accounted for in a manner consistent with originated financial assets. For non-PCD assets, the amount embedded in the purchase price that is attributable to expected credit losses is recognized as a “Day-1” credit loss expense in the income statement.

Under the PCD model, an entity records an allowance and also records the offsetting entry as an addition to the amortized cost basis. Thus, the initial amortized cost basis for PCD assets is an amount equal to the sum of the purchase price and the ACL (commonly referred to as the gross-up approach). The difference, if any, between the amortized cost basis and the par value is a noncredit 2 discount which is accreted or amortized to interest income. Applying the gross-up approach results in the amount embedded in the purchase price attributable to expected credit losses being excluded from interest income.

The initial amortized cost basis for non-PCD assets is equal to the purchase price. An ACL is separately recorded through a charge to credit loss expense equal to the total amount of expected credit losses in the period of acquisition. The purchase discount or premium, if any, is subsequently recognized as interest income using the effective interest rate as of the acquisition date.

Investors, lenders, creditors, and other allocators of capital (collectively, “investors”) and preparers noted that two acquisition accounting approaches (PCD and non-PCD) create unnecessary complexity and reduce comparability. The accounting for non-PCD assets, specifically, has been described by stakeholders as unintuitive because a loss is recorded upon the acquisition of financial assets without more-than-insignificant deterioration in credit quality since origination (non-PCD), whereas no loss is recorded upon the acquisition of financial assets with more-than-insignificant deterioration in credit quality since origination (PCD), which results in accounting that is not economically neutral. To the extent a credit discount is reflected in the fair value and again through a Day-1 allowance for non-PCD assets, the portion reflected in fair value is ultimately reversed as enhanced yield. To compensate for this result, many preparers provide supplemental non-GAAP information that excludes the acquisition accounting accretion effect on yield. In addition, investors explained that the criteria for identifying PCD assets are difficult to understand and are not applied consistently in practice. The majority of feedback (substantially all investors and a majority of practitioners and preparers) from the PIR process suggested that a uniform approach should be applied in the accounting for acquired financial assets and preferred the gross-up approach that is currently applied to PCD assets.

The amendments in this proposed Update would address the comparability and complexity concerns expressed by stakeholders by eliminating the credit deterioration criterion that currently limits the use of the gross-up approach to PCD assets. The proposed Update would require the application of that single accounting approach to all acquired financial assets (with certain limited exceptions, such as available-for-sale [AFS] debt securities).

The amendments in this proposed Update would apply to all entities subject to the guidance in Topic 326 including public business entities, private companies, and not-for-profit entities.

The amendments in this proposed Update would expand the population of financial assets subject to the gross-up approach in Topic 326 that is currently applied to PCD assets. Specifically, an acquirer no longer would be required to determine whether an acquired financial asset is a PCD or non-PCD asset upon acquisition based on the degree of credit deterioration since origination. Instead, the gross-up approach would be applied to all financial assets that are part of a business acquired in a business combination. For financial assets recognized through (1) an asset acquisition or (2) the consolidation of a VIE that is not a business, the acquirer would identify purchased financial assets on the basis of certain criteria that are intended to account for similar transactions in a similar manner. The criteria include a bright-line time-based threshold and a qualitative assessment by the acquirer of its involvement with the origination of the financial asset. When a financial asset is acquired after the bright-line time-based threshold and the acquirer was not involved with the origination, the acquired asset would be accounted for using the gross-up approach.

An acquirer’s assessment of involvement with the origination of a financial asset would consider qualitative characteristics that, if present, indicate that the transaction is economically similar to the acquirer originating the financial asset and, therefore, is required to be accounted for by the acquirer in a manner consistent with originated financial assets. The amendments in this proposed Update expand the use of the gross-up approach without affecting the measurement, presentation, or disclosure requirements.

The effective date and whether early adoption of the amendments in this proposed Update would be permitted will be determined after the Board considers stakeholders’ feedback on the proposed amendments. The proposed amendments would be applied on a modified retrospective basis to the beginning of the fiscal year that an entity has adopted the amendments in Update 2016-13. A cumulative-effect adjustment, if necessary, would be recorded as of the later of (1) the beginning of that reporting period and (2) the beginning of the earliest period presented.

The Board invites individuals and organizations to comment on all matters in this proposed Update, particularly on the issues and questions below. Comments are requested from those who agree with the proposed guidance as well as from those who do not agree. Comments are most helpful if they identify and clearly explain the issue or question to which they relate. Those who disagree with the proposed guidance are asked to describe their suggested alternatives, supported by specific reasoning.

Question 1: The amendments in this proposed Update would expand the population of acquired financial assets accounted for under the gross-up approach, which currently applies only to PCD assets. Should certain classes of financial assets or specific transactions be included (for example, AFS debt securities) or excluded (for example, credit cards or similar revolving credit arrangements)? Please explain why or why not.

Question 2: Would the proposed amendments enhance comparability and improve the decision usefulness of financial information? Are there specific disclosures related to these proposed amendments that would be useful to investors? Please explain why or why not.

Question 3: Do you foresee operability or auditing concerns in applying the grossup approach to certain classes of financial assets (for example, credit cards or other revolving arrangements), certain types of transactions (for example, business combinations, asset acquisitions, or the consolidation of a VIE that is not a business), or certain classes of financial assets in specific transactions (for example, credit cards or other revolving arrangements in an asset acquisition)? Please describe the nature of those concerns and the magnitude of associated costs, differentiating between one-time costs and recurring costs. Are there practical expedients or implementation guidance that would mitigate your concerns? Are there practical expedients or implementation guidance that would enhance comparability? For any proposed practical expedients suggested, please explain your reasoning.

Question 4: There are no proposed amendments to the gross-up approach as it is currently applied to PCD assets; rather, there are proposed amendments that would expand the population of financial assets that apply the gross-up approach at acquisition. Do you agree that no amendments are needed to the existing gross up approach? Please explain why or why not.

Question 5: Do you agree with the proposed seasoning criteria in paragraph 326- 20-30-15 and 30-16? If not, please explain why or why not and describe any potential alternatives for the Board's consideration.

Question 6: Do you agree with the modified retrospective transition guidance in this proposed Update? Should early adoption be permitted? Please explain why or why not.

Question 7: How much time would be needed to implement the proposed amendments? Is additional time needed for entities other than public business entities? Please explain your response.

Staff Review and Commentary:

Comment deadline is Aug. 28, 2023

NAIC staff recommend that ASU's be reviewed under the SAP Maintenance Process as detail in *Appendix F—Policy Statements*.

[https://naiconline.sharepoint.com/sites/NAICSupportStaffHub/Member Meetings/E CMTE/APPTF/2023-2 Summer/Summary and Minutes/SAPWG/Attachments/Att1W-GAAP Exposures.docx](https://naiconline.sharepoint.com/sites/NAICSupportStaffHub/Member%20Meetings/E%20CMTE/APPTF/2023-2%20Summer/Summary%20and%20Minutes/SAPWG/Attachments/Att1W-GAAP%20Exposures.docx)

Draft: 8/3/23

Blanks (E) Working Group
Virtual Meeting
July 27, 2023

The Blanks (E) Working Group of the Accounting Practices and Procedures (E) Task Force met July 27, 2023. The following Working Group members participated: Pat Gosselin, Chair (NH); Kim Hudson, Vice Chair (CA); David Phifer (AK); William Arfanis (CT); N. Kevin Brown (DC); Tom Hudson (DE); Jason Reynolds (FL); Daniel Mathis (IA); Kristin Hynes (MI); Debbie Doggett (MO); Lindsay Crawford (NE); John Sirovetz (NJ); Dale Bruggeman and Tracy Snow (OH); Diane Carter (OK); Diana Sherman (PA); Shawn Frederick (TX); Jake Garn (UT); Nicole Bisping (WA); Mary Jo Lewis (WI); and Michael Erdman (WV).

1. Adopted its May 31 Minutes

Gosselin referenced the Working Group's May 31 minutes. Snow made a motion, seconded by Crawford, to adopt the Working Group's May 31 minutes (Attachment Two-A). The motion passed unanimously.

2. Re-Exposed a Proposal

A. Agenda Item 2023-06BWG

Bruggeman stated that this proposal pertains to the Statutory Accounting Principles (E) Working Group bond project. The proposal details the necessary revisions to: 1) split Schedule D into two separate schedules – Schedule D-1-1 for issuer credit obligations and Schedule D-1-2 for Asset-Backed Securities; 2) incorporate more granular reporting lines for those investments; 3) revise those reporting schedules (columns and instructions) for improved investment information; and 4) incorporate corresponding revisions throughout the entire blank to reflect the revised reporting lines and to update references to the new schedules. With the significant revisions being incorporated, industry provided several comments, most of which were editorial and minor in nature, to improve clarity for reporting purposes. Bruggeman said that industry's dedicated efforts to review these changes in detail are much appreciated, as industry and the Working Group are all working collectively to ensure that the process to transition to the new bond definition, and the revised reporting structure, is as smooth as possible.

Bruggeman made a motion, seconded by Doggett, to re-expose the proposal with the edits for a 75-day public comment period ending Oct. 12. The motion passed unanimously.

3. Deferred Items

A. Agenda Item 2023-05BWG

Sara Robben (NAIC) stated that this proposal was intended to: 1) make changes to the cybersecurity supplement to remove the references to identity theft from the general instructions; 2) combine the claims-made and occurrence to only have the total number of policies in force; and 3) eliminate the first-party and third-party breakdown. Robben stated that during discussions with interested parties, it was decided that additional work was needed to clarify some of the definitions and the reporting. Robben asked for the proposal to be deferred one additional time.

Hudson made a motion, seconded by Phifer, to defer the proposal to allow for further discussion for a 75-day public comment period ending Oct. 12. The motion passed unanimously.

B. Agenda Item 2023-07BWG

Bruggeman stated that this proposal details investment reporting changes that were identified with the review completed for the bond proposal. Although these revisions are not specific to the bond changes, as the changes are affecting the investment schedules, it would be cleaner if the items in this proposal were on the same timeline. Key elements within this proposal include revising the instructions for the “Code Column” to be strictly “Restricted Asset Code” consistently across the schedules, incorporating revisions for an “Investment Characteristic Column,” and then deleting the “LEI Column” for all schedules except for Schedule DB – Derivatives.

Bruggeman made a motion, seconded by Hudson, to defer the proposal to coincide with the 2023-06BWG timeline for a 75-day public comment period ending Oct. 12. The motion passed unanimously.

C. Agenda Item 2023-09BWG

Bruggeman stated that the Statutory Accounting Principles (E) Working Group requested deferral of this proposal in May. The comments regarding redundancy and a request for placement in a different location other than the notes were referred to the Life Risk-Based Capital (E) Working Group. NAIC staff have met with industry, and additional work still needs to be done on this proposal. This delay will necessitate a later effective date of at least 2024. NAIC support staff for the Life Risk-Based Capital (E) Working Group have indicated that the updates to the C-2 mortality charges can still go through for 2023 without this proposal.

Bruggeman made a motion, seconded by Hudson, to defer the proposal to allow for further discussion for a 75-day public comment period ending Oct. 12. The motion passed unanimously.

4. Adopted the Editorial Listing

Hudson made a motion, seconded by Snow, to adopt the editorial listing (Attachment Two-B). The motion passed unanimously.

Having no further business, the Blanks (E) Working Group adjourned.

https://naiconline.sharepoint.com/sites/naicsupportstaffhub/member_meetings/e_cmte/apptf/2023-2_summer/bwg/att2-bwg_07_2023_minutes.docx

Draft: 6/23/23

Blanks (E) Working Group
Virtual Meeting
May 31, 2023

The Blanks (E) Working Group of the Accounting Practices and Procedures (E) Task Force met May 31, 2023. The following Working Group members participated: Pat Gosselin, Chair (NH); Kim Hudson, Vice Chair (CA); Kevin Richard (AK); Michael Shanahan (CT); Yohannes Negash (DC); Tom Hudson (DE); Jason Reynolds (FL); Daniel Mathis (IA); Roy Eft (IN); Kristin Hynes (MI); Debbie Doggett (MO); TJ Addison (NE); John Sirovetz (NJ); Tom Botsko and Dale Bruggeman (OH); Holly Mills (OK); Diana Sherman (PA); Jake Garn (UT); Steve Drutz (WA); Michael Erdman (WI); and Michael Crum (WV).

1. Adopted its March 7 Minutes

Gosselin referenced the Working Group's March 7 minutes.

Hudson made a motion, seconded by Doggett, to adopt the Working Group's March 7 minutes (*see NAIC proceedings – Spring 2023, Accounting Practices and Procedures (E) Task Force, Attachment Two*). The motion passed unanimously.

2. Adopted Items Previously Exposed

A. Agenda Item 2022-17BWG

Bruggeman stated that this proposal adds a new disclosure paragraph for Note 8 – Derivative Instruments and Illustration. The new disclosure is to be data-captured. It adds some electronic-only columns related to derivatives with excluded components to Schedule DB, Part A and Part B, for Section 1 and Section 2. Bruggeman stated that the proposed revisions align with the adopted disclosures and reporting enhancements from adopted derivative revisions to address excluded components in *Statement of Statutory Accounting Principles (SSAP) No. 86—Derivatives*. The Statutory Accounting Principles (E) Working Group adopted a minor editorial change to a derivative reporting category during its May 16 meeting to ensure that the derivative disclosure in SSAP No. 86 and the derivative notes match. There were comments received during the prior exposure period, which are highlighted in the proposal. There were no interested party comments received during the most recent exposure period.

Bruggeman made a motion, seconded by Hudson, to adopt the modifications to the proposal. The motion passed unanimously.

Bruggeman made a motion, seconded by Hudson, to adopt the modified proposal (Attachment Two-A1). The motion passed unanimously.

B. Agenda Item 2023-01BWG

Doggett stated that this proposal removes pet insurance from the inland marine line of business and adds a new line of business to Appendix – Property and Casualty (P/C) Lines of Business definitions. It adds a pet insurance line within the existing property/casualty (P/C) blank for the Underwriting and Investment Exhibits, Exhibit of Premiums and Losses (State Page), and Insurance Expense Exhibit. It adds a new Schedule P, Part 1 through Part 4, specific to pet insurance.

Doggett stated that she and the NAIC support staff for the Working Group met with Eva Yeung (NAIC), support staff for the Property and Casualty Risk-Based Capital (E) Working Group. Yeung indicated that the memorandum intends to make it clear that the Property and Casualty Risk-Based Capital (E) Working Group does not plan to change the risk-based capital (RBC) factor as a result of this proposal. Doggett stated that the proposal separates pet insurance from inland marine and provides more regularity. This will give more insight into the line of business, and it is not intended to affect the RBC factors.

Doggett stated that for RBC purposes, the Schedule P data for inland marine and pet insurance can be added together to calculate the factor.

Botsko, chair of the Property and Casualty Risk-Based Capital (E) Working Group, stated that it is premature to add this as a line in the annual statement while there are two alternatives to retrieve data from industry. One way is to add a supplement to gather the data requested and monitor the information to see if it warrants adding a new line. The other option is to add a note to the Notes to the Financial Statement. Botsko stated that there are very few companies that write pet insurance, and this could be a disadvantage or be expensive for other companies to add this information. He stated that while this may be a growing line of business, there are other growing lines as well that are not separated out but have a supplement.

Gavin Friedman (Trupanion) stated that industry already has this data and has provided such in data calls; therefore, this should not be burdensome to the industry. The companies already produce the data internally for the trade groups every year. Friedman stated that this is perhaps why there were no opposing industry comments indicating a burden to produce the data. He stated that this industry is misclassified as inland marine. It is the opposite of where there is high frequency, very low severity, and ultra-short tail. Waiting another year, as suggested, is not logical since the data is already available. He stated that adding the line in the current blank made more sense rather than drafting an entirely new supplement. Once the data is received, it can be determined whether a new factor is needed. Friedman stated that the industry has grown 25% since the proposal was submitted.

Birny Birnbaum (Center for Economic Justice—CEJ) stated that the rationale for the proposal is developed. He stated that according to the industry trade association, the North American Pet Health Insurance Association (NAPHIA), the premium volume on pet insurance in the U.S. has increased each year from 2018 to 2022 by 24% to 30%—i.e., \$1.3 billion to \$3.2 billion—this being a 250% increase in four years. Many of the same companies that sell in the U.S. also sell in Canada, which adds another \$375 million written premium in 2022. The number of pets insured in the U.S. has grown from 2.2 million in 2018 to 4.9 million in 2022, as well as another 500,000 in Canada. The average premium for a typical accident wellness policy averages \$640 for dogs and \$387 for cats. Birnbaum stated that this line of business is uniquely and qualitatively different from other lines of business included in inland marine. Pet insurance has recurring monthly premiums without a specified term of coverage as opposed to a typical inland marine policy for which there is a single premium paid for a longer specified term of coverage.

Tip Tipton (Thrivent Financial) stated that interested parties support the deferral of this proposal to allow more time to discuss the inclusion. This would also allow time to evaluate the Market Conduct Annual Statement (MCAS) addition of the pet insurance line and review that data. Birnbaum stated that he was involved in the discussions regarding adding pet insurance into the MCAS filing, which serves a different purpose. It highlights underwriting practices and claims settlement practices.

Connie Jasper Woodroof (CJW Associates) stated that this addition would affect other companies that do not write pet insurance in modifying their systems to adjust for the new line. She indicated that she would support a supplement.

Kerri Cutry (MetLife Government Relations and MetLife Metropolitan General Insurance Company) stated that they are a leading carrier for pet insurance, and they support the proposal. She stated that she supports the comments of Friedman. She stated that the information is available, and adding this line will benefit state insurance regulators by providing more visibility and transparency into pet insurance as a growing market.

Doggett made a motion, seconded by Sirovetz, to adopt the proposal, including quarterly reporting (Attachment Two-A2). The motion passed unanimously.

C. Agenda Item 2023-02BWG

Teresa Cooper (NAIC) stated that this proposal adds a supplement to the life, P/C, and health statements. Originally, the request was to identify reportable premiums for MCAS purposes. After discussions with interested parties, it was agreed to ask only for a yes or no response as to whether premiums met the MCAS reporting requirements. The supplement needs only to be completed for those states in which a company writes the lines of business listed on the supplement.

Doggett made a motion, seconded by Garn, to adopt the modifications to the proposal. The motion passed unanimously.

Garn made a motion, seconded by Doggett, to adopt the modified proposal (Attachment Two-A3). The motion passed unanimously.

D. Agenda Item 2023-03BWG

Mary Caswell (NAIC) stated that this proposal removes life and accident and health (A&H)/fraternal blank crosschecks for Columns 2, 6, and 10 on the Accident and Health Policy Experience Exhibit (AHPEE). The life and A&H/fraternal blank crosschecks are not working correctly because Columns 2, 6, and 10 on the AHPEE are on a direct basis, while Exhibit 6 is on an assumed basis.

Hudson made a motion, seconded by Shanahan, to adopt the proposal (Attachment Two-A4). The motion passed unanimously.

E. Agenda Item 2023-04BWG

Angela McNabb (NAIC) stated that this proposal adds instructions for the appointed actuary and qualified actuary contacts to the jurat electronic-only section. In addressing interested party comments, clarification was made to indicate that the qualified actuary would be required by life/fraternal statement filers and by those health statement filers required to file the life supplement to the health blank. The reference to the quarterly filing was also deleted. McNabb stated that there was a comment regarding redundancy since there is some actuarial information in the general interrogatory and included in the actuarial opinion. The problem is that the actuarial opinion information is not captured electronically. The general interrogatory only asks for name, address, and affiliation in an unformatted manner. State insurance regulators need an easier way to electronically locate the actuary's phone number and email address as well.

Hynes made a motion, seconded by Hudson, to adopt the modifications to the proposal. The motion passed unanimously.

Hynes made a motion, seconded by Doggett, to adopt the modified proposal (Attachment Two-A5). The motion passed unanimously.

F. Agenda Item 2023-08BWG

Bruggeman stated that this proposal includes one minor clarification for mutual insurance companies on the instructions for Schedule Y, Part 3. NAIC staff noted that one consistent question received since the adoption of Schedule Y, Part 3, was how to treat mutual insurance companies for this reporting. This blanks proposal intends to clarify that mutual insurance companies that are part of a holding company system should be included on the common schedule.

Bruggeman made a motion, seconded by Hynes, to adopt the proposal (Attachment Two-A6). The motion passed unanimously.

G. Agenda Item 2023-10BWG

Eric King (NAIC) stated that the Long-Term Care Actuarial (B) Working Group requested this proposal to fix the reporting years, which were not intended to change each year. There was a slight modification to the wording within the proposal.

Hudson made a motion, seconded by Bruggeman, to adopt the modifications to the proposal. The motion passed unanimously.

Shanahan made a motion, seconded by Garn, to adopt the modified proposal (Attachment Two-A7). The motion passed unanimously.

H. Agenda Item 2023-11BWG

Bruggeman stated that this item was developed to data-capture the existing note in *SSAP No. 34—Investment Income Due and Accrued* and expand, with data-capturing, to collect more information on interest income. Corresponding revisions to SSAP No. 34 have already been adopted by the Statutory Accounting Principles (E) Working Group. Although these revisions were noted in accordance with the bond project, with investment schedule revisions also proposed under that project, aggregate data-capturing of investment income details for 2023, particularly with items that may be reported and admitted but for which the timing of receipt is uncertain, or that was received in a form other than cash, ensures appropriate state insurance regulator assessment of expected cash flows.

Although industry has made comments proposing to limit the collection of the aggregate note data to bonds, short-term, and cash equivalents, this would be inconsistent with the adopted revisions to SSAP No. 34, as the SSAP guidance is not limited to any specific investment. Industry has also noted that the collection of this data may be duplicative of what is on the balance sheet. However, the intent of this data in a note, along with the information on aggregate deferred interest, is to allow state insurance regulators to easily identify the amount of interest income that has been accrued and admitted but for which interest payments are deferred. With the design of some investments, there are products for which the deferral of interest does not result in a past-due assessment requiring non-admittance. As such, these amounts are still admitted in the financial statements. Without this disclosure, it is not possible to identify the amount of interest being reported from these items and complete a quick comparison to the admitted investment income due and accrued. It should also be noted that these investments may be on Schedule D or Schedule BA (or may move to Schedule BA under the bond project); therefore, limiting the scope of the disclosure would hinder the state insurance regulator benefit.

Bruggeman stated that the Statutory Accounting Principles (E) Working Group has considered comments on ensuring the consistent calculation of the payment-in-kind (PIK) interest in the cumulative principal balance, and

the Working Group has a current exposure to incorporate those elements. That exposure only provides clarifying guidance and does not change the adopted disclosure. If that clarifying expedient guidance is adopted by the Working Group, it can either be subsequently added to the instructions and/or provided as a memorandum for posting on the Blanks (E) Working Group web page.

Bruggeman stated that in response to comments on potential duplication, the intent is to allow state insurance regulators to quickly assess the impact of aggregate deferred interest to admitted interest; therefore, he said he supports the note with the data-captured element included as exposed.

Bruggeman made a motion, seconded by Drutz, to adopt the modifications to the proposal. The motion passed unanimously.

Bruggeman made a motion, seconded by Drutz, to adopt the modified proposal (Attachment Two-A8). The motion passed unanimously.

3. Referenced a Proposal with a Public Comment Period Ending June 30

A. Agenda Item 2023-06BWG

Bruggeman stated that this proposal pertains to the bond project, and it incorporates several revisions to expand the bond reporting schedule into two schedules: one for issuer credit obligations and one for asset-backed securities (ABS). Although the combined total from both schedules will be reflected as "bonds" on the balance sheet, several other corresponding revisions are proposed to ensure that the new schedules and terminology are reflected properly in the various financial statement schedules, exhibits, and notes. In addition to expanding the bond schedules, more granular reporting lines are proposed to identify the type of bond investment held. These additional reporting lines also affect other schedules, and they are reflected in the revisions.

The public comment period on this item ends June 30. No action is required by the Working Group at this time.

4. Deferred Items

A. Agenda Item 2023-05BWG

Sara Robben (NAIC) stated that this proposal was intended to: 1) make changes to the cybersecurity supplement to remove the references to identity theft from the general instructions; 2) combine the claims-made and occurrence to only have the total number of policies in force; and 3) eliminate the first-party and third-party breakdown. Some definitions were also added for clarification. Robben stated that after further discussion with interested parties, she agreed with the recommendation of deferring this proposal to allow more time to work out additional details within the proposal.

Hudson made a motion, seconded by Shanahan, to defer the proposal to allow for further discussion, with a public comment period ending June 30. The motion passed unanimously.

B. Agenda Item 2023-07BWG

Bruggeman stated that this proposal includes revisions to investment schedules identified as part of the review completed under the bond project, but it does not reflect revisions driven specifically by the bond project. The key item is the removal of the legal entity identifier (LEI) reporting column for all schedules except for the derivatives schedule (Schedule DB). After a review of the reporting of the LEI, further understanding of how an LEI

is obtained, and the limited reporting of the LEI on the investment schedules, this data element is proposed to be removed from most investment schedules.

Ultimately, the LEI can only be obtained from the investment issuer or their designated representative. If an issuer does not obtain an LEI, then there is nothing that a reporting entity can do to obtain one on their behalf. Also, the issuer must recertify the LEI each year, and failing to complete that process results in an LEI that is no longer applicable. Since there is no requirement for issuers to get or maintain LEIs when issuing most investments, the information available for reporting entities is very limited. Additionally, even if there were an LEI at one time, companies would have had to manually check the LEI database annually to see if the LEI was still current. With the limited reporting that exists on most investment schedules, from the information obtained, no state insurance regulators have been identified as using the LEI from the investment schedule for any assessment purpose. The LEI for derivatives is proposed to be retained, as that is an investment in which insurers may be required to get LEIs; therefore, the information for LEIs is more prevalent and current.

Bruggeman stated that although not directly related to the bond project, the revisions were identified from the bond project review. Industry has requested for the proposal to mirror the timing of the bond proposal changes, resulting in the investment schedule revisions occurring simultaneously.

Bruggeman made a motion, seconded by Hudson, to defer the proposal to coincide with the 2023-06BWG proposal public comment period ending June 30 (Attachment Two-J). The motion passed unanimously.

C. Agenda Item 2023-09BWG

Bruggeman stated that this item was developed to provide an annual statement note that would provide crosschecks to the updates to the Life RBC C-2 Mortality risk charge. This proposal and the related Statutory Accounting Principles (E) Working Group agenda item 2023-03 were simultaneously exposed. The Statutory Accounting Principles (E) Working Group discussed comments received at its May 16 meeting, which requested moving this information to another location other than the financial statement notes, and some of the information was redundant or not needed to support the C-2 charge. Based on these comments and information received from NAIC staff supporting the Life Risk-Based Capital (E) Working Group that the note was not essential for the updated C-2 charge to go forward, the Statutory Accounting Principles (E) Working Group determined to defer this item and forward the comments received to the Life Risk-Based Capital (E) Working Group.

Bruggeman made a motion, seconded by Hudson, to defer the proposal for a 30-day public comment period ending June 30. The motion passed unanimously.

5. Adopted the Editorial Listing

Hudson made a motion, seconded by Garn, to adopt the editorial listing (Attachment Two-A9). The motion passed unanimously.

Having no further business, the Blanks (E) Working Group adjourned.

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NAIC BLANKS (E) WORKING GROUP

Blanks Agenda Item Submission Form

<p style="text-align: right;">DATE: <u>09/01/2022</u></p> <p>CONTACT PERSON: _____</p> <p>TELEPHONE: _____</p> <p>EMAIL ADDRESS: _____</p> <p>ON BEHALF OF: _____</p> <p>NAME: <u>Dale Bruggeman</u></p> <p>TITLE: <u>Chair SAPWG</u></p> <p>AFFILIATION: <u>Ohio Department of Insurance</u></p> <p>ADDRESS: <u>50W. Town St., 3rd FL., Ste. 300</u> <u>Columbus, OH 43215</u></p>	<p style="text-align: center;">FOR NAIC USE ONLY</p> <p>Agenda Item # <u>2022-17BWG Mod</u> Year <u>2023</u> Changes to Existing Reporting [<input checked="" type="checkbox"/>] New Reporting Requirement [<input type="checkbox"/>]</p> <hr/> <p style="text-align: center;">REVIEWED FOR ACCOUNTING PRACTICES AND PROCEDURES IMPACT</p> <p>No Impact [<input checked="" type="checkbox"/>] Modifies Required Disclosure [<input type="checkbox"/>]</p> <hr/> <p style="text-align: center;">DISPOSITION</p> <p>[<input type="checkbox"/>] Rejected For Public Comment [<input type="checkbox"/>] Referred To Another NAIC Group [<input type="checkbox"/>] Received For Public Comment [<input checked="" type="checkbox"/>] Adopted Date <u>05/31/2023</u> [<input type="checkbox"/>] Rejected Date _____ [<input type="checkbox"/>] Deferred Date _____ [<input type="checkbox"/>] Other (Specify) _____</p>
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| <input checked="" type="checkbox"/> Life, Accident & Health/Fraternal | <input type="checkbox"/> Separate Accounts | <input checked="" type="checkbox"/> Title |
| <input checked="" type="checkbox"/> Property/Casualty | <input type="checkbox"/> Protected Cell | <input type="checkbox"/> Other _____ |
| <input checked="" type="checkbox"/> Health | <input type="checkbox"/> Health (Life Supplement) | |

Anticipated Effective Date: Annual 2023

IDENTIFICATION OF ITEM(S) TO CHANGE

Add new disclosure paragraph for Note 8 – Derivative Instruments and add an illustration to be data captured for the new disclosure. Add electronic only columns related to derivatives with excluded components to Schedule DB, Part A and Part B for both Section 1 and Section 2. Add new code column instructions for Schedule DB, Part A and Part B.

REASON, JUSTIFICATION FOR AND/OR BENEFIT OF CHANGE**

The purpose of this proposal is to modify the instructions for Note 8 and Schedule DB to reflect changes to *SSAP No. 86 – Derivatives* adopted by the Statutory Accounting Principles (E) Working Group in agenda item 2021-20.

NAIC STAFF COMMENTS

Comment on Effective Reporting Date: _____

Other Comments:

** This section must be completed on all forms.

ANNUAL STATEMENT INSTRUCTIONS – LIFE, HEALTH, PROPERTY, FRATERNAL & TITLE

NOTES TO FINANCIAL STATEMENTS

Notes to the Annual Statement are to be filed on March 1.



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8. Derivative Instruments

Instruction:

Disclose the following information by category of derivative financial instrument:

A. Derivatives under *SSAP No. 86—Derivatives*

Disclose the following information by category of derivative financial instrument:

- (1) A discussion of the market risk, credit risk and cash requirements of the derivative.
- (2) A description of the reporting entity's objectives for using derivatives, i.e., hedging, income generation or replication, as well as a description of the context needed to understand those objectives and its strategies for achieving those objectives, including the identification of the category, e.g., fair value hedges, cash flow hedges, or foreign currency hedges, and for all objectives, the type of instrument(s) used.
- (3) A description of the accounting policies for recognizing (or reasons for not recognizing) and measuring the derivatives used, and when recognized and where those instruments and related gains and losses are reported.
- (4) Identification of whether the reporting entity has derivative contracts with financing premiums. (For purposes of this term, this includes scenarios in which the premium cost is paid at the end of the derivative contract or throughout the derivative contract.)
- (5) The net gain or loss recognized in unrealized gains or losses during the reporting period representing the component of the derivative instruments' gain or loss, if any, excluded from the assessment of hedge effectiveness.
- (6) The net gain or loss recognized in unrealized gains or losses during the reporting period resulting from derivatives that no longer qualify for hedge accounting.
- (7) For derivatives accounted for as cash flow hedges of a forecasted transaction, disclose:
 - a. The maximum length of time over which the entity is hedging its exposure to the variability in future cash flows for forecasted transactions excluding those forecasted transactions related to the payment of variable interest on existing financial instruments; and
 - b. The amount of gains and losses classified in unrealized gains/losses related to cash flow hedges that have been discontinued because it was no longer probable that the original forecasted transactions would occur by the end of the originally specified time period or within 2 months of that date.
- (8) Disclose the aggregate, non-discounted total premium cost for these contracts and the premium cost due in each of the following four years, and thereafter. Also disclose the aggregate fair value of

ANNUAL/QUARTERLY STATEMENT INSTRUCTIONS – LIFE, HEALTH, PROPERTY, FRATERNAL & TITLE

SCHEDULE DB – PART A – SECTION 1

OPTIONS, CAPS, FLOORS, COLLARS, SWAPS AND FORWARDS OPEN
DECEMBER 31 OF CURRENT YEAR

Include all options, caps, floors, collars, swaps and forwards owned on December 31 of the current year, including those owned on December 31 of the previous year, and those acquired during the current year.

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Column 15 – Code

Insert “*” in this column if the book/adjusted carrying value is combined with the book/adjusted carrying value of assets or liabilities hedged; the book/adjusted carrying value is combined with the book/adjusted carrying value of underlying/covering assets; or if the amount is combined with consideration paid on underlying/covering assets.

Insert “#” in this column if the book/adjusted carrying value was combined in prior years with the book/adjusted carrying value of assets or liabilities hedged.

Insert “@” in this column if the income/expenses is combined with income/expenses on assets or liabilities hedged.

Insert “^” in this column if the derivative has unpaid financing premiums.

Insert “%” in this column if the derivative has excluded components.

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**** Columns 24 through 36 will be electronic only. ****

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****Columns 34 through 36 are for derivatives that have excluded components****

Column 34 – Fair Value of the Excluded Component

Report the fair value of the excluded component.

Column 35 – Fair Value of the Excluded Component Reflected in the Reported Book/Adjusted Carry Value

Reflect the fair value of the excluded component that is reflected in the reported book/adjusted carry value.

(Not applicable for foreign currency forwards and currency swaps where the forward points or cross-currency basis, respectively, are the excluded component).

Column 36 – The Change in Fair Value Reported as an Unrealized Gain (Loss)

This represents the change in fair value reported as an unrealized gain (loss).

(Not applicable for foreign currency forwards and currency swaps where the forward points or cross-currency basis, respectively, are the excluded component).

ANNUAL STATEMENT INSTRUCTIONS – LIFE, HEALTH, PROPERTY, FRATERNAL & TITLE

SCHEDULE DB – PART A – SECTION 2

**OPTIONS, CAPS, FLOORS, COLLARS, SWAPS AND FORWARDS TERMINATED
DURING CURRENT YEAR**

Include all options, caps, floors, collars, swaps and forwards which were terminated during the current reporting year, both those that were owned on December 31 of the previous reporting year, and those acquired and terminated during the current year.

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Column 18 – Code

Insert “*” in this column if the book/adjusted carrying value is combined with the book/adjusted carrying value of assets or liabilities hedged; if the book/adjusted carrying value is combined with the book/adjusted carrying value of underlying/covering assets; or if the amount is combined with consideration paid on underlying/covering assets.

Insert “#” in this column if the book/adjusted carrying value was combined in prior years with the book/adjusted carrying value of assets or liabilities hedged.

Insert “@” in this column if the income/expenses is combined with income/expenses on assets or liabilities hedged.

Insert “^” in this column if the derivative has unpaid financing premiums.

Insert “%” in this column if the derivative has excluded components.

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**** Column 26 through 35 will be electronic only. ****

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****Columns 33 through 35 are for derivatives that have excluded components****

Column 33 – Fair Value of the Excluded Component

Report the fair value of the excluded component.

Column 34 – Fair Value of the Excluded Component Reflected in the Reported Book/Adjusted Carry Value

Reflect the fair value of the excluded component that is reflected in the reported book/adjusted carry value.

(Not applicable for foreign currency forwards and currency swaps where the forward points or cross-currency basis, respectively, are the excluded component).

Column 35 – The Change in Fair Value Reported as an Unrealized Gain (Loss)

This represents the change in fair value reported as an unrealized gain (loss).

(Not applicable for foreign currency forwards and currency swaps where the forward points or cross-currency basis, respectively, are the excluded component).

ANNUAL/QUARTERLY STATEMENT INSTRUCTIONS – LIFE, HEALTH, PROPERTY, FRATERNAL & TITLE

SCHEDULE DB – PART B – SECTION 1

**FUTURES CONTRACTS OPEN
DECEMBER 31 OF CURRENT YEAR**

Include all futures contracts positions open December 31 of current year, including those which were open on December 31 of previous year, and those acquired during current year.

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**** Columns 23 through 34 will be electronic only. ****

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****Columns 32 through 34 are for derivatives that have excluded components****

- Column 32 – Fair Value of the Excluded Component
Report the fair value of the excluded component.

- Column 33 – Fair Value of the Excluded Component Reflected in the Reported Book/Adjusted Carry Value
Reflect the fair value of the excluded component that is reflected in the reported book/adjusted carry value.

(Not applicable for foreign currency forwards and currency swaps where the forward points or cross-currency basis, respectively, are the excluded component).

- Column 34 – The Change in Fair Value Reported as an Unrealized Gain (Loss)
This represents the change in fair value reported as an unrealized gain (loss).

(Not applicable for foreign currency forwards and currency swaps where the forward points or cross-currency basis, respectively, are the excluded component).

ANNUAL STATEMENT INSTRUCTIONS – LIFE, HEALTH, PROPERTY, FRATERNAL & TITLE

SCHEDULE DB – PART B – SECTION 2

**FUTURES CONTRACTS TERMINATED
DURING CURRENT YEAR**

Include all futures contracts which were terminated during current reporting year, both those that were open on December 31 of previous reporting year, and those acquired and terminated during current year.


Detail Eliminated To Conserve Space


**** Column 21 through 30 will be electronic only. ****


Detail Eliminated To Conserve Space


****Columns 28 through 30 are for derivatives that have excluded components****

- Column 28 – Fair Value of the Excluded Component
Report the fair value of the excluded component.

- Column 29 – Fair Value of the Excluded Component Reflected in the Reported Book/Adjusted Carry Value
Reflect the fair value of the excluded component that is reflected in the reported book/adjusted carry value.

(Not applicable for foreign currency forwards and currency swaps where the forward points or cross-currency basis, respectively, are the excluded component).

- Column 30 – The Change in Fair Value Reported as an Unrealized Gain (Loss)
This represents the change in fair value reported as an unrealized gain (loss).

(Not applicable for foreign currency forwards and currency swaps where the forward points or cross-currency basis, respectively, are the excluded component).

[https://naiconline.sharepoint.com/sites/naicsupportstaffhub/member meetings/e cmte/apptf/2023-2 summer/bwg/att2a1-2022-17bwg_modified.docx](https://naiconline.sharepoint.com/sites/naicsupportstaffhub/member%20meetings/e%20cmte/apptf/2023-2%20summer/bwg/att2a1-2022-17bwg_modified.docx)

NAIC BLANKS (E) WORKING GROUP

Blanks Agenda Item Submission Form

<p style="text-align: right;">DATE: <u>11/4/2022</u></p> <p>CONTACT PERSON: <u>Debbie Doggett (MO DCI) & Gavin Friedman (American Pet Ins Co; ZPIC Ins Co)</u></p> <p>TELEPHONE: <u>Debbie (573) 526-2944 / Gavin (310) 254-5256</u></p> <p>EMAIL ADDRESS: <u>debbie.doggett@insurance.mo.gov / gavin.friedman@trupanion.com</u></p> <p>ON BEHALF OF: <u>Joint submission by (i) the MO Dept of Commerce and Insurance and (ii) American Pet Ins Co and ZPIC Ins Co</u></p> <p>NAME: <u>Debbie Doggett</u></p> <p>TITLE: <u>Chief Financial Analyst</u></p> <p>AFFILIATION: <u>Missouri DCI</u></p> <p>ADDRESS: <u>301 W Hight St. #530, Jefferson City, MO 65101</u></p>	<p style="text-align: center;">FOR NAIC USE ONLY</p> <p>Agenda Item # <u>2023-01BVG MOD</u></p> <p>Year <u>2024</u></p> <p>Changes to Existing Reporting [X]</p> <p>New Reporting Requirement []</p> <hr/> <p style="text-align: center;">REVIEWED FOR ACCOUNTING PRACTICES AND PROCEDURES IMPACT</p> <p>No Impact [X]</p> <p>Modifies Required Disclosure []</p> <p>Is there data being requested in this proposal which is available elsewhere in the Annual/Quarterly Statement? [No]</p> <p><i>*** If Yes, complete question below***</i></p> <hr/> <p style="text-align: center;">DISPOSITION</p> <p>[] Rejected For Public Comment</p> <p>[] Referred To Another NAIC Group</p> <p>[] Received For Public Comment</p> <p>[X] Adopted Date <u>05/31/2023</u></p> <p>[] Rejected Date _____</p> <p>[] Deferred Date _____</p> <p>[] Other (Specify) _____</p>
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| <input checked="" type="checkbox"/> ANNUAL STATEMENT | <input checked="" type="checkbox"/> INSTRUCTIONS | <input checked="" type="checkbox"/> CROSSCHECKS |
| <input checked="" type="checkbox"/> QUARTERLY STATEMENT | <input checked="" type="checkbox"/> BLANK | |
| <input type="checkbox"/> Life, Accident & Health/Fraternal | <input type="checkbox"/> Separate Accounts | <input type="checkbox"/> Title |
| <input checked="" type="checkbox"/> Property/Casualty | <input type="checkbox"/> Protected Cell | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Health | <input type="checkbox"/> Health (Life Supplement) | |

Anticipated Effective Date: January 1, 2024

IDENTIFICATION OF ITEM(S) TO CHANGE

Remove Pet Insurance from Inland Marine line of business and add a new line of business to Appendix – P/C Lines of Business. Add Pet Insurance line within the existing P/C Blank for the Underwriting and Investment Exhibits, Exhibit of Premiums and Losses (State Page), and Insurance Expense Exhibit. Add new Schedule P Parts 1 through 4 specific to Pet Insurance.

REASON, JUSTIFICATION FOR AND/OR BENEFIT OF CHANGE**

See Page 2 for detailed reason and justification for change.

*****IF THE DATA IS AVAILABLE ELSEWHERE IN THE ANNUAL/QUARTERLY STATEMENT, PLEASE NOTE WHY IT IS REQUIRED FOR THIS PROPOSAL*****

NAIC STAFF COMMENTS

Comment on Effective Reporting Date: _____

Other Comments:

** This section must be completed on all forms.

Revised 11/17/2022

REASON, JUSTIFICATION FOR AND/OR BENEFIT OF CHANGE

Pet insurance is reported today as an Inland Marine product. Separating Pet Insurance from Inland Marine for financial reporting purposes within the existing Blank is warranted for a number of reasons, including:

- There is no public or regulator visibility into the vast majority of the pet insurance industry's financial reporting. Other than for a monoline insurer that writes only pet insurance, the rest of the industry's pet insurance business financial reporting is included in Inland Marine, along with anything else in that broadly-defined line that the respective insurer has written. In short, regulators do not have clear visibility into even the most basic information about pet insurers and the pet insurance market, such as who is underwriting pet coverage, the volume being sold, losses, and who is selling it.
- The pet insurance industry has grown rapidly, and this high growth rate continues. The industry's self-reported data shows growth in annual gross written premium from \$836.5 M in 2016 to \$2.59 B in 2021, including more than 30% annual growth from 2020 to 2021. This growth rate makes the absence of visibility into each participating company's financial information more an acute challenge with each passing year.
- Relying on regulator data calls to gather basic information such as premium written and loss information is time-consuming for all involved, and prone to inconsistencies and errors.
- The NAIC's D Committee is proceeding with MCAS for pet insurance. It would be inapposite and have potential for inconsistent data, to require MCAS reporting while not requiring dedicated pet insurance financial reporting. In addition, separate financial reporting will be a useful complement to MCAS reporting, both to supplement the MCAS information and to validate it.
- Dedicated financial reporting of pet insurance will be helpful to state regulators' assessment of the appropriate amount of surplus insurers writing this business should hold. It is anticipated that once sufficient history is obtained, a separate RBC factor for pet insurance can be established.

ANNUAL STATEMENT INSTRUCTIONS – PROPERTY/CASUALTY

APPENDIXPROPERTY AND CASUALTY LINES OF BUSINESS

These definitions should be applied when reporting all applicable amounts for the following schedules: Underwriting and Investment Exhibit Parts 1, 1A, 1B, 2, and 2A; Exhibit of Premiums and Losses (Statutory Page 14); and the Insurance Expense Exhibit. Policy fees, service charges or membership charges are to be included with the line of business or in Other Income, as determined by *SSAP No. 53—Property and Casualty Contracts – Premiums*.

**Detail Eliminated to Conserve Space**

Line 9.1 – Inland Marine

Coverage for property that may be in transit, held by a bailee, at a fixed location, a movable good that is often at different locations (e.g., off-road construction equipment) or scheduled property (e.g., Homeowners Personal Property Floater), including items such as live animals, property with antique or collector's value, etc. This line also includes instrumentalities of transportation and communication, such as bridges, tunnels, piers, wharves, docks, pipelines, power and phone lines, and radio and television towers.

Animal Mortality

Coverage that provides a death benefit to the owner of a policy in the event of the death of the insured livestock.

EDP Policies

Coverage to protect against losses arising out of damage to or destruction of electronic data processing equipment and its software.

Pet Insurance Plans

~~Veterinary care plan insurance policy providing care for a pet animal (e.g., dog or cat) of the insured owner in the event of its illness or accident.~~

Communication Equipment (Cellular Telephones)

Provides insured subscribers of Communications Equipment Service Provider replacement coverage for loss of and damage, theft or mechanical breakdown to communications equipment. Communications equipment means wireless telephones and pagers, and any other devices incorporating wireless phone and pager capabilities, including but not limited to personal digital assistants (PDA) and wireless aircards.

Line 9.2 – Pet Insurance Plans

Veterinary care plan insurance policy providing care for a pet animal (e.g., dog or cat) of the insured owner in the event of its illness or accident.

SCHEDULE P

SCHEDULE P – PART 1

Part 1 – Summary is the total of the Schedule P lines. For the property lines, it is necessary to supplement the data in the individual sections of Schedule P in order to complete the Part 1 – Summary for all lines for all years. Non-proportional assumed reinsurance – Property, Liability and Financial Lines can be summed together as reported.

↓
===== **Detail Eliminated to Conserve Space** =====
↑

Non-proportional assumed reinsurance –Property Reinsurance

Includes all the following lines: Fire, Allied Lines, Ocean Marine, Inland Marine, [Pet Insurance Plans](#), Earthquake, Group Accident and Health, Credit Accident and Health, Other Accident and Health, Auto Physical Damage, Boiler and Machinery, Burglary and Theft and International (of the foregoing).

↓
===== **Detail Eliminated to Conserve Space** =====
↑

SCHEDULE P – PARTS 1A THROUGH ~~1F~~ 1U

Reporting entities should complete Schedule P in thousands only but must report all claim counts in whole numbers.

↓
===== **Detail Eliminated to Conserve Space** =====
↑

ANNUAL STATEMENT BLANKS – PROPERTY/CASUALTY

UNDERWRITING AND INVESTMENT EXHIBIT

PART 1 – PREMIUMS EARNED

Line of Business	1 Net Premiums Written per Column 6, Part 1B	2 Unearned Premiums Dec. 31 Prior Year- per Col. 3, Last Year's Part 1	3 Unearned Premiums Dec. 31 Current Year- per Col. 5 Part 1A	4 Premiums Earned During Year (Cols. 1 + 2 - 3)
1. Fire				
2.1 Allied lines				
2.2 Multiple peril crop				
2.3 Federal flood				
2.4 Private crop				
2.5 Private flood				
3. Farmowners multiple peril				
4. Homeowners multiple peril				
5.1 Commercial multiple peril (non-liability portion).....				
5.2 Commercial multiple peril (liability portion)				
6. Mortgage guaranty				
8. Ocean marine				
9.1 Inland marine				
9.2. <u>Pet Insurance Plans</u>				
10. Financial guaranty				
11.1 Medical professional liability—occurrence				
11.2 Medical professional liability—claims-made				
12. Earthquake				
13.1 Comprehensive (hospital and medical) individual				
13.2 Comprehensive (hospital and medical) group				
14. Credit accident and health (group and individual)				
15.1 Vision only				
15.2 Dental only				
15.3 Disability income				
15.4 Medicare supplement				
15.5 Medicaid Title XIX				
15.6 Medicare Title XVIII				
15.7 Long-term care				
15.8 Federal employees health benefits plan				
15.9 Other health				
16. Workers' compensation				
17.1 Other liability—occurrence				
17.2 Other liability—claims-made				
17.3 Excess workers' compensation				
18.1 Products liability—occurrence				
18.2 Products liability—claims-made				
19.1 Private passenger auto no-fault (personal injury protection)				
19.2 Other private passenger auto liability				
19.3 Commercial auto no-fault (personal injury protection)				
19.4 Other commercial auto liability				
21.1 Private passenger auto physical damage				
21.2 Commercial auto physical damage				
22. Aircraft (all perils)				
23. Fidelity				
24. Surety				
26. Burglary and theft				
27. Boiler and machinery				
28. Credit				
29. International				
30. Warranty				
31. Reinsurance-nonproportional assumed property				
32. Reinsurance-nonproportional assumed liability				
33. Reinsurance-nonproportional assumed financial lines				
34. Aggregate write-ins for other lines of business				
35. TOTALS				
DETAILS OF WRITE-INS				
3401.				
3402.				
3403.				
3498. Sum. of remaining write-ins for Line 34 from overflow page				
3499. Totals (Lines 3401 through 3403 plus 3498) (Line 34 above)				

UNDERWRITING AND INVESTMENT EXHIBIT
PART 1A – RECAPITULATION OF ALL PREMIUMS

Line of Business	1 Amount Unearned (Running One Year or Less from Date of Policy) (a)	2 Amount Unearned (Running More Than One Year from Date of Policy) (a)	3 Earned but Unbilled Premium	4 Reserve for Rate Credits and Retrospective Adjustments Based on Experience	5 Total Reserve for Unearned Premiums Cols. 1+2+3+4
1. Fire.....					
2.1 Allied lines.....					
2.2 Multiple peril crop.....					
2.3 Federal flood.....					
2.4 Private crop.....					
2.5 Private flood.....					
3. Farmowners multiple peril.....					
4. Homeowners multiple peril.....					
5.1 Commercial multiple peril (non-liability portion).....					
5.2 Commercial multiple peril (liability portion).....					
6. Mortgage guaranty.....					
8. Ocean marine.....					
9.1 Inland marine.....					
9.2 <u>Pet Insurance Plans</u>					
10. Financial guaranty.....					
11.1 Medical professional liability—occurrence.....					
11.2 Medical professional liability—claims-made.....					
12. Earthquake.....					
13.1 Comprehensive (hospital and medical) individual.....					
13.2 Comprehensive (hospital and medical) group.....					
14. Credit accident and health..... (group and individual)					
15.1 Vision only.....					
15.2 Dental only.....					
15.3 Disability income.....					
15.4 Medicare supplement.....					
15.5 Medicaid title XIX.....					
15.6 Medicare title XVIII.....					
15.7 Long-term care.....					
15.8 Federal employees health benefits plan.....					
15.9 Other health.....					
16. Workers' compensation.....					
17.1 Other liability—occurrence.....					
17.2 Other liability—claims-made.....					
17.3 Excess workers' compensation.....					
18.1 Products liability—occurrence.....					
18.2 Products liability—claims-made.....					
19.1 Private passenger auto no-fault (personal injury protection).....					
19.2 Other private passenger auto liability.....					
19.3 Commercial auto no-fault (personal injury protection).....					
19.4 Other commercial auto liability.....					
21.1 Private passenger auto physical damage.....					
21.2 Commercial auto physical damage.....					
22. Aircraft (all perils).....					
23. Fidelity.....					
24. Surety.....					
26. Burglary and theft.....					
27. Boiler and machinery.....					
28. Credit.....					
29. International.....					
30. Warranty.....					
31. Reinsurance-nonproportional assumed property.....					
32. Reinsurance-nonproportional assumed liability.....					
33. Reinsurance-nonproportional assumed financial lines.....					
34. Aggregate write-ins for other lines of business.....					
35. TOTALS					
36. Accrued retrospective premiums based on experience.....					
37. Earned but unbilled premiums.....					
38. Balance (Sum of Lines 35 through 37)					
DETAILS OF WRITE-INS					
3401.					
3402.					
3403.					
3498. Sum. of remaining write-ins for Line 34 from overflow page.....					
3499. Totals (Lines 3401 through 3403 plus 3498) (Line 34 above)					

(a) State here basis of computation used in each case.....

UNDERWRITING AND INVESTMENT EXHIBIT
PART 1B – PREMIUMS WRITTEN

Line of Business	1 Direct Business (a)	Reinsurance Assumed		Reinsurance Ceded		6 Net Premiums Written Cols. 1+2+3- 4-5
		2 From Affiliates	3 From Non- Affiliates	4 To Affiliates	5 To Non- Affiliates	
1. Fire						
2.1 Allied lines						
2.2 Multiple peril crop.....						
2.3 Federal flood						
2.4 Private crop						
2.5 Private flood						
3. Farmowners multiple peril						
4. Homeowners multiple peril.....						
5.1 Commercial multiple peril (non-liability portion).....						
5.2 Commercial multiple peril (liability portion) ...						
6. Mortgage guaranty						
8. Ocean marine						
9.1 Inland marine						
9.2 <u>Pet Insurance Plans</u>						
10. Financial guaranty						
11.1 Medical professional liability—occurrence						
11.2 Medical professional liability—claims-made						
12. Earthquake.....						
13.1 Comprehensive (hospital and medical) individual.....						
13.2 Comprehensive (hospital and medical) group ..						
14. Credit accident and health (group and individual).....						
15.1 Vision only						
15.2 Dental only						
15.3 Disability income.....						
15.4 Medicare supplement						
15.5 Medicaid Title XIX						
15.6 Medicare Title XVIII						
15.7 Long-term care.....						
15.8 Federal employees health benefits plan						
15.9 Other Health						
16. Workers' compensation						
17.1 Other liability—occurrence.....						
17.2 Other liability—claims-made.....						
17.3 Excess workers' compensation						
18.1 Products liability—occurrence.....						
18.2 Products liability—claims-made.....						
19.1 Private passenger auto no-fault (personal injury protection).....						
19.2 Other private passenger auto liability						
19.3 Commercial auto no-fault (personal injury protection)						
19.4 Other commercial auto liability						
21.1 Private passenger auto physical damage.....						
21.2 Commercial auto physical damage						
22. Aircraft (all perils).....						
23. Fidelity						
24. Surety						
26. Burglary and theft						
27. Boiler and machinery						
28. Credit.....						
29. International						
30. Warranty.....						
31. Reinsurance-nonproportional assumed property	XXX					
32. Reinsurance-nonproportional assumed liability.....	XXX					
33. Reinsurance-nonproportional assumed financial lines	XXX					
34. Aggregate write-ins for other lines of business ..						
35. TOTALS						
DETAILS OF WRITE-INS						
3401.						
3402.						
3403.						
3498.Sum. of remaining write-ins for Line 34 from overflow page.....						
3499.Totals (Lines 3401 through 3403 plus 3498) (Line 34 above)						

(a) Does the company's direct premiums written include premiums recorded on an installment basis? Yes [] No []
If yes: 1. The amount of such installment premiums \$.....
2. Amount at which such installment premiums would have been reported had they been recorded on an annualized basis \$.....

**UNDERWRITING AND INVESTMENT EXHIBIT
PART 2 – LOSSES PAID AND INCURRED**

Line	Line of Business	Losses Paid Less Salvage			Net Payments (Cols. 1 + 2 - 3)	5 Net Losses Unpaid Current Year (Part 2A, Col. 8)	6 Net Losses Unpaid Prior Year	7 Losses Incurred Current Year (Cols. 4 + 5 - 6)	8 Percentage of Losses Incurred (Col. 7, Part 2) to Premiums Earned (Col. 4, Part 1)
		1 Direct Business	2 Reinsurance Assumed	3 Reinsurance Recovered					
1	Fire								
2.1	Allied lines								
2.2	Multiple peril crop								
2.3	Federal flood								
2.4	Private flood								
2.5	Private flood								
3	Farmowners multiple peril								
4	Homeowners multiple peril								
5.1	Commercial multiple peril (non-liability portion)								
5.2	Commercial multiple peril (liability portion)								
6	Mortgage guaranty								
8	Ocean marine								
9.1	Inland marine								
9.2	Public finance plus								
10	Financial guaranty								
11.1	Medical professional liability—occurrence								
11.2	Medical professional liability—claims-made								
12	Earthquake								
13.1	Comprehensive (hospital and medical) individual								
13.2	Comprehensive (hospital and medical) group								
14	Credit accident and health (group and individual)								
15.1	Vision only								
15.2	Dental only								
15.3	Disability income								
15.4	Medicare supplement								
15.5	Medicaid Title XIX								
15.6	Medicaid Title XVIII								
15.7	Long-term care								
15.8	Federal employees health benefits plan								
15.9	Other health								
16	Workers' compensation								
17.1	Other liability—occurrence								
17.2	Other liability—claims-made								
17.3	Excess workers' compensation								
18.1	Products liability—occurrence								
18.2	Products liability—claims-made								
19.1	Private passenger auto no-fault (personal injury protection)								
19.2	Other private passenger auto liability								
19.3	Commercial auto no-fault (personal injury protection)								
19.4	Other commercial auto liability								
21.1	Private passenger auto physical damage								
21.2	Commercial auto physical damage								
22	Aircraft (all perils)								
23	Fidelity								
24	Surety								
26	Burglary and theft								
27	Boiler and machinery								
28	Credit								
29	International								
30	Warranty								
31	Reinsurance-nonproportional assumed property								
32	Reinsurance-nonproportional assumed liability								
33	Reinsurance-nonproportional assumed financial lines								
34	Aggregate write-ins for other lines of business								
35	TOTALS								
DETAILS OF WRITE-INS									
3401									
3402									
3403									
3498	Sum. of remaining write-ins for Line 34 from overflow page								
3499	Totals (Lines 3401 through 3403 + 3498) (Line 34 above)								

**UNDERWRITING AND INVESTMENT EXHIBIT
PART 2A – UNPAID LOSSES AND LOSS ADJUSTMENT EXPENSES**

Line of Business	Reported Losses					Incurred But Not Reported			Net Unpaid Loss Adjustment Expenses
	1 Direct	2 Reinsurance Assumed	3 Deduct Reinsurance Recoverable	4 Net Losses Excl. Incurred But Not Reported (Cols. 1+2-3)	5 Direct	6 Reinsurance Assumed	7 Reinsurance Ceded	8 Net Losses Unpaid (Cols. 4 + 5 + 6 - 7)	
1. Fire									
2.1 Allied lines									
2.2 Multiple peril crop									
2.3 Federal flood									
2.4 Private crop									
2.5 Private flood									
3. Farmowners multiple peril									
4. Homeowners multiple peril									
5.1 Commercial multiple peril (non-liability portion)									
5.2 Commercial multiple peril (liability portion)									
6. Mortgage guaranty									
8. Ocean marine									
9.1 Inland marine									
9.2 <u>Re Insurance Plans</u>									
10. Financial guaranty—occurrence									
11.1 Medical professional liability—occurrence									
11.2 Medical professional liability—claims-made									
12. Earthquake									
13.1 Comprehensive (hospital and medical) individual									
13.2 Comprehensive (hospital and medical) group									
14. Credit accident and health (group and individual)									
15.1 Vision only									
15.2 Dental only									
15.3 Disability income									
15.4 Medicare supplement									
15.5 Medicaid Title XIX									
15.6 Medicare Title XVIII									
15.7 Long-term care									
15.8 Federal employees health benefits plan									
15.9 Other health									
16. Workers' compensation									
17.1 Other liability—occurrence									
17.2 Other liability—claims-made									
17.3 Excess workers' compensation									
18.1 Products liability—occurrence									
18.2 Products liability—claims-made									
19.1 Private passenger auto no-fault (personal injury protection)									
19.2 Other private passenger auto liability									
19.3 Commercial auto no-fault (personal injury protection)									
19.4 Other commercial auto liability									
21.1 Private passenger auto physical damage									
21.2 Commercial auto physical damage									
22. Aircraft (all perils)									
23. Fidelity									
24. Surety									
26. Burglary and theft									
27. Boiler and machinery									
28. Credit									
29. International									
30. Warranty									
31. Reinsurance-nonproportional assumed property									
32. Reinsurance-nonproportional assumed liability									
33. Reinsurance-nonproportional assumed financial lines									
34. Aggregate write-ins for other lines of business									
35. TOTALS									
DETAILS OF WRITE-INS									
3401.									
3402.									
3403.									
3498. Sum of remaining write-ins for Line 34 from overflow page									
3499. Totals (Lines 3401 through 3403 + 3498) (Line 34 above)									

(a) Including \$.....for present value of life indemnity claims reported in Lines 13 and 15.

INSURANCE EXPENSE EXHIBIT
PART II – ALLOCATION TO LINES OF BUSINESS NET OF REINSURANCE
PREMIUMS, LOSSES, EXPENSES, RESERVES AND PROFITS AND PERCENTAGES TO PREMIUMS EARNED FOR BUSINESS NET OF REINSURANCE
(\$000 OMITTED)

	Premiums Written (Pg. 8, Pt. 1B, Col. 6)		Premiums Earned (Pg. 6, Pt. 1, Col. 4)		Dividends to Policyholders (Pg. 4, Line 17)		Incurred Loss (Pg. 9, Pt. 2, Col. 7)		Loss Adjustment Expense				Unearned Premium Reserves (Pg. 7, Pt. 1A, Col. 5)		Agents' Balances											
	1 Amount	2 %	3 Amount	4 %	5 Amount	6 %	7 Amount	8 %	9 Amount	10 %	11 Amount	12 %	13 Amount	14 %	15 Amount	16 %	17 Amount	18 %	19 Amount	20 %	21 Amount	22 %				
1. Fire.....		XXX		100.0																						
2.1 Allied Lines.....		XXX		100.0																						
2.2 Multiple Peril Crop.....		XXX		100.0																						
2.3 Multiple Peril Non-Crop.....		XXX		100.0																						
2.4 Private Flood.....		XXX		100.0																						
2.5 Private Flood.....		XXX		100.0																						
3. Farmowners Multiple Peril.....		XXX		100.0																						
4. Homeowners Multiple Peril.....		XXX		100.0																						
5.1 Comm Mlt Peril (Non-Lab).....		XXX		100.0																						
5.2 Comm Mlt Peril (Lab).....		XXX		100.0																						
6. Marine.....		XXX		100.0																						
8. Ocean Marine.....		XXX		100.0																						
9.1 Inland Marine.....		XXX		100.0																						
9.2 Inland Marine.....		XXX		100.0																						
10. Financial Guaranty.....		XXX		100.0																						
11.1 Marine.....		XXX		100.0																						
11.2 Marine.....		XXX		100.0																						
12. Earthquake.....		XXX		100.0																						
13.1 Comprehensive Individual.....		XXX		100.0																						
13.2 Comprehensive Group.....		XXX		100.0																						
14.1 Health A&H.....		XXX		100.0																						
15.1 Dental Only.....		XXX		100.0																						
15.2 Dental Only.....		XXX		100.0																						
15.3 Disability Income.....		XXX		100.0																						
15.4 Medicare Supplement.....		XXX		100.0																						
15.5 Medicaid Title XIX.....		XXX		100.0																						
15.6 Long-Term Care.....		XXX		100.0																						
15.7 Long-Term Care.....		XXX		100.0																						
15.8 FEHBP.....		XXX		100.0																						
15.9 Other Health.....		XXX		100.0																						
16. Workers' Compensation.....		XXX		100.0																						
17.1 Other Liability—Occurrences.....		XXX		100.0																						
17.2 Other Liability—Occurrences.....		XXX		100.0																						
17.3 Other Liability—Occurrences.....		XXX		100.0																						
17.3a Workers' Compensation.....		XXX		100.0																						
18.1 Products Lib—Occurrences.....		XXX		100.0																						
18.2 Products Lib—Occurrences.....		XXX		100.0																						
19.1 Priv Passenger Auto No-Fault.....		XXX		100.0																						
19.2 Other Priv Passenger Auto Lib.....		XXX		100.0																						
19.3 Other Priv Passenger Auto Lib.....		XXX		100.0																						
19.4 Other Commercial Auto Liability.....		XXX		100.0																						
21.1 Priv Passenger Auto Phys Damage.....		XXX		100.0																						
21.2 Commercial Auto Phys Damage.....		XXX		100.0																						
22. Aircraft (all perils).....		XXX		100.0																						
23. Fidelity.....		XXX		100.0																						
24. Surety.....		XXX		100.0																						
26. Burglary and Theft.....		XXX		100.0																						
27. Boiler and Machinery.....		XXX		100.0																						
28. Credit.....		XXX		100.0																						
29. Intentional.....		XXX		100.0																						
30. Reins-Nonproportional Assumed Property.....		XXX		100.0																						
31. Reins-Nonproportional Assumed Property.....		XXX		100.0																						
32. Reins-Nonproportional Assumed Lib.....		XXX		100.0																						
33. Reins-Nonproportional Assumed Fin Lib.....		XXX		100.0																						
34. Aggr Write-Ins for Other Lines of Bus.....		XXX		100.0																						
35. TOTAL (Lines 1 through 34).....		XXX		100.0																						
3491.....		XXX		100.0																						
3492.....		XXX		100.0																						
3493.....		XXX		100.0																						
3498. Summary of remaining write-ins for Line 34 from overflow page.....		XXX		100.0																						
3499. TOTAL (Lines 3401 through 3405 plus 3498 (Line 34 above).....		XXX		100.0																						

INSURANCE EXPENSE EXHIBIT
PART II—ALLOCATION TO LINES OF BUSINESS NET OF REINSURANCE (Continued)
PREMIUMS, LOSSES, EXPENSES, RESERVES AND PROFITS AND PERCENTAGES TO PREMIUMS EARNED FOR BUSINESS NET OF REINSURANCE
(\$'000 OMITTED)

	Other Underwriting Expenses										Investment Gain Attributable to Insurance Transactions	Profit or Loss Excluding Investment Gain Attributable to Capital and Surplus	Investment Gain Attributable to Capital and Surplus	Total Profit or Loss							
	Commission and Brokerage Expenses Incurred (IEE Pt. 1, Line 2, 8, Col. 2)	Taxes, Licenses & Fees Incurred (IEE Pt. 1, Line 20-5, Col. 4)	Other Acquisitions, Field Supervision, and Collection Expenses Incurred (IEE Pt. 1, Line 25 minus 2, 8 Col. 2)	General Expenses Incurred (IEE Pt. 1, Line 25 Col. 3)	Other Income Less Other Expenses (Pg. 4, Line 15 minus Line 5)	Pre-Tax Profit or Loss Excluding All Investment Gain	Investment Gain Attributable to Insurance Transactions	Profit or Loss Excluding Investment Gain Attributable to Capital and Surplus	Investment Gain Attributable to Capital and Surplus	Total Profit or Loss											
	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	
	Amount	%	Amount	%	Amount	%	Amount	%	Amount	%	Amount	%	Amount	%	Amount	%	Amount	%	Amount	%	
1. Fire																					
2. Multiple Peril Corp.																					
3. Federal Flood																					
4. Private Corp.																					
5. Farmowners Multiple Peril																					
6. Farmers Multiple Peril																					
7. Commercial Multiple Peril																					
8. Commercial Multiple Peril (Lab)																					
9. Commercial Multiple Peril (Lab)																					
10. Commercial Multiple Peril (Lab)																					
11. Inland Marine																					
12. Multiple Peril																					
13. Med Prof Lab—Occurrences																					
14. Med Prof Lab—Claims-Made																					
15. Earthquake																					
16. Comprehensive Individual																					
17. Comprehensive Group																					
18. Comprehensive Group																					
19. Vision Only																					
20. Dental Only																					
21. Disability Income																					
22. Medicare Supplement																					
23. Medicare Title XIX																					
24. Medicare Title XVIII																					
25. Medicare Title XVIII																					
26. FEHP																					
27. Other Health																					
28. Workers' Compensation																					
29. Other Liability—Occurrences																					
30. Other Liability—Claims-Made																					
31. Products Lib—Occurrences																					
32. Products Lib—Claims-Made																					
33. Priv Passenger Auto No-Fault																					
34. Other Priv Passenger Auto Lib																					
35. Commercial Auto No-Fault																					
36. Other Commercial Auto Lib																					
37. Commercial Auto No-Fault																					
38. Commercial Auto Phys Damage																					
39. Aircraft (all perils)																					
40. Fidelity																					
41. Surety																					
42. Burglary and Theft																					
43. Fire and Machinery																					
44. Credit																					
45. International																					
46. Warranty																					
47. Reins-Nonproportional Assumed Property																					
48. Reins-Nonproportional Assumed Lib																					
49. Ass-Nonproportional Assumed Lib																					
50. Ass-Nonproportional Assumed Lib																					
51. Ass-Nonproportional Assumed Lib																					
52. TOTAL (Lines 1 through 51)																					
DETAILS OF WRITE-INS																					
3401																					
3402																					
3403																					
3498																					
3499																					

NOTE: THE ALLOCATION OF INVESTMENT INCOME FROM CAPITAL AND SURPLUS BY LINE OF BUSINESS MAY NOT ACCURATELY REFLECT THE PROFITABILITY OF A PARTICULAR LINE FOR USE IN THE RATE MAKING PROCESS.

INSURANCE EXPENSE EXHIBIT
PART III – ALLOCATION TO LINES OF DIRECT BUSINESS WRITTEN
PREMIUMS, LOSSES, EXPENSES, RESERVES AND PROFITS AND PERCENTAGES TO PREMIUMS EARNED FOR DIRECT BUSINESS WRITTEN
(\$000 OMITTED)

	Premiums Written (Pg. 8, Pt. I.B, Col. 1)		Premiums Earned (Sch. T, Line 59, Col. 3)		Dividends to Policyholders		Incurred Loss (Sch. T, Line 59, Col. 6)		Loss Adjustment Expense Defense and Cost Containment Expenses Incurred				Loss Adjustment Expense Defense and Cost Containment Expenses Unpaid				Unearned Premium Reserves		Agents' Balances				
	1 Amount	2 %	3 Amount	4 %	5 Amount	6 %	7 Amount	8 %	9 Amount	10 %	11 Amount	12 %	13 Amount	14 %	15 Amount	16 %	17 Amount	18 %	19 Amount	20 %	21 Amount	22 %	
1. Fire	XXX		XXX																				
2. Allied Lines	XXX		XXX																				
2.1 Multiple Peril Crop	XXX		XXX																				
2.2 Multiple Peril Crop	XXX		XXX																				
2.3 Federal Flood	XXX		XXX																				
2.4 Private Crop	XXX		XXX																				
2.5 Private Flood	XXX		XXX																				
3. Homeowners Multiple Peril	XXX		XXX																				
4. Homeowners Multiple Peril	XXX		XXX																				
5.1 Comm Multi Peril (Non-Liab)	XXX		XXX																				
5.2 Comm Multi Peril (Non-Liab)	XXX		XXX																				
6. Mortgages Guaranty	XXX		XXX																				
7. Ocean Marine	XXX		XXX																				
8. Marine	XXX		XXX																				
9.1 Pet Insurance	XXX		XXX																				
9.2 Pet Insurance	XXX		XXX																				
10. Financial Guaranty	XXX		XXX																				
11.1 Med Prof Liab—Occurrence	XXX		XXX																				
11.2 Med Prof Liab—Claims-Made	XXX		XXX																				
12.1 Earthquake	XXX		XXX																				
12.2 Earthquake	XXX		XXX																				
13.2 Competitive Group	XXX		XXX																				
14. Credit A&H	XXX		XXX																				
15.1 Vision Only	XXX		XXX																				
15.2 Dental Only	XXX		XXX																				
15.3 Disability Income	XXX		XXX																				
15.4 Medicare	XXX		XXX																				
15.5 Medicaid Title XIX	XXX		XXX																				
15.6 Medicare Title XVIII	XXX		XXX																				
15.7 Long-Term Care	XXX		XXX																				
15.8 FEHBP	XXX		XXX																				
15.9 Other Health	XXX		XXX																				
16. Workers Compensation	XXX		XXX																				
17.1 Other Liability—Occurrence	XXX		XXX																				
17.2 Other Liability—Claims-Made	XXX		XXX																				
17.3 Excess Workers' Compensation	XXX		XXX																				
18.1 Products Liab—Occurrence	XXX		XXX																				
18.2 Products Liab—Claims-Made	XXX		XXX																				
19.2 Other Priv Passenger Auto Liab	XXX		XXX																				
19.3 Commercial Auto No-Fault	XXX		XXX																				
19.4 Other Commercial Auto Liability	XXX		XXX																				
21.1 Priv Passenger Auto Phys Damage	XXX		XXX																				
21.2 Commercial Auto Phys Damage	XXX		XXX																				
22. Surety (all parts)	XXX		XXX																				
23. Fidelity	XXX		XXX																				
24. Surety	XXX		XXX																				
26. Burglary and Theft	XXX		XXX																				
26. Burglary and Machinery	XXX		XXX																				
27. Boiler and Machinery	XXX		XXX																				
28. Credit	XXX		XXX																				
29. Credit	XXX		XXX																				
30. Warranty	XXX		XXX																				
31. Reins-Nonproportional Assumed Property	XXX		XXX																				
32. Reins-Nonproportional Assumed Liab	XXX		XXX																				
33. Reins-Nonproportional Assumed Fin Lines	XXX		XXX																				
34. Aggr Write-Ins for Other Lines of Bus	XXX		XXX																				
35. TOTAL (Lines 1 through 34)	XXX		XXX																				
3400. Summary of remaining write-ins for Line	XXX		XXX																				
3403. Summary of remaining write-ins for Line	XXX		XXX																				
3498. Summary of remaining write-ins for Line	XXX		XXX																				
3499. Summary of remaining write-ins for Line	XXX		XXX																				
3499. TOTAL (Lines 3400 through 3498 plus 3499)(Line 34 above)	XXX		XXX																				

INSURANCE EXPENSE EXHIBIT
PART III – ALLOCATION TO LINES OF DIRECT BUSINESS WRITTEN (Continued)
PREMIUMS, LOSSES, EXPENSES, RESERVES AND PROFITS AND PERCENTAGES TO PREMIUMS EARNED FOR DIRECT BUSINESS WRITTEN
(\$000 OMITTED)

	Commission and Brokerage Expenses Incurred		Taxes, Licenses & Fees Incurred		Other Underwriting Expenses		General Expenses Incurred		Other Income Less Other Expenses		Pre-Tax Profit or Loss Excluding All Investment	
	23	24	25	26	27	28	29	30	31	32	33	34
	Amount	%	Amount	%	Amount	%	Amount	%	Amount	%	Amount	%
1. Fire												
2.1 Allied Lines												
2.2 Multiple Peril Crop												
2.3 Multiple Peril Non-Crop												
2.4 Private Club												
2.5 Private Flood												
3. Farmowners Multiple Peril												
4. Homeowners Multiple Peril												
5.1 Comm Multi Peril (Non-Liab)												
5.2 Comm Multi Peril (Liab)												
6. Long-Term Care												
7. Long-Term Care												
8. Long-Term Care												
9.1 Inland Marine												
9.2 Per Insurance Plans												
10. Financial Guaranty												
11.1 Med Prof Liability—Occurrence												
11.2 Med Prof Liability—Claims-Made												
12. Earthquake												
13.1 Comprehensive Group												
13.2 Comprehensive Group												
14. Credit A&H												
15.1 Vision Only												
15.2 Dental Only												
15.3 Disability Income												
15.4 Medicare Supplement												
15.5 Medicare Supplement												
15.6 Medicare Title XVIII												
15.7 Long-Term Care												
15.8 FEHBP												
15.9 Other Health												
16. Workers Compensation												
17.1 Other Liability—Occurrence												
17.2 Other Liability—Claims-Made												
17.3 Excess Workers Compensation												
18.1 Products Liab—Occurrence												
18.2 Products Liab—Claims-Made												
19.1 Priv Passenger Auto No-Fault												
19.2. Other Priv Passenger Auto Liab												
19.3 Commercial Auto No-Fault												
20. Commercial Auto Liability												
21.1 Priv Passenger Auto Damage												
21.2 Commercial Auto Phys Damage												
22. Aircraft (all perils)												
23. Fidelity												
24. Surety												
26. Burglary and Theft												
27. Boiler and Machinery												
28. International												
29. International												
30. Warranty												
31. Reins/Nonproportional Assumed Property												
32. Reins/Nonproportional Assumed Liab												
33. Reins/Nonproportional Assumed Fin Lines												
34. Aggr Write-Ins for Other Lines of Bus.												
35. TOTAL (Lines 1 through 34)												
DETAILS OF WRITE-INS												
3401.												
3402.												
3403.												
3408.												
3498.												
3499.												

SCHEDULE P – PART 1U – PET INSURANCE PLANS
(\$000 OMITTED)

Years in Which Premiums Were Earned and Losses Were Incurred	Premiums Earned			Loss and Loss Expense Payments						12 Number of Claims Reported Direct and Assumed		
	1 Direct and Assumed	2 Ceded	3 Net (Cols. 1 - 2)	Loss Payments		Defense and Cost Containment Payments		Adjusting and Other Payments			10 Salvage and Subrogation Received	11 Total Net Paid (Cols. 4 - 5 + 6 - 7 + 8 - 9)
				4 Direct and Assumed	5 Ceded	6 Direct and Assumed	7 Ceded	8 Direct and Assumed	9 Ceded			
1. Prior	XXX	XXX	XXX								XXX	
2. 2023											XXX	
3. 2024											XXX	
4. Totals	XXX	XXX	XXX								XXX	

	Losses Unpaid				Defense and Cost Containment Unpaid				Adjusting and Other Unpaid		23 Salvage and Subrogation Anticipated	24 Total Net Losses and Expenses Unpaid	25 Number of Claims Outstanding Direct and Assumed
	Case Basis		Bulk + IBNR		Case Basis		Bulk + IBNR		21 Direct and Assumed	22 Ceded			
	13 Direct and Assumed	14 Ceded	15 Direct and Assumed	16 Ceded	17 Direct and Assumed	18 Ceded	19 Direct and Assumed	20 Ceded					
1.													
2.													
3.													
4.													

	Total Losses and Loss Expenses Incurred			Loss and Loss Expense Percentage (Incurred/Premiums Earned)			Nontabular Discount		34 Inter-Company Pooling Participation Percentage	Net Balance Sheet Reserves After Discount	
	26 Direct and Assumed	27 Ceded	28 Net	29 Direct and Assumed	30 Ceded	31 Net	32 Loss	33 Loss Expense		35 Losses Unpaid	36 Loss Expenses Unpaid
1.	XXX	XXX	XXX	XXX	XXX	XXX			XXX		
2.											
3.											
4.	XXX	XXX	XXX	XXX	XXX	XXX			XXX		


Detail Eliminated to Conserve Space


SCHEDULE P – PART 2U – PET INSURANCE PLANS

Years in Which Losses Were Incurred	INCURRED NET LOSSES AND DEFENSE AND COST CONTAINMENT EXPENSES REPORTED AT YEAR-END (\$000 OMITTED)										DEVELOPMENT	
	1 2015	2 2016	3 2017	4 2018	5 2019	6 2020	7 2021	8 2022	9 2023	10 2024	11 One Year	12 Two Year
1. Prior	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX
2. 2023	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX
3. 2024	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX
										4.Totals		

SCHEDULE P – PART 3U – PET INSURANCE PLANS

Years in Which Losses Were Incurred	CUMULATIVE PAID NET LOSSES AND DEFENSE AND COST CONTAINMENT EXPENSES REPORTED AT YEAR-END (\$000 OMITTED)										11 Number of Claims Closed With Loss Payment	12 Number of Claims Closed Without Loss Payment
	1 2015	2 2016	3 2017	4 2018	5 2019	6 2020	7 2021	8 2022	9 2023	10 2024		
1. Prior.....	XXX	XXX	XXX	XXX	XXX	XXX	XXX	000	.....	.....	XXX	XXX
2. 2023.....	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	.....	.....	XXX	XXX
3. 2024.....	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	.....	XXX	XXX



Detail Eliminated to Conserve Space



SCHEDULE P – PART 4U – PET INSURANCE PLANS

Years in Which Losses Were Incurred	BULK AND IBNR RESERVES ON NET LOSSES AND DEFENSE AND COST CONTAINMENT EXPENSES REPORTED AT YEAR-END (\$000 OMITTED)									
	1 2015	2 2016	3 2017	4 2018	5 2019	6 2020	7 2021	8 2022	9 2023	10 2024
1. Prior.....	XXX	XXX	XXX	XXX	XXX	XXX	XXX	.....	.....	.....
2. 2023.....	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	.....	.....
3. 2024.....	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	.....

QUARTERLY STATEMENT BLANKS – PROPERTY/CASUALTY

PART 1 – LOSS EXPERIENCE

Line of Business	Current Year to Date			4 Prior Year to Date Direct Loss Percentage
	1 Direct Premiums Earned	2 Direct Losses Incurred	3 Direct Loss Percentage	
1. Fire.....				
2.1 Allied lines				
2.2 Multiple peril crop				
2.3 Federal flood.....				
2.4 Private crop.....				
2.5 Private flood				
3. Farmowners multiple peril				
4. Homeowners multiple peril				
5.1 Commercial multiple peril (non-liability portion).....				
5.2 Commercial multiple peril (liability portion).....				
6. Mortgage guaranty				
8. Ocean marine.....				
9.1 Inland marine.....				
9.2 Pet Insurance Plans.....				
10. Financial guaranty				
11.1. Medical professional liability -occurrence				
11.2. Medical professional liability -claims made.....				
12. Earthquake				
13.1 Comprehensive (hospital and medical) individual				
13.2 Comprehensive (hospital and medical) group.....				
14. Credit accident and health				
15.1 Vision only				
15.2 Dental only				
15.3 Disability income.....				
15.4 Medicare supplement				
15.5 Medicaid Title XIX.....				
15.6 Medicare Title XVIII.....				
15.7 Long-term care				
15.8 Federal employees health benefits plan.....				
15.9 Other health				
16. Workers' compensation				
17.1. Other liability occurrence				
17.2. Other liability-claims made				
17.3. Excess Workers' Compensation.....				
18.1. Products liability-occurrence.....				
18.2. Products liability-claims made				
19.1 Private passenger auto no-fault (personal injury protection)				
19.2 Other private passenger auto liability.....				
19.3 Commercial auto no-fault (personal injury protection).....				
19.4 Other commercial auto liability.....				
21.1 Private passenger auto physical damage				
21.2 Commercial auto physical damage.....				
22. Aircraft (all perils).....				
23. Fidelity.....				
24. Surety.....				
26. Burglary and theft.....				
27. Boiler and machinery				
28. Credit.....				
29. International.....				
30. Warranty.....				
31. Reinsurance-Nonproportional Assumed Property.....	XXX	XXX	XXX	XXX
32. Reinsurance-Nonproportional Assumed Liability.....	XXX	XXX	XXX	XXX
33. Reinsurance-Nonproportional Assumed Financial Lines.....	XXX	XXX	XXX	XXX
34. Aggregate write-ins for other lines of business				
35. TOTALS				
DETAILS OF WRITE-INS				
3401.				
3402.				
3403.				
3498. Sum. of remaining write-ins for Line 34 from overflow page				
3499. Totals (Lines 3401 through 3403 plus 3498) (Line 34)				

PART 2 – DIRECT PREMIUMS WRITTEN

Line of Business	1 Current Quarter	2 Current Year to Date	3 Prior Year Year to Date
1. Fire.....			
2.1 Allied lines			
2.2 Multiple peril crop			
2.3 Federal flood.....			
2.4 Private crop.....			
2.5 Private flood			
3. Farmowners multiple peril			
4. Homeowners multiple peril			
5.1 Commercial multiple peril (non-liability portion).....			
5.2 Commercial multiple peril (liability portion).....			
6. Mortgage guaranty			
8. Ocean marine.....			
9.1 Inland marine.....			
9.2 Pet Insurance Plans.....			
10. Financial guaranty			
11.1. Medical professional liability -occurrence			
11.2. Medical professional liability -claims made.....			
12. Earthquake.....			
13.1 Comprehensive (hospital and medical) individual			
13.2 Comprehensive (hospital and medical) group.....			
14. Credit accident and health			
15.1 Vision only			
15.2 Dental only			
15.3 Disability income.....			
15.4 Medicare supplement			
15.5 Medicaid Title XIX			
15.6 Medicare Title XVIII.....			
15.7 Long-term care			
15.8 Federal employees health benefits plan.....			
15.9 Other health			
16. Workers' compensation			
17.1. Other liability occurrence.....			
17.2. Other liability-claims made			
17.3. Excess Workers' Compensation.....			
18.1. Products liability-occurrence.....			
18.2. Products liability-claims made.....			
19.1 Private passenger auto no-fault (personal injury protection)			
19.2 Other private passenger auto liability.....			
19.3 Commercial auto no-fault (personal injury protection).....			
19.4 Other commercial auto liability.....			
21.1 Private passenger auto physical damage			
21.2 Commercial auto physical damage.....			
22. Aircraft (all perils).....			
23. Fidelity.....			
24. Surety.....			
26. Burglary and theft.....			
27. Boiler and machinery			
28. Credit.....			
29. International.....			
30. Warranty.....			
31. Reinsurance-Nonproportional Assumed Property.....	XXX	XXX	XXX
32. Reinsurance-Nonproportional Assumed Liability.....	XXX	XXX	XXX
33. Reinsurance-Nonproportional Assumed Financial Lines.....	XXX	XXX	XXX
34. Aggregate write-ins for other lines of business			
35. TOTALS			
DETAILS OF WRITE-INS			
3401.			
3402.			
3403.			
3498. Sum. of remaining write-ins for Line 34 from overflow page			

[https://naiconline.sharepoint.com/sites/naicsupportstaffhub/member meetings/e cmte/apptf/2023-2 summer/bwg/att2a2-2023-01bwg_modified.docx](https://naiconline.sharepoint.com/sites/naicsupportstaffhub/member%20meetings/e%20cmte/apptf/2023-2%20summer/bwg/att2a2-2023-01bwg_modified.docx)

NAIC BLANKS (E) WORKING GROUP

Blanks Agenda Item Submission Form

DATE: <u>12/14/2022</u>		FOR NAIC USE ONLY	
CONTACT PERSON:	<u>Teresa Cooper</u>	Agenda Item # <u>2023-02BWG MOD</u>	
TELEPHONE:	<u>816-783-8226</u>	Year <u>2023</u>	
EMAIL ADDRESS:	<u>tcooper@naic.org</u>	Changes to Existing Reporting []	
ON BEHALF OF:	_____	New Reporting Requirement [X]	
NAME:	<u>Jon Pike</u>	REVIEWED FOR ACCOUNTING PRACTICES AND PROCEDURES IMPACT	
TITLE:	<u>Commissioner</u>	No Impact [X]	
AFFILIATION:	<u>Utah Insurance Department</u>	Modifies Required Disclosure []	
ADDRESS:	<u>4315 S 2700 W Suite 2300</u>	Is there data being requested in this proposal which is available elsewhere in the Annual/Quarterly Statement? [No]	
	<u>Taylorsville, UT 84129</u>	***If Yes, complete question below***	
		DISPOSITION	
		[] Rejected For Public Comment	
		[] Referred To Another NAIC Group	
		[] Received For Public Comment	
		[X] Adopted Date <u>05/31/2023</u>	
		[] Rejected Date _____	
		[] Deferred Date _____	
		[] Other (Specify) _____	

BLANK(S) TO WHICH PROPOSAL APPLIES

- | | | |
|---|---|--------------------------------------|
| <input checked="" type="checkbox"/> ANNUAL STATEMENT | <input checked="" type="checkbox"/> INSTRUCTIONS | <input type="checkbox"/> CROSSCHECKS |
| <input type="checkbox"/> QUARTERLY STATEMENT | <input checked="" type="checkbox"/> BLANK | |
| <input checked="" type="checkbox"/> Life, Accident & Health/Fraternal | <input type="checkbox"/> Separate Accounts | <input type="checkbox"/> Title |
| <input checked="" type="checkbox"/> Property/Casualty | <input type="checkbox"/> Protected Cell | <input type="checkbox"/> Other _____ |
| <input checked="" type="checkbox"/> Health | <input type="checkbox"/> Health (Life Supplement) | |

Anticipated Effective Date: Annual 2023

IDENTIFICATION OF ITEM(S) TO CHANGE

Add an exhibit to identify premiums that are reportable for Market Conduct Annual Statement (MCAS) purposes.

REASON, JUSTIFICATION FOR AND/OR BENEFIT OF CHANGE**

Addition of MCAS premium reporting will allow accurate identification of required MCAS filing submissions.

*****IF THE DATA IS AVAILABLE ELSEWHERE IN THE ANNUAL/QUARTERLY STATEMENT, PLEASE NOTE WHY IT IS REQUIRED FOR THIS PROPOSAL*****

NAIC STAFF COMMENTS

Comment on Effective Reporting Date: _____

Other Comments:

** This section must be completed on all forms.

ANNUAL STATEMENT INSTRUCTIONS – LIFE/FRATERNAL, PROPERTY, AND HEALTH**MARKET CONDUCT ANNUAL STATEMENT (MCAS) PREMIUM EXHIBIT FOR YEAR**

This exhibit is required to be filed no later than March 1.

The purpose of this exhibit is to identify premiums that are reportable for Market Conduct Annual Statement purposes. Refer to the Data Call and Definitions document for each individual line of business, found on the MCAS webpage: http://www.naic.org/mcas_main.htm. Indicate a “Yes” in the premium column for the lines of business in which the reporting entity has met the MCAS premium thresholds, otherwise indicate a “No”.

A schedule must be prepared and submitted for each jurisdiction in which the company ~~has direct written premiums or direct earned premiums for the MCAS lines of business~~ answered “Yes” to having MCAS Reportable Premiums/Considerations. ~~In addition, a schedule must be prepared and submitted that contains the grand total (GT) for the company.~~

ANNUAL STATEMENT BLANK – LIFE/FRATERNAL, PROPERTY, AND HEALTH

Affix Bar Code Above

Market Conduct Annual Statement (MCAS) Premium Exhibit For Year

For The Year Ended December 31, 20__
(To Be Filed by March 1)

FOR THE STATE OF

NAIC Group Code.....

NAIC Company Code.....

MCAS Line of Business	MCAS Reportable Premium/Considerations (Yes/No)	MCAS Reportable Premium/Considerations	
		1 Direct Written Premium	2 Direct Earned Premium
1. Disability Income	XXX
2. Health	XXX	.....
3. Homeowners	XXX
4. Individual Annuity	XXX
5. Individual Life	XXX
6. Lender-Placed Home and Auto	XXX
7. Long-Term Care	XXX
8. Other Health	XXX
9. Private Flood	XXX
10. Private Passenger Auto	XXX
11. Short-Term Limited Duration Health Plans	XXX
12. Travel	XXX

[https://naiconline.sharepoint.com/sites/naicsupportstaffhub/member meetings/e cmte/apptf/2023-2 summer/bwg/att2a3-2023-02bwg_modified.docx](https://naiconline.sharepoint.com/sites/naicsupportstaffhub/member%20meetings/e%20cmte/apptf/2023-2%20summer/bwg/att2a3-2023-02bwg_modified.docx)

NAIC BLANKS (E) WORKING GROUP

Blanks Agenda Item Submission Form

<p style="text-align: right;">DATE: <u>1/11/2023</u></p> <p>CONTACT PERSON: _____</p> <p>TELEPHONE: _____</p> <p>EMAIL ADDRESS: _____</p> <p>ON BEHALF OF: _____</p> <p>NAME: <u>Mary Caswell and Jill Youtsey</u></p> <p>TITLE: _____</p> <p>AFFILIATION: <u>NAIC</u></p> <p>ADDRESS: _____</p>	<p style="text-align: center;">FOR NAIC USE ONLY</p> <p>Agenda Item # <u>2023-03BWG</u></p> <p>Year <u>2023</u></p> <p>Changes to Existing Reporting [X]</p> <p>New Reporting Requirement []</p> <hr/> <p style="text-align: center;">REVIEWED FOR ACCOUNTING PRACTICES AND PROCEDURES IMPACT</p> <p>No Impact [X]</p> <p>Modifies Required Disclosure []</p> <p>Is there data being requested in this proposal which is available elsewhere in the Annual/Quarterly Statement? [No]</p> <p><i>***If Yes, complete question below***</i></p> <hr/> <p style="text-align: center;">DISPOSITION</p> <p>[] Rejected For Public Comment</p> <p>[] Referred To Another NAIC Group</p> <p>[] Received For Public Comment</p> <p>[X] Adopted Date <u>05/31/2023</u></p> <p>[] Rejected Date _____</p> <p>[] Deferred Date _____</p> <p>[] Other (Specify) _____</p>
---	---

BLANK(S) TO WHICH PROPOSAL APPLIES

- | | | |
|---|---|---|
| <input checked="" type="checkbox"/> ANNUAL STATEMENT | <input checked="" type="checkbox"/> INSTRUCTIONS | <input checked="" type="checkbox"/> CROSSCHECKS |
| <input type="checkbox"/> QUARTERLY STATEMENT | <input type="checkbox"/> BLANK | |
| <input checked="" type="checkbox"/> Life, Accident & Health/Fraternal | <input type="checkbox"/> Separate Accounts | <input type="checkbox"/> Title |
| <input checked="" type="checkbox"/> Property/Casualty | <input type="checkbox"/> Protected Cell | <input type="checkbox"/> Other _____ |
| <input checked="" type="checkbox"/> Health | <input type="checkbox"/> Health (Life Supplement) | |

Anticipated Effective Date: Annual 2023

IDENTIFICATION OF ITEM(S) TO CHANGE

Remove Life crosschecks for Columns 2, 6, and 10 on the Accident and Health Policy Experience Exhibit (AHPEE).

REASON, JUSTIFICATION FOR AND/OR BENEFIT OF CHANGE**

The Life crosschecks are not working correctly because columns 2, 6, and 10 on the Accident & Health Policy Experience Exhibit are on a direct basis and Exhibit 6 is on an assumed basis.

*****IF THE DATA IS AVAILABLE ELSEWHERE IN THE ANNUAL/QUARTERLY STATEMENT, PLEASE NOTE WHY IT IS REQUIRED FOR THIS PROPOSAL*****

NAIC STAFF COMMENTS

Comment on Effective Reporting Date: _____

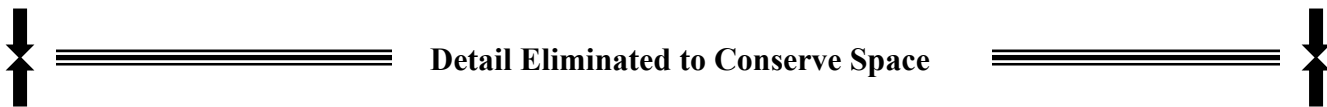
Other Comments:

** This section must be completed on all forms.

ANNUAL STATEMENT INSTRUCTIONS – LIFE/FRATERNAL, PROPERTY, AND HEALTH

ACCIDENT AND HEALTH POLICY EXPERIENCE EXHIBIT

This exhibit is required to be filed no later than April 1.



Detail Eliminated to Conserve Space

CROSS REFERENCES AND OTHER INSTRUCTIONS

The Exhibit

Column 1 – Direct Premiums Written

The grand total reported should equal:

- Life\Fraternal Exhibit 1, Part 1, Lines (6.1+10.1+16.1), Columns (8+9+10).
- Health Underwriting and Investment Exhibit, Part 1, Line 13, Column 1.
- Property Exhibit of Premiums and Losses, Column 1 sum of Lines 13 through 15.

Column 2 – Direct Premiums Earned

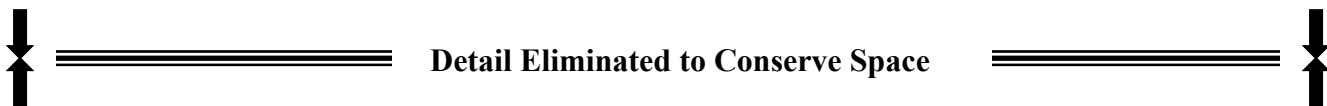
Fractional premium loadings and policy fees must be included in the Earned Premiums.

The grand total reported should equal:

- ~~Life\Fraternal Exhibit 1, Part 1, Lines (6.1+10.1+16.1), Columns (8+9+10).~~
- ~~Plus Exhibit 1, Part 1, Lines (3.1+13.1), Columns (8+9+10).~~
- ~~Minus Exhibit 6, Line 1, Column 1 CY.~~
- ~~Plus Exhibit 6, Line 1, Column 1 PY.~~
- ~~Minus Exhibit 1, Part 1, Lines (4+14), Columns (8+9+10).~~
- ~~Minus Exhibit 6, Line 5, Column 1 CY.~~
- ~~Plus Exhibit 6, Line 5, Column 1 PY.~~

- Health Underwriting and Investment Exhibit, Part 1, Line 13, Column 1
- Less Underwriting and Investment Exhibit Part 2D, Line 1, Column 1 CY
- Plus Underwriting and Investment Exhibit Part 2D, Line 1, Column 1 PY
- Less Underwriting and Investment Exhibit Part 2D, Line 4, Column 1 CY
- Plus Underwriting and Investment Exhibit Part 2D, Line 4, Column 1 PY

Property Exhibit of Premiums and Losses, Column 2 sum of Lines 13 through 15.



Detail Eliminated to Conserve Space

Column 6 – Direct Incurred Claims Amount

This column does not include the “Increase in Policy Reserves.”

The grand total reported should equal:

~~Life\Fraternal~~ ~~Exhibit 8, Part 2, Line 6.1, Columns (9+10+11).~~
~~Minus~~ ~~Exhibit 6, Line 14, Column 1 CY.~~
~~Plus~~ ~~Exhibit 6, Line 14, Column 1 PY.~~

Health Underwriting and Investment Exhibit, Part 2, Line 12.1, Column 1 minus Column 14.

NOTE: This excludes payments for any administrative costs.

Property Exhibit of Premiums and Losses, Column 6 sum of Lines 13 through 15.



Column 10 – Change in Contract Reserves

The Policy Experience Exhibit requires that the change in contract reserves should be on a direct basis. This is the direct basis included in the sum of:

Line 2, Grand Total Individual, Group and Other Business of “D” Total Business should equal:

A. The Change in Additional Reserves

~~Life\Fraternal: Exhibit 6, Lines 2 + 3, Column 1. Current year minus prior year.~~

Health: Underwriting and Investment Exhibit, Part 2D, Line 2, Column 1. Current year minus prior year.

B. Plus the Change in the Reserve for Future Contingent Benefits

~~Life\Fraternal: Exhibit 6, Line 4, Column 1. Current year minus prior year.~~

Health: Underwriting and Investment Exhibit, Part 2D, Line 3, Column 1. Current year minus prior year.

C. Less the Change in the Premium Deficiency Reserve

~~Life\Fraternal
and Property: Footnote (a) Schedule H Part 2. Current year minus prior year.~~

Health: Footnote (a) Underwriting and Investment Exhibit Part 2D. Current year minus prior year.

[https://naiconline.sharepoint.com/sites/naicsupportstaffhub/member meetings/e cme/apptf/2023-2 summer/bwg/att2a4-2023-03bwg.docx](https://naiconline.sharepoint.com/sites/naicsupportstaffhub/member%20meetings/e%20cme/apptf/2023-2%20summer/bwg/att2a4-2023-03bwg.docx)

NAIC BLANKS (E) WORKING GROUP**Blanks Agenda Item Submission Form**

DATE: <u>1/30/2023</u>		FOR NAIC USE ONLY	
CONTACT PERSON:	<u>Pat Allison</u>	Agenda Item # <u>2023-04BWG MOD</u>	
TELEPHONE:	<u>816-783-8528</u>	Year <u>2023</u>	
EMAIL ADDRESS:	<u>pallison@naic.org</u>	Changes to Existing Reporting [X]	
ON BEHALF OF:	<u>LATF</u>	New Reporting Requirement []	
NAME:	<u>Rachel Hemphill, Chair</u>	REVIEWED FOR ACCOUNTING PRACTICES AND PROCEDURES IMPACT	
TITLE:	_____	No Impact [X]	
AFFILIATION:	_____	Modifies Required Disclosure []	
ADDRESS:	_____	Is there data being requested in this proposal which is available elsewhere in the Annual/Quarterly Statement? [No]	
	_____	***If Yes, complete question below***	
	_____	DISPOSITION	
	_____	[]	Rejected For Public Comment
	_____	[]	Referred To Another NAIC Group
	_____	[]	Received For Public Comment
	_____	[X]	Adopted Date <u>05/31/2023</u>
	_____	[]	Rejected Date _____
	_____	[]	Deferred Date _____
	_____	[]	Other (Specify) _____

BLANK(S) TO WHICH PROPOSAL APPLIES

- | | | |
|--|---|---|
| <input type="checkbox"/> ANNUAL STATEMENT | <input type="checkbox"/> INSTRUCTIONS | <input type="checkbox"/> CROSSCHECKS |
| <input checked="" type="checkbox"/> QUARTERLY STATEMENT | <input type="checkbox"/> BLANK | |
| <input type="checkbox"/> Life, Accident & Health/Fraternal | <input type="checkbox"/> Separate Accounts | <input checked="" type="checkbox"/> Title |
| <input type="checkbox"/> Property/Casualty | <input type="checkbox"/> Protected Cell | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Health | <input type="checkbox"/> Health (Life Supplement) | |

Anticipated Effective Date: Annual 2023**IDENTIFICATION OF ITEM(S) TO CHANGE**

Add instructions for the appointed actuary and qualified actuary contacts to the Jurat electronic only section.

REASON, JUSTIFICATION FOR AND/OR BENEFIT OF CHANGE**

Add a contact for the appointed actuary and qualified actuary to address any actuarial questions.

*****IF THE DATA IS AVAILABLE ELSEWHERE IN THE ANNUAL/QUARTERLY STATEMENT, PLEASE NOTE WHY IT IS REQUIRED FOR THIS PROPOSAL*******NAIC STAFF COMMENTS**

Comment on Effective Reporting Date: _____

Other Comments:

ANNUAL/~~QUARTERLY~~ STATEMENT INSTRUCTIONS – LIFE/FRATERNAL, PROPERTY, HEALTH, AND TITLE

JURAT PAGE

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===== **Detail Eliminated To Conserve Space** =====
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To be filed in electronic format only:

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===== **Detail Eliminated To Conserve Space** =====
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Life Experience Data Contact (Life/Fraternal companies only)

Name

List the name of the person able to facilitate communication regarding submission of company experience data to the NAIC (e.g., mortality experience data) as required by the Standard Valuation Law (SVL) and its supporting Valuation Manual (VM) included in each state’s laws.

Address

May be a P.O. Box and the associated ZIP code.

Telephone Number

Telephone number should include area code and extension.

Email Address

Email address of the life experience data contact person as described above.

Appointed Actuary Contact

Name

Life/Fraternal Companies: List the name of the Appointed Actuary appointed by the board of directors to provide the actuarial opinion required by VM-30.

Health, Property, and Title Companies: List the name of the Appointed Actuary appointed by the board of directors to provide the actuarial opinion. Refer to the actuarial opinion instructions for guidance.

Address

May be a P.O. Box and the associated ZIP code.

Telephone Number

Telephone number should include area code and extension.

Email Address

Email address of the Appointed Actuary contact person as described above.

Qualified Actuary Contact 1 (Life/Fraternal companies and Health companies required to file the Life Supplement only)Name

List the name of the Qualified Actuary assigned by the company to prepare one or more sub-reports of the PBR Actuarial Report required by VM-31.

Product Line

Indicate product lines covered by this actuary's sub-report(s).

Telephone Number

Telephone number should include area code and extension.

Email Address

Email address of the Qualified Actuary contact person as described above.

Qualified Actuary Contact 2 (Life/Fraternal companies and Health companies required to file the Life Supplement only – if not applicable, leave blank)Name

List the name of the Qualified Actuary assigned by the company to prepare one or more sub-reports of the PBR Actuarial Report required by VM-31.

Product Line

Indicate product lines covered by this actuary's sub-report(s).

Telephone Number

Telephone number should include area code and extension.

Email Address

Email address of the Qualified Actuary contact person as described above.

Qualified Actuary Contact 3 (Life/Fraternal companies and Health companies required to file the Life Supplement only – if not applicable, leave blank)

Name

List the name of the Qualified Actuary assigned by the company to prepare one or more sub-reports of the PBR Actuarial Report required by VM-31.

Product Line

Indicate product lines covered by this actuary's sub-report(s).

Telephone Number

Telephone number should include area code and extension.

Email Address

Email address of the Qualified Actuary contact person as described above.

NAIC BLANKS (E) WORKING GROUP

Blanks Agenda Item Submission Form

<p style="text-align: right;">DATE: <u>2/7/2023</u></p> <p>CONTACT PERSON: _____</p> <p>TELEPHONE: _____</p> <p>EMAIL ADDRESS: _____</p> <p>ON BEHALF OF: _____</p> <p>NAME: <u>Dale Bruggeman</u></p> <p>TITLE: <u>Chair SAPWG</u></p> <p>AFFILIATION: <u>Ohio Department of Insurance</u></p> <p>ADDRESS: <u>50W. Town St., 3rd FL., Ste. 300</u> <u>Columbus, OH 43215</u></p>	<p style="text-align: center;">FOR NAIC USE ONLY</p> <p>Agenda Item # <u>2023-08BWG</u></p> <p>Year <u>2023</u></p> <p>Changes to Existing Reporting [X]</p> <p>New Reporting Requirement []</p> <hr/> <p style="text-align: center;">REVIEWED FOR ACCOUNTING PRACTICES AND PROCEDURES IMPACT</p> <p>No Impact [X]</p> <p>Modifies Required Disclosure []</p> <p>Is there data being requested in this proposal which is available elsewhere in the Annual/Quarterly Statement? [N]</p> <p><i>***If Yes, complete question below***</i></p> <hr/> <p style="text-align: center;">DISPOSITION</p> <p>[] Rejected For Public Comment</p> <p>[] Referred To Another NAIC Group</p> <p>[] Received For Public Comment</p> <p>[X] Adopted Date <u>05/31/2023</u></p> <p>[] Rejected Date _____</p> <p>[] Deferred Date _____</p> <p>[] Other (Specify) _____</p>
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BLANK(S) TO WHICH PROPOSAL APPLIES

- | | | |
|---|---|---|
| <input checked="" type="checkbox"/> ANNUAL STATEMENT | <input type="checkbox"/> INSTRUCTIONS | <input type="checkbox"/> CROSSCHECKS |
| <input type="checkbox"/> QUARTERLY STATEMENT | <input type="checkbox"/> BLANK | |
| <input checked="" type="checkbox"/> Life, Accident & Health/Fraternal | <input type="checkbox"/> Separate Accounts | <input checked="" type="checkbox"/> Title |
| <input checked="" type="checkbox"/> Property/Casualty | <input type="checkbox"/> Protected Cell | <input type="checkbox"/> Other _____ |
| <input checked="" type="checkbox"/> Health | <input type="checkbox"/> Health (Life Supplement) | |

Anticipated Effective Date: Annual 2023

IDENTIFICATION OF ITEM(S) TO CHANGE

Add clarifying language for mutual insurance companies on the Schedule Y, Part 3

REASON, JUSTIFICATION FOR AND/OR BENEFIT OF CHANGE**

The additional instruction will clarify that mutual insurance companies should be included on the Schedule Y, Part 3.

*****IF THE DATA IS AVAILABLE ELSEWHERE IN THE ANNUAL/QUARTERLY STATEMENT, PLEASE NOTE WHY IT IS REQUIRED FOR THIS PROPOSAL*****

NAIC STAFF COMMENTS

Comment on Effective Reporting Date: _____

Other Comments:

** This section must be completed on all forms.

SCHEDULE Y

PART 3 – ULTIMATE CONTROLLING PARTY AND LISTING OF OTHER U.S. INSURANCE GROUPS OR ENTITIES UNDER THAT ULTIMATE CONTROLLING PARTY’S CONTROL

All insurer and reporting entity members of the holding company system [\(including mutual insurance companies\)](#) shall prepare a common schedule for inclusion in each of the individual annual statements. [Mutual insurance companies that are part of the holding company system should be included in the common schedule.](#)

✂ **====** **Detail Eliminated to Conserve Space** **====** ✂

[https://naiconline.sharepoint.com/sites/naicsupportstaffhub/member meetings/e cmt/apptf/2023-2 summer/bwg/att2a6-2023-08bwg.docx](https://naiconline.sharepoint.com/sites/naicsupportstaffhub/member%20meetings/e%20cmt/apptf/2023-2%20summer/bwg/att2a6-2023-08bwg.docx)

NAIC BLANKS (E) WORKING GROUP

Blanks Agenda Item Submission Form

	DATE: <u>03/24/2023</u>	FOR NAIC USE ONLY
CONTACT PERSON: <u>Eric King</u>		Agenda Item # <u>2023-10BWG MOD</u>
TELEPHONE: <u>816-783-8234</u>		Year <u>2023</u>
EMAIL ADDRESS: <u>eking@naic.org</u>		Changes to Existing Reporting [X]
ON BEHALF OF: _____		New Reporting Requirement []
NAME: <u>Fred Anderson (MN) / Paul Lombardo (CT)</u>		REVIEWED FOR ACCOUNTING PRACTICES AND PROCEDURES IMPACT
TITLE: <u>Co-chairs Long-Term Care Actuarial (B) Working Group</u>		No Impact [X]
AFFILIATION: _____		Modifies Required Disclosure []
ADDRESS: _____		Is there data being requested in this proposal which is available elsewhere in the Annual/Quarterly Statement? [NO]
		If Yes, complete question below
		DISPOSITION
		[] Rejected For Public Comment
		[] Referred To Another NAIC Group
		[] Received For Public Comment
		[X] Adopted Date <u>05/31/2023</u>
		[] Rejected Date _____
		[] Deferred Date _____
		[] Other (Specify) _____

BLANK(S) TO WHICH PROPOSAL APPLIES

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|---|---|---|
| <input checked="" type="checkbox"/> ANNUAL STATEMENT | <input checked="" type="checkbox"/> INSTRUCTIONS | <input type="checkbox"/> CROSSCHECKS |
| <input type="checkbox"/> QUARTERLY STATEMENT | <input checked="" type="checkbox"/> BLANK | |
| <input checked="" type="checkbox"/> Life, Accident & Health/Fraternal | <input type="checkbox"/> Separate Accounts | <input type="checkbox"/> Title |
| <input checked="" type="checkbox"/> Property/Casualty | <input type="checkbox"/> Protected Cell | <input type="checkbox"/> Other _____ |
| <input checked="" type="checkbox"/> Health | <input type="checkbox"/> Health (Life Supplement) | <input type="checkbox"/> Life (Health Supplement) |

Anticipated Effective Date: Annual 2023

IDENTIFICATION OF ITEM(S) TO CHANGE

Update the three primary issue periods on Long-Term Care Experience Reporting Form 2.

REASON, JUSTIFICATION FOR AND/OR BENEFIT OF CHANGE**

The issue periods are not supposed to change each year, they should have stayed fixed and not changed each year.

*****IF THE DATA IS AVAILABLE ELSEWHERE IN THE ANNUAL/QUARTERLY STATEMENT, PLEASE NOTE WHY IT IS REQUIRED FOR THIS PROPOSAL*****

NAIC STAFF COMMENTS

Comment on Effective Reporting Date: _____

Other Comments:

** This section must be completed on all forms.

ANNUAL STATEMENT INSTRUCTIONS – LIFE/FRATERNAL, PROPERTY/CASUALTY, AND HEALTH**LONG-TERM CARE INSURANCE EXPERIENCE REPORTING FORMS 1 THROUGH 5**

These reporting forms must be filed with the NAIC by April 1 each year.

The purpose of the Long-Term Care Insurance Experience Reporting Forms is to monitor the amount of such coverage and to provide data specific to this coverage on a nationwide basis. Long-term care expenses may be paid through life policies, annuity contracts and health contracts. When the long-term benefits portion of the contract is subject to rating rules based on the Long-Term Care Insurance Model Regulation (sections on required disclosure or rating practices to customers, loss ratio and premium rate increases), the adequacy of the pricing and reserve assumptions is critical to meeting the expectation of those sections.

For life or annuity products where no portion is subject to these rating rules, the products are not being included in the reporting in these forms. Companies may use an assumption that long-term care benefits that are “incidental” regardless of the date of issue, may be excluded. Incidental means that the value of long-term care benefits provided is less than ten percent (10%) of the total value of the benefits provided over the life of the policy (measured as of the date of issue).

Form 1 gives an overview of the stand-alone LTC business and claims experience for both individual and group policies. Form 2 focuses on the experience of individual policies broken down into three Primary Issue Periods: ~~Prior to 2005~~ 2002 and prior, 2006-2009, 2010-2013, and 2014-2017 and later. Form 3 focuses on the adequacy of claims reserves by presenting experience based on incurred year over the next several years. Because prior-year values should already be available; this form should be completed for at least the current and past four years. If available, all prior years should be completed. Form 4 focuses on the experience of group business. Form 5 provides a location to report data at the state level and additionally asks for data related to hybrid life or annuity products with LTC extended and/or accelerated benefits.

ANNUAL STATEMENT BLANK – LIFE/FRATERNAL, PROPERTY/CASUALTY, AND HEALTH

LONG-TERM CARE EXPERIENCE REPORTING FORM 2
DIRECT INDIVIDUAL EXPERIENCE STAND-ALONE ONLY (\$000 OMITTED) (a)

REPORTING YEAR 20____
(To Be Filled By April 1)

	1 Calendar Year of Peak Issues	2 Percent Male Lives Insured	3 Average Attained Age	4 Earned Premiums	5 Incurred Claims	6 Number of Lives In Force Year End	7 Number of Terminations	8 Number of New Lives Insured
Primarily 2005-2002 and Prior Issue Years								
1. Current (Comprehensive).....
2. Total Inception-to-Date (Comprehensive).....	XXX	.....	.....	XXX	XXX	.....
3. Current (Institutional Only).....
4. Total Inception-to-Date (Institutional Only).....	XXX	.....	.....	XXX	XXX	.....
5. Current (Non-Institutional Only).....
6. Total Inception-to-Date (Non-Institutional Only).....	XXX	.....	.....	XXX	XXX	.....
7. Current (Grand Total).....	XXX	.....	.....	XXX	XXX	.....
8. Total Inception-to-Date (Grand Total).....	XXX	.....	.....	XXX	XXX	.....
Primarily 2006-2003 to 2013-2010 Issue Years								
9. Current (Comprehensive).....
10. Total Inception-to-Date (Comprehensive).....	XXX	.....	.....	XXX	XXX	.....
11. Current (Institutional Only).....
12. Total Inception-to-Date (Institutional Only).....	XXX	.....	.....	XXX	XXX	.....
13. Current (Non-Institutional Only).....
14. Total Inception-to-Date (Non-Institutional Only).....	XXX	.....	.....	XXX	XXX	.....
15. Current (Grand Total).....	XXX	.....	.....	XXX	XXX	.....
16. Total Inception-to-Date (Grand Total).....	XXX	.....	.....	XXX	XXX	.....
Primarily 2014-2011 and Later Issue Years								
17. Current (Comprehensive).....
18. Total Inception-to-Date (Comprehensive).....	XXX	.....	.....	XXX	XXX	.....
19. Current (Institutional Only).....
20. Total Inception-to-Date (Institutional Only).....	XXX	.....	.....	XXX	XXX	.....
21. Current (Non-Institutional Only).....
22. Total Inception-to-Date (Non-Institutional Only).....	XXX	.....	.....	XXX	XXX	.....
23. Current (Grand Total).....	XXX	.....	.....	XXX	XXX	.....
24. Total Inception-to-Date (Grand Total).....	XXX	.....	.....	XXX	XXX	.....

NAIC Company Code _____

NAIC Group Code _____

(a) Indicate whether policies are assigned to a Primary Issue Period on a per-policy or per-policy form basis.
 Policy
 Policy Form

https://naiconline.sharepoint.com/sites/naicsupportstaffhub/membermeetings/e-entm/appf/2023-2-summer/bwg/at2a7-2023-10bwg_modified.docx

NAIC BLANKS (E) WORKING GROUP

Blanks Agenda Item Submission Form

<p style="text-align: right;">DATE: <u>03/28/2023</u></p> <p>CONTACT PERSON: _____</p> <p>TELEPHONE: _____</p> <p>EMAIL ADDRESS: _____</p> <p>ON BEHALF OF: _____</p> <p>NAME: <u>Dale Bruggeman</u></p> <p>TITLE: <u>Chair SAPWG</u></p> <p>AFFILIATION: <u>Ohio Department of Insurance</u></p> <p>ADDRESS: <u>50W. Town St., 3rd FL., Ste. 300</u> <u>Columbus, OH 43215</u></p>	<p style="text-align: center;">FOR NAIC USE ONLY</p> <p>Agenda Item # <u>2023-11BWG MOD</u></p> <p>Year <u>2023</u></p> <p>Changes to Existing Reporting [X]</p> <p>New Reporting Requirement []</p> <hr/> <p style="text-align: center;">REVIEWED FOR ACCOUNTING PRACTICES AND PROCEDURES IMPACT</p> <p>No Impact [X]</p> <p>Modifies Required Disclosure []</p> <p>Is there data being requested in this proposal which is available elsewhere in the Annual/Quarterly Statement? [YES]</p> <p><i>***If Yes, complete question below***</i></p> <p style="text-align: center;">DISPOSITION</p> <p>[] Rejected For Public Comment</p> <p>[] Referred To Another NAIC Group</p> <p>[] Received For Public Comment</p> <p>[X] Adopted Date <u>05/31/2023</u></p> <p>[] Rejected Date _____</p> <p>[] Deferred Date _____</p> <p>[] Other (Specify) _____</p>
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BLANK(S) TO WHICH PROPOSAL APPLIES

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|---|---|---|
| <input checked="" type="checkbox"/> ANNUAL STATEMENT | <input checked="" type="checkbox"/> INSTRUCTIONS | <input type="checkbox"/> CROSSCHECKS |
| <input type="checkbox"/> QUARTERLY STATEMENT | <input type="checkbox"/> BLANK | |
| <input checked="" type="checkbox"/> Life, Accident & Health/Fraternal | <input type="checkbox"/> Separate Accounts | <input checked="" type="checkbox"/> Title |
| <input checked="" type="checkbox"/> Property/Casualty | <input type="checkbox"/> Protected Cell | <input type="checkbox"/> Other _____ |
| <input checked="" type="checkbox"/> Health | <input type="checkbox"/> Health (Life Supplement) | <input type="checkbox"/> Life (Health Supplement) |

Anticipated Effective Date: Annual 2023

IDENTIFICATION OF ITEM(S) TO CHANGE

Add additional instructions and illustration to be data captured for Note 7 – Investment Income in the Notes to Financials Statement to disclose more information on interest.

REASON, JUSTIFICATION FOR AND/OR BENEFIT OF CHANGE**

The purpose of this proposal is to modify the instructions for Note 7 to reflect changes to *SSAP No. 34—Investment Income Due and Accrued* adopted by the Statutory Accounting Principles (E) Working Group in agenda item 2022-17.

*****IF THE DATA IS AVAILABLE ELSEWHERE IN THE ANNUAL/QUARTERLY STATEMENT, PLEASE NOTE WHY IT IS REQUIRED FOR THIS PROPOSAL*****

Although the data for Note 7C might be found elsewhere in the statement, the intent is to have information in a single location for easy comparability. Note 7D (aggregate deferred interest) is interest that is not considered past due, as there is no due date, therefore it is not nonadmitted. With having Note 7C in the updates to Note 7, it will allow regulators to compare the interest.

NAIC STAFF COMMENTS

Comment on Effective Reporting Date: _____

Other Comments: _____

** This section must be completed on all forms.

ANNUAL STATEMENT INSTRUCTIONS – LIFE/FRATERNAL, HEALTH, PROPERTY, & TITLE

NOTES TO FINANCIAL STATEMENTS

Notes to the Annual Statement are to be filed on March 1.



Detail Eliminated To Conserve Space

7. Investment Income

Instruction:

Disclose the following for investment income due and accrued in the financial statements:

- A. The bases, by category of investment income, for excluding (nonadmitting) any investment income due and accrued,
- B. The total amount excluded.
- C. The gross, nonadmitted and admitted amounts for interest income due and accrued.

(1) Gross amount for interest income due and accrued. (Should equal Assets Page, Line 14, Column 1)

(2) Nonadmitted amount for interest income due and accrued. (Should equal Assets Page, Line 14, Column 2)

(3) Admitted amount for interest income due and accrued. (Should equal Assets Page, Line 14, Column 3)

- D. The aggregate deferred interest.

Some investments allow for interest payments to be deferred past the originally scheduled payment date without being considered past due under the agreement terms. Include the amount of interest reported as due and accrued for which the reporting entity has not received within 90 days of the originally scheduled payment date, that has not been nonadmitted under SSAP No. 34 – Investment Income Due and Accrued. For the avoidance of doubt, this should also include all accrued interest for investments that pay interest in full less frequently than annually per the agreement terms.

- E. The cumulative amounts of paid-in-kind (PIK) interest included in the current principal balance.

Include the amount of reported interest in which the terms of the investment permit paid-in-kind (PIK) instead of cash. The amount captured shall reflect the cumulative amount of PIK interest included in the current principal balance.

Illustration:

- A. Due and accrued income was excluded from surplus on the following bases:

All investment income due and accrued with amounts that are over 90 days past due with the exception of mortgage loans in default.

- B. The total amount excluded was \$ _____.

THIS EXACT FORMAT MUST BE USED IN THE PREPARATION OF THIS NOTE FOR THE TABLES (7C, 7D, AND 7E) BELOW. REPORTING ENTITIES ARE NOT PRECLUDED FROM PROVIDING CLARIFYING DISCLOSURE BEFORE OR AFTER THESE ILLUSTRATIONS.

C. The gross, nonadmitted and admitted amounts for interest income due and accrued.

<u>Interest Income Due and Accrued</u>	<u>Amount</u>
<u>1. Gross</u>	<u>\$ _____</u>
<u>2. Nonadmitted</u>	<u>\$ _____</u>
<u>3. Admitted</u>	<u>\$ _____</u>

D. The aggregate deferred interest.

<u>Aggregate Deferred Interest</u>	<u>Amount</u>
	<u>\$ _____</u>

E. The cumulative amounts of paid-in-kind (PIK) interest included in the current principal balance.

<u>Cumulative amounts of PIK interest included in the current principal balance</u>	<u>Amount</u>
	<u>\$ _____</u>

[https://naiconline.sharepoint.com/sites/naicsupportstaffhub/member meetings/e cmtf/apptf/2023-2 summer/bwg/att2a8-2023-11bwg_modified.docx](https://naiconline.sharepoint.com/sites/naicsupportstaffhub/member%20meetings/e%20cmtf/apptf/2023-2%20summer/bwg/att2a8-2023-11bwg_modified.docx)

**Blanks (E) Working Group
Editorial Revisions to the Blanks and Instructions
(presented at the May 31, 2023, Meeting)**

Statement Type:
H = Health; **L/F** = Life/Fraternal Combined; **P/C** = Property/Casualty; **SA** = Separate Accounts; **T** = Title

Effective	Table Name	Description	Statement Type	Filing Type
2023	Liabilities, Surplus and Other Funds	<p>CHANGE TO BLANK</p> <p>Update Line 4 crosschecks to Exhibit 8, Part 1</p> <p>4. Contract claims: 4.1 Life (Exhibit 8, Part 1, Line 4.4, Col. 1 less sum of Cols. 9, 10 and 12, 3, 4 and 5) 4.2 Accident and health (Exhibit 8, Part 1, Line 4.4, sum of Cols. 9, 10 and 11 and 6)</p>	L/F	Annual
2023	Accident and Health Policy Experience Exhibit	<p>CHANGE TO INSTRUCTION</p> <p>Update Column 1 Life/Fraternal Crosscheck for Exhibit 1, Part 1 Column updates</p> <p>Column 1 – Direct Premiums Written</p> <p>The grand total reported should equal: Life\Fraternal Exhibit 1, Part 1, Lines (6.1+10.1+16.1), Columns (8+9+10).</p>	H, L/F, P/C	Annual
2023	Schedule T – Premium and Annuity Considerations	<p>CHANGE TO BLANK</p> <p>Update Footnote (c) for Exhibit 1 Column updates</p> <p>(c) Column 4 should balance with Exhibit 1, Lines 6.4, 10.4 and 16.4, Cols. 8, 9 and 10 and 6, or with Schedule H, Part 1, Column 1, Line 1 indicate which;</p>	H/L/F	Annual
2023	Schedule T – Premium and Annuity Considerations	<p>CHANGE TO INSTRUCTION</p> <p>Update Column 4 crosscheck for Exhibit 1 Column updates</p> <p>Column 4 should balance with either Exhibit 1, Part 1, Lines 6.4, 10.4, 16.4, Columns 8, 9 and 10 and 6 or Schedule H, Part 1, Line 1, Column 1.</p>	H/L/F	Annual

Effective	Table Name	Description	Statement Type	Filing Type
2023	Schedule T – Premium and Annuity Considerations	<p>CHANGE TO INSTRUCTION Update Line 99 crosscheck for Exhibit 1 Column updates</p> <p>The sum of Columns 2 and 3 should agree with Exhibit 1, Lines 6.4 plus 10.4 plus 16.4, Column 1 less Columns 8, 9, 10 and 11 8.</p>	H L/F	Annual
2023	Schedule H, Part 5	<p>CHANGE TO INSTRUCTION Update Line 4 Life/Fraternal Crosscheck for Exhibit 8, Part 2 Column updates</p> <p>A. DIRECT Line 4 – Claims Paid</p> <p>Life/Fraternal: Column 13 should agree with Exhibit 8, Part 2, Line 1.1, ##### of Columns 9, 10 and 11 6.</p> <p>B. ASSUMED REINSURANCE Line 4 – Claims Paid</p> <p>Life/Fraternal: Column 13 should agree with Exhibit 8, Part 2, Line 1.2, ##### of Columns 9, 10 and 11 6.</p> <p>C. CEDED REINSURANCE Line 2 – Beginning Claim Reserves and Liabilities</p> <p>Life/Fraternal: Column 13 should agree with Exhibit 8, Part 2, Line 4.3, plus Line 5, ##### of Columns 9, 10 and 11 6, plus Exhibit 6, Line 15, Column 1, Prior Year.</p> <p>Line 3 – Ending Claim Reserves and Liabilities</p> <p>Life/Fraternal: Column 13 should agree with Exhibit 8, Part 2, Line 2.3, plus Line 3, ##### of Columns 9, 10 and 11 6, plus Exhibit 6, Line 15, Column 1.</p> <p>Line 4 – Claims Paid</p> <p>Life/Fraternal: Column 13 should agree with Exhibit 8, Part 2, Line 1.3, ##### of Columns 9, 10 and 11 6.</p>	L/F, P/C	Annual

Effective	Table Name	Description	Statement Type	Filing Type
		<p>D. NET</p> <p>Line 2 – Beginning Claim Reserves and Liabilities</p> <p>Life/Fraternal: Column 13 should agree with Schedule H, Part 2, Line C2, Column 1, minus Exhibit 8, Part 2, Line 5, sum of Columns 9, 10 and 11.</p> <p>Line 3 – Ending Claim Reserves and Liabilities</p> <p>Life/Fraternal: Column 13 should agree with Schedule H, Part 2, Line C1, Column 1, minus Exhibit 8, Part 2, Line 3, sum of Columns 9, 10 and 11.</p> <p>Line 4 – Claims Paid</p> <p>Life/Fraternal: Column 13 should agree with Exhibit 8, Part 2, Line 1.4, sum of Columns 9, 10 and 11.</p>		
2023	Life Supplement to the Health Annual Statement	<p>CHANGE TO INSTRUCTION</p> <p>Add clarifying language one what companies should be filing the Life Supplement.</p> <p>NOTE: Only companies licensed as Life, Accident & Health insurers with life business in force, actively writing life business, or holding reserves for the life lines of business should complete the schedules included in the Life Supplement to the Health Annual Statement.</p>	H	Annual
2023	General Interrogatories Part 2	<p>CHANGE TO INSTRUCTION</p> <p>Line 2.1 - Update the Analysis of Operations by Lines of Business column references to be consistent with the changes to that schedule.</p> <p>Reporting Year Annual Statement Data</p> <p>Health Premium values listed in the Analysis of Operations by Lines of Business, Line 1, Column 2 through Column 8-9 plus Line 1, Column 9-13 in part (excluding credit-A&H dread disease coverage, LTC, Disability Income) of the reporting year's annual statement.</p>	H	Annual

Effective	Table Name	Description	Statement Type	Filing Type
2024	General Interrogatories Part 2	<p>CHANGE TO INSTRUCTION</p> <p>Line 2.1 - Update the Analysis of Operations by Lines of Business column references to be consistent with the changes to that schedule.</p> <p>Prior Year Annual Statement Data</p> <p>Health Premium values listed in the Analysis of Operations by Lines of Business, Line 1, Column 2 through Column 9-9 plus Line 1, Column 9-13 in part (excluding credit-A&H and dread disease coverage, LTC-Disability Income) of the reporting year's annual statement.</p> <p>CHANGE TO INSTRUCTION</p> <p>Update Line 3 with the correct line references to Schedule D Part 1A</p> <p>Line 3 – Report by NAIC designation, the amounts and percentages of the reporting entity's total admitted assets held in bonds and preferred stocks (perpetual preferred and redeemable preferred).</p> <p>Report the total amount for each subcategory. The amounts reported in the bond subcategories should be consistent with the amounts reported in Schedule D, Part 1A, Section 1, Column 7, Lines 12.1 – 12.6. Schedule D, Part 1A, Section 1 is reported gross and will not tie to this line if any amounts are reported and nonadmitted for bonds and preferred stocks on the asset page.</p>	H	Annual
2023	Supplemental Investment Interrogatories	<p>CHANGE TO INSTRUCTION</p> <p>Remove reserve factors from Annual Statement Instructions. References added in instructions on where to find factors in the Annual Statement Blank.</p> <p>Line 1 – Unaffiliated Common Stocks – Public</p> <p>Report the book/adjusted carrying value of all publicly issued common stock, including mutual funds, unit investment trusts, closed-end funds and ETFs (reported as common stock) in unaffiliated companies in Columns 1 and 4. Exclude money market mutual funds appropriately reported on Schedule E, Part 2. Multiply Column 4 by the reserve factor calculated for Columns 5, 7 and 9, and report the products in Columns 6, 8 and 10, respectively.</p>	H, L/F, P/C, T	Annual
2023	Asset Valuation Reserve – Equity and Other Invested Asset Component – Basic Contribution, Reserve Objective and Maximum Reserve Calculations	<p>CHANGE TO INSTRUCTION</p> <p>Remove reserve factors from Annual Statement Instructions. References added in instructions on where to find factors in the Annual Statement Blank.</p> <p>Line 1 – Unaffiliated Common Stocks – Public</p> <p>Report the book/adjusted carrying value of all publicly issued common stock, including mutual funds, unit investment trusts, closed-end funds and ETFs (reported as common stock) in unaffiliated companies in Columns 1 and 4. Exclude money market mutual funds appropriately reported on Schedule E, Part 2. Multiply Column 4 by the reserve factor calculated for Columns 5, 7 and 9, and report the products in Columns 6, 8 and 10, respectively.</p>	L/F	Annual

Effective	Table Name	Description	Statement Type	Filing Type
		<p>The Line 1, Column 7 and 9 reserve factors must be at least 12.15% but not more than 24.31%. See Footnote (a) on the Annual Statement Blank for reference on the minimum and maximum reserve factors for Line 1, Column 7 and 9.</p> <p>The reserve factor is equal to 15.8% times the company's weighted average portfolio beta. The weighted average portfolio beta is the market value weighted average of four (4) portfolio betas, one from the end of the prior year and the remaining from the first three (3) quarters of the current year.</p> <p>***Detail Eliminated to Conserve Space***</p> <p>Aggregate Method</p> <p>The portfolio beta at the end of a quarter is determined by a simple linear regression using 52 weeks of time-weighted rates of return for the entire unaffiliated common stock portfolio and for the Standard & Poor's 500 Stock Index. For non-U.S. stock portfolios, a company shall use an appropriate foreign index (TSE 300 index for Canadian stock portfolios, FT ALL SHARES index for U.K. stock portfolios, and the TOPIX index for Japanese stock portfolios) to calculate beta if it has identified common stock investments that support liabilities, both of which, are in the same foreign currency.</p> <p>Companies that do not want the extra administrative complexity of calculating the beta factor may use the maximum AVR factor of 20% (see Footnote (a) for <u>maximum AVR factor</u>).</p>	L/F	Annual
2023	Supplemental Term and Universal Life Insurance Reinsurance Exhibit – Part 1 All Cessions of Term and Universal Life Insurance	<p>CHANGE TO INSTRUCTION</p> <p>Update Column 6 – Certified Reinsurer to include Reciprocal Jurisdiction Reinsurer. Column 6 – Certified Reinsurer / <u>Reciprocal Jurisdiction Reinsurer</u> (YES/NO)</p> <p>Enter “YES” if the reinsurance was ceded to an assuming insurer that meets the applicable requirements of Section 2E of the NAIC <i>Credit for Reinsurance Model Law</i> (#785) and has been certified in the ceding insurer's domiciliary state or if the assuming insurer meets the applicable requirements of Section 2F of Model #785 and has been granted status as a Reciprocal Jurisdiction Reinsurer by the ceding insurer's domiciliary state, if that state has not adopted a provision equivalent to Section 2E, in a minimum of five states.</p>	L/F	Annual

Effective	Table Name	Description	Statement Type	Filing Type
2023	Supplemental Term and Universal Life Insurance Reinsurance Exhibit – Part 1 All Cessions of Term and Universal Life Insurance	<p>CHANGE TO BLANK</p> <p>Update Column 6 – Certified Reinsurer to include Reciprocal Jurisdiction Reinsurer.</p> <p>Column 6 – Certified Reinsurer / Reciprocal Jurisdiction Reinsurer (YES/NO)</p>	L/F	Annual
2023	Life Insurance (State Page)	<p>CHANGE TO BLANK</p> <p>Update column header for columns 13 through 22 to include Annuity Benefits to be consistent with the Analysis of Operations.</p> <p>Direct Death Benefits and Matured Endowments Incurred, and Annuity Benefits</p>	L/F, H	Annual

[https://naiconline.sharepoint.com/sites/naicsupportstafhub/membermeetings/e cmte/apptf/2023-2 summer/bwvg/at2a9-blanks editorial changes may 2023.docx](https://naiconline.sharepoint.com/sites/naicsupportstafhub/membermeetings/e%20cmte/apptf/2023-2%20summer/bwvg/at2a9-blanks%20editorial%20changes%20may%202023.docx)

**Blanks (E) Working Group
Editorial Revisions to the Blanks and Instructions
(presented at the July 27, 2023, Meeting)**

Statement Type:
H = Health; **L/F** = Life/Fraternal Combined; **P/C** = Property/Casualty; **SA** = Separate Accounts; **T** = Title

Effective	Table Name	Description	Statement Type	Filing Type
2023	Schedule H, Part 5	<p>CHANGE TO INSTRUCTION</p> <p>Add column references for Exhibit 6 and Exhibit 8, Part 1 for clarification.</p> <p>SECTION C – CLAIM RESERVES AND LIABILITIES</p> <p>Line 1 – Total Current Year</p> <p>Life/Fraternal: Should agree appropriately with the sum of Exhibit 6, Line 16, Column 1 and Exhibit 8, Part 1, Line 4.4, Column 6.</p>	L/F, P/C	Annual
2024	Premiums Attributed to Protected Cells Exhibit	<p>CHANGE TO BLANK</p> <p>Renumber line 9 to 9.1 Inland marine and add line 9.2 Pet insurance from proposal 2023-01BWG as this exhibit was missed during exposure and adoption.</p> <p>9.1 Inland marine</p> <p>9.2 Pet insurance</p>	P/C	Annual
2024	Earned But Unbilled (EBUB) Premium Implementation Statutory Reporting Pro Forma Exhibits	<p>CHANGE TO INSTRUCTION</p> <p>Update Example B – Underwriting and Investment Exhibit Part 1 and Part 2 to renumber line 9 to 9.1 Inland Marine and add line 9.2 Pet Insurance from proposal 2023-01BWG as this instructions was missed during exposure and adoption.</p> <p>9.1 Inland marine</p> <p>9.2 Pet insurance</p>	P/C	Annual
2023	Analysis of Operations by Lines of Business	<p>CHANGE TO INSTRUCTION</p> <p>Update Column order in Health Instructions for the update to proposal 2022-20BWG</p> <p>Column 5 – Vision Only</p> <p>Column 6 – Dental Only</p>	H	Annual

Effective	Table Name	Description	Statement Type	Filing Type
2023	Health Supplement Analysis of Operations by Lines of Business	CHANGE TO INSTRUCTION Update Column order in Health Instructions for the update to proposal 2022-20BWG Column 5 – Vision Only Column 6 – Dental Only	L/F	Annual
2023	Underwriting and Investment Exhibit – Part 1	CHANGE TO INSTRUCTION Update Column order in Health Instructions for the update to proposal 2022-20BWG Line 4 – Vision Only Line 5 – Dental Only	H	Annual
2023	General Interrogatories – Part 2	CHANGE TO INSTRUCTION Update Column references for the prior year column, Item 2.1. Column 1 is the total column and shouldn't be included. Column 10 is non-health and should not be included. Item 2.1 – Prior Year Health Premium values listed in the Analysis of Operations by Line of Business, Line 1, Column 2 through Column 9 (in part for credit A&H and dread disease coverage, LTC, Disability Income).	H	Annual
2023	Health Supplement Life State Page	CHANGE TO INSTRUCTION Update column reference for validation to look at correct column. Column 22 – Unpaid December 31, Current Year Should equal Column 22 (prior year) plus Column 13 minus Column 21. Note: Prior Year data for this formula will not be available until 2024 reporting.	H	Annual

Effective	Table Name	Description	Statement Type	Filing Type
2023	Property General Instructions	<p>CHANGE TO INSTRUCTION</p> <p>Remove reference to property/casualty supplements. These supplements were removed from the Health blank a few years ago.</p> <p>1. Health Statement Test: Passing the Test:</p> <p>A reporting entity is deemed to have passed the Health Statement Test if:</p> <p>The values for the premium and reserve ratios in the Health Statement Test equal or exceed 95% for both the reporting and prior year.</p> <p>If a reporting entity is a) licensed as a property and casualty insurer; b) completes the property and casualty annual statement for the reporting year; and c) passes the Health Statement Test (as described above), the reporting entity must complete the health statement beginning with the first quarter's statement for the second year following the reporting year in which the reporting entity passes the Health Statement Test and must also file the corresponding risk-based capital report.</p>	P/C	Annual
2023	General Interrogatories Part 2	<p>CHANGE TO INSTRUCTION</p> <p>Update column reference on Line 2.4(a) for Exhibit 8, Part 1</p> <p>Net A&H Policy and Contract Claims without Credit Health (Exhibit 8, Part 1, Line 4.4, Column 6(excluding Dread Disease, Disability Income and Long-Term Care)) plus Aggregate Reserves for A&HPolicies without Credit Health (Exhibit 6, Column 1 less Columns 10, 11, 12 and Dread Disease included in Column 13) for Unearned Premiums (Line 1) and Future Contingent Benefits (Line 4)</p>	L/F	Annual

2024 Proposed Charges**ACCOUNTING PRACTICES AND PROCEDURES (E) TASK FORCE**

The mission of the Accounting Practices and Procedures (E) Task Force is to identify, investigate, and develop solutions to accounting problems with the ultimate goal of guiding insurers in properly accounting for various aspects of their operations; modify the *Accounting Practices and Procedures Manual* (AP&P Manual) to reflect changes necessitated by Task Force action; and study innovative insurer accounting practices that affect the ability of state insurance regulators to determine the true financial condition of insurers.

Ongoing Support of NAIC Programs, Products, or Services

1. The **Accounting Practices and Procedures (E) Task Force** will:
 - A. Oversee the activities of the Blanks (E) Working Group and the Statutory Accounting Principles (E) Working Group.
2. The **Blanks (E) Working Group** will:
 - A. Consider improvements and revisions to the various annual/quarterly statement blanks to:
 - i. Conform these blanks to changes made in other areas of the NAIC to promote uniformity in reporting of financial information by insurers.
 - ii. Develop reporting formats for other entities subject to the jurisdiction of state insurance departments.
 - iii. Conform the various NAIC blanks and instructions to adopted NAIC policy.
 - iv. Oversee the development of additional reporting formats within the existing annual financial statements as needs are identified.
 - B. Continue to monitor state filing checklists to maintain current filing requirements.
 - C. Continue to monitor and improve the quality of financial data filed by insurance companies by recommending improved or additional language for the *Annual Statement Instructions*.
 - D. Continue to monitor and review all proposals necessary for the implementation of statutory accounting guidance to ensure proper implementation of any action taken by the Accounting Practices and Procedures (E) Task Force affecting annual financial statements and/or instructions.
 - E. Continue to coordinate with other task forces of the NAIC to ensure proper implementation of reporting and instructions changes as proposed by these taskforces.
 - F. Coordinate with the applicable task forces and working groups as needed to avoid duplication of reporting within the annual and quarterly statement blanks.
 - G. Consider proposals presented that would address duplication in reporting, eliminate data elements, financial schedules and disclosures that are no longer needed, and coordinate with other NAIC task forces and working groups if applicable, to ensure revised reporting still meets the needs of regulators.
 - H. Review requests for investment schedule blanks and instructions changes in connection with the work being performed by the Capital Adequacy (E) Task Force and its working groups.
 - I. Review changes requested by the Valuation of Securities (E) Task Force relating to its work on other invested assets reporting for technical consistency within the investment reporting schedules and instructions.

ACCOUNTING PRACTICES AND PROCEDURES (E) TASK FORCE*(Continued)*

3. The **Statutory Accounting Principles (E) Working Group** will:
 - A. Maintain codified statutory accounting principles by providing periodic updates to the guidance that address new statutory issues and new generally accepted accounting principles (GAAP) pronouncements. Provide authoritative responses to questions of application and clarifications for existing statutory accounting principles. Report all actions and provide updates to the Accounting Practices and Procedures (E) Task Force.
 - B. At the discretion of the Working Group chair, develop comments on exposed GAAP and International Financial Reporting Standards (IFRS) pronouncements affecting financial accounting and reporting. Any comments are subject to review and approval by the chairs of the Accounting Practices and Procedures (E) Task Force and the Financial Condition (E) Committee.
 - C. Coordinate with the Life Actuarial (A) Task Force on changes to the AP&P Manual related to the *Valuation Manual* VM-A, Requirements, and VM-C, Actuarial Guidelines, as well as other *Valuation Manual* requirements. This process will include the receipt of periodic reports on changes to the *Valuation Manual* on items that require coordination.
 - D. Obtain, analyze, and review information on permitted practices, prescribed practices, or other accounting treatments suggesting that issues or trends occurring within the industry may compromise the consistency and uniformity of statutory accounting, including, but not limited to, activities conducted by insurers for which there is currently no statutory accounting guidance or where the states have prescribed statutory accounting that differs from the guidance issued by the NAIC. Use this information to consider possible changes to statutory accounting.

NAIC Support Staff: Robin Marcotte

[https://naiconline.sharepoint.com/sites/naicsupportstaffhub/member meetings/e cmte/apptf/2023-2 summer/summary and minutes/3-2024 apptf charges.docx](https://naiconline.sharepoint.com/sites/naicsupportstaffhub/member%20meetings/e%20cmte/apptf/2023-2%20summer/summary%20and%20minutes/3-2024%20apptf%20charges.docx)

CAPITAL ADEQUACY (E) TASK FORCE

Capital Adequacy (E) Task Force Aug. 14, 2023, Minutes 9-490

 Capital Adequacy (E) Task Force June 30, 2023, Minutes (Attachment One) 9-495

 Proposal 2023-02-P (MOD) (Attachment One-A)..... 9-498

 Proposal 2023-09-IRE (Attachment One-B)..... 9-501

 Proposal 2023-10-IRE (Attachment One-C)..... 9-503

 Proposal 2022-09-CA(MOD) (Attachment One-D) 9-505

 Proposal 2022-16-CA (Attachment One-E)..... 9-528

 Proposal 2023-01-CA (Attachment One-F)..... 9-536

 Capital Adequacy (E) Task Force April 28, 2023, Minutes (Attachment Two) 9-555

 Proposal 2023-02-P (Attachment Two-A) 9-559

 Proposal 2023-03-IRE (Attachment Two-B) 9-562

 Proposal 2023-04-IRE (Attachment Two-C) 9-566

 Proposal 2023-05-L (Attachment Two-D)..... 9-570

 Proposal 2023-06-L (Attachment Two-E) 9-573

 Proposal 2023-07-L (Attachment Two-F) 9-606

 Health Risk-Based Capital (E) Working Group July 25, 2023, Minutes (Attachment Three) 9-639

 Health Risk-Based Capital (E) Working Group May 17, 2023, Minutes
 (Attachment Three-A)..... 9-644

 Health Risk-Based Capital (E) Working Group April 17, 2023, Minutes (Attachment Three-B)..... 9-647

 Graphical Representation of the Initial Analysis Results of the Health Care Receivables
 Project (Attachment Three-B1) 9-651

 2023 Health Risk-Based Capital (RBC) Newsletter (Attachment Three-C) 9-654

 2022 Health RBC Statistics (Attachment Three-D) 9-657

 Health Test Proposal (Attachment Three-E) 9-658

 Update Letter from the Academy of Actuaries (Academy) on the H2—Underwriting Risk
 Review (Attachment Three-F)..... 9-669

 Life Risk-Based Capital (E) Working Group Aug. 13, 2023, Minutes (Attachment Four) 9-671

 Life Risk-Based Capital (E) Working Group June 22, 2023, Minutes (Attachment Four-A)..... 9-673

 Proposal 2023-08-L (Attachment Four-A1)..... 9-674

 Life Risk-Based Capital (E) Working Group April 14, 2023, Minutes (Attachment Four-B)..... 9-677

 Comment Letter from the American Council of Life Insurers (ACLI) Regarding the Academy
 Proposal for Life C-2 Structural and Instruction Updates and a New Financial Statement
 Note (Attachment Four-B1)..... 9-679

 2023 Life RBC Newsletter (Attachment Four-C)..... 9-681

 2022 Life RBC Statistics (Attachment Four-D) 9-684

 Property and Casualty Risk-Based Capital (E) Working Group July 27, 2023, Minutes
 (Attachment Five)..... 9-685

 Property and Casualty Risk-Based Capital (E) Working Group June 16, 2023, Minutes
 (Attachment Five-A)..... 9-687

 Property and Casualty Risk-Based Capital (E) Working Group April 24, 2023, Minutes
 (Attachment Five-B)..... 9-688

 Blanks Proposal 2023-01BWG (Attachment Five-B1) 9-690

 Referral to the Blanks (E) Working Group Regarding Deferral of Adoption of Blanks Proposal
 2023-01BWG (Attachment Five-B2) 9-706

 Blanks Proposal 2022-15BWG (Attachment Five-B3) 9-708

 Catastrophe Risk (E) Subgroup July 18, 2023, Minutes (Attachment Five-C) 9-710

 Presentation from Verisk on a Severe Convective Storms Model Update and Technical
 Review (Attachment Five-C1)..... 9-712

Presentation from the NAIC on the National Flood Insurance Program (NFIP) Update (Attachment Five-C2)	9-719
Presentation from Milliman on the U.S. Private Flood Market (Attachment Five-C3).....	9-722
2023 Property/Casualty (P/C) RBC Newsletter (Attachment Five-D).....	9-724
Presentation on Current P/C RBC Projects from the Academy (Attachment Five-E).....	9-728
RBC Investment Risk and Evaluation (E) Working Group Aug. 13, 2023, Minutes (Attachment Six)	9-731
RBC Investment Risk and Evaluation (E) Working Group June 14, 2023, Minutes (Attachment Six-A).....	9-733
Comment Letter from Iowa and Connecticut on Residual Factor and Sensitivity Test Factor (Attachment Six-A1)	9-735
Comment Letter from Texas on Residual Factor and Sensitivity Test Factor (Attachment Six-A2)	9-744
Comment Letter from Global Atlantic Financial Group (Global Atlantic) on Residual Factor and Sensitivity Test Factor (Attachment Six-A3)	9-746
Comment Letter from Athene on Residual Factor and Sensitivity Test Factor (Attachment Six-A4)	9-750
RBC Investment Risk and Evaluation (E) Working Group May 17, 2023, Minutes (Attachment Six-B)	9-751
2022 Data Reported for Residual Tranches (Attachment Six-B1).....	9-753
Comment Letters on the Residual Factor and Sensitivity Test (Attachment Six-B2).....	9-757
RBC Investment Risk and Evaluation (E) Working Group April 20, 2023, Minutes (Attachment Six-C)	9-808
Presentation from the Academy on Principles for Structured Securities RBC (Attachment Six-D).....	9-810
Working Agenda (Attachment Seven)	9-820

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Draft: 8/22/23

Capital Adequacy (E) Task Force
Seattle, Washington
August 14, 2023

The Capital Adequacy (E) Task Force met Aug. 14, 2023. The following Task Force members participated: Judith L. French, Chair, represented by Tom Botsko and Dale Bruggeman (OH); Grace Arnold, Vice Chair, represented by Fred Andersen (MN); Lori K. Wing-Heier represented by David Phifer (AK); Mark Fowler represented by Sheila Travis (AL); Ricardo Lara represented by Laura Clements (CA); Andrew N. Mais represented by Wanchin Chou (CT); Karima M. Woods represented by Philip Barlow (DC); Michael Yaworsky represented by Bradley Trim (FL); Doug Ommen represented by Mike Yanacheak (IA); Dana Popish Severinghaus represented by Bruce Sartain (IL); Amy L. Beard represented by Roy Eft (IN); Vicki Schmidt represented by Tish Becker (KS); Sharon P. Clark represented by Vicki Lloyd (KY); Kathleen A. Birrane represented by Lynn Beckner (MD); Chlora Lindley-Myers represented by John Rehagen and Debbie Doggett (MO); Troy Downing represented by Erin Snyder (MT); Mike Causey represented by Jackie Obusek (NC); Jon Godfread represented by Matt Fischer (ND); Eric Dunning represented by Margaret Garrison and Michael Muldoon (NE); D.J. Bettencourt represented by Jennifer Li and Christian Citarella (NH); Justin Zimmerman represented by David Wolf (NJ); Glen Mulready represented by Diane Carter (OK); Michael Wise represented by Will Davis (SC); Cassie Brown represented by Jamie Walker (TX); Mike Kreidler represented by Steve Drutz (WA); and Nathan Houdek and Amy Malm (WI).

1. Adopted its June 30 and April 28 Minutes

Botsko said the Task Force met June 30 and April 28. During its June 30 meeting, the Task Force took the following action: 1) adopted proposals: a) 2023-02-P (MOD) (Underwriting Risk Line 1 Factor Modification); b) 2023-09-IRE (Residual Factor for Life) and 2023-10-IRE (Residual Sensitivity Test Factor for Life); c) adopted proposal 2022-09-CA (MOD) (Revised Affiliated Investments Structure and Instructions); d) 2022-16-CA (Underwriting Risk Factors – Investment Income Adjustment); and e) 2023-01-CA (Stop Loss Premiums); 2) adopted the Generator of Economic Scenarios (E/A) Subgroup charges; 3) discussed the current turmoil in the banking sector; 4) received an update from its Risk Evaluation Ad Hoc Group.

During its April 28 meeting, the Task Force took the following action: 1) adopted its Spring National Meeting minutes; 2) discussed the current turmoil in the banking sector; 3) adopted proposals: a) 2023-02-P (Underwriting Risk Line 1 Factors); b) 2023-03-IRE (Revised Residual Structure for life); c) 2023-04-IRE (Residual Sensitivity Test for Life); d) 2023-05-L (Remove Dual Trend Test); e) 2023-06-L (C-2 Mortality Risk Structure Changes); and f) 2023-07-L (CM6 & CM7 Mortgages Structures Changes); 4) exposed proposals: a) 2022-16-CA (Underwriting Risk Factors Investment Income Adjustment); and b) 2023-01-CA (Stop Loss Premiums) for a 30-day public comment period ending May 27; 3) discussed a referral from the Valuation of Securities (E) Task Force; and 4) received an update from its Risk Evaluation Ad Hoc Group.

Eft made a motion, seconded by Davis, to adopt the Task Force's June 30 (Attachment One) and April 28 minutes (Attachment Two). The motion passed unanimously.

2. Adopted the Reports of its Working Groups

A. Health Risk-Based Capital (E) Working Group

Drutz said the Health Risk-Based Capital (E) Working Group met July 25 and took the following action: 1) adopted its May 17 and April 17 minutes, which included the following action: a) adopted its Spring National Meeting minutes; b) referred proposal 2023-01-CA to the Capital Adequacy (E) Task Force for exposure; c) received

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an update from the American Academy of Actuaries (Academy) on the health care receivables and H2-underwriting risk review projects; d) discussed pandemic risk; and e) exposed the proposal on the health test language for a 45-day public comment period ending June 30; 2) adopted its 2023 health risk-based capital (RBC) newsletter; 3) adopted its 2022 health RBC statistics report; 4) exposed proposal 2023-11-H (XR014 Fee-for-Service & Other Risk Revenue-Medicare & Medicaid) for a 30-day public comment period ending Aug. 24. The proposal was drafted to include Medicare and Medicaid fee-for-service and other risk revenue amounts in Column (1), Lines (4) and (10) on pages XR014 and XR013; 5) received comments from the New York Department of Financial Services on the health test language proposal. The Working Group referred the proposal to the Blanks (E) Working Group; 6) received an update from the Academy on the health care receivables and H2-underwriting risk review projects. The Working Group agreed to reach out to companies where there are questions related to the reporting of health care receivables. The Working Group agreed to expose the Academy's update letter on the H2-underwriting risk review and work with the Academy to address the questions provided in its letter; 7) adopted its 2023 working agenda; 8) received an update on the work being performed by the Excessive Growth Charge Ad Hoc group; and 9) discussed a way forward on evaluating pandemic risk in the health RBC formula.

B. Risk-Based Capital Investment Risk and Evaluation (E) Working Group

Barlow said the RBC Investment Risk and Evaluation (E) Working Group met Aug. 13 and took the following action: 1) adopted its June 14, May 17, April 20, and Spring National Meeting minutes, which included the following action: a) discussed comments received on proposed structural and factor changes for residual tranches; and b) adopted structural changes and factors for the base factor and a sensitivity test for residual tranches; 2) received updates from the Valuation of Securities (E) Task Force and the Statutory Accounting Principles (E) Working Group; and 3) heard a presentation from the Academy on principles for structured securities RBC.

C. Life Risk-Based Capital (E) Working Group

Barlow also said the Life Risk-Based Capital (E) Working Group met Aug. 13 and took the following action: 1) adopted its June 22, April 14, and Spring National Meeting minutes, which included the following action: a) adopted the Generator of Economic Scenarios (GOES) (E/A) Subgroup charges; b) discussed proposal 2023-08-L (Custody Control Accounts); c) discussed its working agenda; d) adopted proposals: i) 2023-05-L (C-2 Mortality Structure and Instruction Changes); ii) 2023-07-L (CM6 & CM7 Mortgage Structure Change); iii) 2023-08-L (Custody Control Accounts); and e) discussed C-2 mortality risk; 2) adopted its 2023 life RBC newsletter; 3) adopted its 2022 life RBC statistics report; 4) adopted its working agenda; 5) heard a presentation from the American Council of Life Insurers (ACLI) on repurchase agreements and exposed it for a 45-day public comment period.

D. Property and Casualty Risk-Based Capital (E) Working Group

Botsko said the Property and Casualty Risk-Based Capital (E) Working Group met July 27 and took the following action: 1) adopted its June 16 and April 24 minutes, which included the following action: a) adopted its Spring National Meeting Minutes; b) adopted proposal 2023-02-P (UW Risk Line 1 Factors); c) adopted proposal 2023-02-P-MOD (UW Risk Line 1 Factors Modification), which updated the H/F, WC, and CMP reserve factors due to an incorrect calculation; 2) adopted the report of the Catastrophe Risk (E) Subgroup, which took the following action: a) adopted its Spring National Meeting minutes; b) discussed its working agenda; c) received a status update from its Catastrophe Model Technical Review Ad Hoc Group; d) discussed wildfire peril impact analysis; e) heard a presentation from Verisk on severe convective storms model update and technical review; and f) discussed the flood insurance market; 3) adopted its 2023 property/casualty (P/C) RBC newsletter; 4) discussed its 2022 P/C RBC statistics report; 5) discussed its working agenda; and 6) heard an update on current P/C RBC projects from the Academy.

Draft Pending Adoption

Drutz made a motion, seconded by Travis, to adopt the reports of the Health Risk-Based Capital (E) Working Group (Attachment Three), the Life Risk-Based Capital (E) Working Group (Attachment Four), the Property and Casualty Risk-Based Capital (E) Working Group (Attachment Five), and the Risk-Based Capital Investment Risk and Evaluation (E) Working Group (Attachment Six). The motion passed unanimously.

3. Adopted its Working Agenda

Botsko summarized the changes to the 2023 working agenda. He said the following items were updated in the Life Risk-Based Capital (E) Working Group section: 1) item L3 was changed to “provide recommendation for the appropriate treatment of longevity risk transfers by updated longevity factors and consider expanding the scope to include all payout annuities”; 2) item L4, which is “monitor the economic scenario governance framework, review material economic scenario generator updates, key economic conditions and metrics, support the implementation of an economic scenario generator for use in statutory reserve and capital calculations and develop and maintain acceptance criteria,” was added to the ongoing life RBC section; 3) the original item L5, which is “work with the Life Actuarial (A) Task Force and Conning to develop the economic scenario generator for implementation,” was removed; and 4) the last item of the life RBC carryover section was updated to “work with the Academy on creating guidance for the adopted C-2 mortality treatment for 2023 and next steps.” Botsko stated that there is no change on the Risk-Based Capital Investment Risk and Evaluation (E) Working Group section in the working agenda.

Regarding the Property and Casualty Risk-Based Capital (E) Working Group section, he said the working agenda included the following substantial changes: 1) update the Sept. 26 comment from “conduct a review on different convective storm models” and add an additional comment of “the SG is finishing reviewing the following SCS vendor models: RMS, Verisk, KCC and Corelogic” in the comment section in item P1; 2) remove item # P5 as the proposal 2022-07-P has been adopted at the 2022 Fall National Meeting; and 3) add a new item P8 for adding pet insurance line in the RBC formula due to the adoption of the Annual Statement Blanks proposal 2023-01BWG.

Botsko also said the Health Risk-Based Capital (E) Working Group agenda item was revised to incorporate the following changes: 1) item X1 was updated to reference the adoption of proposal 2022-16-CA; 2) item X3 was updated to reference the adoption of proposal 2023-01-CA; 3) item X4 was updated to include the work with the Academy on the health care receivables; and 4) items X5 and X10 were deleted because these items have been completed.

Lastly, Botsko stated that the Task Force working agenda was updated as follows: 1) items CA1 and CA5 were updated to reference the adoption of proposals: a) 2022-09-CA; b) 2022-09-CA-MOD; and c) 2022-13-CA. These two items will be removed from the working agenda due to the adoption of the proposal; 2) the comment for CA4 was updated to reflect that the Task Force forwarded the responses to the Restructuring Mechanism (E) Subgroup at the Spring National Meeting. This item is considered completed, and it will also be removed from the working agenda shortly; and 3) add a new item, CA6, for establishing the Risk Evaluation Ad Hoc Group at the Spring National Meeting.

Drutz made a motion, seconded by Andersen, to adopt the Task Force’s revised 2023 working agenda (Attachment Seven). The motion passed unanimously.

4. Exposed its 2024 Proposed Charges

Botsko said the only added item in the 2024 proposed charges is the establishment of a new subgroup, which is the Generator of Economic Scenarios (GOES) (E/A) Subgroup of the Life Risk-Based Capital (E) Working Group and the Life Actuarial (A) Task Force. He encouraged the interested parties to review the charges of the new subgroup, and he welcomed any comments during the exposure period.

Draft Pending Adoption

The Task Force agreed to expose its 2024 proposed charges for a 30-day public comment period ending Sept. 13.

5. Exposed its Revised Procedures Document

Botsko said the purpose of the revision is to allow the exposure deadline to be extended to March 15 for either the Task Force or Working Groups in only rare instances when the structure is urgent. He encouraged the interested parties to review the revision and welcomed any comments during the exposure period.

The Task Force agreed to expose its revised procedure documents for a 30-day public comment period ending Sept. 13.

6. Received an Update from its Risk Evaluation Ad Hoc Group

Botsko said the Risk Evaluation Ad Hoc Group met July 26 and decided to establish three subgroups to potentially streamline the process of making progress on specific topics: 1) Asset Concentration Ad Hoc Subgroup; 2) RBC Purposes and Guidelines Ad Hoc Subgroup; and 3) Geographic Concentration Ad Hoc Subgroup. He encouraged all interested parties to contact NAIC staff if anyone is interested in joining the ad hoc subgroups. Also, Botsko announced that the ad hoc subgroups will start meeting regularly after the Summer National Meeting and will provide monthly updates to the Risk Evaluation Ad Hoc Group.

7. Discussed the Implications of the Recent Market Turmoil and Their Impact on Insurer Investments

Ed Toy (Risk & Regulatory Consulting—RRC) provided an update on the banking situation, noting that it continues to evolve. This has included banking regulators announcing increased regulation for larger banks that are below the largest bank. He stated that the July 2023 Senior Loan Officer Opinion Survey on bank lending practices reported tightening of lending to all businesses and household categories. The impact on commercial real estate also continues to evolve. There have been announcements of major investors selling properties at significant losses or letting lenders take properties upon debt defaults, and national index values of commercial real estate were already hitting a dip beginning the end of last year. Office properties have dropped as much as 30% in the last 12 months.

Toy also addressed some comments on the Fitch Ratings downgrade of the U.S. Federal Government debt from AAA to AA+ on Aug. 1. He said he believes that the ratings change does not trigger material impact within the RBC framework, as U.S. full faith and credit obligation is in an exempt category under the RBC guidance. However, agencies that are not backed by full faith and credit of the U.S. government (such as Fannie Mae and Freddie Mac) may have a change in factors, but the overall RBC impact should be relatively immaterial.

Botsko said the Task Force appreciates Toy continuing to provide updates in upcoming meetings. He also reiterated that the Task Force is open to hearing thoughts or information that affects RBC. He encouraged parties to contact him or NAIC staff if they are interested in presenting any topics during a Task Force meeting.

8. Discussed Other Matters

A. RBC Statistics Operational Risk Component

Botsko said during the Health Risk-Based Capital (E) Working Group meeting on July 25, the interested parties suggested that adding the operational risk component will provide a complete picture of the RBC formula. Without hearing any objections, the Task Force agreed to include the operational risk amount in the 2023 RBC statistics for all lines of business.

Draft Pending Adoption

B. Negative IMR

Bruggeman said the Statutory Accounting Principles (E) Working Group adopted the short-term interpretation project during its meeting at this Summer National Meeting. He stated that this project is good through year-ending 2025 to give the industry, regulators, and other interested parties time to hash out a long-term approach. Bruggeman also stated that the adopted short-term interpretation reflects the following: 1) requirement for RBC ratio over 300% after adjustment to remove admitted positive goodwill, electronic data processing (EDP) equipment and operating system software, deferred tax assets (DTAs), and admitted negative interest maintenance reserve (IMR); 2) allowance to admit up to 10% of adjusted capital and surplus; 3) application guidance for admitting/recognizing IMR in both the general and separate accounts; 4) there is no exclusion for derivatives losses included in negative IMR, if the company can demonstrate historical practice in which realized gains from derivatives were also reversed to IMR and amortized; and 5) inclusion of a new reporting entity attestation, which continues the existing practice that losses cannot be deferred as a result of a forced sale due to liquidity issues, along with commentary that assets were sold as part of prudent asset management.

In addition, Bruggeman said the Statutory Accounting Principles (E) Working Group adopted the principles-based bond definition, to be effective Jan. 1, 2025, along with creating an expanded Schedule D, Part 1 to Schedule D, Part 1, Section 1 and Schedule D, Part 1, Section 2.

Having no further business, the Capital Adequacy (E) Task Force adjourned.

SharePoint/NAIC Support Staff Hub/Member Meetings/E CMTE/CADTF/2023-2-Summer/Aug 14 CADTF minutes.docx

Draft: 7/14/23

Capital Adequacy (E) Task Force
Virtual Meeting
June 30, 2023

The Capital Adequacy (E) Task Force met June 30, 2023. The following Task Force members participated: Judith L. French, Chair, and Tom Botsko (OH); Grace Arnold, Vice Chair, represented by David Nelson (MN); Mark Fowler represented by Charles Hale (AL); Ricardo Lara represented by Thomas Reedy (CA); Michael Conway represented by Keith Warburton (CO); Andrew N. Mais represented by Wanchin Chou (CT); Karima M. Woods represented by Philip Barlow (DC); Michael Yaworsky represented by Virginia Christy (FL); Doug Ommen represented by Mike Yanacheak (IA); Dana Popish Severinghaus represented by Vincent Tsang (IL); Amy L. Beard represented by Roy Eft (IN); Vicki Schmidt represented by Tish Becker (KS); Sharon P. Clark (KY); Kathleen A. Birrane represented by Lynn Beckner (MD); Chlora Lindley-Myers (MO); Mike Causey represented by Jessica Price (NC); Jon Godfread represented by Matt Fischer (ND); Eric Dunning represented by Lindsay Crawford (NE); Glen Mulready represented by Andrew Schallhorn (OK); Cassie Brown represented by Jamie Walker (TX); Mike Kreidler represented by Steve Drutz (WA); and Nathan Houdek (WI).

1. Adopted Proposal 2023-02-P(MOD)

Botsko said proposal 2023-02-P(MOD) (Underwriting Risk Line 1 Factors) provides a routine annual update to the Line 1 premium and reserve industry underwriting factors in the property/casualty (P/C) risk-based capital (RBC) formula, which was adopted during the Task Force's April 28 meeting. He also stated that the purpose of this modification is to update the H/F, WC, and CMP reserve factors due to an incorrect calculation. The Property and Casualty Risk-Based Capital (E) Working Group and the Catastrophe Risk (E) Subgroup conducted an e-vote to adopt this proposal on June 16.

Chou made a motion, seconded by Drutz, to adopt proposal 2023-02-P(MOD) (Attachment One-A). The motion passed unanimously.

2. Adopted Proposals 2023-09-IRE and 2023-10-IRE

Barlow said the purpose of proposals 2023-09-IRE (Residual Factor for Life) and 2023-04-IRE (Residual Sensitivity Test Factor for Life) is to apply RBC factors for residual tranches and sensitivity tests in the life RBC formula. He stated that during the RBC Investment Risk and Evaluation (E) Working Group's June 14 meeting, the Working Group adopted: 1) the residual tranches factor of 30% for year-end 2023 and then 45% for year-end 2024 with consideration of positive or negative adjustment based on additional information; and 2) the sensitivity factor of 15% for year-end 2023. He also indicated that both proposals passed unanimously in the Working Group's last meeting. Lastly, Botsko stated that these two proposals will only apply to the life formula. The Working Group will evaluate the P/C and health formulas in the near future.

Barlow made a motion, seconded by Hemphill, to adopt proposals 2023-09-IRE (Attachment One-B) and 2023-10-IRE (Attachment One-C). The motion passed unanimously.

3. Adopted the Generator of Economic Scenarios (E/A) Subgroup Charges

Barlow said the Life Risk-Based Capital (E) Working Group adopted the Generator of Economic Scenarios (E/A) Subgroup charges during its June 22 meeting. He asked the Task Force to consider adoption of the proposed charges.

Barlow made a motion, seconded by Yanacheak, to adopt the Generator of Economic Scenarios (E/A) Subgroup's proposed charges (see *NAIC Proceedings – Summer 2023, Financial Condition (E) Committee, Attachment One-B*). The motion passed unanimously.

4. Adopted Proposal 2022-09-CA(MOD)

Botsko said the purpose of proposal 2022-09-CA(MOD) (Revised Affiliated Investments Structure and Instructions) is to provide editorial changes to: 1) clarify the examples provided in the indirectly owned alien insurance affiliates/subsidiaries section; and 2) add a footnote to the "% owned" column in the blank.

Chou made a motion, seconded by Warburton, to adopt proposal 2022-09-CA(MOD) (Attachment One-D). The motion passed unanimously.

5. Adopted Proposal 2022-16-CA

Drutz said the purpose of proposal 2022-16-CA (Underwriting Risk Factors – Investment Income Adjustment) is to update the underwriting risk factors for the annual investment income adjustment to the comprehensive medical, Medicare supplement, and dental and vision factors. He also stated that the Task Force received no comments during a 30-day public comment period.

Drutz made a motion, seconded by Chou, to adopt proposal 2022-16-CA (Attachment One-E). The motion passed unanimously.

6. Adopted Proposal 2023-01-CA

Drutz said the purpose of proposal 2023-01-CA (Stop Loss Premiums) is to clarify the instructions for the stop loss business in the health RBC formula and align the life and P/C RBC formulas with these changes. He also stated that the Task Force received no comments during a 30-day public comment period.

Drutz made a motion, seconded by Chou, to adopt proposal 2023-01-CA (Attachment One-F). The motion passed unanimously.

7. Discussed the Current Turmoil in the Banking Sector

Ed Toy (Risk & Regulatory Consulting LLC—RRC) said the Democrats in the U.S. House of Representatives (House) have proposed a raft of bills to deal with recent banking problems. He stated that four items focus on reforms or improvements to banking regulation: 1) closing the Enhanced Prudential Standards Loophole Act; 2) closing the Chief Risk Officer Enforcement and Accountability Act; 3) closing the Effective Bank Regulation Act; and 4) closing the Secure and Fair Enforcement (SAFE) Banking Act. He said he believes the SAFE Banking Act may have the most immediate impact if the bills pass as proposed since the affected banks will need to market investments that have heretofore been exempted. Botsko said the Task Force welcomes Toy to provide constant updates regarding this issue.

Botsko said the Task Force is open to hearing thoughts or information that affects RBC. He encouraged parties to contact him or NAIC staff if they are interested in presenting any topics during a Task Force meeting.

8. Received an Update from its Risk Evaluation Ad Hoc Group

Botsko said the Risk Evaluation Ad Hoc Group met June 14 and May 22. During these two meetings, the Ad Hoc Group discussed: 1) the purpose of the RBC; and 2) the possibility of developing a process or guidelines for reviewing, adding, or deleting factors to the RBC formulas. Botsko also stated that the Ad Hoc Group agreed that it should focus on reviewing items such as risk factors in different RBC components, company size, geographic concentration, reinsurance, purpose of RBC, deferred tax asset, covariance, and benchmark. He said this Ad Hoc Group will meet once every other week before the Summer National Meeting. The next meeting is scheduled for July 12. Botsko welcomed all interested parties to actively participate in the Ad Hoc Group discussion during the upcoming meeting.

Having no further business, the Capital Adequacy (E) Task Force adjourned.

SharePoint/NAIC Support Staff Hub/Member Meetings/E CMTE/CADTF/2023-2-Summer/June 30 CADTF minutes.docx

**Capital Adequacy (E) Task Force
RBC Proposal Form**

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| <input type="checkbox"/> Capital Adequacy (E) Task Force | <input type="checkbox"/> Health RBC (E) Working Group | <input type="checkbox"/> Life RBC (E) Working Group |
| <input type="checkbox"/> Catastrophe Risk (E) Subgroup | <input type="checkbox"/> Investment RBC (E) Working Group | <input type="checkbox"/> Longevity Risk (A/E) Subgroup |
| <input type="checkbox"/> Variable Annuities Capital. & Reserve (E/A) Subgroup | <input checked="" type="checkbox"/> P/C RBC (E) Working Group | <input type="checkbox"/> RBC Investment Risk & Evaluation (E) Working Group |

<p align="right">DATE: <u>3/22/23</u></p> <p>CONTACT PERSON: <u>Eva Yeung</u></p> <p>TELEPHONE: <u>816-783-8407</u></p> <p>EMAIL ADDRESS: <u>eyeung@naic.org</u></p> <p>ON BEHALF OF: <u>P/C RBC (E) Working Group</u></p> <p>NAME: <u>Tom Botsko</u></p> <p>TITLE: <u>Chair</u></p> <p>AFFILIATION: <u>Ohio Department of Insurance</u></p> <p>ADDRESS: <u>50 West Town Street, Suite 300</u> <u>Columbus, OH 43215</u></p>	<p align="center">FOR NAIC USE ONLY</p> <p>Agenda Item # <u>2023-02-P(MOD)</u> Year <u>2023</u></p> <p align="center">DISPOSITION</p> <p>ADOPTED: <input checked="" type="checkbox"/> TASK FORCE (TF) <u>6/30/23 (MOD)</u> <input type="checkbox"/> WORKING GROUP (WF) _____ <input type="checkbox"/> SUBGROUP (SG) _____</p> <p>EXPOSED: <input type="checkbox"/> TASK FORCE (TF) _____ <input checked="" type="checkbox"/> WORKING GROUP (WG) <u>5/15/23</u> <input type="checkbox"/> SUBGROUP (SG) _____</p> <p>REJECTED: <input type="checkbox"/> TF <input type="checkbox"/> WG <input type="checkbox"/> SG _____</p> <p>OTHER: <input type="checkbox"/> DEFERRED TO _____ <input type="checkbox"/> REFERRED TO OTHER NAIC GROUP _____ <input type="checkbox"/> (SPECIFY) _____</p>
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IDENTIFICATION OF SOURCE AND FORM(S)/INSTRUCTIONS TO BE CHANGED

- | | | |
|--|--|--|
| <input type="checkbox"/> Health RBC Blanks | <input checked="" type="checkbox"/> Property/Casualty RBC Blanks | <input type="checkbox"/> Life and Fraternal RBC Blanks |
| <input type="checkbox"/> Health RBC Instructions | <input type="checkbox"/> Property/Casualty RBC Instructions | <input type="checkbox"/> Life and Fraternal RBC Instructions |
| <input type="checkbox"/> Health RBC Formula | <input type="checkbox"/> Property/Casualty RBC Formula | <input type="checkbox"/> Life and Fraternal RBC Formula |
| <input type="checkbox"/> OTHER _____ | | |

DESCRIPTION/REASON OR JUSTIFICATION OF CHANGE(S)

The proposed change would provide routine annual update of the industry underwriting factors (premium and reserve) in the PCRBC formula.

Additional Staff Comments:

4-25-23 TF adopted proposal
 5-15-23 PCRBC WG re-expose the proposal for seven days due to the incorrect calculation of H/F, WC, and CMP reserve factors.
 6-30-23 TF adopted Modified proposal

** This section must be completed on all forms.

Revised 2-2023

PRO17 Line 1 Reserves

Schedule P Line of Business	LOB	Proposed for adoption - 2023 Industry Average Development Ratio	2022 Industry Average Development	2021 Industry Average Development	2020 Industry Average Development	2019 Industry Average Development	2018 Industry Average Development	2017 Industry Average Development	2016 Industry Average Development	2015 Industry Average Development	2014 Industry Average Development
H/F	A	0.999	1.001	0.998	0.993	0.989	0.989	0.984	0.972	0.962	0.967
PPA	B	1.047	1.022	1.025	1.035	1.026	1.022	1.012	1.002	1.002	0.994
CA	C	1.106	1.082	1.083	1.078	1.087	1.060	1.034	1.015	0.987	0.979
WC	D	0.873	0.906	0.912	0.916	0.955	0.952	0.971	0.971	0.961	0.986
CMP	E	1.026	1.037	0.999	1.016	0.992	0.967	0.956	0.942	0.938	0.941
MM Occurrence	F1	0.906	0.887	0.874	0.861	0.864	0.871	0.868	0.841	0.866	0.966
MM Clms Made	F2	0.984	0.983	0.973	0.940	0.907	0.886	0.854	0.822	0.839	0.808
SL	G	0.994	0.990	0.976	0.963	0.938	0.933	0.926	0.919	0.975	0.990
OL	H	0.969	0.995	0.964	0.968	0.971	0.966	0.952	0.929	0.923	0.916
Fidelity / Surety	K	0.852	0.842	0.915	0.907	0.995	0.996	1.016	1.035	1.016	1.050
Special Property	I	0.983	0.993	0.978	0.977	0.972	0.971	0.982	0.973	0.991	0.992
Auto Physical Damage	J	1.016	1.011	0.989	0.993	0.996	1.000	1.001	0.995	0.995	1.005
Other (Credit, A&H)	L	0.946	0.955	0.965	0.971	0.973	0.976	0.981	0.986	1.041	1.061
Financial / Mortgage Guaranty	S	0.674	0.694	0.723	0.682	0.788	0.870	0.820	0.853	1.185	1.444
Intl	M	2.414	3.041	1.104	1.162	1.037	0.851	0.855	0.897	1.350	0.742
Rein. Property & Financial Lines	NP	0.924	0.917	0.893	0.886	0.872	0.834	0.814	0.814	1.002	0.976
Rein. Liability	O	1.024	1.008	0.989	0.985	0.955	0.945	0.914	0.896	0.938	0.905
PL	R	0.874	0.867	0.879	0.900	0.913	0.921	0.935	0.937	1.072	1.018
Warranty	T	0.995	0.998	1.007	1.013	1.017	1.015	0.989	0.977	0.994	1.040

PRO18 Line 1 Premiums

Schedule P Line of Business	LOB	Proposed 2023 Industry Average Loss & Expense Ratio	2022 Industry Average Loss & Expense Ratio	2021 Industry Average Loss & Expense Ratio	2020 Industry Average Loss & Expense Ratio	2019 Industry Average Loss & Expense Ratio	2018 Industry Average Loss & Expense Ratio	2017 Industry Average Loss & Expense Ratio	2016 Industry Average Loss & Expense Ratio	2015 Industry Average Loss & Expense Ratio	2014 Industry Average Loss & Expense Ratio
H/F	A	0.679	0.665	0.681	0.678	0.681	0.687	0.687	0.688	0.701	0.713
PPA	B	0.791	0.793	0.795	0.810	0.810	0.806	0.806	0.800	0.792	0.780
CA	C	0.777	0.761	0.761	0.759	0.737	0.724	0.724	0.706	0.689	0.676
WC	D	0.651	0.664	0.682	0.705	0.726	0.744	0.705	0.751	0.752	0.749
CMP	E	0.671	0.661	0.673	0.672	0.666	0.664	0.664	0.647	0.648	0.652
MM Occurrence	F1	0.767	0.750	0.731	0.726	0.730	0.780	0.777	0.777	0.767	0.883
MM Clms Made	F2	0.815	0.829	0.821	0.797	0.768	0.747	0.722	0.722	0.691	0.680
SL	G	0.578	0.585	0.593	0.603	0.593	0.569	0.569	0.567	0.572	0.645
OL	H	0.641	0.637	0.635	0.639	0.638	0.633	0.633	0.629	0.618	0.617
Fidelity / Surety	K	0.363	0.366	0.394	0.384	0.399	0.417	0.417	0.430	0.464	0.473
Special Property	I	0.550	0.547	0.559	0.553	0.554	0.563	0.563	0.555	0.559	0.571
Auto Physical Damage	J	0.727	0.718	0.726	0.732	0.730	0.732	0.732	0.727	0.711	0.703
Other (Credit, A&H)	L	0.702	0.698	0.693	0.684	0.682	0.709	0.709	0.712	0.699	0.706
Financial / Mortgage Guaranty	S	0.209	0.203	0.252	0.513	0.811	1.099	1.099	1.175	1.293	1.242
Intl	M	1.136	1.166	0.769	0.758	0.795	0.584	0.584	0.565	0.607	1.150
Rein. Property & Financial Lines	NP	0.578	0.566	0.558	0.534	0.522	0.486	0.486	0.459	0.512	0.764
Rein. Liability	O	0.743	0.725	0.713	0.708	0.679	0.666	0.666	0.609	0.600	0.748
PL	R	0.597	0.601	0.617	0.645	0.656	0.671	0.671	0.670	0.684	0.716
Warranty	T	0.652	0.665	0.681	0.691	0.695	0.732	0.732	0.645	0.611	0.789

Capital Adequacy (E) Task Force
RBC Proposal Form

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| <input type="checkbox"/> Capital Adequacy (E) Task Force | <input type="checkbox"/> Health RBC (E) Working Group | <input type="checkbox"/> Life RBC (E) Working Group |
| <input type="checkbox"/> Catastrophe Risk (E) Subgroup | <input type="checkbox"/> P/C RBC (E) Working Group | <input type="checkbox"/> Longevity Risk (A/E) Subgroup |
| <input type="checkbox"/> Variable Annuities Capital. & Reserve (E/A) Subgroup | <input type="checkbox"/> Economic Scenarios (E/A) Subgroup | <input checked="" type="checkbox"/> RBC Investment Risk & Evaluation (E) Working Group |

<p align="right">DATE: <u>4/20/23</u></p> <p>CONTACT PERSON: <u>Dave Fleming</u></p> <p>TELEPHONE: <u>816-783-8121</u></p> <p>EMAIL ADDRESS: <u>dfleming@naic.org</u></p> <p>ON BEHALF OF: <u>RBC Inv. Risk & Eval. (E) Working Group</u></p> <p>NAME: <u>Philip Barlow</u></p> <p>TITLE: <u>Associate Commissioner for Insurance</u></p> <p>AFFILIATION: <u>District of Columbia</u></p> <p>ADDRESS: <u>1050 First Street, NE Suite 801</u> <u>Washington, DC 20002</u></p>	<p align="center">FOR NAIC USE ONLY</p> <p>Agenda Item # <u>2023-09-IRE</u></p> <p>Year <u>2023</u></p> <p align="center">DISPOSITION</p> <p>ADOPTED:</p> <p><input type="checkbox"/> TASK FORCE (TF) _____</p> <p><input checked="" type="checkbox"/> WORKING GROUP (WG) <u>6/14</u></p> <p><input type="checkbox"/> SUBGROUP (SG) _____</p> <p>EXPOSED:</p> <p><input type="checkbox"/> TASK FORCE (TF) _____</p> <p><input checked="" type="checkbox"/> WORKING GROUP (WG) _____</p> <p><input type="checkbox"/> SUBGROUP (SG) _____</p> <p>REJECTED:</p> <p><input type="checkbox"/> TF <input type="checkbox"/> WG <input type="checkbox"/> SG _____</p> <p>OTHER:</p> <p><input type="checkbox"/> DEFERRED TO _____</p> <p><input type="checkbox"/> REFERRED TO OTHER NAIC GROUP _____</p> <p><input type="checkbox"/> (SPECIFY) _____</p>
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IDENTIFICATION OF SOURCE AND FORM(S)/INSTRUCTIONS TO BE CHANGED

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|--|---|---|
| <input type="checkbox"/> Health RBC Blanks | <input type="checkbox"/> Property/Casualty RBC Blanks | <input checked="" type="checkbox"/> Life and Fraternal RBC Blanks |
| <input type="checkbox"/> Health RBC Instructions | <input type="checkbox"/> Property/Casualty RBC Instructions | <input type="checkbox"/> Life and Fraternal RBC Instructions |
| <input type="checkbox"/> Health RBC Formula | <input type="checkbox"/> Property/Casualty RBC Formula | <input type="checkbox"/> Life and Fraternal RBC Formula |
| <input type="checkbox"/> OTHER _____ | | |

DESCRIPTION/REASON OR JUSTIFICATION OF CHANGE(S)

This proposal applies a .45 base RBC factor in the life RBC formula for residual tranches..

Additional Staff Comments:

DF – The Working Group adopted a factor of .30 for yearend 2023.

**** This section must be completed on all forms.**

Revised 2-2023

	(1) Book / Adjusted Carrying Value	(2) Unrated Items †	(3) RBC Subtotal †	(4) Factor	(5) RBC Requirement
OTHER LONG-TERM ASSETS (CONTINUED)					
	<u>Annual Statement Source</u>				
(42) Schedule BA - Unaffiliated Common Stock					
(43) Schedule BA Unaffiliated Common Stock-Public		AVR Equity Component Column 1 Line 65	X	\$	
(44) Total Schedule BA Unaffiliated Common Stock (pre-MODCO/Funds Withheld)		AVR Equity Component Column 1 Line 66 Line (42) + (43)	X	0.3000	
(45) Reduction in RBC for MODCO/Funds Withheld Reinsurance Ceded Agreements		Company Records (enter a pre-tax amount)			
(46) Increase in RBC for MODCO/Funds Withheld Reinsurance Assumed Agreements		Company Records (enter a pre-tax amount)			
(47) Total Schedule BA Unaffiliated Common Stock (including MODCO/Funds Withheld.)		Lines (44) - (45) + (46)			
Schedule BA - All Other					
(48.1) BA Affiliated Common Stock - Life with AVR		AVR Equity Component Column 1 Line 67			
(48.2) BA Affiliated Common Stock - Certain Other		AVR Equity Component Column 1 Line 68			
(48.3) Total Schedule BA Affiliated Common Stock - C-1o		Line (48.1) + (48.2)	X	0.3000	
(49.1) BA Affiliated Common Stock - All Other		AVR Equity Component Column 1 Line 69			
(49.2) Total Sch. BA Affiliated Common Stock - C-1es		Line (49.1) + AVR Equity Component Column 1 Line 93- Schedule BA Part 1 Column 12 Line 2999999 + Line 3099999	X	0.3000	
(50) Schedule BA Collateral Loans			X	0.0680	
(51) Total Residual Tranches or Interests		AVR Equity Component Column 1 Line 93	X	0.3000	
(52.1) NAIC 01 Working Capital Finance Notes		AVR Equity Component Column 1 Line 94	X	0.0050	
(52.2) NAIC 02 Working Capital Finance Notes		AVR Equity Component Column 1 Line 95	X	0.0050	
(52.3) Total Admitted Working Capital Finance Notes		Line (52.1) + (52.2)	X	0.0163	
(53.1) Other Schedule BA Assets					
(53.2) Less NAIC 2 thru 6 Rated/Designated Surplus Notes and Capital Notes		AVR Equity Component Column 1 Line 96 Column (1) Lines (23) through (27) + Column (1)			
(53.3) Net Other Schedule BA Assets		Lines (33) through (37)			
(54) Total Schedule BA Assets C-1o (pre-MODCO/Funds Withheld)		Line (53.1) less (53.2) Lines (1) + (21) + (31) + (41) + (48.3) + (50) + (52.3) + (53.3)	X	0.3000	
(55) Reduction in RBC for MODCO/Funds Withheld Reinsurance Ceded Agreements		Company Records (enter a pre-tax amount)			
(56) Increase in RBC for MODCO/Funds Withheld Reinsurance Assumed Agreements		Company Records (enter a pre-tax amount)			
(57) Total Schedule BA Assets C-1o (including MODCO/Funds Withheld.)		Lines (54) - (55) + (56)			
(58) Total Schedule BA Assets Excluding Mortgages and Real Estate		Line (47) + (49.2) + (51) + (57)			

† Fixed income instruments and surplus notes designated by the NAIC Capital Markets and Investment Analysis Office or considered exempt from filing as specified in the *Purposes and Procedures Manual of the NAIC*

‡ *Investment Analysis Office* should be reported in Column (3).

§ The factor for Schedule BA publicly traded common stock should equal 1.30 percent adjusted up or down by the weighted average beta for the Schedule BA publicly traded common stock portfolio subject to a minimum of 22.5 percent and a maximum of 45 percent in the same manner that this similar 1.58 percent factor for Schedule BA publicly traded common stock in the Asset Valuation Reserve (AVR) calculation is adjusted up or down. The rules for calculating the beta adjustment are set forth in the AVR section of the annual statement instructions.

Denotes items that must be manually entered on the filing software.

**Capital Adequacy (E) Task Force
RBC Proposal Form**

- | | | |
|---|--|--|
| <input type="checkbox"/> Capital Adequacy (E) Task Force | <input type="checkbox"/> Health RBC (E) Working Group | <input type="checkbox"/> Life RBC (E) Working Group |
| <input type="checkbox"/> Catastrophe Risk (E) Subgroup | <input type="checkbox"/> P/C RBC (E) Working Group | <input type="checkbox"/> Longevity Risk (A/E) Subgroup |
| <input type="checkbox"/> Variable Annuities Capital. & Reserve (E/A) Subgroup | <input type="checkbox"/> Economic Scenarios (E/A) Subgroup | <input checked="" type="checkbox"/> RBC Investment Risk & Evaluation (E) Working Group |

<p align="right">DATE: <u>4/20/23</u></p> <p>CONTACT PERSON: <u>Steve Clayburn</u></p> <p>TELEPHONE: <u>(202)624-2197</u></p> <p>EMAIL ADDRESS: <u>steveclayburn@acli.com</u></p> <p>ON BEHALF OF: <u>American Council of Life Insurers (ACLI)</u></p> <p>NAME: <u>Steve Clayburn</u></p> <p>TITLE: _____</p> <p>AFFILIATION: _____</p> <p>ADDRESS: _____</p>	<p align="center">FOR NAIC USE ONLY</p> <p>Agenda Item # <u>2023-10-IRE</u></p> <p>Year <u>2023</u></p> <p align="center">DISPOSITION</p> <p>ADOPTED:</p> <p><input type="checkbox"/> TASK FORCE (TF) _____</p> <p><input checked="" type="checkbox"/> WORKING GROUP (WG) <u>6/14</u></p> <p><input type="checkbox"/> SUBGROUP (SG) _____</p> <p>EXPOSED:</p> <p><input type="checkbox"/> TASK FORCE (TF) _____</p> <p><input checked="" type="checkbox"/> WORKING GROUP (WG) _____</p> <p><input type="checkbox"/> SUBGROUP (SG) _____</p> <p>REJECTED:</p> <p><input type="checkbox"/> TF <input type="checkbox"/> WG <input type="checkbox"/> SG _____</p> <p>OTHER:</p> <p><input type="checkbox"/> DEFERRED TO _____</p> <p><input type="checkbox"/> REFERRED TO OTHER NAIC GROUP _____</p> <p><input type="checkbox"/> (SPECIFY) _____</p>
---	--

IDENTIFICATION OF SOURCE AND FORM(S)/INSTRUCTIONS TO BE CHANGED

- | | | |
|--|---|---|
| <input type="checkbox"/> Health RBC Blanks | <input type="checkbox"/> Property/Casualty RBC Blanks | <input checked="" type="checkbox"/> Life and Fraternal RBC Blanks |
| <input type="checkbox"/> Health RBC Instructions | <input type="checkbox"/> Property/Casualty RBC Instructions | <input type="checkbox"/> Life and Fraternal RBC Instructions |
| <input type="checkbox"/> Health RBC Formula | <input type="checkbox"/> Property/Casualty RBC Formula | <input type="checkbox"/> Life and Fraternal RBC Formula |
| <input type="checkbox"/> OTHER _____ | | |

DESCRIPTION/REASON OR JUSTIFICATION OF CHANGE(S)

The adoption by the Working Group of proposal 2023-04-IRE provides the structure for this sensitivity test. This proposal is to address the factor to be applied in that test.

Additional Staff Comments:

DF – The Working Group adopted a factor of .15 for yearend 2023.

**** This section must be completed on all forms.**

Revised 2-2023

SENSITIVITY TESTS - AUTHORIZED CONTROL LEVEL

	(1)	(2)	(3)	(4)
	Statement Value	Additional Sensitivity Factor	Authorized Control Level Before Test	Authorized Control Level After Test
Sensitivity Tests Affecting Authorized Control Level <u>Risk-Based Capital</u>				
(1.1) Other Affiliates: Company		0.700		
(1.2) Other Affiliates: Subsidiaries		0.700		
(1.99) Total Other Affiliates		0.700		
(2.1) Noncontrolled Assets - Company		0.020		
(2.2) Noncontrolled Assets - Subsidiaries		0.020		
(2.99) Total Noncontrolled Assets		0.020		
(3.1) Guarantees for Affiliates: Company		0.020		
(3.2) Guarantees for Affiliates: Subsidiaries		0.020		
(3.99) Total Guarantees for Affiliates		0.020		
(4.1) Contingent Liabilities: Company		0.020		
(4.2) Contingent Liabilities: Subsidiaries		0.020		
(4.99) Total Contingent Liabilities		0.020		
(5.1) Long-Term Leases: Company		0.030		
(5.2) Long-Term Leases: Subsidiaries		0.030		
(5.99) Total Long-Term Leases		0.030		
(7.1) Affiliated Investments†: Company		0.100		
(7.2) Affiliated Investments†: Subsidiaries		0.100		
(7.99) Total Affiliated Investments		0.100		
(8.1) Total Residual Tranches or Interests		0.150		

	Source
LR042 Summary for Affiliated Investments Column (1) Line (13)	
LR038 Additional Information Required Column (1) Line (1.2)	
LR017 Off-Balance Sheet and Other Items Column (1) Line (15)	
LR038 Additional Information Required Column (1) Line (2.2)	
LR017 Off-Balance Sheet and Other Items Column (1) Line (24)	
LR038 Additional Information Required Column (1) Line (3.2)	
LR017 Off-Balance Sheet and Other Items Column (1) Line (25)	
LR038 Additional Information Required Column (1) Line (4.2)	
LR017 Off-Balance Sheet and Other Items Column (1) Line (26)	
LR038 Additional Information Required Column (1) Line (5.2)	
LR038 Additional Information Required Column (1) Line (7.14)	
LR038 Additional Information Required Column (1) Line (7.2)	
LR038 Additional Information Required Column (1) Line (11.1)	

† Excluding affiliated preferred and common stock

Denotes items that must be manually entered on the filing software.

Capital Adequacy (E) Task Force

RBC Proposal Form

- | | | |
|---|---|--|
| <input checked="" type="checkbox"/> Capital Adequacy (E) Task Force | <input type="checkbox"/> Health RBC (E) Working Group | <input type="checkbox"/> Life RBC (E) Working Group |
| <input type="checkbox"/> Catastrophe Risk (E) Subgroup | <input type="checkbox"/> Investment RBC (E) Working Group | <input type="checkbox"/> Operational Risk (E) Subgroup |
| <input type="checkbox"/> C3 Phase II/ AG43 (E/A) Subgroup | <input type="checkbox"/> P/C RBC (E) Working Group | <input type="checkbox"/> Longevity Risk (A/E) Subgroup |

DATE: <u>8/11/22</u>	<u>FOR NAIC USE ONLY</u>
CONTACT PERSON: <u>Eva Yeung</u>	Agenda Item # <u>2022-09-CA MOD</u>
TELEPHONE: <u>816-783-8407</u>	Year <u>2023</u>
EMAIL ADDRESS: <u>eyeung@naic.org</u>	<u>DISPOSITION</u>
ON BEHALF OF: <u>Capital Adequacy (E) Task Force</u>	<input checked="" type="checkbox"/> ADOPTED <u>3/23/23</u>
NAME: <u>Tom Botsko</u>	<input type="checkbox"/> REJECTED _____
TITLE: <u>Chair</u>	<input type="checkbox"/> DEFERRED TO _____
AFFILIATION: <u>Ohio Department of Insurance</u>	<input type="checkbox"/> REFERRED TO OTHER NAIC GROUP
ADDRESS: <u>50 West Town Street, Suite 300</u>	<input checked="" type="checkbox"/> EXPOSED <u>8/11/22, 6/1/23 (MOD)</u>
<u>Columbus, OH 43215</u>	<input type="checkbox"/> OTHER (SPECIFY) _____

IDENTIFICATION OF SOURCE AND FORM(S)/INSTRUCTIONS TO BE CHANGED

- Health RBC Blanks
 Property/Casualty RBC Blanks
 Life and Fraternal RBC Instructions
 Health RBC Instructions
 Property/Casualty RBC Instructions
 Life and Fraternal RBC Instructions
 OTHER _____

DESCRIPTION OF CHANGE(S)

The proposed change would revise the instructions and structure for the Affiliated Investments for all lines.

MODIFIED: The Health and P/C instructions and blanks have been modified with an editorial change to clarify the examples provided in the Indirectly Owned Alien Insurance Affiliates/Subsidiaries section and add a footnote to the % Owned column in the blank.

REASON OR JUSTIFICATION FOR CHANGE **

The proposed revisions will improve the risk-based capital formulas and provide consistency to the treatment of affiliates for all lines of business.

Additional Staff Comments:

8/11/22 - The Task Force exposed this proposal for a 60-day public comment period ending Oct, 10.

3/23/23 – The Task Force adopted the proposal on 3/23/23

5/17/23 – EDITORIAL CHANGE to Indirectly Owned Alien Insurance Affiliates/Subsidiaries section and % owned column.

6/1/23 – The Task Force exposed this proposal for a 14-day public comment period ending Jun 14.

** This section must be completed on all forms.

Revised 2-2019

AFFILIATED/SUBSIDIARY STOCKS
XR002 – XR004

There are nine categories of affiliated/subsidiary investments that are subject to Risk-Based Capital requirements for common stock and preferred stock holdings. Those nine categories are:

1. Directly Owned U.S. Insurance Affiliates/Subsidiaries Subject to a Risk-Based Capital (RBC)-Look-Through Calculation
 - a. Health Insurance Company or Health Entity
 - b. Property and Casualty Insurance Company
 - c. Life Insurance Company
2. Indirectly Owned U.S. Insurance Affiliates/Subsidiaries Subject to RBC-Look-Through Calculation
 - a. Health Insurance Company or Health Entity
 - b. Property and Casualty Insurance Company
 - c. Life Insurance Company
3. Holding Company Value in Excess of Indirectly Owned Insurance Affiliates/Subsidiaries
4. Investment Subsidiaries
5. Directly Owned Alien Insurance Affiliates/Subsidiaries
 - a. Health Insurance Company or Health Entity
 - b. Property and Casualty Insurance Company
 - c. Life Insurance Company
6. Indirectly Owned Alien Insurance Affiliates/Subsidiaries
 - a. Health Insurance Company or Health Entity
 - b. Property and Casualty Insurance Company
 - c. Life Insurance Company
7. Investments in Upstream Affiliate (Parent)
8. Directly Owned U.S. Insurance Affiliates/Subsidiaries Not Subject to RBC
 - a. Health Insurance Companies and Health Entities Not Subject to RBC
 - b. Property and Casualty Insurance Companies Not Subject to RBC
 - c. Life Insurance Companies Not Subject to RBC
9. Non-Insurance Affiliates/Subsidiaries Not Subject to RBC
 - a. Entities with a capital requirement imposed by a regulatory body
 - b. Other Financial Entities without regulatory capital requirements
 - c. Other Non-financial entities



Detail Eliminated to Conserve Space

6. Indirectly Owned Alien Insurance Affiliates/Subsidiaries

For Indirectly Owned Alien Insurance Affiliates/Subsidiaries, the carrying value and RBC charge is calculated in a similar manner as for directly owned Alien Insurance Affiliates/Subsidiaries.

SSAP No. 97 provides guidance for the reporting and admittance requirements of SCAs. Accordingly, there may be cases where an indirectly owned Alien insurer may not be separately reported in the statutory financial statements (e.g., they are captured within the carrying value of an intermediate holding company). The SSAP No. 97 guidance permits reporting SCAs at the directly owned holding company level or via look-through to the downstream entity (including where the downstream entity is an Alien insurer), but an audit of the entity is required for admittance (i.e. if reporting is at the directly owned holding company level, the holding company must be audited, if the reporting is on a look-through basis then the downstream entity must be audited). Regardless of whether there is a look-through applied pursuant to Statutory Accounting Principles (SAP) for annual financial statement reporting, for RBC purposes the reporting insurer must “look-through” all intermediate holding and subsidiary companies to determine the carrying value and the RBC charge that would be imposed had the Alien insurance affiliate/subsidiary companies been directly held by the reporting insurer. This involves looking down to the first alien insurer affiliate/subsidiary, unless there is an RBC filer in between, and adjusting for percentage ownership of the intermediate entity directly owning the RBC filing affiliate/subsidiary. Both the RBC charge and carrying value of the alien insurer must be reported for RBC purposes, in order to appropriately balance the numerator with the addition to the denominator value. Enter the carrying value of the insurer on Line (6) of the Calculation of Total Adjusted Capital page to satisfy these instructions.

The carrying value of an alien insurance affiliate/subsidiary is deducted from the value of the directly held holding company or other entity that in turn directly owns the U.S. Insurance Affiliate/Subsidiary that is subject to RBC, based on the value reported for each insurance subsidiary on the downstream immediate holding company or non-insurance owner’s balance sheet. That value is prescribed by the NAIC Accounting Practices and Procedures Manual (SSAP No. 97, paragraph 22.a.). A similar exercise is required for each RBC filing insurer and each non-U.S. insurer in order to determine the remaining excess value of the holding company.

The RBC charge to be applied to each indirectly owned alien insurance affiliate/subsidiary is the annual statement book adjusted carrying value of the reporting company’s interest in the affiliate/subsidiary multiplied by 1.0 and adjusted to reflect the reporting company’s ownership on the holding company. For example, assume NEWBIE Insurance Company acquired 100 percent shares of Holder (a holding company), and Holder owns an Alien Life Insurance Company, which represents 50 percent of the book adjusted carrying value of Holder. If Holder has a book adjusted carrying value of \$20,000,000, NEWBIE Insurance Company would enter \$10,000,000 (1/2 of \$20,000,000) as the carrying value of the Alien Life Insurance Company and the RBC charge for the indirect ownership of the alien insurance affiliate/subsidiary would be \$10,000,000 (4-5.1,000 times \$10,000,000). The risk-based capital charge for the parent insurer preparing the calculation is a 30 percent charge against the holding company value in excess of the indirectly owned insurance affiliates/subsidiaries.

XR002 Columns			
(1) Affiliate/Subsidiary	(2) Affiliate/Subsidiary Type	(5) Book Adjusted Carrying Value (Statement Value) of Affiliate’s Common Stock	(12) RBC Required
Alien Life Insurance Company	6c	10,000,000	10,000,000
Holder Holding Company	3	10,000,000	3,000,000

If NEWBIE Insurance Company only acquired 50 percent shares of Holder, NEWBIE Insurance Company would enter \$5,000,000 (50 percent of 1/2 of \$20,000,000) as the carrying value of the Alien Life Insurance Company and the RBC charge for the indirect ownership of the Alien insurance affiliate/subsidiary would be \$5,000,000 (1.0 times \$5,000,000). Enter information for any indirectly owned alien insurance subsidiaries.

<u>XR002 Columns</u>			
(1) <u>Affiliate/Subsidiary</u>	(2) <u>Affiliate/Subsidiary Type</u>	(5) <u>Book Adjusted Carrying Value (Statement Value) of Affiliate's Common Stock</u>	(12) <u>RBC Required</u>
<u>Alien Life Insurance Company</u>	<u>6c</u>	<u>5,000,000</u>	<u>5,000,000</u>
<u>Holder Holding Company</u>	<u>3</u>	<u>15,000,000</u>	<u>4,500,000</u>

For each affiliate/subsidiary enter the following information:

- Company Name,
- Alien Insurer Identification Number,
- Book Adjusted carrying value of common and preferred stock,
- ~~Total Outstanding value of common and preferred stock~~
- Book/adjusted carrying value of the common and preferred stock from Schedule D, Part 6, Section 1, Line 1499999. If no value is reported in the Total Value of Affiliate's Common and preferred stock column.



Detail Eliminated to Conserve Space



**AFFILIATED COMPANIES RISK - DETAILS
DETAILS FOR AFFILIATED STOCKS**

(1) Name of Affiliate	(2) Affiliate Type Code	(3) NAIC Company Code or Alien ID Number	(4) Affiliate's RBC after Covenant Before Basic Operational Risk XR025 Line (37) PR022 Line (67) LR031 Line (67) + (71)	(5) Book/Adjusted Carrying Value (statutory value) of Affiliate's Common Stock	(6) Valuation Basis of Col (5) M - Market Value after any "discount" A - All Other	(7) Total Value of Affiliate's Outstanding Common Stock	(8) Head-Statutory Surplus of Affiliate Subject to RBC (Adjusted for % Owned)	(9) Book/Adjusted Carrying Value (statutory value) of Affiliate's Preferred Stock	(10) Total Value of Affiliate's Outstanding Preferred Stock	(11) Percent Owned* (Col 5 + 9) / (Cols 7 + 10)	(12) RBC Required (HQ Component)	(13) Market Value Excess Component Affiliated Common Stock RBC Required (H1 Component)
(01)										100.0000%		
(02)										100.0000%		
(03)										100.0000%		
(04)										100.0000%		
(05)										100.0000%		
(06)										100.0000%		
(07)										100.0000%		
(08)										100.0000%		
(09)										100.0000%		
(10)										100.0000%		
(11)										100.0000%		
(12)										100.0000%		
(13)										100.0000%		
(14)										100.0000%		
(15)										100.0000%		
(16)										100.0000%		
(17)										100.0000%		
(18)										100.0000%		
(19)										100.0000%		
(20)										100.0000%		
(21)										100.0000%		
(22)										100.0000%		
(23)										100.0000%		
(24)										100.0000%		
(25)										100.0000%		
(26)										100.0000%		
(27)										100.0000%		
(28)										100.0000%		
(29)										100.0000%		
(30)										100.0000%		
(31)										100.0000%		
(32)										100.0000%		
(33)										100.0000%		
(34)										100.0000%		
(35)										100.0000%		
(36)										100.0000%		
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(40)										100.0000%		
(41)										100.0000%		
(42)										100.0000%		
(43)										100.0000%		
(44)										100.0000%		
(45)										100.0000%		
(46)										100.0000%		
(47)										100.0000%		
(48)										100.0000%		
(49)										100.0000%		
(50)										100.0000%		
(9999999)	XXX	XXX	0	0	XXX	0	0	0	0	XXX	0	0
Total												

Remark: Subcategory 8a, 8b and 8c are referring to the directly owned insurance affiliates not subject to RBC look-through

* Indirectly owned insurance affiliate not subject to RBC will be included Category 4

Only applies to Affiliate Type 1 and 2.

If Col(2) = 5 and Col(6) = 1 Do Calculation

Calculation

Col(12) = Min(Col(4) * Col(11), Col(8) * Col(11))

If Col(5) = Col(9) → Max(Col(4) * Col(11), Col(8) * Col(11)) then

Col(12) = Max(Col(5) + Col(9) - Col(8) * Col(11), Col(4) * Col(11) - Col(8) * Col(11))

If Col(4) * Col(11) > Col(5) + Col(9) → Col(8) * Col(11) then

Col(12) = Col(5) + Col(9) - Col(8) * Col(11)

Otherwise

Col(12) = 0

Col(12) and (13) cannot be less than 0

**SUBSIDIARY, CONTROLLED AND AFFILIATED INVESTMENTS
AFFILIATED COMPANIES RISK**

	Type of Affiliate	Affiliate Type	Type Code	Basis	(1) Number of Companies	(2) Total RBC Required
(1)	Directly Owned Health Insurance Companies or Health Entities		1a	Affiliate's RBC's	0	\$0
(2)	Directly Owned Property and Casualty Insurance Affiliates		1b	Sub's RBC After Covariance	0	\$0
(3)	Directly Owned Life Insurance Affiliates		1c	Affiliate's RBC's	0	\$0
(4)	Indirectly Owned Health Insurance Companies or Health Entities		2a	Sub's RBC After Covariance	0	\$0
(5)	Indirectly Owned Property and Casualty Insurance Affiliates		2b	Affiliate's RBC's	0	\$0
(6)	Indirectly Owned Life Insurance Affiliates		2c	Sub's RBC After Covariance	0	\$0
(7)	Holding Company in Excess of Indirect Subs		3	Sub's RBC After Covariance	0	\$0
(8)	Investment Subsidiary		4	0.300	0	\$0
(9)	Directly Owned Alien Health Insurance Companies or Health Entities		5a	0.300	0	\$0
(10)	Directly Owned Alien Property and Casualty Insurance Affiliates		5b	1.000	0	\$0
(11)	Directly Owned Alien Life Insurance Affiliates		5c	1.000	0	\$0
(12)	Indirectly Owned Alien Health Insurance Companies or Health Entities		6a	1.000	0	\$0
(13)	Indirectly Owned Alien Property and Casualty Insurance Affiliates		6b	1.000	0	\$0
(14)	Indirectly Owned Alien Life Insurance Affiliates		6c	1.000	0	\$0
(15)	Investment in Upstream Affiliate (Parent)		7	0.300	0	\$0
(16)	Directly Owned Health Insurance Companies or Health Entities Not Subject to RBC		8a	0.300	0	\$0
(17)	Directly Owned Property and Casualty Insurance Companies Not Subject to RBC		8b	0.300	0	\$0
(18)	Directly Owned Life Insurance Companies Not Subject to RBC		8c	0.300	0	\$0
(19)	Non-Insurance Entities with a Capital Requirement Imposed by a Regulatory Body		9a	0.300	0	\$0
(20)	Non-Insurance Other Financial Entities without Regulatory Capital Requirements		9b	0.300	0	\$0
(21)	Other Non-financial Entities		9c	0.300	0	\$0
(22)	Total				0	\$0

CROSS-CHECKING FOR AFFILIATED INVESTMENTS
SUMMARY FOR SUBSIDIARY, CONTROLLED AND AFFILIATED INVESTMENTS FOR CROSS-CHECKING STATEMENT VALUES

Affiliated Preferred Stock		(1)	(2)	(3)
Annual Statement Line Number	Annual Statement	Total Preferred Stock	Total From RBC Report	Difference
(1)	Parent	0	0	0
(2)	U.S. P&C Insurer	0	0	0
(3)	U.S. Life Insurer	0	0	0
(4)	U.S. Health Insurer	0	0	0
(5)	Alien Insurer	0	0	0
(6)	Non-Insurer Which Controls Insurer	0	0	0
(7)	Investment Subsidiary	0	0	0
(8)	Other Affiliates	0	0	0
(9)	Subtotal	0	0	0

Affiliated Common Stock		(1)	(2)	(3)
Annual Statement Line Number	Annual Statement	Total Common Stock	Total From RBC Report	Difference
(10)	Parent	0	0	0
(11)	U.S. P&C Insurer	0	0	0
(12)	U.S. Life Insurer	0	0	0
(13)	U.S. Health Insurer	0	0	0
(14)	Alien Insurer	0	0	0
(15)	Non-Insurer Which Controls Insurer	0	0	0
(16)	Investment Subsidiary	0	0	0
(17)	Other Affiliates	0	0	0
(18)	Subtotal	0	0	0

EQUITY ASSETS

PREFERRED STOCK - UNAFFILIATED

	<u>Annual Statement Source</u>	<u>Bk/Adj Carrying Value</u>	<u>Factor</u>	<u>RBC Requirement</u>
(1) NAIC 01 Preferred Stock	Included in Schedule D, Part 2, Section 1		0.003	\$0
(2) NAIC 02 Preferred Stock	Included in Schedule D, Part 2, Section 1		0.010	\$0
(3) NAIC 03 Preferred Stock	Included in Schedule D, Part 2, Section 1		0.020	\$0
(4) NAIC 04 Preferred Stock	Included in Schedule D, Part 2, Section 1		0.045	\$0
(5) NAIC 05 Preferred Stock	Included in Schedule D, Part 2, Section 1		0.100	\$0
(6) NAIC 06 Preferred Stock	Included in Schedule D, Part 2, Section 1		0.300	\$0
(7) Total - Unaffiliated Preferred Stock	Sum of Lines (1) through (6)	\$0		\$0

(Should equal Page 2, Column 3, Line 2.1 less Sch D Sum, Column 1, Line 18)

COMMON STOCK - UNAFFILIATED

(8) Federal Home Loan Bank Stock	Company Records		0.023	\$0
(9) Total Common Stock	Schedule D, Summary, Column 1, Line 25			
(10) Affiliated Common Stock	Schedule D, Summary, Column 1, Line 24			
(11) Other Unaffiliated Common Stock	Lines (9) - (8) - (10)	\$0	0.150	\$0
(12) Market Value Excess Affiliated Common Stock	XR002 C(13) L(9999999)			\$0
(13) Total Unaffiliated Common Stock	Lines (8) + (11) + (12)	\$0		\$0

CALCULATION OF TOTAL RISK-BASED CAPITAL AFTER COVARIANCE

	(1) RBC Amount
H0 - INSURANCE AFFILIATES AND MISC. OTHER AMOUNTS	
(1) Off-Balance Sheet Items	\$0
(2) Directly Owned Health Insurance Companies or Health Entities	\$0
(3) Directly Owned Property and Casualty Insurance Affiliates	\$0
(4) Directly Owned Life Insurance Affiliates	\$0
(5) Indirectly Owned Health Insurance Companies or Health Entities	\$0
(6) Indirectly Owned Property and Casualty Insurance Affiliates	\$0
(7) Indirectly Owned Life Insurance Affiliates	\$0
(8) Affiliated Alien Insurers - Directly Owned	\$0
(9) Affiliated Alien Insurers - Indirectly Owned	\$0
(10) Total H0	\$0
H1 - ASSET RISK - OTHER	
(11) Investment-Affiliates	\$0
(12) Holding Company Excess of Subsidiaries	\$0
(13) Investment in Parent	\$0
(14) Other-Affiliates	\$0
(15) Fair-Value Excess-Affiliate-Common-Stock	\$0
(16) Holding Company in Excess of Indirect Subs	\$0
(17) Investment Subsidiary	\$0
(18) Investment in Upstream Affiliate (Parent)	\$0
(19) Directly Owned Health Insurance Companies or Health Entities Not Subject to RBC	\$0
(20) Directly Owned Property and Casualty Insurance Companies Not Subject to RBC	\$0
(21) Directly Owned Life Insurance Companies Not Subject to RBC	\$0
(22) Affiliated Non-Insurer	\$0
(23) Fixed Income Assets	\$0
(24) Replication & Mandatory Convertible Securities	\$0
(25) Unaffiliated Preferred Stock	\$0
(26) Unaffiliated Common Stock	\$0
(27) Property & Equipment	\$0
(28) Asset Concentration	\$0
(29) Total H1	\$0
H2 - UNDERWRITING RISK	
(30) Net Underwriting Risk	\$0
(31) Other Underwriting Risk	\$0
(32) Disability Income	\$0
(33) Long-Term Care	\$0
(34) Limited Benefit Plans	\$0
(35) Premium Stabilization Reserve	\$0
(36) Total H2	\$0
Sum Lines (1) through (9)	\$0
Sum Lines (11) through (23)	\$0
Sum Lines (25) through (30)	\$0

CALCULATION OF TOTAL ADJUSTED CAPITAL

	Annual Statement Source	(1) Amount	Factor	(2) Adjusted Capital
Company Amounts				
(1) Capital and Surplus	Page 3, Column 3, Line 33		1.000	\$0
Subsidiary Adjustments				
(2) AVR - Life Subs	Affiliate's Statement \$		1.000	\$0
(3) Dividend Liability - Life Subsidiaries	Affiliate's Statement		0.500	\$0
(4) Tabular Discounts - P&C Subsidiaries	Affiliate's Statement		-1.000	\$0
(5) Non-Tabular Discounts - P&C Subsidiaries	Affiliate's Statement		-1.000	\$0
(6) Carrying Value of Non-Admitted Insurance Affiliates	Included in XR002 Column 5 and Column 9	0	1.000	\$0
(7) Total Adjusted Capital, Post-Deferred Tax				\$0
SENSITIVITY TEST:				
(8) DTA Value for Company	Page 2, Column 3, Line 18.2		1.000	\$0
(9) DTL Value for Company	Page 3, Column 3, Line 10.2		1.000	\$0
(10) DTA Value for Insurance Subsidiaries	Company Records		1.000	\$0
(11) DTL Value for Insurance Subsidiaries	Company Records		1.000	\$0
(12) Total Adjusted Capital, Pre-Deferred Tax (Sensitivity)	Lines (7) - (8) + (9) - (10) + (11)			\$0
Ex DTA ACL RBC Ratio Sensitivity Test				
(13) Deferred Tax Asset	Page 2 Column 3, Line 18.2		1.000	\$0
(14) Total Adjusted Capital Less Deferred Tax Asset	Lines (7) less (13)			\$0
(15) Authorized Control Level RBC	XR027 Comparison of Total Adjusted Capital to Risk-Based Capital Line (4)			\$0
(16) Ex DTA ACL RBC Ratio	Line (14)/(15)			0.0000%

§ The portion of the AVR that can be counted as capital is limited to the amount not utilized in asset adequacy testing in support of the Actuarial Opinion for reserves.

**AFFILIATED/SUBSIDIARY STOCKS
PR003 – PR005**

There are nine categories of affiliated/subsidiary investments that are subject to Risk-Based Capital requirement for common stock and preferred stock holdings. Those nine categories are:

1. Directly Owned U.S. Insurance Affiliates/Subsidiaries Subject to a Risk-Based Capital (RBC)-Look-Through Calculation
 - a. Health Insurance Company or Health Entity
 - b. Property and Casualty Insurance Company
 - c. Life Insurance Company
2. Indirectly Owned U.S. Insurance Affiliates/Subsidiaries Subject to RBC-Look-Through Calculation
 - a. Health Insurance Company or Health Entity
 - b. Property and Casualty Insurance Company
 - c. Life Insurance Company
3. Holding Company Value in Excess of Indirectly Owned Insurance Affiliates/Subsidiaries
4. Investment Subsidiaries
5. Directly Owned Alien Insurance Affiliates/Subsidiaries
 - a. Health Insurance Company or Health Entity
 - b. Property and Casualty Insurance Company
 - c. Life Insurance Company
6. Indirectly Owned Alien Insurance Affiliates/Subsidiaries
 - a. Health Insurance Company or Health Entity
 - b. Property and Casualty Insurance Company
 - c. Life Insurance Company
7. Investments in Upstream Affiliate (Parent)
8. Directly Owned U.S. Insurance Affiliates/Subsidiaries Not Subject to RBC
 - a. Health Insurance Companies or Health Entities Not Subject to RBC
 - b. Property and Casualty Insurance Companies Not Subject to RBC
 - c. Life Insurance Companies Not Subject to RBC
9. Non-Insurance Affiliates/Subsidiaries Not Subject to RBC
 - a. Entities with a capital requirement imposed by a regulatory body
 - b. Other Financial Entities without regulatory capital requirements
 - c. Other Non-financial entities



Detail Eliminated to Conserve Space

6. Indirectly Owned Alien Insurance Affiliates/Subsidiaries

For Indirectly Owned Alien Insurance Affiliates/Subsidiaries, the carrying value and RBC charge is calculated in a similar manner as for directly owned Alien Insurance Affiliates/Subsidiaries.

SSAP No. 97 provides guidance for the reporting and admittance requirements of SCAs. Accordingly, there may be cases where an indirectly owned Alien insurer may not be separately reported in the statutory financial statements (e.g., they are captured within the carrying value of an intermediate holding company). The SSAP No. 97 guidance permits reporting SCAs at the directly owned holding company level or via look-through to the downstream entity (including where the downstream entity is an Alien insurer), but an audit of the entity is required for admittance (i.e. if reporting is at the directly owned holding company level, the holding company must be audited, if the reporting is on a look-through basis then the downstream entity must be audited). Regardless of whether there is a look-through applied pursuant to Statutory Accounting Principles (SAP) for annual financial statement reporting, for RBC purposes the reporting insurer must “look-through” all intermediate holding and subsidiary companies to determine the carrying value and the RBC charge that would be imposed had the alien insurance affiliate/subsidiary companies been directly held by the reporting insurer. This involves looking down to the first alien insurer affiliate/subsidiary, unless there is an RBC filer in between and adjusting for percentage ownership of the intermediate entity directly owning the RBC filing affiliate/subsidiary. Both the RBC charge and carrying value of the alien insurer must be reported for RBC purposes, in order to appropriately balance the numerator with the addition to the denominator value. Enter the carrying value of the insurer on Line **XXX** of the Calculation of Total Adjusted Capital page to satisfy these instructions.

The carrying value of an alien insurance Affiliate/Subsidiary is deducted from the value of the directly held holding company or other entity that in turn directly owns the U.S. Insurance Affiliate/Subsidiary that is subject to RBC, based on the value reported for each insurance subsidiary on the downstream immediate holding company or non-insurance owner’s balance sheet. That value is prescribed by the NAIC Accounting Practices and Procedures Manual (SSAP No. 97, paragraph 22.a.). A similar exercise is required for each non-U.S. insurer in order to determine the remaining excess value of the holding company.

The RBC charge to be applied to each indirectly owned alien insurance affiliate/subsidiary is the annual statement book adjusted carrying value of the reporting company’s interest in the affiliate/subsidiary multiplied by 0.500 and adjusted to reflect the reporting company’s ownership on the holding company. For example, assume NEWBIE Insurance Company acquired 100 percent shares of Holder (a holding company), and Holder owns an Alien Life Insurance Company, which represents 50 percent of the book adjusted carrying value of Holder. If Holder has a book adjusted carrying value of \$20,000,000, NEWBIE Insurance Company would enter \$10,000,000 (1/2 of \$20,000,000) as the carrying value of the Alien Life Insurance Company and the RBC charge for the indirect ownership of the ~~a~~ Alien insurance affiliate/subsidiary would be \$5,000,000 (0.500 times \$10,000,000). The risk-based capital charge for the parent insurer preparing the calculation is a 22.5 percent charge against the holding company value in excess of the indirectly owned insurance affiliates/subsidiaries.

<u>PR003 Columns</u>			
<u>(1)</u> <u>Affiliate/Subsidiary</u>	<u>(2)</u> <u>Affiliate/Subsidiary Type</u>	<u>(5)</u> <u>Book Adjusted Carrying Value (Statement Value) of Affiliate's Common Stock</u>	<u>(12)</u> <u>RBC Required</u>
<u>Alien Life Insurance Company</u>	<u>6c</u>	<u>10,000,000</u>	<u>5,000,000</u>
<u>Holder Holding Company</u>	<u>3</u>	<u>10,000,000</u>	<u>2,250,000</u>

If NEWBIE Insurance Company only acquired 50 percent shares of Holder, NEWBIE Insurance Company would enter \$5,000,000 (50 percent of 1/2 of \$20,000,000) as the carrying value of the Alien Life Insurance Company and the RBC charge for the indirect ownership of the Alien insurance affiliate/subsidiary would be \$2,500,000 (0.500 times \$5,000,000). Enter information for any indirectly owned alien insurance subsidiaries.

<u>PR003 Columns</u>			
<u>(1)</u>	<u>(2)</u>	<u>(5)</u>	<u>(12)</u>
<u>Affiliate/Subsidiary</u>	<u>Affiliate/Subsidiary Type</u>	<u>Book Adjusted Carrying Value (Statement Value) of Affiliate's Common Stock</u>	<u>RBC Required</u>
<u>Alien Life Insurance Company</u>	<u>6c</u>	<u>5,000,000</u>	<u>2,500,000</u>
<u>Holder Holding Company</u>	<u>3</u>	<u>15,000,000</u>	<u>3,375,000</u>

For each affiliate/subsidiary enter the following information:

- Company Name,
- Alien Insurer Identification Number,
- Book Adjusted carrying value of common and preferred stock,
- ~~Total Outstanding value of common and preferred stock,~~
- Book/adjusted carrying value of the common and preferred stock from Schedule D, Part 6, Section 1, Line 1499999. If no value is reported in the Total Value of Affiliate's Common and preferred stock column.

DETAILS FOR AFFILIATED STOCKS PR003

(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)
Name of Affiliate	Affiliate Type	NAIC Company Code or Alien ID Number	Affiliate's RBC After Covariance before Basic Operational Risk* LR031 L67 + L71 PR032 L67 XR025 L37	Book/Adjusted Carrying Value (statement value) of Affiliate's Common Stock**	Valuation Basis of Column (5) M - Market Value after any "discount" A - All Other	Total Value of Affiliate's Outstanding Common Stock	Statutory Surplus of Affiliate Subject to RBC (Adjusted for % Owned)	Book/Adjusted Carrying Value (statement value) of Affiliate's Preferred Stock	Total Value of Affiliate's Outstanding Preferred Stock	Percent Owned*	RBC Required (R0 Component)	Market Value Excess Component Affiliate Common Stock RBC Required (R2 Component)
0000001										100.000%	0	0
0000002										100.000%	0	0
0000003										100.000%	0	0
0000004										100.000%	0	0
0000005										100.000%	0	0
0000006										100.000%	0	0
0000007										100.000%	0	0
0000008										100.000%	0	0
0000009										100.000%	0	0
0000010										100.000%	0	0
0000011										100.000%	0	0
0000012										100.000%	0	0
0000013										100.000%	0	0
0000014										100.000%	0	0
0000015										100.000%	0	0
0000016										100.000%	0	0
0000017										100.000%	0	0
0000018										100.000%	0	0
0000019										100.000%	0	0
0000020										100.000%	0	0
0000021										100.000%	0	0
0000022										100.000%	0	0
0000023										100.000%	0	0
0000024										100.000%	0	0
0000025										100.000%	0	0
0000026										100.000%	0	0
0000027										100.000%	0	0
0000028										100.000%	0	0
0000029										100.000%	0	0
0000030										100.000%	0	0
0000031										100.000%	0	0
0000032										100.000%	0	0
0000033										100.000%	0	0
0000034										100.000%	0	0
0000035										100.000%	0	0
0000036										100.000%	0	0
0000037										100.000%	0	0
0000038										100.000%	0	0
0000039										100.000%	0	0
0000040										100.000%	0	0
0000041										100.000%	0	0
0000042										100.000%	0	0
0000043										100.000%	0	0
0000044										100.000%	0	0
0000045										100.000%	0	0
0000046										100.000%	0	0
0000047										100.000%	0	0
0000048										100.000%	0	0
0000049										100.000%	0	0
0000050										100.000%	0	0
(9999999)	XXX	XXX	0	0	XXX	XXX	XXX	0	XXX	100.000%	0	0
Total												

Remark: Subcategory 8a, 8b and 8c are referring to the directly owned insurance affiliates not subject to RBC look-through
Indirectly owned insurance affiliate not subject to RBC will be included Category 4
* Only applies to Affiliate Type 1 and 2.
Note: PR007 L12 should now refers to PR003 C(13) L9999999

#REF!
SUBSIDIARY, CONTROLLED AND AFFILIATED INVESTMENTS PR004

	Affiliate Types	Affl Code	RBC Basis	(1) Number of Companies	(2) Total RBC Required
(1)	Directly Owned Health Insurance Companies or Health Entities	1a	Sub's RBC After Covariance	0	0
(2)	Directly Owned Property and Casualty Insurance Affiliates	1b	Sub's RBC After Covariance	0	0
(3)	Directly Owned Life Insurance Affiliates	1c	Sub's RBC After Covariance	0	0
(4)	Indirectly Owned Health Insurance Companies or Health Entities	2a	Sub's RBC After Covariance	0	0
(5)	Indirectly Owned Property and Casualty Insurance Affiliates	2b	Sub's RBC After Covariance	0	0
(6)	Indirectly Owned Life Insurance Affiliates	2c	Sub's RBC After Covariance	0	0
(7)	Holding Company in Excess of Indirect Subs	3	0.225	0	0
(8)	Investment Subsidiary	4	0.225	0	0
(9)	Directly Owned Alien Health Insurance Companies or Health Entities	5a	0.5	0	0
(10)	Directly Owned Alien Property and Casualty Insurance Affiliates	5b	0.5	0	0
(11)	Directly Owned Alien Life Insurance Affiliates	5c	0.5	0	0
(12)	Indirectly Owned Alien Health Insurance Companies or Health Entities	6a	0.5	0	0
(13)	Indirectly Owned Alien Property and Casualty Insurance Affiliates	6b	0.5	0	0
(14)	Indirectly Owned Alien Life Insurance Affiliates	6c	0.5	0	0
(15)	Investment in Upstream Affiliate (Parent)	7	0.225	0	0
(16)	Directly Owned Health Insurance Companies or Health Entities Not Subject to RBC	8a	0.225	0	0
(17)	Directly Owned Property and Casualty Insurance Companies Not Subject to RBC	8b	0.225	0	0
(18)	Directly Owned Life Insurance Companies Not Subject to RBC	8c	0.225	0	0
(19)	Non-Insurance Entities with a Capital Requirement Imposed by a Regulatory Body	9a	0.225	0	0
(20)	Non-Insurance Other Financial Entities without Regulatory Capital Requirements	9b	0.225	0	0
(21)	Other Non-financial Entities	9c	0.225	0	0
(22)	Total			0	0

PR004

SUMMARY FOR SUBSIDIARY, CONTROLLED AND AFFILIATED INVESTMENTS FOR CROSS-CHECKING STATEMENT VALUES PR005

Affiliated Preferred Stock		Annual Statement Line Number	(1) Annual Statement Total Preferred Stock	(2) Total From RBC Report	(3) Difference
Schedule D Part 6 Section 1 C7					
(1)	Parent	0199999	0	0	0
(2)	U.S. P&C Insurer	0299999	0	0	0
(3)	U.S. Life Insurer	0399999	0	0	0
(4)	U.S. Health Insurer	0499999	0	0	0
(5)	Alien Insurer	0599999	0	0	0
(6)	Non-Insurer Which Controls Insurer	0699999	0	0	0
(7)	Investment Subsidiary	0799999	0	0	0
(8)	Other Affiliates	0899999	0	0	0
(9)	Subtotal	0999999	0	0	0

Affiliated Common Stock		Annual Statement Line Number	(1) Annual Statement Total Common Stock	(2) Total From RBC Report	(3) Difference
Schedule D Part 6 Section 1 C7					
(10)	Parent	1099999	0	0	0
(11)	U.S. P&C Insurer	1199999	0	0	0
(12)	U.S. Life Insurer	1299999	0	0	0
(13)	U.S. Health Insurer	1399999	0	0	0
(14)	Alien Insurer	1499999	0	0	0
(15)	Non-Insurer Which Controls Insurer	1599999	0	0	0
(16)	Investment Subsidiary	1699999	0	0	0
(17)	Other Affiliates	1799999	0	0	0
(18)	Subtotal	1899999	0	0	0

PR005

UNAFFILIATED PREFERRED AND COMMON STOCK PR007

	Annual Statement Source	(1) Book/Adjusted Carrying Value	Factor	(2) RBC Requirement
(1) Unaffiliated Preferred Stock				
(2) NAIC 01 Preferred Stock	Sch D Pt 2 Sn 1	0	0.003	0
(3) NAIC 02 Preferred Stock	Sch D Pt 2 Sn 1	0	0.010	0
(4) NAIC 03 Preferred Stock	Sch D Pt 2 Sn 1	0	0.020	0
(5) NAIC 04 Preferred Stock	Sch D Pt 2 Sn 1	0	0.045	0
(6) NAIC 05 Preferred Stock	Sch D Pt 2 Sn 1	0	0.100	0
(7) TOTAL - UNAFFILIATED PREFERRED STOCK (should equal P2 L2.1 C3 less Sch D-Sum C1 L18)	Sum of Ls (1) through (6)	0	0.300	0
(8) Unaffiliated Common Stock				
(9) Total Common Stock	Sch D - Summary C1 L25	0		
(10) Affiliated Common Stock	Sch D - Summary C1 L24	0		
(11) Non-Admitted Unaffiliated Common Stock	P2 C2 L2.2 - Sch D Pt 6 Sn 1 C9 L1899999	0		
(12) Admitted Unaffiliated Common Stock	L(8) - L(9) - L(10)	0	0.150	0
(13) Market Value Excess Affiliated Common Stock	PR003 C(13) L(9999999)	0		0
Total Unaffiliated Common Stock	L(11) + L(12)	0		0

Denotes items that must be manually entered on the filing software.

PR007

CALCULATION OF TOTAL ADJUSTED CAPITAL

PR029

	Annual Statement Reference	Statement Value*	Factor	Adjusted Capital
(1) Capital and Surplus	P3 CI L37	0	1,000	0
(2) Non-Tabular Discount - Losses	Sch P P1-Sum C32 L12	0	1,000	0
(3) Non-Tabular Discount - Expense	Sch P P1-Sum C33 L12	0	1,000	0
(4) Discount on Medical Loss Reserves Reported as Tabular in Schedule P	Company Records	0	1,000	0
(5) Discount on Medical Expense Reserves Reported as Tabular in Schedule P	Company Records	0	1,000	0
(6) P&C Subs Non-Tabular Discount - Losses	Subs' Sch P P1-Sum C32 L12	0	1,000	0
(7) P&C Subs Non-Tabular Discount - Expense	Subs' Sch P P1-Sum C33 L12	0	1,000	0
(8) P&C Subs Discount on Medical Loss Reserves Reported as Tabular in Schedule P	Subs' Company Records	0	1,000	0
(9) P&C Subs Discount on Medical Expense Reserves Reported as Tabular in Schedule P	Subs' Company Records	0	1,000	0
(10) AVR - Life Subs \$	Subs P3 CI L24.01 \$	0	1,000	0
(11) Dividend Liability - Life Subs	Subs P3 CI L6.1 + L6.2	0	0.500	0
(12) Carrying Value of Non-Admitted Insurance Affiliates	Included in PR003 Column 5 and Column 9	0	1,000	0
(13) Total Adjusted Capital Before Capital Notes	L(1)-L(2)+L(3)-L(4)-L(5)-L(6)-L(7)-L(8)-L(9)+L(10)+L(11)+L(12)	0	0	0
Credit for Capital Notes				
(14.1) Surplus Notes	Page 3 Column 1 Line 33	0		
(14.2) Limitation on Capital Notes	0.5*(Line(13)+Line(14.1))-Line 14.1, but not less than zero	0		
(14.3) Capital Notes Before Limitation	PR028 Column (4) Line (18)	#REF!		#REF!
(14.4) Credit for Capital Notes	Lesser of Column (1) Line(14.2) or Line (14.3)			
(15) Total Adjusted Capital (Post-Deferred Tax)	Line (13) + Line (14.4)			
Sensitivity Test :				
(16) Deferred Tax Assets	Page 2, Column 3, Line 18.2	0	1,000	0
(16.1) Deferred Tax Liabilities	Page 3, Column 1, Line 7.2	0	1,000	0
(17) Deferred Tax Assets for Subsidiary	Company Record	0	1,000	0
(17.1) Deferred Tax Liabilities for Subsidiary	Company Record	0	1,000	0
(18) Total Adjusted Capital For Sensitivity Test	Line (15) - Line (16)+(16.1)+(17)-(17.1)			
Ex DTA ACL RBC Ratio Sensitivity Test				
(19) Deferred Tax Asset	Page 2 Column 3 Line 18.2	0	1,000	0
(20) Total Adjusted Capital Less Deferred Tax Asset	Line (15) less Line (19)			
(21) Authorized Control Level RBC	PR034 Comparison of Total Adjusted Capital to Risk-Based Capital Line (4)			
(22) Ex DTA ACL RBC Ratio	Line (20) / Line (21)			

* Report amounts in this column as whole dollars.
Denotes items that must be manually entered on the filing software.
The portion of the AVR that can be counted as capital is limited to the amount not utilized in asset adequacy testing in support of the Actuarial Opinion for reserves.

PR029

CALCULATION OF TOTAL RISK-BASED CAPITAL AFTER COVARIANCE PR030 R0-RI

R0—Subsidiary Insurance Companies and Misc. Other Amounts		PRBC O&I Reference	(1)	RBC Amount
(1)	Affiliated US P&C Insurers - Directly Owned	PR004.L(2)(C)(2)		0
(2)	Affiliated US P&C Insurers - Indirectly Owned	PR004.L(5)(C)(2)		0
(3)	Affiliated US Life Insurers - Directly Owned	PR004.L(3)(C)(2)		0
(4)	Affiliated US Life Insurers - Indirectly Owned	PR004.L(6)(C)(2)		0
(5)	Affiliated US Health Insurer - Directly Owned	PR004.L(1)(C)(2)		0
(6)	Affiliated US Health Insurer - Indirectly Owned	PR004.L(4)(C)(2)		0
(7)	Affiliated Alien Insurers - Directly Owned	PR004.L(9)+L(10)+L(11)(C)(2)		0
(8)	Affiliated Alien Insurers - Indirectly Owned	PR004.L(12)+L(13)+L(14)(C)(2)		0
(9)	Misc Off-Balance Sheet - Non-Controlled Assets	PR014.L(15)(C)(3)		0
(10)	Misc Off-Balance Sheet - Guarantees for Affiliates	PR014.L(16)(C)(3)		0
(11)	Misc Off-Balance Sheet - Contingent Liabilities	PR014.L(17)(C)(3)		0
(12)	Misc Off-Balance Sheet - SSAP No.101 Par. 11A DTA	PR014.L(19)(C)(3)		0
(13)	Misc Off-Balance Sheet - SSAP No.101 Par. 11B DTA	PR014.L(20)(C)(3)		0
(14)	Total R0	L(1)+L(2)+L(3)+L(4)+L(5)+L(6)+L(7)+L(8)+L(9)+L(10)+L(11)+L(12)+L(13)		0
RI - Asset Risk - Fixed Income				
(15)	Bonds Subject to Size Factor	PR006.L(27)(C)(5)		0
(16)	Bond Size Factor RBC	PR006.L(30)(C)(5)		0
(17)	Off-balance Sheet Collateral & Sch DL, PFI - Total Bonds	PR015.L(27)(C)(4)		0
(18)	Off-balance Sheet Collateral & Sch DL, PFI - Cash & Short-Term Investments and Mort Loans on Real Est.	PR015.L(28)+L(29)(C)(4)		0
(19)	Other Long-Term Assets - Mortgage Loans, LIHTC & WCPI	PR008.L(10)+L(13)+L(14)+L(15)+L(16)+L(17)+L(20)+L(21)(C)(2)		0
(20)	Misc Assets - Collateral Loans	PR009.L(13)(C)(2)		0
(21)	Misc Assets - Cash	PR009.L(3)(C)(2)		0
(22)	Misc Assets - Cash Equivalents	PR009.L(10)(C)(2)		0
(23)	Misc Assets - Other Short-Term Investments	PR010.L(9999999)(C)(7)		0
(24)	Replication - Synthetic Asset: One Half			0
(25)	Asset Concentration RBC - Fixed Income	PR011.L(2)(C)(3) Grand Total Page		0
(26)	Total RI	L(15)+L(16)+L(17)+L(18)+L(19)+L(20)+L(21)+L(22)+L(23)+L(24)+L(25)		0

PR030

#REF!
CALCULATION OF TOTAL RISK-BASED CAPITAL AFTER COVARIANCE PR031 R2-R3

R2 - Asset Risk - Equity	PRBC O&I Reference	RBC Amount
(27) Common & Preferred- Affiliate Investment Subsidiary	PR004 L(8)C(2)	0
(28) Common & Preferred- Affiliate Hold. Company, in excess of Ins. Subs.	PR004 L(7)C(2)	0
(29) Common & Preferred- Investment in Parent	PR004 L(15)C(2)	0
(30) Common & Preferred- Aff'd US P&C Not Subj to RBC	PR004 L(17)C(2)	0
(31) Common & Preferred- Affil US Life Not Subj to RBC	PR004 L(18)C(2)	0
(32) Common & Preferred- Affil US Health Insurer Not Subj to RBC	PR004 L(16)C(2)	0
(33) Common & Preferred- Aff'd Non-insurer	PR004 L(19)+L(20)+L(21)C(2)	0
(34) Preferred- Aff'd Invest Sub	PR004 L(7)C(3)	0
(35) Preferred- Aff'd Hold. Co. in excess of Ins. Subs.	PR004 L(10)C(3)	0
(36) Preferred- Investment in Parent	PR004 L(11)C(3)	0
(37) Preferred- Affil US P&G Not Subj to RBC	PR004 L(12)C(3)	0
(38) Preferred- Affil US Life Not Subj to RBC	PR004 L(13)C(3)	0
(39) Preferred- Affil US Health Insurer Not Subj to RBC	PR004 L(14)C(3)	0
(40) Preferred- Affil Non-insurer	PR004 L(15)C(3)	0
(34) Unaffiliated Preferred Stock	PR007 L(7)C(2)+PR015 L(34)C(4)	0
(35) Unaffiliated Common Stock	PR007 L(13)C(2)+PR015 L(35)C(4)	0
(36) Other Long-Term Assets - Real Estate	PR008 L(7)C(2)	0
(37) Other Long-Term Assets - Schedule BA Assets	PR008 L(19)C(2)+PR015 L(36)+L(37)C(4)	0
(38) Misc Assets - Receivable for Securities	PR009 L(1)C(2)	0
(39) Misc Assets - Aggregate Write-ins for Invested Assets	PR009 L(2)C(2)	0
(40) Misc Assets - Derivatives	PR009 L(14)C(2)	0
(41) Replication - Synthetic Asset: One Half	PR010 L(9999999)(7)	0
(42) Asset Concentration RBC - Equity	PR011 L(33)C(3) Grand Total Page	0
(43) Total R2	L(27)+L(28)+L(29)+L(30)+L(31)+L(32)+L(33)+L(34)+L(35)+L(36)+L(37)+L(38)+L(39)+L(40)+L(41)+L(42)+L(43)+L(44)+L(45)+L(46)+L(47)+L(48)+L(49)	0
R3 - Asset Risk - Credit		
(44) Other Credit RBC	PR012 L(8))-L(1)-L(2)C(2)	0
(45) One half of Rein Recoverables	0.5 x (PR012 L(1)+L(2)C(2))	0
(46) Other half of Rein Recoverables	IF R4 L(51)>(R3 L(45) + R3 L(46)), 0, otherwise, R3 L(46)	0
(47) Health Credit Risk	PR013 L(12)C(2)	0
(48) Total R3	L(45) + L(46) + L(47) + L(48)	0

PR031

CALCULATION OF TOTAL RISK-BASED CAPITAL AFTER COVARIANCE PR032 R4-Rcat

	PRBC O&I Reference	RBC Amount
(1)		
R4 - Underwriting Risk - Reserves		
(49) One half of Reinsurance RBC	$\text{IF R4 L(51)} > (\text{R3 L(45)} + \text{R3 L(46)}), \text{R3 L(46)}, \text{otherwise}, 0$	0
(50) Total Adjusted Unpaid Loss/Expense Reserve RBC	PR0017 L(15)C(20)	0
(51) Excessive Premium Growth - Loss/Expense Reserve	PR016 L(13) C(8)	0
(52) A&H Claims Reserves Adjusted for LCF	PR024 L(5) C(2) + PR023 L(6) C(4)	0
(53) Total R4	$\text{L(50)} + \text{L(51)} + \text{L(52)} + \text{L(53)}$	0
R5 - Underwriting Risk - Net Written Premium		
(54) Total Adjusted NWP RBC	PR018 L(15)C(20)	0
(55) Excessive Premium Growth - Written Premiums Charge	PR016 L(14)C(8)	0
(56) Total Net Health Premium RBC	PR022 L(21)C(2)	0
(57) Health Stabilization Reserves	PR025 L(6)C(2) + PR023 L(3) C(2)	0
(58) Total R5	$\text{L(54)} + \text{L(56)} + \text{L(57)} + \text{L(58)}$	0
Rcat - Catastrophe Risk		
(59) Total Rcat	PR027 L(3) C(1)	0
(60) Total RBC After Covariance Before Basic Operational Risk = $\text{R0} + \text{SQRT}(\text{R1}^2 + \text{R2}^2 + \text{R3}^2 + \text{R4}^2 + \text{R5}^2 + \text{Rcat}^2)$		0
(61) Basic Operational Risk = $0.030 \times \text{L(61)}$		0
(62) C-4a of U.S. Life Insurance Subsidiaries (from Company records)		0
(63) Net Basic Operational Risk = Line (62) - Line (63) (Not less than zero)		0
(64) Total RBC After Covariance including Basic Operational Risk = $\text{L(61)} + \text{L(64)}$		0
(65) Authorized Control Level RBC including Basic Operational Risk = $.5 \times \text{L(65)}$		0

PR032

Capital Adequacy (E) Task Force
RBC Proposal Form

- | | | |
|---|---|---|
| <input checked="" type="checkbox"/> Capital Adequacy (E) Task Force | <input type="checkbox"/> Health RBC (E) Working Group | <input type="checkbox"/> Life RBC (E) Working Group |
| <input type="checkbox"/> Catastrophe Risk (E) Subgroup | <input type="checkbox"/> Investment RBC (E) Working Group | <input type="checkbox"/> Longevity Risk (A/E) Subgroup |
| <input type="checkbox"/> Variable Annuities Capital. & Reserve (E/A) Subgroup | <input type="checkbox"/> P/C RBC (E) Working Group | <input type="checkbox"/> RBC Investment Risk & Evaluation (E) Working Group |

DATE: <u>01-30-23</u>	FOR NAIC USE ONLY
CONTACT PERSON: <u>Crystal Brown</u>	Agenda Item # <u>2022-16-CA</u>
TELEPHONE: <u>816-783-8146</u>	Year <u>2023</u>
EMAIL ADDRESS: <u>cbrown@naic.org</u>	DISPOSITION
ON BEHALF OF: <u>Health Risk-Based Capital (E) Working Grp</u>	<input type="checkbox"/> ADOPTED _____
NAME: <u>Steve Drutz</u>	<input type="checkbox"/> REJECTED _____
TITLE: <u>Chief Financial Analyst/Chair</u>	<input type="checkbox"/> DEFERRED TO _____
AFFILIATION: <u>WA Office of Insurance Commissioner</u>	<input type="checkbox"/> REFERRED TO OTHER NAIC GROUP _____
ADDRESS: <u>5000 Capitol Blvd SE</u>	<input checked="" type="checkbox"/> EXPOSED <u>2-7-23</u>
<u>Tumwater, WA 98501</u>	<input type="checkbox"/> OTHER (SPECIFY) _____

IDENTIFICATION OF SOURCE AND FORM(S)/INSTRUCTIONS TO BE CHANGED

- Health RBC Blanks Property/Casualty RBC Blanks Life and Fraternal RBC Instructions
 Health RBC Instructions Property/Casualty RBC Instructions Life and Fraternal RBC Blanks
 OTHER _____

DESCRIPTION OF CHANGE(S)

Update the underwriting factors for Comprehensive Medical, Medicare Supplement and Dental & Vision on pages XR013, LR019, LR020, PR019 and PR020 for the investment income adjustment.

REASON OR JUSTIFICATION FOR CHANGE **

Annual update of the underwriting factors for Comprehensive Medical, Medicare Supplement and Dental & Vision for investment income adjustment.

Additional Staff Comments:

- 2-7-23 cgb Exposed for 30-day comment period ending on March 9.
 2-28-23 cgb EDITORIAL CHANGE: An editorial correction was made to the Health portion of the instructions to change the investment income adjustment reference from 0.5% to 5.0%.
 3-9-23 cgb No comments received.
 3-21-23 cgb The WG agreed to refer the proposal to the CapAd TF for exposure for all lines of business.



February 2, 2023

Steve Drutz
Chair, Health Risk-Based Capital (E) Working Group
National Association of Insurance Commissioners (NAIC)

Re: Request for Additional Analysis to Incorporate Investment Income into the Underwriting Risk Component of the Health Risk-Based Capital (HRBC) Formula

Dear Mr. Drutz:

On behalf of the American Academy of Actuaries¹ Health Solvency Subcommittee (the subcommittee), I am pleased to provide this response letter to the NAIC's Health Risk-Based Capital (E) Working Group request to provide additional investment return scenarios within the subcommittee's summary of the Investment Income Adjusted Health H2 Experience Fluctuation Risk Factors. These factors are included within the table below.

Investment Income Adjusted Tiered Risk-Based Capital (RBC) Factors

Assumed Investment Return	Comprehensive Medical (CM)	Medicare Supplement	Dental/Vision
	High Tier (i.e., less than \$3Million (M) or less than \$25M)		
0.0%	15.00%	10.50%	12.00%
3.5%	14.53%	10.01%	11.63%
4.0%	14.47%	9.94%	11.58%
4.5%	14.40%	9.87%	11.53%
5.0%	14.34%	9.80%	11.48%
5.5%	14.27%	9.73%	11.43%
6.0%	14.21%	9.67%	11.38%
	Low Tier		
0.0%	9.00%	6.70%	7.60%
3.5%	8.56%	6.23%	7.25%
4.0%	8.50%	6.16%	7.20%
4.5%	8.44%	6.09%	7.16%
5.0%	8.38%	6.03%	7.11%
5.5%	8.32%	5.96%	7.06%
6.0%	8.25%	5.90%	7.01%

¹ The American Academy of Actuaries is a 19,500-member professional association whose mission is to serve the public and the U.S. actuarial profession. For more than 50 years, the Academy has assisted public policymakers on all levels by providing leadership, objective expertise, and actuarial advice on risk and financial security issues. The Academy also sets qualification, practice, and professionalism standards for actuaries in the United States.

Please note that the subcommittee updated the claims completion pattern assumptions slightly in this analysis. The impact of this change on the RBC factors is approximately 0.01%. Otherwise, the methodology is unchanged.

If you have any questions or would like to discuss further, please contact Matthew Williams, the Academy's senior health policy analyst, at williams@actuary.org.

Sincerely,

Derek Skoog, MAAA, FSA
Chairperson, Health Solvency Subcommittee
American Academy of Actuaries

Cc: Crystal Brown, Senior Health RBC Analyst & Education Coordinator, Financial Regulatory Affairs, NAIC

HEALTH

**UNDERWRITING RISK - L(1) THROUGH L(21)
XR013**



Line (13) Underwriting Risk Factor. A weighted average factor based on the amount reported in Line (6), Underwriting Risk Revenue. The factors for Column (1) through (3) have incorporated an investment income yield of ~~5.04~~5%.

	\$0 - \$3 Million	\$3 - \$25 Million	Over \$25 Million
Comprehensive Medical & Hospital	0.143493	0.143493	0.083893
Medicare Supplement	0.09804043	0.060363	0.060363
Dental & Vision	0.114895	0.071155	0.071155
Stand-Alone Medicare Part D Coverage	0.251	0.251	0.151
Other Health	0.130	0.130	0.130
Other Non-Health	0.130	0.130	0.130

The investment income yield was incorporated into the Comprehensive Medical & Hospital, Medicare Supplement and Dental & Vision lines of business. The purpose was to incorporate an offset to reduce the underwriting risk factor for investment income earned by the insurer. The Working Group incorporated a 0.5% income yield that was based on the yield of a 6-month US Treasury Bond. Each year, the Working Group will identify the yield of the 6-month Treasury bond ([U.S. Department of the Treasury](#)) on each Monday through the month of January and determine if further modifications to the ~~5.04~~5% adjustment ~~is~~ needed. Any adjustments will be rounded up to the nearest 0.5%.



LIFE

**Underwriting Risk – Experience Fluctuation Risk
LR020**



Line (10) Underwriting Risk Factor
A weighted average factor based on the amount reported in Line (5), Underwriting Risk Revenue. The factors for Column 1-3 have incorporated investment income.

	\$0 - \$3 Million	\$3 - \$25 Million	Over \$25 Million
Comprehensive Medical	0.143493	0.143493	0.083893
Medicare Supplement	0.09804043	0.060363	0.060363
Dental	0.114895	0.071155	0.071155
Stand-Alone Medicare Part D Coverage	0.251	0.251	0.151



UNDERWRITING RISK

Experience Fluctuation Risk

	(1) Comprehensive Medical	(2) Medicare Supplement	(3) Dental & Vision	(4) Stand-Alone Medicare Part D Coverage	(5) Other Health	(6) Other Non-Health	(7) Total
Line of Business							
(1) † Premium							
(2) † Title XVII-Medicare		XXX	XXX	XXX	XXX	XXX	
(3) † Title XIX-Medicare		XXX	XXX	XXX	XXX	XXX	
(4) † Other Health Risk Revenue		XXX			XXX	XXX	
(5) Medicaid Pass-Through Payments Reported as Premiums		XXX	XXX	XXX	XXX	XXX	
(6) Underwriting Risk Revenue = Lines (1) + (2) + (3) + (4) - (5)							
(7) † Net Incurred Claims							
(8) Medicaid Pass-Through Payments Reported as Claims		XXX	XXX	XXX	XXX	XXX	
(9) Total Net Incurred Claims Less Medicaid Pass-Through Payments Reported as Claims = Lines (7) - (8)							
(10) † Fee-For-Service Offset		XXX				XXX	
(11) Underwriting Risk Incurred Claims = Lines (9) - (10)							
(12) Underwriting Risk Claims Ratio = For Column (1) through (5), Line (11)/(6)					0.130	0.130	XXX
(13) Underwriting Risk Factor*							XXX
(14) Base Underwriting Risk RBC = Lines (6) x (12) x (13)							XXX
(15) Managed Care Discount Factor							XXX
(16) RBC After Managed Care Discount = Lines (14) x (15)							XXX
(17) † Maximum Per-Individual Risk After Reinsurance							XXX
(18) Alternate Risk Charge **							XXX
(19) Alternate Risk Adjustment							XXX
(20) Net Alternate Risk Charge***							XXX
(21) Net Underwriting Risk RBC (MAX(Line (16), Line (20))) for Columns (1) through (5), Column (6), Line (14)							XXX

TIERED RBC FACTORS*						
	Comprehensive Medical	Medicare Supplement	Dental & Vision	Stand-Alone Medicare Part D Coverage	Other Health	Other Non-Health
\$0 - \$3 Million	0.4493-0.1434	0.4043-0.0980	0.4495-0.1148	0.251	0.130	0.130
\$3 - \$25 Million	0.4493-0.1434	0.4663-0.0603	0.4755-0.0711	0.251	0.130	0.130
Over \$25 Million	0.4893-0.0838	0.4663-0.0603	0.4755-0.0711	0.151	0.130	0.130

ALTERNATE RISK CHARGE**						
** The Line (18) Alternate Risk Charge is calculated as follows:						
	Comprehensive Medical	Medicare Supplement	Dental & Vision	Stand-Alone Medicare Part D Coverage	Other Health	Other Non-Health
LESSER OF:	\$1,500,000 or 2 x Maximum Individual Risk	\$50,000 or 2 x Maximum Individual Risk	\$50,000 or 2 x Maximum Individual Risk	\$150,000 or 6 x Maximum Individual Risk	\$50,000 or 2 x Maximum Individual Risk	N/A

Denotes items that must be manually entered on filing software.

† The Annual Statement Sources are found on page XR014.

* This column is for a single result for the Comprehensive Medical & Hospital, Medicare Supplement and Dental/Vision managed care discount factor.

*** Limited to the largest of the applicable alternate risk adjustments, prorated if necessary.

UNDERWRITING RISK

Experience Fluctuation Risk

	(1) Comprehensive Medical	(2) Medicare Supplement	(3) Dental & Vision	(4) Stand-Alone Medicare Part D Coverage	(5) Total
Line of Business					
(1.1) Premium – Individual					
(1.2) Premium – Group					
(1.3) Premium – Total = Line (1.1) + Line (1.2)					
(2) Title XVIII-Medicare†	XXX				
(3) Title XIX-Medicaid‡	XXX				
(4) Other Health Risk Revenue†	XXX				
(5) Underwriting Risk Revenue = Lines (1.3) + (2) + (3) + (4)					
(6) Net Incurred Claims					
(7) Fee-for-Service Offset†	XXX				
(8) Underwriting Risk Incurred Claims = Line (6) – Line (7)					
(9) Underwriting Risk Claims Ratio = Line (8) / Line (5)					XXX
(10.1) Underwriting Risk Factor for Initial Amounts Of Premium‡	0.4493-0.1434	0.4043-0.0980	0.4195-0.1148	0.251	XXX
(10.2) Underwriting Risk Factor for Excess of Initial Amount‡	0.0893-0.0838	0.0663-0.0603	0.0755-0.0711	0.151	XXX
(10.3) Composite Underwriting Risk Factor					XXX
(11) Base Underwriting Risk RBC = Line (5) x Line (9) x Line (10.3)					
(12) Managed Care Discount Factor = LR022 Line (17)					XXX
(13) Base RBC After Managed Care Discount = Line (11) x Line (12)					
(14) RBC Adjustment For Individual = [Line(1.1) x 1.2 + Line (1.2)] / Line (1.3)] x Line (13)§					
(15) Maximum Per-Individual Risk After Reinsurance†					XXX
(16) Alternate Risk Charge*					
(17) Net Alternate Risk Charge†					
(18) Net Underwriting Risk RBC (Maximum of Line (14) or Line (17))					

† Source is company records unless already included in premiums.
 ‡ For Comprehensive Medical, the Initial Premium Amount is \$25,000,000 or the amount in Line (1.3) if smaller. For Medicare Supplement and Dental & Vision, the Initial Premium Amount is \$3,000,000 or the amount in Line (1.3) if smaller. For Stand-Alone Medicare Part D, the Initial Premium Amount is \$25,000,000 or the amount in Line (1.3) if smaller.
 § Formula applies only to Column (1), for all other columns Line (14) should equal Line (13).
 * The Line (16) Alternate Risk Charge is calculated as follows:

LESSER OF:	\$1,500,000 or 2 x Maximum Individual Risk	\$50,000 or 2 x Maximum Individual Risk	\$50,000 or 2 x Maximum Individual Risk	\$150,000 or 6 x Maximum Individual Risk	Maximum of Columns (1), (2), (3) and (4)
------------	---	--	--	---	---

 † Applicable only if Line (16) for a column equals Line (16) for Column (5), otherwise zero.
 ‡ Denotes items that must be manually entered on the filing software.

UNDERWRITING RISK - PREMIUM RISK FOR COMPREHENSIVE MEDICAL, MEDICARE SUPPLEMENT AND DENTAL & VISION PR020

(Experience Fluctuation Risk in Life RBC Formula)

	(1) Comprehensive Medical	(2) Medicare Supplement	(3) Dental & Vision	(4) Stand-Alone Medicare Part D Coverage	(5) TOTAL
(1.1) Premium - Individual	0	0	0	0	0
(1.2) Premium - Group	0	0	0	0	0
(1.3) Premium - Total = Line (1.1) + Line (1.2)	0	0	0	0	0
(2) Title XVIII-Medicare†	0	XXX	XXX	XXX	0
(3) Title XIX-Medicaid†	0	XXX	XXX	XXX	0
(4) Other Health Risk Revenue†	0	XXX	0	0	0
(5) Underwriting Risk Revenue = Lines (1.3) + (2) + (3) + (4)	0	0	0	0	0
(6) Net Insured Claims	0	0	0	0	0
(7) Fee-for-Service Offset†	0	XXX	0	0	0
(8) Underwriting Risk Incurred Claims = Line (6) - Line (7)	0	0	0	0	0
(9) Underwriting Risk Claims Ratio = Line (8) / Line (5)	0.0000	0.0000	0.0000	0.000	XXX
(10.1) Underwriting Risk Factor for Initial Amounts of Premium‡	0.4493-0.1454	0.4463-0.0980	0.4495-0.1448	0.251	XXX
(10.2) Underwriting Risk Factor for Excess of Initial Amount‡	0.0893-0.0838	0.4463-0.0603	0.4755-0.0711	0.151	XXX
(10.3) Composite Underwriting Risk Factor	0.0000	0.0000	0.0000	0.000	XXX
(11) Base Underwriting Risk RBC = Line (5) x Line (9) x Line (10.3)	0	0	0	0	0
(12) Managed Care Discount Factor = PR021 Line (12)	0.0000	0.0000	0.0000	0.000	XXX
(13) Base RBC After Managed Care Discount = Line (11) x Line (12)	0	0	0	0	0
(14) RBC Adjustment For Individual = [Line(1.1) x 1.2 + Line (1.2)] / Line (1.3)] x Line (13) §	0	0	0	0	0
(15) Maximum Per-Individual Risk After Reinsurance†	0	0	0	0	XXX
(16) Alternate Risk Charge*	0	0	0	0	0
(17) Net Alternate Risk Charge†	0	0	0	0	0
(18) Net Underwriting Risk RBC (Maximum of Line (14) or Line (17))	0	0	0	0	0

† Source is company records unless already included in premiums.

‡ For Comprehensive Medical the Initial Premium Amount is \$25,000,000 or the amount in Line (1.3) if smaller. For Medicare Supplement and Dental & Vision the Initial Premium Amount is \$3,000,000 or the amount in Line (1.3) if smaller. For Stand-Alone Medicare Part D the Initial Premium Amount is \$25,000,000 or the amount in Line (1.3) if smaller.

§ Formula applies only to Column (1), for all other columns Line (14) should equal Line (13).

* The Line (16) Alternate Risk Charge is calculated as follows:

LESSER OF:	\$1,500,000 or 2 x Maximum Individual Risk	\$50,000 or 2 x Maximum Individual Risk	\$50,000 or 2 x Maximum Individual Risk	\$150,000 or 6 x Maximum Individual Risk	Maximum of Columns (1), (2), (3) and (4)
	0	0	0	0	0

† Applicable only if Line (16) for a column equals Line (16) for Column (5), otherwise zero.

Denotes items that must be manually entered on the filing software.

Capital Adequacy (E) Task Force
RBC Proposal Form

- | | | |
|---|---|---|
| <input checked="" type="checkbox"/> Capital Adequacy (E) Task Force | <input type="checkbox"/> Health RBC (E) Working Group | <input type="checkbox"/> Life RBC (E) Working Group |
| <input type="checkbox"/> Catastrophe Risk (E) Subgroup | <input type="checkbox"/> Investment RBC (E) Working Group | <input type="checkbox"/> Longevity Risk (A/E) Subgroup |
| <input type="checkbox"/> Variable Annuities Capital. & Reserve (E/A) Subgroup | <input type="checkbox"/> P/C RBC (E) Working Group | <input type="checkbox"/> RBC Investment Risk & Evaluation (E) Working Group |

DATE: <u>03-03-23</u>	<u>FOR NAIC USE ONLY</u>
CONTACT PERSON: <u>Crystal Brown</u>	Agenda Item # <u>2023-01-CA</u>
TELEPHONE: <u>816-783-8146</u>	Year <u>2023</u>
EMAIL ADDRESS: <u>cbrown@naic.org</u>	<u>DISPOSITION</u>
ON BEHALF OF: <u>Health Risk-Based Capital (E) Working Grp</u>	<input type="checkbox"/> ADOPTED _____
NAME: <u>Steve Drutz</u>	<input type="checkbox"/> REJECTED _____
TITLE: <u>Chief Financial Analyst/Chair</u>	<input type="checkbox"/> DEFERRED TO _____
AFFILIATION: <u>WA Office of Insurance Commissioner</u>	<input type="checkbox"/> REFERRED TO OTHER NAIC GROUP _____
ADDRESS: <u>5000 Capitol Blvd SE</u>	<input checked="" type="checkbox"/> EXPOSED <u>4-10-23</u>
<u>Tumwater, WA 98501</u>	<input type="checkbox"/> OTHER (SPECIFY) _____

IDENTIFICATION OF SOURCE AND FORM(S)/INSTRUCTIONS TO BE CHANGED

- Health RBC Blanks Property/Casualty RBC Blanks Life and Fraternal RBC Blanks
 Health RBC Instructions Property/Casualty RBC Instructions Life and Fraternal RBC Instructions
 OTHER _____

DESCRIPTION OF CHANGE(S)

Clarify the instructions for stop loss premiums in the Underwriting Risk – Experience Fluctuation Risk, Other Underwriting Risk and Stop Loss Interrogatories.

REASON OR JUSTIFICATION FOR CHANGE **

Provide clarity on reporting stop loss premiums in the RBC formula.

Additional Staff Comments:

- 3-21-23 cgb The Working Group exposed the proposal for a 20-day comment period ending on 4/10/23.
 3-24-23 cgb Editorial changes to: 1) replace i.e. with e.g. and 2) corrected the reference from “treaty” to “contract” in the example provided under the Calendar Year changes.
 3-28-23 cgb Editorial correction to proposal # on proposal form from 2022-17-CA to 2023-01-CA

** This section must be completed on all forms.



Detail Eliminated to Conserve Space

UNDERWRITING RISK - L(1) THROUGH L(21)
XR013

Underwriting Risk is the largest portion of the risk-based capital charge for most reporting entities. The Underwriting Risk page generates the RBC requirement for the risk of fluctuations in underwriting experience. The credit that is allowed for managed care in this page comes from the Managed Care Credit Calculation page.

Underwriting risk is present when the next dollar of unexpected claim payments comes directly out of the reporting entity's capital and surplus. It represents the risk that the portion of premiums intended to cover medical expenses will be insufficient to pay such expense. For example, a reporting entity may charge an individual \$100 in premium in exchange for a guaranty that all medical costs will be paid by that reporting entity. If the individual incurs \$101 in claims costs, the reporting entity's surplus will decline because it did not charge a sufficient premium to pick up the additional risk for that individual.

There are other arrangements where the reporting entity is not at risk for excessive claims payments, such as when an HMO agrees to serve as a third-party administrator for a self-insured employer. The self-insured employer pays for actual claim costs, so the risk of excessive claims experience is borne by the self-insured employer, not the reporting entity. The underwriting risk section of the formula, therefore, requires some adjustments to remove non-underwriting risk business (both premiums and claims) before the RBC requirement is calculated. Appendix 1 contains commonly used terms for general types of health insurance. Refer to INT 05-05: Accounting for Revenue under Medicare Part D Cover for terms specifically used with respect to Medicare Part D coverage of prescription drugs.

Claims Experience Fluctuation

The RBC requirement for claims experience fluctuation is based on the greater of the following calculations:

A. Underwriting risk revenue, times the underwriting risk claims ratio, times a set of tiered factors. The tiered factors are determined by the underwriting risk revenue volume.

or

B. An alternative risk charge that addresses the risk of catastrophic claims on any single individual. The alternative risk charge is equal to multiple of the maximum retained risk on any single individual in a claims year. The maximum retained risk (level of potential claim exposure) is capped at \$750,000 per individual and \$1,500,000 total for medical coverage; \$25,000 per individual and \$50,000 total for all other coverage except Medicare Part D coverage and \$25,000 per individual and \$150,000 total for Medicare Part D coverage. Additionally, for multi-line organizations (e.g., writing more than one coverage type), the alternative risk charge for each subsequent line of business is reduced by the amount of the highest cap. For example, if an organization is writing both comprehensive medical (with a cap of \$1,500,000) and dental (with a cap of \$50,000), then only the larger alternative risk charge is considered when calculating the RBC requirement (i.e., the alternative risk charges for each line of business are not cumulative).

For RBC reports to be filed by a health organization commencing operations in this reporting year, the health organization shall estimate the initial RBC levels using operating (revenue and expense) projections (considering managed care arrangements) for its first full year (12 months) of managed care operations. The projections, including the risk-based capital requirement, should be the same as those filed as part of a comprehensive business plan that is submitted as part of the application for licensure. The Underwriting, Credit (capitation risk only), and Business Risk sections of the first RBC report submitted shall be completed using the health organization's actual operating data for the period from the commencement of operations until year-end, plus projections for the number of months necessary to provide 12 months of data. The affiliate, asset and portions of the credit risk section that are based on balance sheet information shall be reported using actual data. For subsequent years' reports, the RBC results for all of the formula components shall be calculated using actual data.

L(1) through L(21)

There are six lines of business used in the formula for calculating the RBC requirement for this risk: (1) Comprehensive Medical and Hospital; (2) Medicare Supplement; (3) Dental/Vision; (4) Stand-Alone Medicare Part D Coverage; ~~and~~ (5) Other Health; and (6) Other Non-Health. Each of these lines of business has its own column in the Underwriting Risk – Experience Fluctuation Risk table. The categories listed in the columns of this page include all risk revenue and risk revenue that is received from another reporting entity in exchange for medical services provided to its members. The descriptions of the items are described as follows:

Column (1) - Comprehensive Medical & Hospital. Includes policies providing for medical coverages including hospital, surgical, major medical, Medicare risk coverage (but NOT Medicare Supplement), and Medicaid risk coverage. This category DOES NOT include administrative services contracts (ASC), administrative services only (ASO) contracts, or any non-underwritten business. These programs are reported in the Business Risk section of the formula. Neither does it include Federal Employees Health Benefit Plan (FEHBP) or TRICARE, which are reported in Line 24 of this section. Medicaid Pass-Through Payments reported as premiums should also be excluded from this category and should be reported in Line 25.2 of this section. The alternative risk charge, which is twice the maximum retained risk after reinsurance on any single individual, cannot exceed \$1,500,000. Prescription drug benefits included in major medical insurance plans (including Medicare Advantage plans with prescription drug coverage) should be reported in this line. These benefits should also be included in the Managed Care Credit calculation.

Column (2) - Medicare Supplement. This is business reported in the Medicare Supplement Insurance Experience Exhibit of the annual statement and includes Medicare Select. Medicare risk business is reported under comprehensive medical and hospital.

Column (3) - Dental & Vision. This is limited to policies providing for dental-only or vision-only coverage issued as a stand-alone policy or as a rider to a medical policy, which is not related to the medical policy through deductibles or out-of-pocket limits.

Column (4) - Stand-Alone Medicare Part D Coverage. This includes both individual coverage and group coverage of Medicare Part D coverage where the plan sponsor has risk corridor protection. See INT 05-05: Accounting for Revenue under Medicare Part D Coverage for definition of these terms. Medicare drug benefits included in major medical plans or benefits that do not meet the above criteria are not to be included in this line. Supplemental benefits within Medicare Part D (benefits in excess of the standard benefit design) are addressed separately on page XR015. Employer-based Part D coverage that is in an uninsured plan as defined in *SSAP No. 47—Uninsured Plans* is not to be included here.

Column (5) – Other Health Coverages. This includes other health coverages such as other stand-alone prescription drug benefit plans, ~~NOT INCLUDED ABOVE~~ that have not been specifically addressed in ~~the other~~ Columns (1) through (4) listed above and those lines of business addressed separately on page XR015, such as stop loss. Stop loss premiums are addressed separately in Line (25) on page XR015.

Column (6) - Other Non-Health Coverages. This includes life and property and casualty coverages.

The following paragraphs explain the meaning of each line of the table for computing the experience fluctuation underwriting risk RBC.

Line (1) Premium. This is the amount of money charged by the reporting entity for the specified benefit plan. It is the earned amount of prepayments (usually on a per member per month basis) made by a covered group or individual to the reporting entity in exchange for services to be provided or offered by such organization. However, it does not include receipts under administrative services only (ASO) contracts; or administrative services contracts (ASC); or any non-underwritten business. Nor does it include federal employees health benefit programs (FEHBP) and TRICARE. Report premium net of payments for stop-loss or other reinsurance. The amounts reported in the individual columns should come directly from Analysis of Operations by Lines of Business, Page 7, Lines 1 and 2 of the annual statement. For Stand-Alone Medicare Part D Coverage the premium includes beneficiary premium (standard coverage portion), direct subsidy, low-income subsidy (premium portion), Part D payment demonstration amounts and risk corridor payment adjustments. See INT 05-05: Accounting for Revenue under Medicare Part D Coverage for definition of these terms. It

does not include revenue received for reinsurance payments or low-income subsidy (cost-sharing portion), which are considered funds received for uninsured plans in accordance with Emerging Accounting Issues Working Group (EAIWG) INT. No. 05-05. Also exclude the beneficiary premium (supplemental benefit portion) for Stand-Alone Medicare Part D coverage.

NOTE: Where premiums are paid on a monthly basis, they are generally fully earned at the end of the month for which coverage is provided. In cases where the mode of payment is less frequent than monthly, a portion of the premium payment will be unearned at the end of any given reporting period.

Line (2) Title XVIII Medicare. This is the earned amount of money charged by the reporting entity (net of reinsurance) for Medicare risk business where the reporting entity, for a fee, agrees to cover the full medical costs of Medicare subscribers. This includes the beneficiary premium and federal government's direct subsidy for prescription drug coverage under MA-PD plans. The total of this line will tie to the Analysis of Operations by Lines of Business, Page 7, Lines 1 and 2 of the annual statement.

Line (3) Title XIX Medicaid. This is the earned amount of money charged by the reporting entity for Medicaid risk business where the reporting entity, for a fee, agrees to cover the full medical costs of Medicaid subscribers. The total of this line will tie to the Analysis of Operations by Lines of Business, Page 7, Lines 1 and 2 of the annual statement. Stand-Alone Medicare Part D coverage of low-income enrollees is not included in this line.

Line (4) Other Health Risk Revenue. This is earned amounts charged by the reporting entity as a provider or intermediary for specified medical (e.g., full professional, dental, radiology, etc.) services provided to the policyholders, or members of another insurer or health entity. Unlike premiums, which are collected from an employer group or individual member, risk revenue is the prepaid (usually on a capitated basis) payments, made by another insurer or health entity to the reporting entity in exchange for services to be provided or offered by such organization. Payments to providers under risk revenue arrangements are included in the RBC calculation as underwriting risk revenue and are included in the calculation of managed care credits. Exclude fee-for-service revenue received by the reporting entity from another reporting entity. This revenue is reported in the Business Risk section of the formula as non-underwritten and limited risk revenue. The amounts reported in the individual columns will come directly from Page 7, Line 4 of the annual statement.

Line (5) Medicaid Pass-Through Payments Reported as Premiums. Medicaid Pass-Through Payments that are included as premiums in the Analysis of Operations by Lines of Business, Page 7, Lines 1 and 2 should be reported in this line.

Line (6) Underwriting Risk Revenue. The sum of Lines (1) through (4) minus Line (5).

Line (7) Net Incurred Claims. Claims incurred (paid claims + change in unpaid claims) during the reporting year (net of reinsurance) that are arranged for or provided by the reporting entity. Paid claims include capitation and all other payments to providers for services to members of the reporting entity, as well as reimbursement directly to members for covered services. Paid claims also include salaries paid to reporting entity employees that provide medical services to members and related expenses. Do not include ASC payments or federal employees health benefit program (FEHBP) and TRICARE claims. These amounts are found on Page 7, Line 17 of the annual statement.

For Stand-Alone Medicare Part D Coverage, net incurred claims should reflect claims net of reinsurance coverage (as defined in INT 05-05: Accounting for Revenue under Medicare Part D Coverage). Where there has been prepayment under the reinsurance coverage, paid claims should be offset from the cumulative deposits. Unpaid claims liabilities should reflect expected recoveries from the reinsurance coverage, for claims unpaid by the PDP or for amounts covered under the reinsurance coverage that exceed the cumulative deposits. Where there has not been any prepayment under the reinsurance coverage, unpaid claim liabilities should reflect expected amounts still due from CMS. Exclude the beneficiary incurred claims (supplemental benefit portion) for Stand-Alone Medicare Part D coverage and report the incurred claims amount (supplemental benefit portion) on Line (25.1) of page XR015.

Line (8) Medicaid Pass-Through Payments Reported as Claims. Medicaid Pass-Through Payments that are included as claims in the Analysis of Operations by Lines of Business, Page 7, Line 17 should be reported in this line.

Line (9) Total Net Incurred Claims Less Medicaid Pass-Through Payments Reported as Claims, Line (7) minus Line (8).

Line (10) Fee-for-Service Offset. Report fee for service revenue that is directly related to medical expense payments. The fee for service line does not include revenue where there is no associated claim payment (e.g., fees from non-member patients where the provider receives no additional compensation from the reporting entity) and when such revenue was excluded from the pricing of medical benefits. The amounts reported in the individual columns should come directly from Page 7, Line 3 of the annual statement.

Line (11) Underwriting Risk Incurred Claims, Line (9) minus Line (10).

Line (12) Underwriting Risk Claims Ratio. For Columns (1) through (5), Line (11) / Line (6). If either Line (6) or Line (11) is zero or negative, Line (12) is zero.

Line (13) Underwriting Risk Factor. A weighted average factor based on the amount reported in Line (6), Underwriting Risk Revenue. The factors for Column (1) through (3) have incorporated an investment income yield of 0.5%.

	\$0 – \$3 Million	\$3 – \$25 Million	Over \$25 Million
Comprehensive Medical & Hospital	0.1493	0.1493	0.0893
Medicare Supplement	0.1043	0.0663	0.0663
Dental & Vision	0.1195	0.0755	0.0755
Stand-Alone Medicare Part D Coverage	0.251	0.251	0.151
Other Health	0.130	0.130	0.130
Other Non-Health	0.130	0.130	0.130

The investment income yield was incorporated into the Comprehensive Medical & Hospital, Medicare Supplement and Dental & Vision lines of business. The purpose was to incorporate an offset to reduce the underwriting risk factor for investment income earned by the insurer. The Working Group incorporated a 0.5% income yield that was based on the yield of a 6-month US Treasury Bond. Each year, the Working Group will identify the yield of the 6-month Treasury bond (U.S. Department of the Treasury) on each Monday through the month of January and determine if further modifications to the 0.5% adjustment are needed. Any adjustments will be rounded up to the nearest 0.5%.

Line (14) Base Underwriting Risk RBC, Line (6) x Line (12) x Line (13).

Line (15) Managed Care Discount. For Comprehensive Medical & Hospital, Medicare Supplement (including Medicare Select) and Dental/Vision, a managed care discount, based on the type of managed care arrangements an organization has with its providers, is included to reflect the reduction in the uncertainty about future claim payments attributable to the managed care arrangements. The discount factor is from Column (3), Line (17) of the Managed Care Credit Calculation page. An average factor based on the combined results of these three categories is used for all three.

For Stand-Alone Medicare Part D Coverage, a separate managed care discount (or federal program credit) is included to reflect only the reduction in uncertainty about future claims payments attributable to federal risk arrangements. The discount factor is from Column (4), Line (17) of the Managed Care Credit Calculation page.

There is no discount given for the Other Health and Other Non-Health lines of business.

Line (16) RBC After Managed Care Discount, Line (14) x Line (15).

Line (17) Maximum Per-Individual Risk After Reinsurance. This is the maximum after-reinsurance loss for any single individual. Where specific stop-loss reinsurance protection is in place, the maximum per-individual risk after reinsurance is equal to the highest attachment point on such stop-loss reinsurance, subject to the following:

- Where coverage under the stop-loss protection (plus retention) with the highest attachment point is capped at less than \$750,000 per member, the maximum retained loss will be equal to such attachment point plus the difference between the coverage (plus retention) and \$750,000.
- Where the stop-loss layer is subject to participation by the reporting entity, the maximum retained risk as calculated above will be increased by the reporting entity's participation in the stop-loss layer (up to \$750,000 less retention).

If there is no specific stop-loss or reinsurance in place, enter \$9,999,999.

Examples of the calculation are presented below:

EXAMPLE 1 (Reporting entity provides Comprehensive Care):

Highest Attachment Point (Retention) Reinsurance Coverage	\$100,000
Maximum reinsured coverage	90% of \$500,000 in excess of \$100,000 \$600,000 (\$100,000 + \$500,000)
Maximum Ret. Risk =	\$100,000 deductible + \$150,000 (\$750,000 – \$600,000) + \$ 50,000 (10% of (\$600,000 – \$100,000) coverage layer) = \$300,000

EXAMPLE 2 (Reporting entity provides Comprehensive Care):

Highest Attachment Point (Retention) Reinsurance Coverage	\$75,000
Maximum reinsured coverage	90% of \$1,000,000 in excess of \$75,000 \$1,075,000 (\$75,000 + \$1,000,000)
Maximum Ret. Risk =	\$ 75,000 deductible + 0 (\$750,000 – \$1,075,000) + \$ 67,500 (10% of (\$750,000 – \$75,000)) coverage layer = \$142,500

Line (18) Alternate Risk Charge. This is twice the amount in Line (17) for columns (1), (2), (3) and (5) and Column (4) is six times the amount in Line (17), subject to a maximum of \$1,500,000 for Column (1), \$50,000 for Columns (2), (3) and (5) and \$150,000 for Column (4). Column (6) is excluded from this calculation.

Line (19) Alternate Risk Adjustment. This line shows the largest value in Line (18) for the column and all columns left of the column. Column (6) is excluded from this calculation.

Line (20) Net Alternate Risk Charge. This is the amount in Line (18), less the amount in the previous column of Line (19), but not less than zero. Column (6) is excluded from this calculation.

Line (21) Net Underwriting Risk RBC. This is the maximum of Line (16) and Line (20) for each of columns (1) through (5). This is the amount in Line (14), Column (6). The amount in Column (7) is the sum of the values in Columns (1) through (6).

OTHER UNDERWRITING RISK – L(22) THROUGH L(45) XR015–XR017

In addition to the general risk of fluctuations in the claims experience, there is an additional risk generated when reporting entities guarantee rates for extended periods beyond one year. If rate guarantees are extended between 15 and 36 months from policy inception, a factor of 0.024 is applied against the direct premiums earned for those guaranteed policies. Where a rate guaranty extends beyond 36 months, the factor is increased to 0.064. This calculation only applies to those lines of accident and health business, which include a medical trend risk, (i.e., Comprehensive Medical, Medicare Supplement, Dental/Vision, Stand-Alone Medicare Part D Coverage, Supplemental benefits within Medicare Part D Coverage, Stop-Loss, and Minimum Premium). Premiums entered should be earned premium for the current calendar year period and not for the entire period of the rate guarantees. Premium amounts should be shown net of reinsurance only when the reinsurance ceded premium is also subject to the same rate guarantee.

A separate risk factor has been established to recognize the reduced risk associated with safeguards built into the Federal Employees Health Benefit Program (FEHBP) created under Section 8909(f)(1) of Title 5 of the United States Code and TRICARE business. Claims incurred are multiplied by two percent to determine total underwriting RBC on this business.

The American Academy of Actuaries submitted a report to the Health Risk-Based Capital (E) Working Group in 2016 to apply a tiered risk factor approach to the Stop-Loss Premium. The premiums for this coverage should not be included within Comprehensive Medical or Other Health Coverages (Page XR013). It is not expected that the transfer of risk through the various managed care credits will reduce the risk of stop-loss coverage. Medical Stop-Loss exhibits a much higher variability than Comprehensive Medical. A factor of 35 percent will be applied to the first \$25,000,000 in premium and a factor of 2.5 percent will be applied to premium in excess of \$25,000,000. Stop loss premiums should be reported on a net basis.

Line (25.1) Supplemental Benefits within Stand-Alone Medicare Part D Coverage. A separate risk factor has been established to recognize the different risk (as described in INT 05-05: Accounting for Revenue under Medicare Part D Coverage) for the incurred claims associated with the beneficiaries for these supplemental drug benefits.

Line (25.2) Medicaid Pass-Through Payments Reported as Premium. The treatment of Medicaid Pass-Through Payments varies from state to state, and in some instances is treated as premium. The Health Risk-Based Capital Working Group however, determined that the risk associated with these payments is more administrative in nature and similar to uninsured plans. As such, the Working Group determined that the charge should follow that of the uninsured plans (ASC and ASO) and apply a 2 percent factor charge to those Medicaid Pass-Through Payments reported as premiums. This amount should be equal to the amount reported on page XR013, Column (1), Line (5).

Lines (26) through (32) Disability Income. Disability Income Premiums are to be separately entered depending upon category (Individual and Group). For Individual Disability Income, a further split is between noncancellable (NC) or other (guaranteed renewable, etc.). For Group Disability Income, the further splits are between Credit Monthly Balance, Credit Single Premium (with additional reserves), Credit Single Premium (without additional reserves), Group Long-Term (benefit periods of two years or longer) and Group Short-Term (benefit periods less than two years). The RBC factors vary by the amount of premium reported such that a higher factor is applied to amounts below \$50,000,000 for similar types. In determining the premiums subject to the higher factors, Individual Disability Income NC and Other are combined. All types of Group and Credit Disability Income are combined in a different category from Individual.

STOP LOSS ELECTRONIC ONLY TABLES

The Health Risk-Based Capital (E) Working Group revised the stop loss factors in 2017. The American Academy of Actuaries submitted a report to the Health Risk-Based Capital (E) Working Group and suggested that the factors be revised based on data from 1998-2008. The Health Risk-Based Capital (E) Working Group agreed to continue analyzing the stop loss factors as a result of the changes to life-time maximum amounts included in the Federal Affordable Care Act.

Electronic Table 1 – Stop Loss Interrogatories

The interrogatories are designed to gather the information by product type and will be reviewed on a go-forward basis. The data will be used in the continued evaluation of the factors. The data collected will be collected on a one-year run-out basis. For example, the RBC filed at year-end 2019, will reflect the incurred data for calendar year 2018 run-out through December 31, 2019.

For those insurers where the stop loss gross premium written is both under \$2,000,000 and is less than 10% of the insurer’s total gross premium written are exempt from completing Table 1.

The categories used in the interrogatories are separated as follows:

Product Type

Specific Stop Loss = (including aggregating specific). This coverage was included in the 1998 to 2008 factor development.

Aggregate Stop Loss = This coverage was included in the 1998 to 2008 factor development.

HMO Reinsurance = specific reinsurance of an HMO’s commercial, Medicare, Medicaid or Point of Service products. This coverage was not included in the 1998 to 2008 factor development.

Provider Excess = specific excess written on Providers including IPAs, hospitals, clinics. This coverage was not included in the 1998 to 2008 factor development.

Medical Excess Reinsurance = specific reinsurance of an insurance company’s medical business (first dollar or self-insured). This coverage was not included in the 1998 to 2008 factor development.

Do not include quota share or excess reinsurance written on Stop Loss business.

Calendar Year - Submit experience information for the calendar year preceding the year for which the RBC report is being filed, e.g., the RBC report filed for 2019 should provide experience information for calendar year 2018 with run-out through December 31, 2019. If the contract year does not follow a calendar year (i.e. 7/1-6/30), the impact on the interrogatories would be spread across two years in the same manner it would be reported in two annual statements (i.e., half of premium and ~~expense~~ ~~expense~~ applicable portion of the liability/expense would hit the first year, the remainder would hit the second year). Report based on the calendar year even if the calendar year includes two separate contracts (For example: Contract 1 started on 7/1/2017 and ran through 6/30/2018. Contract 2 started on 7/1/2018 and ran through 6/30/2019. The 2018 calendar year experience information would be comprised of the experience information in Contract 1 from 1/1/2018 through 6/30/2018 AND Treaty 2 from 7/1/2018 to 12/31/2018.). Contracts that do not follow a calendar year should NOT be excluded.

Total [Gross/Net] Premium - This is the [gross/net] premium revenue, [before/after] ceded reinsurance and including commissions. Report the data as reported for the prior calendar year including amounts paid for the prior year through the end of the current calendar year. Do not adjust for any anomalies in the experience.

Total Gross Claims + Expenses =

Total Gross Claims – These are the gross incurred claims, before ceded reinsurance. Do not adjust for any anomalies in the experience. Claims are defined as claims incurred during prior calendar year and paid through the end of the current calendar (reporting) year, plus any remaining gross claim liability.
+

Expenses – These are the gross incurred expense during the prior calendar year and paid through the end of the current reporting year plus any incurred expenses that are unpaid as of the end of the run-out period. Premium tax amounts should be included in the expense amounts; however, income taxes would be excluded.

Gross Combined Ratio - This is equal to (Total Gross Claims + Expenses) / Total Gross Premium.

Premiums Net of Reinsurance – This is the net premium revenue, net of reinsurance. Report data as reported in the annual statement and do not adjust for any anomalies in the experience.

Total Net Claims + Expenses =
Total Net Claims – These are the net incurred claims after ceded reinsurance. Do not adjust for any anomalies in the experience. Claims are defined as claims incurred during prior calendar year and paid through the end of the current calendar (reporting) year, plus any remaining net claim liability.
 +

Expenses – These are the net incurred expenses during the prior calendar year and paid through the end of the current reporting year plus any incurred expenses that are unpaid as of the end of the run-out period. Premium tax amounts should be included in the expense amounts; however, income taxes would be excluded.

Net Combined Ratio – This is equal to (Total Net Claims + Expenses)/Premiums Net of Reinsurance.

Electronic Table 2a – Calendar Year Specific Stop Loss Contracts by Group Size and Table 2b – Calendar Year Aggregate Stop Loss Contracts by Group Size

For those insurers where the stop loss gross premium written is both under \$2,000,000 and is less than 10% of the insurer’s total gross premium written are exempt from completing Table 2.

Table 2a should reflect the specific stop loss data and Table 2b should reflect the aggregate stop loss data.

Report the number of groups, average specific attachment point and average aggregate attachment as of December 31st of the calendar (reporting) year. If the contract does not follow a calendar year (i.e., 7/1-6/30), report the policies written during the year of the annual statement and in effect at the end of the calendar year.

The number of covered lives in a group (group size) should be based on the size of the group as of December 31 of the calendar year. The number of covered lives counted should include all enrolled members (that is, total number of lives insured, including dependents).

Number of Groups – list the number of groups for each stop-loss contract based on the number of covered lives in the group.

Average Specific Attachment Point (Table 2a) – The average should be weighted by the number of covered lives in the respective group size bracket, excluding the count of covered lives within the denominator where specific/aggregate coverage was not provided.

Example: Average Specific Attachment Point (\$) (Table 2a, 50-99 Covered Lives in Group) =
 (Sum of Specific Attachment Points X Reported Lives) / (Sum of Reported Lives)

Insured Group	Specific Att Point (\$)	Aggregate Att (%)	Number of Lives		Reason to Exclude	
			Include	Exclude	Include	Exclude
1	\$200,000	115%	90		Include	
2	\$100,000	120%	60		Include	
3	\$50,000	140%	40		Exclude	Not in Group Size Band

4 \$120,000 N/A 50 Include
 Calculation: $(200,000 \times 90 + 100,000 \times 60 + 120,000 \times 50) / (90 + 60 + 50) = \$150,000$

Average Aggregate Attachment Percentage (Table 2b) – Is based on expected claims. Subgroups that have separate stop loss contracts should be aggregated in terms of determining the group size. The average should be weighted by expected claims in the respective group size bracket, excluding the expected claims within the denominator where aggregate coverage was not provided.

Example: Average Aggregate Attachment Percentage (%) (Table 2b, 50-99 Covered Lives in Group) = $(\text{Sum of Expected Claims} \times \text{Attachment Percentage} \%) / (\text{Sum of Expected Claims})$

Insured Group	Specific Att Point (\$)	Aggregate Att (%)	Expected Claims	Number of Lives	Reason to	
					Exclude	Exclude
1	\$200,000	115%	\$ 500,000	90	Include	
2	\$100,000	120%	\$ 300,000	60	Include	
3	\$50,000	140%	\$ 200,000	40	Exclude	Not in Group Size Band
4	\$120,000	N/A	\$ 400,000	50	Exclude	Aggregate not purchased by group

Calculation: $(500,000 \times 115\% + 300,000 \times 120\%) / (500,000 + 300,000) = 116.7\%$

Footnote – The number of covered lives for stop loss coverage is reported in the Accident and Health Policy Experience Exhibit for Year (April 1st filing) in Column 13, Section C. Other Business, Line 2.

If stop loss policies are sold on a Per Employee Per Month basis and the actual number of covered lives is unknown, it would be reasonable to estimate the number of covered lives if the exact information is not administratively available to the reporting entity. This method of estimation may be similar to estimations provided for the Accident and Health Policy Experience Exhibit for Year. If estimated, an explanation of the method used to estimate the number of covered lives should be provided in the footnote.



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APPENDIX 1 – COMMONLY USED TERMS

The Definitions of Commonly Used Terms are frequently duplicates from the main body of the text. If there are any inconsistencies between the definitions in this section and the definitions in the main body of the instructions, the main body definition should be used.



Detail Eliminated to Conserve Space

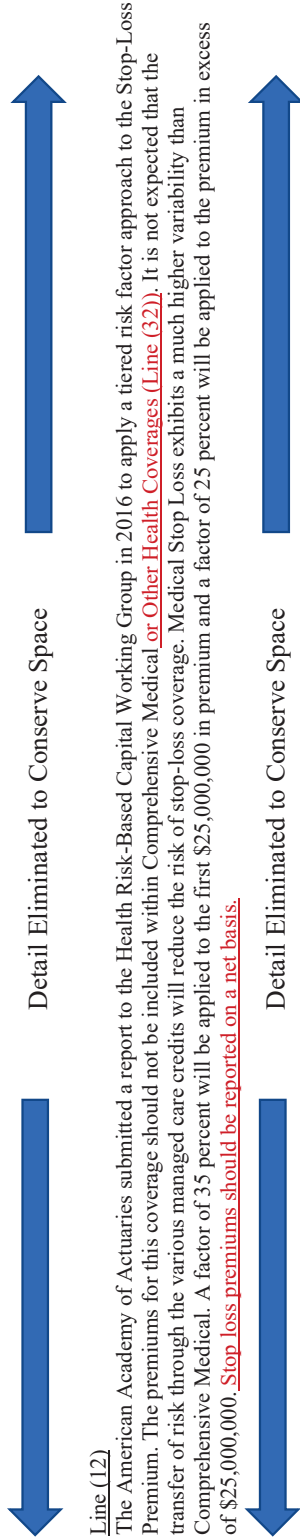
Stop-Loss Coverage – Coverage for a self-insured group plan, a provider/provider group or non-proportional reinsurance of a medical insurance product. Coverage may apply on a specific basis, an aggregate basis or both. Specific coverage means that the stop-loss carrier's risk begins after a minimum of at least \$5,000 of claims for any

one covered Life has been covered by the group plan, provider/provider group or direct writer. Aggregate coverage means that the stop-loss carrier's risk begins after the group plan, provider/provider group or direct writer has retained at least 90 percent of expected claims, or the economic equivalent.



HEALTH PREMIUMS and HEALTH CLAIMS RESERVES

LR019, LR023 and LR024



Line (12)

The American Academy of Actuaries submitted a report to the Health Risk-Based Capital Working Group in 2016 to apply a tiered risk factor approach to the Stop-Loss Premium. The premiums for this coverage should not be included within Comprehensive Medical or Other Health Coverages (Line (32)). It is not expected that the transfer of risk through the various managed care credits will reduce the risk of stop-loss coverage. Medical Stop Loss exhibits a much higher variability than Comprehensive Medical. A factor of 35 percent will be applied to the first \$25,000,000 in premium and a factor of 25 percent will be applied to the premium in excess of \$25,000,000. Stop loss premiums should be reported on a net basis.

Line (32)

It is anticipated that most health premium will have been included in one of the other lines. In the event that some coverage does not fit into any of these categories, the "Other Health" category continues the RBC factor from the 1998 and prior formula for Other Limited Benefits Anticipating Rate Increases. Stop loss premiums are addressed separately in Line (12).

Stop Loss Electronic Only Tables

The Health Risk-Based Capital (E) Working Group revised the stop loss factors in 2017. The American Academy of Actuaries submitted a report to the Health Risk-Based Capital (E) Working Group and suggested that the factors be revised based on data from 1998-2008. The Health Risk-Based Capital (E) Working Group agreed to continue analyzing the stop loss factors as a result of the changes to life time maximum amounts included in the Federal Affordable Care Act.

Electronic Table 1 – Stop Loss Interrogatories

The interrogatories are designed to gather the information by product type and will be reviewed on a go forward basis. The data will be used in the continued evaluation of the factors. The data collected will be collected on a one-year run-out basis. For example, the RBC filed at year-end 2018, will reflect the incurred data for calendar year 2017 run-out through December 31st, 2018.

For those insurers where the stop loss gross premium written is both under \$2,000,000 and is less than 10% of the insurer's total gross premium written are exempt from completing Table 1.

The categories used in the interrogatories are separated as follows:

Product Type

Specific Stop Loss = (including aggregating specific). This coverage was included in the 1998 to 2008 factor development.
Aggregate Stop Loss = This coverage was included in the 1998 to 2008 factor development.

HMO Reinsurance = specific reinsurance of an HMO's commercial, Medicare, Medicaid or Point of Service products. This coverage was not included in the 1998 to 2008 factor development.
 Provider Excess = specific excess written on Providers including IPAs, hospitals, clinics. This coverage was not included in the 1998 to 2008 factor development.
 Medical Excess Reinsurance = specific reinsurance of an insurance company's medical business (first dollar or self-insured). This coverage was not included in the 1998 to 2008 factor development.

Please do not include quota share or excess reinsurance written on Stop Loss business.

Calendar Year - Submit experience information for the calendar year preceding the year for which the RBC report is being filed; e.g., the RBC report filed for 2018 should provide experience information for calendar year 2017 with run-out through December 31st, 2018. —If the contract year does not follow a calendar year (i.e. 7/1-6/30), the impact on the interrogatories would be spread across two years in the same manner it would be reported in two annual statements (i.e., half of premium and the applicable portion of the liability/expense would hit the first year, the remainder would hit the second year). Report based on the calendar year even if the calendar year includes two separate contracts (For example: Contract 1 started on 7/1/2017 and ran through 6/30/2018. Contract 2 started on 7/1/2018 and ran through 6/30/2019. The 2018 calendar year experience information would be comprised of the experience information in Contract 1 from 1/1/2018 through 6/30/2018, AND Treaty 2 from 7/1/2018 to 12/31/2018.). Contracts that do not follow a calendar year should NOT be excluded.

Total [Gross/Net] Premium - This is the [gross/net] premium revenue, [before/after] ceded reinsurance and including commissions. Report the data as reported for the prior calendar year including amounts paid for the prior year through the end of the current calendar year. Do not adjust for any anomalies in the experience.

Total Gross Claims + Expenses =

Total Gross Claims - These are the gross incurred claims, before ceded reinsurance. Do not adjust for any anomalies in the experience. Claims are defined as claims incurred during prior calendar year and paid through the end of the current calendar (reporting) year, plus any remaining gross claim liability.

+

Expenses – These are the gross incurred expense during the prior calendar year and paid through the end of the current reporting year plus any incurred expenses that are unpaid as of the end of the run-out period. Premium tax amounts should be included in the expense amounts; however, income taxes would be excluded.

Gross Combined Ratio - This is equal to (Total Gross Claims + Expenses) / Total Gross Premium.

Premiums Net of Reinsurance – This is the net premium revenue, net of reinsurance. Report data as reported in the annual statement and do not adjust for any anomalies in the experience.

Total Net Claims + Expenses =

Total Net Claims - These are the net incurred claims after ceded reinsurance. Do not adjust for any anomalies in the experience. Claims are defined as claims incurred during prior calendar year and paid through the end of the current calendar (reporting) year, plus any remaining net claim liability.

+

Expenses – These are the net incurred expenses during the prior calendar year and paid through the end of the current reporting year plus any incurred expenses that are unpaid as of the end of the run-out period. Premium tax amounts should be included in the expense amounts; however, income taxes would be excluded.

Net Combined Ratio – This is equal to I(Total Net Claims + Expenses)/Premiums Net of Reinsurance.

Table 2a – Calendar Year **Specific** Stop Loss Contracts By Group Size and Table 2b – Calendar Year Aggregate Stop Loss Contracts by Group Size

For those insurers where the stop loss gross premium written is both under \$2,000,000 and is less than 10% of the insurer's total gross premium written are exempt from completing Table 2.

Table 2a should reflect the specific stop loss data and Table 2b should reflect the aggregate stop loss data.

Report the number of groups, average specific attachment point and average aggregate attachment as of December 31st of the calendar (reporting) year. If the contract does not follow a calendar year (i.e. 7/1-6/30), report the policies written during the year of the annual statement and in effect at the end of the calendar year.

The number of covered lives in a group (group size) should be based on the size of the group as of December 31 of the calendar year. The number of covered lives counted should include all enrolled members (that is, **total number of lives insured, including dependents**).

Number of Groups – list the number of groups for each stop loss contract based on the number of covered lives in the group.

Average Specific Attachment Point (**Table 2a**) – The average should be weighted by the number of covered lives in the respective group size bracket, excluding the count of covered lives within the denominator where specific/aggregate coverage was not provided.

Example: Average Specific Attachment Point (\$) (Table 2a, 50-99 Covered Lives in Group) =
(Sum of Specific Attachment Points X Reported Lives) / (Sum of Reported Lives)

Insured Group	Specific Att Point (\$)	Aggregate Att (%)	Number of Lives	Reason to	
				Include	Exclude
1	\$ 200,000	115%	90	Include	
2	\$ 100,000	120%	60	Include	
3	\$ 50,000	140%	40	Exclude	Not in Group Size Band
4	\$ 120,000	N/A	50	Include	

Calculation: $(200,000 \times 90 + 100,000 \times 60 + 120,000 \times 50) / (90 + 60 + 50) = \$150,000$

Average Aggregate Attachment Percentage (Table 2b) – Is based on expected claims. Subgroups that have separate stop loss contracts should be aggregated in terms of determining the group size. The average should be weighted by expected claims in the respective group size bracket, excluding the count of covered lives within the denominator where aggregate coverage was not provided.

Example: Average Aggregate Attachment Percentage (%) (Table 2b, 50-99 Covered Lives in Group) =
(Sum of Expected Claims x Attachment Percentage %) / (Sum of Expected Claims)

Insured Group	Specific Att Point (\$)	Aggregate Att (%)	Expected Claims	Number of Lives	Reason to	
					Include	Exclude
1	\$ 200,000	115%	\$ 500,000	90	Include	
2	\$ 100,000	120%	\$ 300,000	60	Include	

3	\$ 50,000	140%	\$ 200,000	40	Exclude	Not in Group Size Band
4	\$ 120,000	N/A	\$ 400,000	50	Exclude	Aggregate not purchased by group

Calculation: $(500,000 \times 115\% + 300,000 \times 120\%) / (500,000 + 300,000) = 116.7\%$

Footnote – The number of covered lives for stop loss coverage is reported in the Accident and Health Policy Experience Exhibit for Year (April 1st filing) in Column 6, Section C. Other Business, Line 2.

If stop loss policies are sold on a Per Employee Per Month basis and the actual number of covered lives is unknown, it would be reasonable to estimate the number of covered lives if the exact information is not administratively available to the reporting entity. This method of estimation may be similar to estimations provided for the Accident and Health Policy Experience Exhibit for Year. If estimated, an explanation of the method used to estimate the number of covered lives should be provided in the footnote.

LRBC FORMULA APPLICATION FOR P&C COMPANY'S A&H BUSINESS
PR019 – PR026

PR019 - Health Premiums



Detail Eliminated to Conserve Space



Line (9)

The American Academy of Actuaries submitted a report to the Health Risk-Based Capital Working Group in 2016 to apply a tiered risk factor approach to the Stop-Loss Premium. The premiums for this coverage should not be included within Comprehensive Medical or Other Health Coverages (Line (25)). It is not expected that the transfer of risk through the various managed care credits will reduce the risk of stop-loss coverage. Medical Stop Loss exhibits a much higher variability than Comprehensive Medical. A factor of 35 percent will be applied to the first \$25,000,000 in premium and a factor of 25 percent will be applied to the premium in excess of \$25,000,000. Stop loss premiums should be reported on a net basis.



Detail Eliminated to Conserve Space



Line (25)

Most Health Premium will have been included in one of the prior lines. In the event that some coverage does not fit into any of these categories, “Other Health” category is applied with a 12% factor, which is from 1998 formula for Other Limited Benefits Anticipating Rate Increases. Stop loss premiums are addressed separately in Line (9).

Stop Loss Electronic Only Tables

The Health Risk-Based Capital (E) Working Group revised the stop loss factors in 2017. The American Academy of Actuaries submitted a report to the Health Risk-Based Capital (E) Working Group and suggested that the factors be revised based on data from 1998-2008. The Health Risk-Based Capital (E) Working Group agreed to continue analyzing the stop loss factors as a result of the changes to life-time maximum amounts included in the Federal Affordable Care Act.

Electronic Table 1 – Stop Loss Interrogatories

The interrogatories are designed to gather the information by product type and will be reviewed on a go-forward basis. The data will be used in the continued evaluation of the factors. The data collected will be collected on a one-year run-out basis. For example, the RBC filed at year-end ~~2019~~ 2018, will reflect the incurred data for calendar year ~~2018-2017~~ run-out through December 31, 2019-2018.

For those insurers where the stop loss gross premium written is both under \$2,000,000 and is less than 10% of the insurer's total gross premium written are exempt from completing Table 1.

The categories used in the interrogatories are separated as follows:

Product Type

Specific Stop Loss = (including aggregating specific). This coverage was included in the 1998 to 2008 factor development.
 Aggregate Stop Loss = This coverage was included in the 1998 to 2008 factor development.
 HMO Reinsurance = specific reinsurance of an HMO's commercial, Medicare, Medicaid or Point of Service products. This coverage was not included in the 1998 to 2008 factor development.
 Provider Excess = specific excess written on Providers including IPAs, hospitals, clinics. This coverage was not included in the 1998 to 2008 factor development.
 Medical Excess Reinsurance = specific reinsurance of an insurance company's medical business (first dollar or self-insured). This coverage was not included in the 1998 to 2008 factor development.

Please do not include quota share or excess reinsurance written on Stop Loss business.

Calendar Year - Submit experience information for the calendar year preceding the year for which the RBC report is being filed; e.g., the RBC report filed for ~~2021-201922~~ should provide experience information for calendar year ~~2019-201824~~ with run-out through December 31, ~~2021-201922~~. If the contract year does not follow a calendar year (i.e., 7/1-6/30), the impact on the interrogatories would be spread across two years in the same manner it would be reported in two annual statements (i.e., half of premium and the applicable portion of the liability/expense would hit the first year, the remainder would hit the second year). Report based on the calendar year even if the calendar year includes two separate contracts (For example: Contract 1 started on 7/1/2017 and ran through 6/30/2018, Contract 2 started on 7/1/2018 and ran through 6/30/2019. The 2018 calendar year experience information would be comprised of the experience information in Contract 1 from 1/1/2018 through 6/30/2018 AND Treaty 2 from 7/1/2018 to 12/31/2018.). Contracts that do not follow a calendar year should NOT be excluded.

Total [Gross/Net] Premium - This is the [gross/net] premium revenue, [before/after] ceded reinsurance and including commissions. Report the data as reported for the prior calendar year including amounts paid for the prior year through the end of the current calendar year. Do not adjust for any anomalies in the experience.

Total Gross Claims + Expenses =

Total Gross Claims - These are the gross incurred claims, before ceded reinsurance. Do not adjust for any anomalies in the experience. Claims are defined as claims incurred during prior calendar year and paid through the end of the current calendar (reporting) year, plus any remaining gross claim liability.

+

Expenses - These are the gross incurred expense during the prior calendar year and paid through the end of the current reporting year plus any incurred expenses that are unpaid as of the end of the run-out period. Premium tax amounts should be included in the expense amounts; however, income taxes would be excluded.

Gross Combined Ratio - This is equal to (Total Gross Claims + Expenses) / Total Gross Premium.

Premiums Net of Reinsurance - This is the net premium revenue, net of reinsurance. Report data as reported in the annual statement and do not adjust for any anomalies in the experience.

Total Net Claims + Expenses =

Total Net Claims - These are the net incurred claims after ceded reinsurance. Do not adjust for any anomalies in the experience. Claims are defined as claims incurred during prior calendar year and paid through the end of the current calendar (reporting) year, plus any remaining net claim liability.

+

Expenses - These are the net incurred expenses during the prior calendar year and paid through the end of the current reporting year plus any incurred expenses that are unpaid as of the end of the run-out period. Premium tax amounts should be included in the expense amounts; however, income taxes would be excluded.

Net Combined Ratio - This is equal to (Total Net Claims + Expenses)/Premiums Net of Reinsurance.

Table 2a – Calendar Year Specific Stop Loss Contracts by Group Size and Table 2b – Calendar Year Aggregate Stop Loss Contract by Group Size

For those insurers where the stop loss gross premium written is both under \$2,000,000 and is less than 10% of the insurer's total gross premium written are exempt from completing Table 2.

Table 2a should reflect the specific stop loss data and Table 2b should reflect the aggregate stop loss data.

Report the number of groups, average specific attachment point and average aggregate attachment as of December 31st of the calendar (reporting) year. If the contract does not follow a calendar year (i.e. 7/1-6/30), report the policies written during the year of the annual statement and in effect at the end of the calendar year.

The number of covered lives in a group (group size) should be based on the size of the group as of December 31 of the calendar year. The number of covered lives counted should include all enrolled members (that is, total number of lives insured, including dependents).

Number of Groups – list the number of groups for each stop loss contract based on the number of covered lives in the group.

Average Specific Attachment Point (Table 2a) - The average should be weighted by the number of covered lives in the respective group size bracket, excluding the count of covered lives within the denominator where specific/aggregate coverage was not provided.

Example: Average Specific Attachment Point (\$) (Table 2a, 50-99 Covered Lives in Group) =
(Sum of Specific Attachment Points X Reported Lives) / (Sum of Reported Lives)

Insured Group	Specific Att Point (\$)	Aggregate Att (%)	Number of Lives	Reason to	
				Include	Exclude
1	\$ 200,000	115%	90	Include	
2	\$ 100,000	120%	60	Include	
3	\$ 50,000	140%	40	Exclude	Not in Group Size Band
4	\$ 120,000	N/A	50	Include	

Calculation: $(200,000 \times 90 + 100,000 \times 60 + 120,000 \times 50) / (90 + 60 + 50)$
= \$150,000

Average Aggregate Attachment Percentage (Table 2b) – Is based on expected claims. Subgroups that have separate stop loss contracts should be aggregated in terms of determining the group size. The average should be weighted by expected claims in the respective group size bracket, excluding the expected claims within the denominator where aggregate coverage was not provided.

Example: Average Aggregate Attachment Percentage (%) (Table 2b, 50-99 Covered Lives in Group) =
(Sum of Expected Claims x Attachment Percentage %) / (Sum of Expected Claims)

Insured	Specific	Aggregate	Expected	Number	Include
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Group	Att Point (\$)	Att (%)	Claims	of Lives	Exclude
1	\$ 200,000	115%	\$ 500,000	90	Include
2	\$ 100,000	120%	\$ 300,000	60	Include
3	\$ 50,000	140%	\$ 200,000	40	Exclude
4	\$ 120,000	N/A	\$ 400,000	50	Exclude

Calculation: $(500,000 \times 115\% + 300,000 \times 120\%) / (500,000 + 300,000)$
 = 116.7%

Footnote – The number of covered lives for stop loss coverage is reported in the Accident and Health Policy Experience Exhibit for Year (April 1st filing) in Column 13, Section C. Other Business, Line 2.

If stop loss policies are sold on a Per Employee Per Month basis and the actual number of covered lives is unknown, it would be reasonable to estimate the number of covered lives if the exact information is not administratively available to the reporting entity. This method of estimation may be similar to estimations provided for the Accident and Health Policy Experience Exhibit for Year. If estimated, an explanation of the method used to estimate the number of covered lives should be provided in the footnote.

Draft: 5/15/23

Capital Adequacy (E) Task Force
Virtual Meeting
April 28, 2023

The Capital Adequacy (E) Task Force met April 28, 2023. The following Task Force members participated: Judith L. French, Chair, represented by Tom Botsko (OH); Grace Arnold, Vice Chair, represented by Fred Andersen (MN); Lori K. Wing-Heier represented by David Phifer (AK); Mark Fowler represented by Charles Hale (AL); Ricardo Lara represented by Thomas Reedy (CA); Michael Conway represented by Rolf Kaumann and Mitchell Bronson (CO); Andrew N. Mais represented by Wanchin Chou and Jack Broccoli (CT); Karima M. Woods represented by Philip Barlow (DC); Michael Yaworsky represented by Champa Whitaker Burns (FL); Doug Ommen represented by Carrie Mears, Kevin Clark, Mike Yanacheak, and Kim Cross (IA); Dana Popish Severinghaus represented by Vincent Tsang (IL); Amy L. Beard represented by Roy Eft (IN); Vicki Schmidt represented by Chut Tee (KS); Sharon P. Clark represented by Russell Coy (KY); Kathleen A. Birrane represented by Lynn Beckner (MD); Chlora Lindley-Myers and Julie Lederer (MO); Mike Causey represented by Jackie Obusek (NC); Jon Godfread represented by Matt Fischer (ND); Eric Dunning represented by Andrea Johnson and Lindsay Crawford (NE); Marlene Caride represented by David Wolf (NJ); Glen Mulready represented by Diane Carter (OK); Michael Wise represented by Thomas Baldwin, Ryan Basnett, and Daniel Morris (SC); Cassie Brown represented by Amy Garcia, Miriam Fisk, Ludi Skinner, Dan Paschal, Jamie Walker, and Rachel Hemphill (TX); Mike Kreidler represented by Steve Drutz (WA); and Nathan Houdek, Michael Erdman, Adrian Jaramillo, and Amy Malm (WI).

1. Adopted its Spring National Meeting Minutes

Chou made a motion, seconded by Eft, to adopt the Task Force's March 28 minutes (*see NAIC Proceedings – Spring 2023, Capital Adequacy (E) Task Force*). The motion passed unanimously.

2. Discussed the Current Turmoil in the Banking Sector

Ed Toy (Risk & Regulatory Consulting—RRC) provided an update on the problems in the banking sector. He noted that there has not been any major negative news since the Spring National Meeting. While this provides a respite to be able to assess what happened and why, the strong consensus among analysts is that there are fundamental issues and that those issues still exist.

There is also a building consensus on where there are probable contagion concerns. Topping the list is the commercial real estate market. There is concern about potential defaults in the bank mortgage portfolios given several overlapping factors 1) more conservative lending practices by banks given the current turmoil; 2) continuing softening of commercial real estate values; 3) higher officer vacancy rates; 4) higher interest rates, which drive up cap rates for valuing properties; and 5) expiring commercial office leases. The continuing concerns in the banking sector put downward pressure on equity values and bond valuations. This will have a near-term impact on the valuations of insurer portfolios that have significant exposure to financial institutions. Typical bond portfolios can range anywhere from 15%–40% exposure to financial institutions.

However, it is not all bad news, as some mitigating factors have developed. The Federal Home Loan Banks (FHLBs) have stepped up and provided some funding for banks that need liquidity. There has been a modest downtick in interest rates (of about 50 basis points) since the end of 2022, slightly offsetting the significant increase in interest rates in 2022. This should help a little with asset valuations. Botsko said the Task Force appreciates Toy continuing to provide updates in upcoming meetings.

3. Adopted Proposal 2023-02-P (Underwriting Risk Line 1 Factors)

Botsko said proposal 2023-02-P provides a routine annual update to the Line 1 premium and reserve industry underwriting factors in the property/casualty (P/C) risk-based capital (RBC) formula. He also stated that the Working Group did not receive any comments during the exposure period.

Chou made a motion, seconded by Malm, to adopt proposal 2023-02-P (Attachment Two-A). The motion passed unanimously.

4. Adopted Proposal 2023-03-IRE (Revised Residual Structure for Life)

Barlow said the purpose of proposal 2023-03-IRE is to add a line to isolate residual tranches reported on Annual Statement, Schedule BA and the Asset Valuation Reserve (AVR). He stated that this is just a structure proposal: The factors proposal is currently exposed and will be considered in the Investment Risk and Evaluation (E) Working Group and brought back to the Task Force meeting in June. Walker commented that Texas is supportive of the structural change and encourages the Working Group to continue to be transparent on the data-driven process.

Barlow made a motion, seconded by Tsang, to adopt proposal 2023-03-IRE (Attachment Two-B). The motion passed unanimously.

5. Adopted Proposal 2023-04-IRE (Residual Sensitivity Test for Life)

Barlow said the purpose of this proposal is to add additional lines in the sensitivity testing exhibits for residual tranches. He also stated that the updated sensitivity testing could be an additional tool to help state insurance regulators in reviewing companies and their investments in residual tranches. He said that this is also just a structure proposal; therefore, the factors proposal is currently exposed and will be considered in the Investment Risk and Evaluation (E) Working Group and brought back to the Task Force meeting in June. Barlow also indicated that this proposal has been revised since the initial exposure in January, and no further comments have been received regarding the proposal. Botsko said the Task Force will revisit this item and make adjustments to the proposal if necessary.

Barlow made a motion, seconded by Tsang, to adopt proposal 2023-04-IRE (Attachment Two-C). The motion passed unanimously.

6. Adopted Proposal 2023-05-L (Remove Dual Trend Test)

Barlow said the current dual presentation of the Life Risk-Based Capital trend test was implemented as an interim approach while member jurisdictions transitioned to the higher 300% threshold. He stated that the dual approach is no longer needed as the transition process is now completed.

Barlow made a motion, seconded by Eft, to adopt proposal 2023-05-L (Attachment Two-D). The motion passed unanimously.

7. Adopted Proposal 2023-06-L (C-2 Mortality Risk Structure Changes)

Barlow said this proposal provides the following proposed life C-2 updates for consideration for 2023 year-end financial statements: 1) structural updates where it pertains to the treatment of group permanent life and miscellaneous other instructions updates. The proposal assigns the same factors to group permanent life as individual permanent life for categories stating with and without pricing flexibility; and 2) a new financial

statement note to provide the development of net amounts at risk for the life C-2 categories to create a direct link to a financial statement source, and accompanying life C-2 structural and instruction updates. The proposed second update includes the updates specified in the first update. He also stated that the second update was adopted by the Life Risk-Based Capital (E) Working Group with the caveat that the adoption of the new financial statement note by the Blanks (E) Working Group. Otherwise, company records will be used instead of a direct link to a financial statement source.

Barlow made a motion, seconded by Kaumann, to adopt proposal 2023-06-L (Attachment Two-E). The motion passed unanimously.

8. Adopted Proposal 2023-07-L (CM6 & CM7 Mortgages Structures Changes)

Barlow said this proposal serves the following purposes: 1) aligns the CM6 and CM7 life RBC factors for nonperforming commercial and farm mortgages with the RBC factors for the Annual Statement, Schedule A and Schedule BA investments in real estate, as those factors were adjusted in 2021; and 2) adopts the same formula for calculating RBC amounts for nonperforming and performing residential, commercial, and farm mortgages.

Barlow made a motion, seconded by Kaumann, to adopt proposal 2023-07-L (Attachment Two-F). The motion passed unanimously.

9. Exposed Proposal 2022-16-CA (Underwriting Risk Factors Investment Income Adjustment)

Drutz said the purpose of this proposal is to update the underwriting risk factors for the annual investment income adjustment to the comprehensive medical, Medicare supplement, and dental and vision factors. This proposal was originally exposed to the Health Risk-Based Capital (E) Working Group for a 30-day comment period ending March 9. No comments were received. The Working Group requests that the Task Force exposes this proposal for another 30-day comment period to address the factor changes for all three lines of business. Botsko said the Task Force and the Health Risk-Based Capital (E) Working Group welcome any comments during the exposure period.

The Task Force agreed to expose proposal 2022-16-CA for a 30-day public comment period ending May 27.

10. Exposed Proposal 2023-01-CA (Stop Loss Premiums)

Drutz said the purpose of this proposal is to clarify the instructions for the stop-loss business in the health RBC formula and align the life and P/C RBC formulas with these changes. The Health Risk-Based Capital (E) Working Group previously exposed this proposal for a 20-day comment period and only received minor editorial change suggestions. He stated that the Working Group requests that the Task Force exposes the proposal for a 30-day comment period to address the changes for all three lines of business.

The Task Force agreed to expose proposal 2023-01-CA for a 30-day public comment period ending May 27.

11. Discussed a Referral from the Valuation of Securities (E) Task Force

Botsko said the Valuation of Securities (E) Task Force and the Risk-Based Capital Investment Risk and Evaluation (E) Working Group exposed a referral jointly regarding additional market and analytical information for bond investments and requested comments from interested parties by March 31. He pointed out that the Task Force and Working Group did not receive any comments during the exposure period. Also, Botsko said the Task Force is not planning to send a response to the Valuation of Securities (E) Task Force at this time, as the information that is being proposed in the referral is not needed by the Task Force on a consistent basis. Barlow commented that

the Working Group will likely follow the same path as the Task Force. Mears said she appreciates that the Task Force and Working Group exposed the referral. She urged all interested parties to provide any further comments directly to the Valuation of Securities (E) Task Force.

12. Received an Update from its Risk Evaluation Ad Hoc Group

Botsko said the Capital Adequacy (E) Task Force established the Risk Evaluation Ad Hoc Group during the Spring National Meeting to: 1) re-evaluate some of the missing risks to determine if it should now include them in the RBC calculation or if it appropriately handles those risks utilizing other regulatory methods; and 2) review those factors and instructions that have not been reviewed since development to determine if modifications should be made. He stated that NAIC staff received more than 80 industry requests to be involved in the ad hoc group. Botsko commented that being a member of the group will require active participation in the group discussions and that status updates will be provided in every Task Force meeting. Botsko asked all interested parties to contact Eva Yeung (NAIC) if they do not plan on participating in the group discussion. Lastly, he said the ad hoc group plans to schedule its first meeting in May.

Having no further business, the Capital Adequacy (E) Task Force adjourned.

SharePoint/NAIC Support Staff Hub/Member Meetings/E CMTE/CADTF/2023-2-Summer/Apr 28 CADTF minutes.docx

**Capital Adequacy (E) Task Force
RBC Proposal Form**

- | | | |
|---|---|---|
| <input type="checkbox"/> Capital Adequacy (E) Task Force | <input type="checkbox"/> Health RBC (E) Working Group | <input type="checkbox"/> Life RBC (E) Working Group |
| <input type="checkbox"/> Catastrophe Risk (E) Subgroup | <input type="checkbox"/> Investment RBC (E) Working Group | <input type="checkbox"/> Longevity Risk (A/E) Subgroup |
| <input type="checkbox"/> Variable Annuities Capital. & Reserve (E/A) Subgroup | <input checked="" type="checkbox"/> P/C RBC (E) Working Group | <input type="checkbox"/> RBC Investment Risk & Evaluation (E) Working Group |

	DATE: <u>3/22/23</u>
CONTACT PERSON: <u>Eva Yeung</u>	FOR NAIC USE ONLY
TELEPHONE: <u>816-783-8407</u>	Agenda Item # <u>2023-02-P</u>
EMAIL ADDRESS: <u>eyeung@naic.org</u>	Year _____
ON BEHALF OF: <u>P/C RBC (E) Working Group</u>	DISPOSITION
NAME: <u>Tom Botsko</u>	ADOPTED:
TITLE: <u>Chair</u>	<input type="checkbox"/> TASK FORCE (TF) _____
AFFILIATION: <u>Ohio Department of Insurance</u>	<input type="checkbox"/> WORKING GROUP (WG) _____
ADDRESS: <u>50 West Town Street, Suite 300</u>	<input type="checkbox"/> SUBGROUP (SG) _____
<u>Columbus, OH 43215</u>	EXPOSED:
	<input type="checkbox"/> TASK FORCE (TF) _____
	<input checked="" type="checkbox"/> WORKING GROUP (WG) <u>3/22/23</u>
	<input type="checkbox"/> SUBGROUP (SG) _____
	REJECTED:
	<input type="checkbox"/> TF <input type="checkbox"/> WG <input type="checkbox"/> SG _____
	OTHER:
	<input type="checkbox"/> DEFERRED TO _____
	<input type="checkbox"/> REFERRED TO OTHER NAIC GROUP _____
	<input type="checkbox"/> (SPECIFY) _____

IDENTIFICATION OF SOURCE AND FORM(S)/INSTRUCTIONS TO BE CHANGED

- | | | |
|--|--|--|
| <input type="checkbox"/> Health RBC Blanks | <input checked="" type="checkbox"/> Property/Casualty RBC Blanks | <input type="checkbox"/> Life and Fraternal RBC Blanks |
| <input type="checkbox"/> Health RBC Instructions | <input type="checkbox"/> Property/Casualty RBC Instructions | <input type="checkbox"/> Life and Fraternal RBC Instructions |
| <input type="checkbox"/> Health RBC Formula | <input type="checkbox"/> Property/Casualty RBC Formula | <input type="checkbox"/> Life and Fraternal RBC Formula |
| <input type="checkbox"/> OTHER _____ | | |

DESCRIPTION/REASON OR JUSTIFICATION OF CHANGE(S)

The proposed change would provide routine annual update of the industry underwriting factors (premium and reserve) in the PCRBC formula.

Additional Staff Comments:

** This section must be completed on all forms.

Revised 2-2023

PR017 Line 1 Reserves

Schedule P Line of Business	LOB	Proposed for adoption - 2023 Industry Average Development Ratio	2022 Industry Average Development		2021 Industry Average Development		2020 Industry Average Development		2019 Industry Average Development		2018 Industry Average Development		2017 Industry Average Development		2016 Industry Average Development		2015 Industry Average Development		2014 Industry Average Development	
			Average	Development	Average	Development	Average	Development	Average	Development	Average	Development	Average	Development	Average	Development	Average	Development	Average	Development
H/F			1.001		0.998		0.993		0.989		0.989		0.984		0.972		0.962		0.967	
PPA	A	1.004	1.022		1.025		1.035		1.026		1.022		1.012		1.002		1.002		0.994	
C/A	B	1.047	1.082		1.083		1.078		1.087		1.060		1.034		1.015		0.987		0.979	
WC	C	1.106	0.906		0.912		0.916		0.955		0.952		0.971		0.971		0.961		0.986	
	D	0.834	1.037		0.999		1.016		0.992		0.967		0.956		0.942		0.938		0.941	
CMP	E	0.991	0.887		0.874		0.861		0.864		0.871		0.868		0.841		0.966		0.966	
	F1	0.906	0.983		0.973		0.940		0.907		0.886		0.854		0.822		0.839		0.808	
MM Clms Made	F2	0.984	0.990		0.976		0.963		0.938		0.933		0.926		0.919		0.975		0.990	
SL	G	0.994	0.995		0.964		0.968		0.971		0.966		0.952		0.929		0.923		0.916	
OL	H	0.969	0.842		0.915		0.907		0.995		0.996		1.016		1.035		1.016		1.050	
Fidelity / Surety	K	0.852	0.993		0.978		0.977		0.972		0.971		0.982		0.973		0.991		0.992	
Special Property	I	0.983	1.011		0.989		0.993		0.996		1.000		1.001		0.995		0.995		1.005	
Auto Physical Damage	J	1.016	0.955		0.965		0.971		0.973		0.976		0.981		0.986		1.041		1.061	
Other (Credit, A&H)	L	0.946	0.694		0.723		0.682		0.788		0.870		0.820		0.853		1.185		1.444	
Financial / Mortgage Guaranty	S	0.674	3.041		1.104		1.162		1.037		0.851		0.855		0.897		1.350		0.742	
Intl	M	2.414	0.917		0.893		0.886		0.872		0.834		0.814		0.814		1.002		0.976	
Rein. Property & Financial Lines	NP	0.924	1.008		0.989		0.985		0.955		0.945		0.914		0.896		0.938		0.905	
Rein. Liability	O	1.024	0.867		0.879		0.900		0.913		0.921		0.935		0.937		1.072		1.018	
PL	R	0.874	0.998		1.007		1.013		1.017		1.015		0.989		0.977		0.994		1.040	
Warranty	T	0.995																		

PR018 Line 1 Premiums

Schedule P Line of Business	LOB	Proposed 2023 Industry Average Loss & Expense Ratio	2022 Industry Average Loss & Expense Ratio	2021 Industry Average Loss & Expense Ratio	2020 Industry Average Loss & Expense Ratio	2019 Industry Average Loss & Expense Ratio	2018 Industry Average Loss & Expense Ratio	2017 Industry Average Loss & Expense Ratio	2016 Industry Average Loss & Expense Ratio	2015 Industry Average Loss & Expense Ratio	2014 Industry Average Loss & Expense Ratio
H/F	A	0.679	0.665	0.681	0.678	0.681	0.687	0.688	0.701	0.701	0.713
PPA	B	0.791	0.793	0.795	0.810	0.810	0.806	0.800	0.792	0.786	0.780
CA	C	0.777	0.761	0.761	0.759	0.737	0.724	0.706	0.689	0.684	0.676
WC	D	0.651	0.664	0.682	0.705	0.726	0.744	0.751	0.752	0.751	0.749
CMP	E	0.671	0.661	0.673	0.672	0.666	0.664	0.647	0.648	0.655	0.652
MM Occurrence	F1	0.767	0.750	0.731	0.726	0.730	0.780	0.777	0.767	0.880	0.883
MM Clms Made	F2	0.815	0.829	0.821	0.797	0.768	0.747	0.722	0.691	0.697	0.680
SL	G	0.578	0.585	0.593	0.603	0.593	0.569	0.567	0.572	0.630	0.645
OL	H	0.641	0.637	0.635	0.639	0.638	0.633	0.629	0.618	0.616	0.617
Fidelity / Surety	K	0.363	0.366	0.394	0.384	0.399	0.417	0.430	0.464	0.462	0.473
Special Property	I	0.550	0.547	0.559	0.553	0.554	0.563	0.555	0.559	0.571	0.572
Auto Physical Damage	J	0.727	0.718	0.726	0.732	0.730	0.732	0.727	0.711	0.703	0.686
Other (Credit, A&H)	L	0.702	0.698	0.693	0.684	0.682	0.709	0.712	0.699	0.706	0.754
Financial / Mortgage Guaranty	S	0.209	0.203	0.252	0.513	0.811	1.099	1.175	1.293	1.096	1.242
Intl	M	1.136	1.166	0.769	0.758	0.795	0.584	0.565	0.607	1.150	1.131
Rein. Property & Financial Lines	NP	0.578	0.566	0.558	0.534	0.522	0.486	0.459	0.512	0.723	0.764
Rein. Liability	O	0.743	0.725	0.713	0.708	0.679	0.666	0.609	0.600	0.749	0.748
PL	R	0.597	0.601	0.617	0.645	0.656	0.671	0.670	0.684	0.715	0.716
Warranty	T	0.652	0.665	0.681	0.691	0.695	0.732	0.645	0.611	0.799	0.789

**Capital Adequacy (E) Task Force
RBC Proposal Form**

- | | | |
|---|--|--|
| <input type="checkbox"/> Capital Adequacy (E) Task Force | <input type="checkbox"/> Health RBC (E) Working Group | <input type="checkbox"/> Life RBC (E) Working Group |
| <input type="checkbox"/> Catastrophe Risk (E) Subgroup | <input type="checkbox"/> P/C RBC (E) Working Group | <input type="checkbox"/> Longevity Risk (A/E) Subgroup |
| <input type="checkbox"/> Variable Annuities Capital. & Reserve (E/A) Subgroup | <input type="checkbox"/> Economic Scenarios (E/A) Subgroup | <input checked="" type="checkbox"/> RBC Investment Risk & Evaluation (E) Working Group |

<p align="right">DATE: <u>3/23/23</u></p> <p>CONTACT PERSON: <u>Dave Fleming</u></p> <p>TELEPHONE: <u>816-783-8121</u></p> <p>EMAIL ADDRESS: <u>dfleming@naic.org</u></p> <p>ON BEHALF OF: <u>RBC Inv. Risk & Eval. (E) Working Group</u></p> <p>NAME: <u>Philip Barlow</u></p> <p>TITLE: <u>Associate Commissioner for Insurance</u></p> <p>AFFILIATION: <u>District of Columbia</u></p> <p>ADDRESS: <u>1050 First Street, NE Suite 801</u> <u>Washington, DC 20002</u></p>	<p align="center">FOR NAIC USE ONLY</p> <p>Agenda Item # <u>2023-03-IRE</u> Year <u>2023</u></p> <p align="center">DISPOSITION</p> <p>ADOPTED:</p> <p><input type="checkbox"/> TASK FORCE (TF) _____</p> <p><input type="checkbox"/> WORKING GROUP (WG) _____</p> <p><input type="checkbox"/> SUBGROUP (SG) _____</p> <p>EXPOSED:</p> <p><input type="checkbox"/> TASK FORCE (TF) _____</p> <p><input checked="" type="checkbox"/> WORKING GROUP (WG) _____</p> <p><input type="checkbox"/> SUBGROUP (SG) _____</p> <p>REJECTED:</p> <p><input type="checkbox"/> TF <input type="checkbox"/> WG <input type="checkbox"/> SG _____</p> <p>OTHER:</p> <p><input type="checkbox"/> DEFERRED TO _____</p> <p><input type="checkbox"/> REFERRED TO OTHER NAIC GROUP _____</p> <p><input type="checkbox"/> (SPECIFY) _____</p>
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IDENTIFICATION OF SOURCE AND FORM(S)/INSTRUCTIONS TO BE CHANGED

- | | | |
|--|---|---|
| <input type="checkbox"/> Health RBC Blanks | <input type="checkbox"/> Property/Casualty RBC Blanks | <input checked="" type="checkbox"/> Life and Fraternal RBC Blanks |
| <input type="checkbox"/> Health RBC Instructions | <input type="checkbox"/> Property/Casualty RBC Instructions | <input type="checkbox"/> Life and Fraternal RBC Instructions |
| <input type="checkbox"/> Health RBC Formula | <input type="checkbox"/> Property/Casualty RBC Formula | <input type="checkbox"/> Life and Fraternal RBC Formula |
| <input type="checkbox"/> OTHER _____ | | |

DESCRIPTION/REASON OR JUSTIFICATION OF CHANGE(S)

Add a line to isolate residual tranches reported on Schedule BA and the asset valuation reserve.

Additional Staff Comments:

**** This section must be completed on all forms.**

Revised 2-2023

	(1) Book / Adjusted Carrying Value	(2) Unrated Items ‡	(3) RBC Subtotal †	(4) Factor	(5) RBC Requirement
OTHER LONG-TERM ASSETS (CONTINUED)					
	Annual Statement Source				
(42)	Schedule BA - Unaffiliated Common Stock				
(43)	Schedule BA Unaffiliated Common Stock-Public	AVR Equity Component Column 1 Line 65		X .3	
(44)	Schedule BA Unaffiliated Common Stock-Private Total Schedule BA Unaffiliated Common Stock (pre-MODCO/Funds Withheld)	AVR Equity Component Column 1 Line 66 Line (42) + (43)		X 0.3000	
(45)	Reduction in RBC for MODCO/Funds Withheld Reinsurance Ceded Agreements	Company Records (enter a pre-tax amount)			
(46)	Increase in RBC for MODCO/Funds Withheld Reinsurance Assumed Agreements	Company Records (enter a pre-tax amount)			
(47)	Total Schedule BA Unaffiliated Common Stock (including MODCO/Funds Withheld.)	Lines (44) - (45) + (46)			
	Schedule BA - All Other				
(48.1)	BA Affiliated Common Stock - Life with AVR	AVR Equity Component Column 1 Line 67			
(48.2)	BA Affiliated Common Stock - Certain Other	AVR Equity Component Column 1 Line 68			
(48.3)	Total Schedule BA Affiliated Common Stock - C-10	Line (48.1) + (48.2)		X 0.3000	
(49.1)	BA Affiliated Common Stock - All Other	AVR Equity Component Column 1 Line 69			
(49.2)	Total Sch. BA Affiliated Common Stock - C-10s	Line (49.1) + AVR Equity Component Column 1 Line 93 - Schedule BA Part 1 Column 12 Line 2999999 + Line 3099999		X 0.3000	
(50)	Schedule BA Collateral Loans	AVR Equity Component Column 1 Line 93		X 0.0680	
(51)	Total Residual Tranches or Interests	AVR Equity Component Column 1 Line 94		X TBD	
(52.1)	NAIC 01 Working Capital Finance Notes	AVR Equity Component Column 1 Line 95		X 0.0050	
(52.2)	NAIC 02 Working Capital Finance Notes	Line (52.1) + (52.2)		X 0.0163	
(53.1)	Total Admitted Working Capital Finance Notes	AVR Equity Component Column 1 Line 96			
(53.2)	Other Schedule BA Assets	AVR Equity Component Column 1 Line 96			
(53.3)	Less NAIC 2 thru 6 Rated/Designated Surplus Notes and Capital Notes	Column (1) Lines (23) through (27) + Column (1) Lines (33) through (37)			
(54)	Net Other Schedule BA Assets	Line (53.1) less (53.2)		X 0.3000	
(55)	Total Schedule BA Assets C-10 (pre-MODCO/Funds Withheld)	Lines (11) + (21) + (31) + (41) + (48.3) + (50) + (52.3) + (53.3)			
(56)	Reduction in RBC for MODCO/Funds Withheld Reinsurance Ceded Agreements	Company Records (enter a pre-tax amount)			
(57)	Increase in RBC for MODCO/Funds Withheld Reinsurance Assumed Agreements	Company Records (enter a pre-tax amount)			
(58)	Total Schedule BA Assets Excluding Mortgages and Real Estate	Lines (54) - (55) + (56)			
		Line (47) + (49.2) + (51) + (57)			

† Fixed income instruments and surplus notes designated by the NAIC Capital Markets and Investment Analysis Office or considered exempt from filing as specified in the *Purposes and Procedures Manual of the NAIC*

‡ *Investment Analysis Office* should be reported in Column (3).

§ Column (2) is calculated as Column (1) less Column (3) for Lines (1) through (17). Column (2) equals Column (3) - Column (1) for Line (53.3).

The factor for Schedule BA publicly traded common stock should equal 30 percent adjusted up or down by the weighted average beta for the Schedule BA publicly traded common stock portfolio subject to a minimum of 22.5 percent and a maximum of 45 percent in the same manner that the similar 15.8 percent factor for Schedule BA publicly traded common stock in the Asset Valuation Reserve (AVR) calculation is adjusted up or down. The rules for calculating the beta adjustment are set forth in the AVR section of the annual statement instructions.

Denotes items that must be manually entered on the filing software.

CALCULATION OF TAX EFFECT FOR LIFE AND FRATERNAL RISK-BASED CAPITAL (CONTINUED)

	(1)	Tax Factor	RBC Tax Effect	#REF!
(102) Replications				
(103) Reinsurance		0.1575		
(104) Investment Affiliates		0.2100		
(105) Investment in Parent		0.2100		
(106) Other Affiliated Risk-Based Capital		0.2100		
(107) Other Affiliated Capital		0.2100		
(108) Publicly Traded Insurance Affiliates		0.2100		
(109) Subtotal for C-to Assets				
C-to Affiliated Common Stock				
(110) OF-Balance Sheet and Other Items		0.1575		
(111) OF-Balance Sheet Items Reduction - Reinsurance		0.2100		
(112) OF-Balance Sheet Items Increase - Reinsurance		0.2100		
(113) Affiliated US Property - Casualty Insurers Directly Owned		0.2100		
(114) Affiliated US Life Insurers Directly Owned		0.2100		
(115) Affiliated US Health Insurers Directly and Indirectly Owned		0.2100		
(116) Affiliated US Property - Casualty Insurers Indirectly Owned		0.2100		
(117) Affiliated US Life Insurers Indirectly Owned		0.2100		
(118) Affiliated Alien Life Insurers - Canadian		0.2100		
(119) Affiliated Alien Life Insurers - All Others		0.0000		
(120) Subtotal for C-to Affiliated Common Stock				
Common Stock				
(121) Unaffiliated Common Stock		0.2100		
(122) Credit for Hedging - Common Stock		0.2100		
(123) Stock Reduction - Reinsurance		0.2100		
(124) Stock Increase - Reinsurance		0.2100		
(125) BA Common Stock Unaffiliated		0.2100		
(126) BA Common Stock Affiliated - C-Tes		0.2100		
(127) Common Stock Concentration Factor		0.2100		
(128) NAIC 01 Working Capital Finance Notes		0.1575		
(129) NAIC 02 Working Capital Finance Notes		0.1575		
(130) Affiliated Preferred Stock and Common Stock - Holding Company in Excess of Indirect Subs		0.2100		
(131) Affiliated Preferred Stock and Common Stock - All Other		0.2100		
(132) Total for C-Tes Assets				

Source

LR013 Replication (Synthetic Asset) Transactions and Mandatory Convertible Securities Column (7) Line (999999)

LR016 Reinsurance Column (4) Line (17)

LR042 Summary for Affiliated Investments Column (4) Line (6)

LR042 Summary for Affiliated Investments Column (4) Line (10)

LR042 Summary for Affiliated Investments Column (4) Line (11)

LR042 Summary for Affiliated Investments Column (4) Line (12)

LR042 Summary for Affiliated Investments Column (4) Line (14)

Sum of Lines (80) through (108). Reorganizing the Deduction of Lines (013), (014), (015), (036), (044), (049), (056), (061), (069), (077), (084), (089) and (100)

LR017 OF-Balance Sheet and Other Items Column (5) Line (27)

LR017 OF-Balance Sheet and Other Items Column (5) Line (28)

LR017 OF-Balance Sheet and Other Items Column (5) Line (29)

LR042 Summary for Affiliated Investments Column (4) Line (1)

LR042 Summary for Affiliated Investments Column (4) Line (2)

LR042 Summary for Affiliated Investments Column (4) Line (3)

LR042 Summary for Affiliated Investments Column (4) Line (4)

LR042 Summary for Affiliated Investments Column (4) Line (5)

LR042 Summary for Affiliated Investments Column (4) Line (8)

LR042 Summary for Affiliated Investments Column (4) Line (9)

Lines (110)+(111)+(112)+(113)+(114)+(115)+(116)+(117)+(118)+(119)

LR005 Unaffiliated Preferred and Common Stock Column (5) Line (17) +

LR018 OF-Balance Sheet Collateral Column (3) Line (16)

LR015 Hedged Asset Common Stock Schedule Column (10) Line (0299999)

LR005 Unaffiliated Preferred and Common Stock Column (5) Line (19)

LR005 Unaffiliated Preferred and Common Stock Column (5) Line (20)

LR008 Other Long-Term Assets Column (5) Line (47)

LR008 Other Long-Term Assets Column (5) Line (49.2) + (51)

LR011 Common Stock Concentration Factor Column (6) Line (6)

LR008 Other Long-Term Assets Column (5) Line (52.1)

LR008 Other Long-Term Assets Column (5) Line (52.2)

LR042 Summary for Affiliated Investments Column (4) Line (7)

LR042 Summary for Affiliated Investments Column (4) Line (13)

Lines (121)-(122)-(123)+(124)+(125)+(126)+(127)+(128)+(129)+(130)+(131)

† Denotes lines that are deducted from the total rather than added.

Denotes items that must be manually entered on the filing software.

CALCULATION OF AUTHORIZED CONTROL LEVEL RISK-BASED CAPITAL

	Source	(1) RBC Requirement
(12) Asset Risk - Unaffiliated Common Stock, and Affiliated Non-Insurance Stock (C-1s) Schedule D Unaffiliated Common Stock	LR005 Unaffiliated Common Stock Column (5) Line (21) + LR018 OF-Balance Sheet Collateral Column (3) Line (16)	
(13) Schedule BA Unaffiliated Common Stock	LR008 Other Long-Term Assets Column (5) Line (47)	
(14) Schedule BA Affiliated Common Stock - C-1s	LR008 Other Long-Term Assets Column (5) Line (48) + (51)	
(15) Common Stock Concentration Factor	LR011 Common Stock Concentration Factor Column (6) Line (6)	
(16) Affiliated Preferred Stock and Common Stock - Holding Company in Excess of Indirect Subsidiaries	LR042 Summary for Affiliated Investments Column (4) Line (7)	
(17) Affiliated Preferred Stock and Common Stock - All Other	LR042 Summary for Affiliated Investments Column (4) Line (13)	
(18) Total (C-1s) - Pre-Tax	Sum of Lines (12) through (17)	
(19) (C-1s) Tax Effort	LR030 Calculation of Tax Effect for Life and Fraternal Risk-Based Capital Column (2) Line (132)	
(20) Net (C-1s) - Post-Tax	Line (18) - Line (19)	
(21) Asset Risk - All Other (C-Lo) Bonds after Size Factor	LR002 Bonds Column (2) Line (27) + LR018 OF-Balance Sheet Collateral Column (3) Line (8)	
(22) Mortgages (including past due and unpaid taxes)	LR004 Mortgages Column (6) Line (31)	
(23) Unaffiliated Preferred Stock	LR005 Unaffiliated Preferred and Common Stock Column (5) Line (10) + LR018 OF-Balance Sheet Collateral Column (3) Line (15)	
(24) Affiliated Preferred Stock and Common Stock - Investment Subsidiaries	LR042 Summary for Affiliated Investments Column (4) Line (6)	
(25) Affiliated Preferred Stock and Common Stock - Parent	LR042 Summary for Affiliated Investments Column (4) Line (10)	
(26) Affiliated Preferred Stock and Common Stock - Property and Casualty Insurers not Subject to Risk-Based Capital	LR042 Summary for Affiliated Investments Column (4) Line (11)	
(27) Affiliated Preferred Stock and Common Stock - Life Insurers not Subject to Risk-Based Capital	LR042 Summary for Affiliated Investments Column (4) Line (12)	
(28) Affiliated Preferred Stock and Common Stock - Publicly Traded Insurers Held at Fair Value (excess of statement value over book value)	LR042 Summary for Affiliated Investments Column (4) Line (14)	
(29) Separate Accounts with Guarantees	LR006 Separate Accounts Column (3) Line (7)	
(73) Authorized Control Level Risk-Based Capital (After Covariance Adjustment and Sharefall) Total Risk-Based Capital After Covariance Times Fifty Percent	Line (72) x 0.50	
Tax Sensitivity Test		
(74) Tax Sensitivity Test: Total Risk-Based Capital After Covariance	$L(9)+L(61) + \text{Square Root of } [(L(40) + L(50))^2 + (L(18) + L(56))^2 + L(47)^2 + L(53)^2 + L(64)^2]$	
(75) Tax Sensitivity Test: Authorized Control Level Risk-Based Capital	Line (74) x 0.50	

Denotes items that must be manually entered on the filing software.

**Capital Adequacy (E) Task Force
RBC Proposal Form**

- | | | |
|---|--|--|
| <input type="checkbox"/> Capital Adequacy (E) Task Force | <input type="checkbox"/> Health RBC (E) Working Group | <input type="checkbox"/> Life RBC (E) Working Group |
| <input type="checkbox"/> Catastrophe Risk (E) Subgroup | <input type="checkbox"/> P/C RBC (E) Working Group | <input type="checkbox"/> Longevity Risk (A/E) Subgroup |
| <input type="checkbox"/> Variable Annuities Capital. & Reserve (E/A) Subgroup | <input type="checkbox"/> Economic Scenarios (E/A) Subgroup | <input checked="" type="checkbox"/> RBC Investment Risk & Evaluation (E) Working Group |

<p align="right">DATE: <u>3/23/23</u></p> <p>CONTACT PERSON: <u>Steve Clayburn</u></p> <p>TELEPHONE: <u>(202)624-2197</u></p> <p>EMAIL ADDRESS: <u>steveclayburn@acli.com</u></p> <p>ON BEHALF OF: <u>American Council of Life Insurers (ACLI)</u></p> <p>NAME: <u>Steve Clayburn</u></p> <p>TITLE: _____</p> <p>AFFILIATION: _____</p> <p>ADDRESS: _____</p>	<p align="center">FOR NAIC USE ONLY</p> <p>Agenda Item # <u>2023-04-IRE</u></p> <p>Year <u>2023</u></p> <p align="center">DISPOSITION</p> <p>ADOPTED:</p> <p><input type="checkbox"/> TASK FORCE (TF) _____</p> <p><input type="checkbox"/> WORKING GROUP (WG) _____</p> <p><input type="checkbox"/> SUBGROUP (SG) _____</p> <p>EXPOSED:</p> <p><input type="checkbox"/> TASK FORCE (TF) _____</p> <p><input checked="" type="checkbox"/> WORKING GROUP (WG) _____</p> <p><input type="checkbox"/> SUBGROUP (SG) _____</p> <p>REJECTED:</p> <p><input type="checkbox"/> TF <input type="checkbox"/> WG <input type="checkbox"/> SG _____</p> <p>OTHER:</p> <p><input type="checkbox"/> DEFERRED TO _____</p> <p><input type="checkbox"/> REFERRED TO OTHER NAIC GROUP _____</p> <p><input type="checkbox"/> (SPECIFY) _____</p>
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IDENTIFICATION OF SOURCE AND FORM(S)/INSTRUCTIONS TO BE CHANGED

- | | | |
|--|---|---|
| <input type="checkbox"/> Health RBC Blanks | <input type="checkbox"/> Property/Casualty RBC Blanks | <input checked="" type="checkbox"/> Life and Fraternal RBC Blanks |
| <input type="checkbox"/> Health RBC Instructions | <input type="checkbox"/> Property/Casualty RBC Instructions | <input type="checkbox"/> Life and Fraternal RBC Instructions |
| <input type="checkbox"/> Health RBC Formula | <input type="checkbox"/> Property/Casualty RBC Formula | <input type="checkbox"/> Life and Fraternal RBC Formula |
| <input type="checkbox"/> OTHER _____ | | |

DESCRIPTION/REASON OR JUSTIFICATION OF CHANGE(S)

The additional lines are to add residual tranches to the sensitivity testing exhibits for RBC.
 As regulators develop designations for asset back securities to then be assigned appropriate C-1 RBC factors, the updated sensitivity testing could be an additional tool to help regulators in reviewing companies and there investments in residual tranches.

Additional Staff Comments:

**** This section must be completed on all forms.**

Revised 2-2023

ADDITIONAL INFORMATION REQUIRED

	Source	Statement Value
(1.2) Other Affiliates: Subsidiaries	Subsidiaries' Life and Fraternal Risk-Based Capital LR042 Summary for Affiliated Investments Column (1) Line (13); Property and Casualty Risk-Based Capital PR005 Summary For Subsidiary, Controlled and Affiliated Investments for Cross-Checking Statement Values Column (1) Line (8) and Line (17)	
(2.2) Noncontrolled Assets: Subsidiaries	Subsidiaries' Life and Fraternal Risk-Based Capital LR017 Off-Balance Sheet and Other Items Column (1) Line (15); Property and Casualty PR014 Miscellaneous Off-Balance Sheet Items Column (1) Line (15)	
(3.2) Guarantees for Affiliates: Subsidiaries	Subsidiaries' Life Notes to Financial Statements #14A3e1; Property and Casualty Notes to Financial Statements #14A3c1	
(4.2) Contingent Liabilities: Subsidiaries	Subsidiaries' Life Notes to Financial Statements #14A1; Property and Casualty Notes to Financial Statements #14A1	
(5.2) Long Term Leases: Subsidiaries	Subsidiaries' Life Notes to Financial Statements #15A2a1; Property and Casualty Notes to Financial Statements #15A2a1	
(7.11) Total Affiliated Investments: Company	Company's Annual Statement Five-Year Historical Data Column 1 Line 50	
(7.12) Less Affiliated Common Stock: Company	Company's Annual Statement Five-Year Historical Data Column 1 Line 46	
(7.13) Less Affiliated Preferred Stock: Company	Company's Annual Statement Five-Year Historical Data Column 1 Line 45	
(7.14) Net Affiliated Investments: Company	Lines (7.11) - (7.12) - (7.13)	
(7.2) Affiliated Investments: Subsidiaries	Subsidiaries' Life Annual Statement Five-Year Historical Data Column 1 Line 50 Less Lines 45 and 46; Property and Casualty Annual Statement Five-Year Historical Data Column 1 Line 48 Less Lines 43 and 44	
(9.1) Surplus Notes: Company	Company's Annual Statement Page 3 Column 1 Line 32	
(9.2) Surplus Notes: Subsidiaries	Subsidiaries' Life Annual Statement Page 3 Column 1 Line 32; Property and Casualty Annual Statement Page 3 Column 1 Line 33	
(10.11) Capital Paid In: Company	Company's Annual Statement Page 4 Column 1 Line 50.1	
(10.12) Surplus Paid In: Company	Company's Annual Statement Page 4 Column 1 Line 51.1	
(10.13) Total Current Year's Capital Contributions: Company	Line (10.11) + Line (10.12)	
(10.2) Current Year's Capital Contributions: Subsidiaries	Subsidiaries' Life Annual Statement Page 4 Column 1 Lines 50.1 + 51.1; Property and Casualty Annual Statement Page 4 Column 1 Lines 32.1 + 33.1	
(11.1) Total Residual Tranches or Interests	Company's Annual Statement Asset Valuation Reserve, Equity and Other Invested Asset Component, Column 1, Line 93	

Denotes items that must be manually entered on the filing software.

SENSITIVITY TESTS - AUTHORIZED CONTROL LEVEL

	(1) Statement Value	Additional Sensitivity Factor	(2) Additional RBC	(3) Authorized Control Level Before Test	(4) Authorized Control Level After Test
Sensitivity Tests Affecting Authorized Control Level Risk-Based Capital					
(1.1) Other Affiliates: Company		0.700			
(1.2) Other Affiliates: Subsidiaries		0.700			
(1.99) Total Other Affiliates		0.700			
(2.1) Noncontrolled Assets - Company		0.020			
(2.2) Noncontrolled Assets - Subsidiaries		0.020			
(2.99) Total Noncontrolled Assets		0.020			
(3.1) Guarantees for Affiliates: Company		0.020			
(3.2) Guarantees for Affiliates: Subsidiaries		0.020			
(3.99) Total Guarantees for Affiliates		0.020			
(4.1) Contingent Liabilities: Company		0.020			
(4.2) Contingent Liabilities: Subsidiaries		0.020			
(4.99) Total Contingent Liabilities		0.020			
(5.1) Long-Term Leases: Company		0.030			
(5.2) Long-Term Leases: Subsidiaries		0.030			
(5.99) Total Long-Term Leases		0.030			
(7.1) Affiliated Investments†: Company		0.100			
(7.2) Affiliated Investments†: Subsidiaries		0.100			
(7.99) Total Affiliated Investments		0.100			
(8.1) Total Residual Tranches or Interests		0.100			

Source

LR042 Summary for Affiliated Investments Column (1) Line (13)
LR038 Additional Information Required Column (1) Line (1.2)

LR017 Off-Balance Sheet and Other Items Column (1) Line (15)
LR038 Additional Information Required Column (1) Line (2.2)

LR017 Off-Balance Sheet and Other Items Column (1) Line (24)
LR038 Additional Information Required Column (1) Line (3.2)

LR017 Off-Balance Sheet and Other Items Column (1) Line (25)
LR038 Additional Information Required Column (1) Line (4.2)

LR017 Off-Balance Sheet and Other Items Column (1) Line (26)
LR038 Additional Information Required Column (1) Line (5.2)

LR038 Additional Information Required Column (1) Line (7.14)
LR038 Additional Information Required Column (1) Line (7.2)

LR038 Additional Information Required Column (1) Line (11.1)

† Excluding affiliated preferred and common stock

Denotes items that must be manually entered on the filing software.

SENSITIVITY TESTS - TOTAL ADJUSTED CAPITAL

	(1)	(2)	(3)	(4)
	<u>Statement Value</u>	<u>Change to Total Adjusted Capital</u>	<u>Total Adjusted Capital Before Test</u>	<u>Total Adjusted Capital After Test</u>
		<u>Additional Sensitivity Factor</u>		
<u>Sensitivity Tests Affecting Total Adjusted Capital</u>				
(9.1) Dividend Liability: Company		-0.250		
(9.2) Dividend Liability: Subsidiaries		-0.250		
(9.99) Total Dividend Liability		-0.250		
(10.1) Surplus Notes: Company		-1.000		
(10.2) Surplus Notes: Subsidiaries		-1.000		
(10.99) Total Surplus Notes		-1.000		
(11.1) Current Year Capital Contribution: Company		-1.000		
(11.2) Current Year Capital Contribution: Subsidiaries		-1.000		
(11.99) Total Current Year Capital Contributions		-1.000		

Source

LR033 Calculation of Total Adjusted Capital Column (1) Line (3) + Line (4)
 LR033 Calculation of Total Adjusted Capital Column (1) Line (7)

LR038 Additional Information Required Column (1) Line (9.1)
 LR038 Additional Information Required Column (1) Line (9.2)

LR038 Additional Information Required Column (1) Line (10.13)
 LR038 Additional Information Required Column (1) Line (10.2)

Denotes items that must be manually entered on the filing software.

**Capital Adequacy (E) Task Force
RBC Proposal Form**

- | | | |
|---|--|---|
| <input type="checkbox"/> Capital Adequacy (E) Task Force | <input type="checkbox"/> Health RBC (E) Working Group | <input checked="" type="checkbox"/> Life RBC (E) Working Group |
| <input type="checkbox"/> Catastrophe Risk (E) Subgroup | <input type="checkbox"/> P/C RBC (E) Working Group | <input type="checkbox"/> Longevity Risk (A/E) Subgroup |
| <input type="checkbox"/> Variable Annuities Capital. & Reserve (E/A) Subgroup | <input type="checkbox"/> Economic Scenarios (E/A) Subgroup | <input type="checkbox"/> RBC Investment Risk & Evaluation (E) Working Group |

	DATE: <u>1/26/2023</u>
CONTACT PERSON: <u>Dave Fleming</u>	FOR NAIC USE ONLY
TELEPHONE: <u>816-783-8121</u>	Agenda Item # <u>2023-05-L</u>
EMAIL ADDRESS: <u>dfleming@naic.org</u>	Year <u>2023</u>
ON BEHALF OF: <u>Life Risk-Based Capital (E) Working Group</u>	DISPOSITION
NAME: <u>Philip Barlow, Chair</u>	ADOPTED:
TITLE: <u>Associate Commissioner of Insurance</u>	<input type="checkbox"/> TASK FORCE (TF) _____
AFFILIATION: <u>District of Columbia</u>	<input type="checkbox"/> WORKING GROUP (WG) _____
ADDRESS: <u>1050 First Street, NE Suite 801</u>	<input type="checkbox"/> SUBGROUP (SG) _____
<u>Washington, DC 20002</u>	EXPOSED:
	<input type="checkbox"/> TASK FORCE (TF) _____
	<input checked="" type="checkbox"/> WORKING GROUP (WG) _____
	<input type="checkbox"/> SUBGROUP (SG) _____
	REJECTED:
	<input type="checkbox"/> TF <input type="checkbox"/> WG <input type="checkbox"/> SG _____
	OTHER:
	<input type="checkbox"/> DEFERRED TO _____
	<input type="checkbox"/> REFERRED TO OTHER NAIC GROUP _____
	<input type="checkbox"/> (SPECIFY) _____

IDENTIFICATION OF SOURCE AND FORM(S)/INSTRUCTIONS TO BE CHANGED

- | | | |
|--|---|---|
| <input type="checkbox"/> Health RBC Blanks | <input type="checkbox"/> Property/Casualty RBC Blanks | <input checked="" type="checkbox"/> Life and Fraternal RBC Blanks |
| <input type="checkbox"/> Health RBC Instructions | <input type="checkbox"/> Property/Casualty RBC Instructions | <input type="checkbox"/> Life and Fraternal RBC Instructions |
| <input type="checkbox"/> Health RBC Formula | <input type="checkbox"/> Property/Casualty RBC Formula | <input type="checkbox"/> Life and Fraternal RBC Formula |
| <input type="checkbox"/> OTHER _____ | | |

DESCRIPTION/REASON OR JUSTIFICATION OF CHANGE(S)

The dual presentation of the life risk-based capital trend test was adopted as an interim approach while member jurisdictions transitioned to the higher 300% threshold. That transition is now complete, so the dual presentation is no longer needed.

Additional Staff Comments:

**** This section must be completed on all forms.**

Revised 2-2023

RISK-BASED CAPITAL LEVEL OF ACTION
(Including Tax Sensitivity Test)

	Source	(1) RBC Amount
(1)	Total Adjusted Capital - REPORT AMOUNT IN FIVE-YEAR HISTORICAL DATA PAGE 22 COLUMN 1 LINE 30	LR033 Calculation of Total Adjusted Capital Column (2) Line (12)
(2)	Trigger Points for Level of Regulatory Action: Company Action Level = 200% of Authorized Control Level Risk-Based Capital	2.0 times LR031 Calculation of Total Authorized Control Level Risk-Based Capital Column (1) Line (73)
(3)	Regulatory Action Level = 150% of Authorized Control Level Risk-Based Capital	1.5 times LR031 Calculation of Total Authorized Control Level Risk-Based Capital Column (1) Line (73)
(4)	Authorized Control Level Risk-Based Capital - REPORT AMOUNT IN FIVE-YEAR HISTORICAL DATA PAGE 22 COLUMN 1 LINE 31	1.0 times LR031 Calculation of Total Authorized Control Level Risk-Based Capital Column (1) Line (73)
(5)	Mandatory Control Level = 70% of Authorized Control Level Risk-Based Capital	0.7 times LR031 Calculation of Total Authorized Control Level Risk-Based Capital Column (1) Line (73)
(6)	Level of Action†:	
(7)	Authorized Control Level RBC Ratio	Line (1) / Line (4) 0.000%
(8)	Tax Sensitivity Test	
(9)	Tax Sensitivity Test: Total Adjusted Capital	LR033 Calculation of Total Adjusted Capital Column (2) Line (17)
(10)	Tax Sensitivity Test: Company Action Level = 200% of Authorized Control Level Risk-Based Capital	2.0 times LR031 Calculation of Total Authorized Control Level Risk-Based Capital Column (1) Line (73)
(11)	Tax Sensitivity Test: Regulatory Action Level = 150% of Authorized Control Level Risk-Based Capital	1.5 times LR031 Calculation of Total Authorized Control Level Risk-Based Capital Column (1) Line (73)
(12)	Tax Sensitivity Test: Authorized Control Level Risk-Based Capital	1.0 times LR031 Calculation of Total Authorized Control Level Risk-Based Capital Column (1) Line (73)
(13)	Tax Sensitivity Test: Mandatory Control Level = 70% of Authorized Control Level Risk-Based Capital	0.7 times LR031 Calculation of Total Authorized Control Level Risk-Based Capital Column (1) Line (73)
†	Tax Sensitivity Test: Level of Action:	
	If Total Adjusted Capital Line (1) exceeds Company Action Level Risk-Based Capital Line (2), None will be indicated (unless the Trend Test triggers Company Action Level). Otherwise, the appropriate level of action will be indicated.	
	If the trend test is applicable for the company, the level that the trend test applies to for the state of domicile as reported on LR035 Trend Test Line (49) is indicated as being:	
	(00000001) If 3.0 had been selected for LR035 Trend Test Line (49) as the state of domicile level, the Line (6) level of action above would have been:	
	(00000002) If 2.5 had been selected for LR035 Trend Test Line (49) as the state of domicile level, the Line (6) level of action above would have been:	

Denotes items that must be manually entered on the filing software.

TREND TEST	Source	(1) <u>3.0 Amount</u>	(2) <u>3.0 Result</u>	(3) <u>2.5 Amount</u>	(4) <u>2.5 Result</u>
Criteria for Applying Trend Test					
(1) Authorized Control Level Risk-Based Capital	LR031 Calculation of Authorized Control Level Risk-Based Capital Column (1) Line (73)				
(2) Trend Test Safe Harbor	Column (4) = 3.0 x Line (1) - Column (3) = 2.5 x Line (1)				
(3) Total Adjusted Capital	LR033 Calculation of Total Adjusted Capital Line (12)				
Trend Test Data					
(4) First Prior Year Total Adjusted Capital	Five-Year Historical Data Page 22 Column 2 Line 30				
(5) First Prior Year Authorized Control Level Risk-Based Capital	Five-Year Historical Data Page 22 Column 2 Line 31				
(6) Third Prior Year Total Adjusted Capital	Five-Year Historical Data Page 22 Column 4 Line 30				
(7) Third Prior Year Authorized Control Level Risk-Based Capital	Five-Year Historical Data Page 22 Column 4 Line 31				
Trend Test Calculation (only if applicable†)					
(8) Current Year Margin	Line (3) - Line (1)				
(9) First Prior Year Margin	Line (4) - Line (5)				
(10) Third Prior Year Margin	Line (6) - Line (7)				
(11) Decrease in Margin from First Prior Year	Line (9) - Line (8) (use zero if negative)				
(12) Decrease in Margin from Third Prior Year	Line (10) - Line (8) (use zero if negative)				
(13) Average decrease in Last Three Years	1/3 of Line (12)				
(14) Marginal Difference	Greater of Line (11) and Line (13)				
(15) Total Adjusted Capital Less Margin Difference	Line (3) - Line (14)				
(16) Level of Risk-Based Capital‡	1.9 x Line (1)				
(17) Negative Trend‡‡					
(18) For companies where one of the above trend tests applies, does the state of domicile require action at 2.5 or 3.0 times Authorized Control Level RBC?‡	Select "2.5", "3.0", or "N/A"				

† The Trend Test applies only if Total Adjusted Capital Line (3) is less than the Trend Test Safe Harbor Line (2) and the LR034 Risk-Based Capital Level of Action Line (6) is "None".
‡ If Line (15) is less than Line (16), the company triggers regulatory attention at the Company Action Level based on the trend test. ~~The NAC is in the process of changing the upper level where the trend test can be triggered from 2.5 times the Authorized Control Level RBC to 3.0 times the Authorized Control Level RBC. Until all states have transitioned to the 3.0 standard, there may be differences between states as to whether columns (4) and (2) or columns (3) and (4) of the LR035 Trend Test page apply to a particular company, so information is provided to alert users to potential alternative trend test results during the transition period.~~

‡‡ Denotes items that must be manually entered on the filing software.



January 12, 2023

Mr. Philip Barlow
Chair, Life Risk-Based Capital (E) Working Group (LRBCWG)
National Association of Insurance Commissioners (NAIC)
Via email: Dave Fleming (dfleming@naic.org)

Re: Proposal for Life C-2 Structural and Instruction Updates and a New Financial Statement Note

Dear Philip,

On behalf of the C-2 Mortality Work Group of the American Academy of Actuaries¹, we are providing the following proposed Life C-2 updates for consideration for 2023 year-end financial statements.

1. Structural updates where it pertains to the treatment of group permanent life and miscellaneous other instruction updates. The proposal assigns the same factors to group permanent life as individual permanent life for categories stating with and without pricing flexibility.
2. A new financial statement note to provide the development of net amounts at risk for the Life C-2 categories to create a direct link to a financial statement source, and accompanying Life C-2 structural and instruction updates. The proposed second update includes the updates specified in the first update.

If you have any questions on the above topics, please contact Amanda Barry-Moilanen, life policy analyst, at barrymoilanen@actuary.org.

Sincerely,

Chris Trost, MAAA, FSA
Chairperson, C-2 Mortality Work Group

Ryan Fleming, MAAA, FSA
Vice Chairperson, C-2 Mortality Work Group

American Academy of Actuaries

¹ The American Academy of Actuaries is a 19,500-member professional association whose mission is to serve the public and the U.S. actuarial profession. For more than 50 years, the Academy has assisted public policymakers on all levels by providing leadership, objective expertise, and actuarial advice on risk and financial security issues. The Academy also sets qualification, practice, and professionalism standards for actuaries in the United States.

Capital Adequacy (E) Task Force
RBC Proposal Form

- | | | |
|---|---|--|
| <input type="checkbox"/> Capital Adequacy (E) Task Force | <input type="checkbox"/> Health RBC (E) Working Group | <input checked="" type="checkbox"/> Life RBC (E) Working Group |
| <input type="checkbox"/> Catastrophe Risk (E) Subgroup | <input type="checkbox"/> Investment RBC (E) Working Group | <input type="checkbox"/> Longevity Risk (A/E) Subgroup |
| <input type="checkbox"/> C3 Phase II/ AG43 (E/A) Subgroup | <input type="checkbox"/> P/C RBC (E) Working Group | |

DATE: <u>1/12/23</u>	<u>FOR NAIC USE ONLY</u>
CONTACT PERSON: <u>Ryan Fleming, MAAA, FSA</u>	Agenda Item # _____
TELEPHONE: <u>(414) 665-5020</u>	Year <u>2023</u>
EMAIL ADDRESS: <u>ryanfleming@northwesternmutual.com</u>	<u>DISPOSITION</u>
ON BEHALF OF: <u>AAA C-2 Mortality Work Group</u>	<input type="checkbox"/> ADOPTED _____
NAME: <u>Ryan Fleming, MAAA, FSA</u>	<input type="checkbox"/> REJECTED _____
TITLE: <u>Vice Chairperson</u>	<input type="checkbox"/> DEFERRED TO _____
AFFILIATION: <u>American Academy of Actuaries</u>	<input type="checkbox"/> REFERRED TO OTHER NAIC GROUP _____
ADDRESS: <u>1850 M Street NW, Suite 300</u>	<input type="checkbox"/> EXPOSED _____
<u>Washington, DC 20036</u>	<input type="checkbox"/> OTHER (SPECIFY) _____

IDENTIFICATION OF SOURCE AND FORM(S)/INSTRUCTIONS TO BE CHANGED

- | | | |
|---|---|---|
| <input type="checkbox"/> Health RBC Blanks | <input type="checkbox"/> Property/Casualty RBC Blanks | <input checked="" type="checkbox"/> Life and Fraternal RBC Instructions |
| <input type="checkbox"/> Health RBC Instructions | <input type="checkbox"/> Property/Casualty RBC Instructions | <input checked="" type="checkbox"/> Life and Fraternal RBC Blanks |
| <input checked="" type="checkbox"/> OTHER _Notes to Financial Statements_____ | | |

DESCRIPTION OF CHANGE(S)

Update 1: proposed updated blank for C2 Life Mortality on LR025, LR026, LR030 and LR031 and instruction updates.

Update 2: proposed new financial statement note and accompanying LR025 structural and instruction updates. Update 2 includes the updates included in the first update.

REASON OR JUSTIFICATION FOR CHANGE **

Update 1: Structural changes and instruction updates to address the treatment of group permanent life policies. Other instruction updates are included to add clarity.

Update 2: The new financial statement note will develop the net amounts at risk in the categories needed for the Life C-2 schedule to create a direct link to a financial statement source.

Additional Staff Comments:

** This section must be completed on all forms.

Revised 2-2019

Proposed 2023 Update 1
LIFE INSURANCE

	(1) Statement Value	Factor	(2) RBC Requirement
<u>Individual & Industrial Life Net Amount at Risk</u>			
(1) Ordinary Life In Force			
(2) Plus Industrial Life In Force			
(3) Total Individual & Industrial Life In Force			
(4) Ordinary Life Reserves			
(5) Plus Industrial Life Reserves			
(6) Plus Ordinary Life Separate Accounts			
(7) Plus Ordinary & Industrial Life Modified Contingance Assumed Reserves			
(8) Less Ordinary & Industrial Life Modified Contingance Ceded Reserves			
(9) Total Individual & Industrial Life Reserves			
(10) Total Individual & Industrial Life Net Amount at Risk			
(11) Individual & Industrial Life Policies with Pricing Flexibility In Force			
(12) Less Individual & Industrial Life Policies with Pricing Flexibility In Force Reserves			
(13) Total Individual & Industrial Life Policies with Pricing Flexibility Net Amount at Risk			
(14) Individual & Industrial Term Life Policies without Pricing Flexibility In Force			
(15) Less Individual & Industrial Term Life Policies without Pricing Flexibility Reserves			
(16) Total Individual & Industrial Term Life Policies without Pricing Flexibility Net Amount at Risk			
(17) Individual & Industrial Permanent Life Policies without Pricing Flexibility In Force			
(18) Less Individual & Industrial Permanent Life Policies without Pricing Flexibility Reserves			
(19) Total Individual & Industrial Permanent Life Policies without Pricing Flexibility Net Amount at Risk			
(20) Total Individual & Industrial Life			
<u>Group & Credit Life Net Amount at Risk</u>			
(21) Group Life In Force			
(22) Plus Credit Life In Force			
(23) Less Group FEGLI In Force			
(24) Less Group SGLI In Force			
(25) Less Credit FEGLI In Force			
(26) Less Credit SGLI In Force			
(27) Total Group & Credit Life In Force Excluding FEGLI/SGLI			
(28) Group Life Reserves			
(29) Plus Credit Life Reserves			
(30) Plus Group Life Separate Accounts			
(31) Plus Group & Credit Life Modified Contingance Assumed Reserves			
(32) Less Group & Credit Life Modified Contingance Ceded Reserves			
(33) Total Group & Credit Life Reserves			
(34) Total Group & Credit Life Net Amount at Risk Excluding FEGLI/SGLI			
(35) Group & Credit Term Life In Force with Remaining Rate Terms 36 Months and Under			
(36) Less Group & Credit Term Life Reserves with Remaining Rate Terms 36 Months and Under			
(37) Group & Credit Term Life Net Amount at Risk with Remaining Rate Terms 36 Months and Under			
(38) Group & Credit Term Life In Force with Remaining Rate Terms Over 36 Months			
(39) Less Group & Credit Term Life Reserves with Remaining Rate Terms Over 36 Months			
(40) Group & Credit Term Life Net Amount at Risk with Remaining Rate Terms Over 36 Months			
(41) Group & Credit Permanent Life Policies with Pricing Flexibility In Force			
(42) Less Group & Credit Permanent Life Policies with Pricing Flexibility Reserves			
(43) Group & Credit Permanent Life Policies with Pricing Flexibility Net Amount at Risk			
(44) Group & Credit Permanent Life Policies without Pricing Flexibility In Force			
(45) Less Group & Credit Permanent Life Policies without Pricing Flexibility Reserves			
(46) Group & Credit Permanent Life Policies without Pricing Flexibility Net Amount at Risk			
(44)+(47) FEGLI/SGLI Life In Force			
(44)+(48) Total Group & Credit Life			
(44)+(49) Total Life			

* The definitions are specified in the Life Insurance section of the risk-based capital instructions.
† The tiered calculation is illustrated in the Life Insurance section of the risk-based capital instructions.
‡ Include only the portion which relates to policy reserves that, if written on a direct basis, would be included on Exhibit 5.
Denotes items that must be manually entered on the filing software.

LR025

**Proposed 2023 Update 1
PREMIUM STABILIZATION RESERVES**

	Annual Statement Source	(1) Statement Value	Factor	(2) RBC Requirement
<u>Group and Credit Life and Health Reported Premium Stabilization Reserves</u>				
(1)	Stabilization Reserves and Experience Rating Refunds included in Line 3		X	
(2)	Provision for Experience Rating Refunds		X	
(3)	Reserve for Group Rate Credits		X	
(4)	Reserve for Credit Rate Credits		X	
(5)	Premium Stabilization Reserves		X	
(6)	Total of Preliminary Premium Stabilization Reserve Credit			
<u>Group & Credit Life and Health Risk-Based Capital</u>				
(7)	Life			
(8)	Health			
(9)	Maximum Risk-Based Capital			
(10)	Final Premium Stabilization Reserve		X	

Page 3 Column 1 Line 3 in part
 Page 3 Column 1 Line 9.2 in part
 Company Records
 Company Records
 Page 3 Column 1 Line 25 in part
 Sum of Lines (1) through (5)
 LR025 Life Insurance Column (2) Line ~~(42)~~(48)
 LR024 Health Claim Reserves Column (4) Line (16)
 + [LR024 Column (4) Line (15) x 0.65] + LR019
 Health Premiums Column (2) Lines (12), (17), (18)
 and (19) + [[LR019 Column (2) Lines (23), (24),
 and (27)] x 0.65] + [LR020 Underwriting Risk -
 Experience Fluctuation Risk Column (5) Line (18) -
 Column (4) Line (18) x Line (1.2) / Line (1.3)]
 Lines (7) + (8)
 Column (2) Line (6), but not more than
 Column (1) Line (9)

LR026

Company Name

Confidential when Completed

NAIC Company Code

Proposed 2023 Update 1
CALCULATION OF TAX EFFECT FOR LIFE AND FRATERNAL RISK-BASED CAPITAL

ASSET RISKS	Source	RBC Amount	Tax Factor	RBC Tax Effect
Bonds				
(001) Long-term Bonds - NAIC 1	LR002 Bonds Column (2) Line (2.8) + LR018 Off-Balance Sheet Collateral Column (3) Line (2.8)	X	0.1680	=
(002) Long-term Bonds - NAIC 2	LR002 Bonds Column (2) Line (3.4) + LR018 Off-Balance Sheet Collateral Column (3) Line (3.4)	X	0.1680	=
(003) Long-term Bonds - NAIC 3	LR002 Bonds Column (2) Line (4.4) + LR018 Off-Balance Sheet Collateral Column (3) Line (4.4)	X	0.1680	=
(004) Long-term Bonds - NAIC 4	LR002 Bonds Column (2) Line (5.4) + LR018 Off-Balance Sheet Collateral Column (3) Line (5.4)	X	0.1680	=
(005) Long-term Bonds - NAIC 5	LR002 Bonds Column (2) Line (6.4) + LR018 Off-Balance Sheet Collateral Column (3) Line (6.4)	X	0.1680	=
(006) Long-term Bonds - NAIC 6	LR002 Bonds Column (2) Line (7) + LR018 Off-Balance Sheet Collateral Column (3) Line (7)	X	0.2100	=
(007) Short-term Bonds - NAIC 1	LR002 Bonds Column (2) Line (10.8)	X	0.1680	=
(008) Short-term Bonds - NAIC 2	LR002 Bonds Column (2) Line (11.4)	X	0.1680	=
(009) Short-term Bonds - NAIC 3	LR002 Bonds Column (2) Line (12.4)	X	0.1680	=
(010) Short-term Bonds - NAIC 4	LR002 Bonds Column (2) Line (13.4)	X	0.1680	=
(011) Short-term Bonds - NAIC 5	LR002 Bonds Column (2) Line (14.4)	X	0.1680	=
(012) Short-term Bonds - NAIC 6	LR002 Bonds Column (2) Line (15)	X	0.2100	=
(013) Credit for Hedging - NAIC 1 Through 5 Bonds	LR014 Hedged Asset Bond Schedule Column (13) Line (0199999)	X	0.1680	=
(014) Credit for Hedging - NAIC 6 Bonds	LR014 Hedged Asset Bond Schedule Column (13) Line (0299999)	X	0.1680	=
(015) Bond Reduction - Reinsurance	LR002 Bonds Column (2) Line (19)	X	0.2100	=
(016) Bond Increase - Reinsurance	LR002 Bonds Column (2) Line (20)	X	0.2100	=
(017) Non-Exempt NAIC 1 U.S. Government Agency	LR002 Bonds Column (2) Line (22)	X	0.1680	=
(018) Bonds Size Factor	LR002 Bonds Column (2) Line (26) + LR002 Bonds Column (2) Line (21)	X	0.1680	=
Mortgages				
(019) In Good Standing	LR004 Mortgages Column (6) Line (1)	X	0.1575	=
(020) Residential Mortgages - Insured	LR004 Mortgages Column (6) Line (2)	X	0.1575	=
(021) Residential Mortgages - Other	LR004 Mortgages Column (6) Line (3)	X	0.1575	=
(022) Commercial Mortgages - Insured	LR004 Mortgages Column (6) Line (4)	X	0.1575	=
(023) Commercial Mortgages - All Other	LR004 Mortgages Column (6) Line (5)	X	0.1575	=
(024) Total Farm Mortgages	LR004 Mortgages Column (6) Line (15)	X	0.1575	=
90 Days Overdue				
(025) Farm Mortgages	LR004 Mortgages Column (6) Line (16)	X	0.1575	=
(026) Residential Mortgages - Insured	LR004 Mortgages Column (6) Line (17)	X	0.1575	=
(027) Residential Mortgages - Other	LR004 Mortgages Column (6) Line (18)	X	0.1575	=
(028) Commercial Mortgages - Insured	LR004 Mortgages Column (6) Line (19)	X	0.1575	=
(029) Commercial Mortgages - Other	LR004 Mortgages Column (6) Line (20)	X	0.1575	=
(029) In Process of Foreclosure	LR004 Mortgages Column (6) Line (21)	X	0.1575	=

† Denotes lines that are deducted from the total rather than added.

Denotes items that must be manually entered on the filing software.

LR030

Company Name

Confidential when Completed

NAIC Company Code

CALCULATION OF TAX EFFECT FOR LIFE AND FRATERNAL RISK-BASED CAPITAL (CONTINUED)

	Source	(1) RBC Amount	Tax Factor	(2) RBC Tax Effect
(030) Residential Mortgages - Insured	LR004 Mortgages Column (6) Line (22)	X	0.1575	=
(031) Residential Mortgages - Other	LR004 Mortgages Column (6) Line (23)	X	0.1575	=
(032) Commercial Mortgages - Insured	LR004 Mortgages Column (6) Line (24)	X	0.1575	=
(033) Commercial Mortgages - Other	LR004 Mortgages Column (6) Line (25)	X	0.1575	=
(034) Due & Unpaid Taxes Mortgages	LR004 Mortgages Column (6) Line (26)	X	0.1575	=
(035) Due & Unpaid Taxes - Forfeitures	LR004 Mortgages Column (6) Line (27)	X	0.1575	=
(036) Mortgage Reduction - Reinsurance	LR004 Mortgages Column (6) Line (29)	X	0.2100	†
(037) Mortgage Increase - Reinsurance	LR004 Mortgages Column (6) Line (30)	X	0.2100	=
(038) Unaffiliated Preferred Stock NAIC 1	LR005 Unaffiliated Preferred and Common Stock Column (5) Line (1)	X	0.1575	=
(039) Unaffiliated Preferred Stock NAIC 2	+ LR018 Off-Balance Sheet Collateral Column (3) Line (9)	X	0.1575	=
(040) Unaffiliated Preferred Stock NAIC 3	LR005 Unaffiliated Preferred and Common Stock Column (5) Line (2)	X	0.1575	=
(041) Unaffiliated Preferred Stock NAIC 4	+ LR018 Off-Balance Sheet Collateral Column (3) Line (10)	X	0.1575	=
(042) Unaffiliated Preferred Stock NAIC 5	LR005 Unaffiliated Preferred and Common Stock Column (5) Line (3)	X	0.1575	=
(043) Unaffiliated Preferred Stock NAIC 6	+ LR018 Off-Balance Sheet Collateral Column (3) Line (11)	X	0.1575	=
(044) Preferred Stock Reduction-Reinsurance	LR005 Unaffiliated Preferred and Common Stock Column (5) Line (4)	X	0.1575	=
(045) Preferred Stock Increase-Reinsurance	+ LR018 Off-Balance Sheet Collateral Column (3) Line (12)	X	0.1575	=
(046) Guaranteed Index	LR005 Unaffiliated Preferred and Common Stock Column (5) Line (5)	X	0.2100	=
(047) Nonindex-Book Reserve	+ LR018 Off-Balance Sheet Collateral Column (3) Line (13)	X	0.2100	=
(048) Separate Accounts Nonindex-Market Reserve	LR005 Unaffiliated Preferred and Common Stock Column (5) Line (6)	X	0.2100	†
(049) Separate Accounts Reduction-Reinsurance	+ LR018 Off-Balance Sheet Collateral Column (3) Line (14)	X	0.2100	=
(050) Separate Accounts Increase-Reinsurance	LR005 Unaffiliated Preferred and Common Stock Column (5) Line (8)	X	0.2100	=
(051) Synthetic GICs	LR005 Unaffiliated Preferred and Common Stock Column (5) Line (9)	X	0.2100	=
(052) Separate Account Surplus	LR006 Separate Accounts Column (3) Line (1)	X	0.1575	=
(053) Company Occupied Real Estate	LR006 Separate Accounts Column (3) Line (2)	X	0.1575	=
(054) Foreclosed Real Estate	LR006 Separate Accounts Column (3) Line (3)	X	0.1575	=
(055) Investment Real Estate	LR006 Separate Accounts Column (3) Line (4)	X	0.1575	=
(056) Real Estate Reduction - Reinsurance	LR006 Separate Accounts Column (3) Line (5)	X	0.2100	†
(057) Real Estate Increase - Reinsurance	LR006 Separate Accounts Column (3) Line (6)	X	0.2100	=
(058) Sch BA Real Estate Excluding Low Income Housing Tax Credits	LR006 Separate Accounts Column (3) Line (8)	X	0.1575	=
(059) Guaranteed Low Income Housing Tax Credits	LR007 Real Estate Column (3) Line (3)	X	0.2100	=
(060) Non-Guaranteed and All Other Low Income Housing Tax Credits	LR007 Real Estate Column (3) Line (6)	X	0.2100	=
(061) Sch BA Real Estate Reduction - Reinsurance	LR007 Real Estate Column (3) Line (9)	X	0.2100	=
(062) Sch BA Real Estate Increase - Reinsurance	LR007 Real Estate Column (3) Line (11)	X	0.2100	=
	LR007 Real Estate Column (3) Line (12)	X	0.2100	=
	LR007 Real Estate Column (3) Line (16)	X	0.2100	=
	LR007 Real Estate Column (3) Line (17) + Line (19)	X	0.0000	=
	LR007 Real Estate Column (3) Line (18) + Line (20) + Line (21)	X	0.0000	=
	LR007 Real Estate Column (3) Line (23)	X	0.2100	†
	LR007 Real Estate Column (3) Line (24)	X	0.2100	=

† Denotes lines that are deducted from the total rather than added.
Denotes items that must be manually entered on the filing software.

LR030

NAIC Company Code

Confidential when Completed

Company Name

CALCULATION OF TAX EFFECT FOR LIFE AND FRATERNAL RISK-BASED CAPITAL (CONTINUED)

(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
RBC Amount	Tax Factor	RBC Tax Effect							
X	0.1575	=							
X	0.1575	=							
X	0.1575	=							
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X	0.1575	=							
X	0.1575	=							

Company Name

Confidential when Completed

NAIC Company Code

CALCULATION OF TAX EFFECT FOR LIFE AND FRATERNAL RISK-BASED CAPITAL (CONTINUED)

	(1)	Tax Factor	(2)
	RBC Amount	0.1575	RBC Tax Effect
(102) Replications			
(103) Reinsurance	X	0.1575	=
(104) Investment Affiliates	X	0.2100	=
(105) Investment in Parent	X	0.2100	=
(106) Other Affiliate: Property and Casualty Insurers not Subject to Risk-Based Capital	X	0.2100	=
(107) Other Affiliate: Life Insurers not Subject to Risk-Based Capital	X	0.2100	=
(108) Publicly Traded Insurance Affiliates	X	0.2100	=
(109) Subtotal for C-1o Assets			
C-0 Affiliated Common Stock			
(110) OF-Balance Sheet and Other Items	X	0.1575	=
(111) OF-Balance Sheet Items Reduction - Reinsurance	X	0.2100	=
(112) OF-Balance Sheet Items Increase - Reinsurance	X	0.2100	=
(113) Affiliated US Property - Casualty Insurers Directly Owned	X	0.2100	=
(114) Affiliated US Life Insurers Directly Owned	X	0.2100	=
(115) Affiliated US Health Insurers Directly and Indirectly Owned	X	0.2100	=
(116) Affiliated US Property - Casualty Insurers Indirectly Owned	X	0.2100	=
(117) Affiliated US Life Insurers Indirectly Owned	X	0.2100	=
(118) Affiliated Alien Life Insurers - Canadian	X	0.2100	=
(119) Affiliated Alien Life Insurers - All Others	X	0.0000	=
(120) Subtotal for C-0 Affiliated Common Stock			
Common Stock			
(121) Unaffiliated Common Stock	X	0.2100	=
(122) Credit for Hedging - Common Stock	X	0.2100	=
(123) Stock Reduction - Reinsurance	X	0.2100	=
(124) Stock Increase - Reinsurance	X	0.2100	=
(125) BA Common Stock Unaffiliated	X	0.2100	=
(126) BA Common Stock Affiliated - C-1es	X	0.2100	=
(127) Common Stock Concentration Factor	X	0.2100	=
(128) NAIC 01 Working Capital Finance Notes	X	0.1575	=
(129) NAIC 02 Working Capital Finance Notes	X	0.1575	=
(130) Affiliated Preferred Stock and Common Stock - Holding Company in Excess of Indirect Subs	X	0.2100	=
(131) Affiliated Preferred Stock and Common Stock - All Other	X	0.2100	=
(132) Total for C-1es Assets			
(133) Insurance Risk	X	0.2100	=
Disability Income Premium	X	0.2100	=

† Denotes lines that are deducted from the total rather than added.
Denotes items that must be manually entered on the filing software.

LR030

Company Name

Confidential when Completed

NAIC Company Code

CALCULATION OF TAX EFFECT FOR LIFE AND FRATERNAL RISK-BASED CAPITAL (CONTINUED)

	(1) RBC Amount	Tax Factor	(2) RBC Tax Effect
(134) Long-Term Care	X	0.2100	=
(135) Individual & Industrial Life Insurance C-2 Risk	X	0.2100	=
(136) Group & Credit Life Insurance C-2 Risk	X	0.2100	=
(136b) Longevity C-2 Risk	X	0.2100	=
(137) Disability and Long-Term Care Health Claim Reserves	X	0.2100	=
(138) Premium Stabilization Credit	X	0.0000	=
(139) Total C-2 Risk			
(140) Interest Rate Risk	X	0.2100	=
(141) Health Credit Risk	X	0.0000	=
(142) Market Risk	X	0.2100	=
(143) Business Risk	X	0.2100	=
(144) Health Administrative Expenses	X	0.0000	=
(145) Total Tax Effect			

Source

LR019 Health Premiums Column (2) Line (28) + LR023 Long-Term Care Column (4) Line (7)
 LR025 Life Insurance Column (2) Line (20)
 LR025 Life Insurance Column (2) Line (42) (48)
 LR025-A Longevity Risk Column (2) Line (5)
 LR024 Health Claim Reserves Column (4) Line (9) + Line (15)
 LR026 Premium Stabilization Reserves Column (2) Line (10)
 L(133) + L(134) + L(137) + L(138) + Greatest of [Guardrail Factor * (L(135)+L(136)), Guardrail Factor * L(136b), Square Root of [(L(135)+L(136))^2 + L(136b)^2] + 2 * (Correlation Factor) * (L(135) + L(136)) * L(136b)]
 LR027 Interest Rate Risk Column (3) Line (36)
 LR028 Health Credit Risk Column (2) Line (7)
 LR027 Interest Rate Risk Column (3) Line (37)
 LR029 Business Risk Column (2) Line (40)
 LR029 Business Risk Column (2) Line (57)
 Lines (109) + (120) + (132) + (139) + (140) + (141) + (142) + (143) + (144)

↑ Denotes lines that are deducted from the total rather than added.
 Denotes items that must be manually entered on the filing software.

LR030

(1) RBC Requirement	NAIC Company Code	Source	Confidential when Completed
		Insurance, Affiliates and Misc. Other Amounts (C-1b)	
(1)		Affiliated US Property-Casualty Insurers Directly Owned	LR042 Summary for Affiliated Investments Column (4) Line (1)
(2)		Affiliated US Life Insurers Directly Owned	LR042 Summary for Affiliated Investments Column (4) Line (2)
(3)		Affiliated US Health Insurers Directly and Indirectly Owned	LR042 Summary for Affiliated Investments Column (4) Line (3)
(4)		Affiliated US Property-Casualty Insurers Indirectly Owned	LR042 Summary for Affiliated Investments Column (4) Line (4)
(5)		Affiliated US Life Insurers Indirectly Owned	LR042 Summary for Affiliated Investments Column (4) Line (5)
(6)		Affiliated Alien Life Insurers - Canadian	LR042 Summary for Affiliated Investments Column (4) Line (8)
(7)		Affiliated Alien Life Insurers - All Others	LR042 Summary for Affiliated Investments Column (4) Line (9)
(8)		Off-Balance Sheet and Other Items	LR017 Off-Balance Sheet and Other Items Column (5) Line (34)
(9)		Total (C-0) - Pre-Tax	LR030 Calculation of Tax Effort for Life and Fraternal Risk-Based Capital Column (2) Line (120)
(10)		(C-0) Tax Effort	Sum of Lines (1) through (8)
(11)		Net (C-0) - Post-Tax	LR030 Calculation of Tax Effort for Life and Fraternal Risk-Based Capital Column (2) Line (120) Line (9) - Line (10)
(12)		Asset Risk - Unaffiliated Common Stock, and Affiliated Non-Insurance Stock (C-1es)	
		Schedule D Unaffiliated Common Stock	LR005 Unaffiliated Common Stock Column (5) Line (21) + LR018 Off-Balance Sheet Collateral Column (3) Line (16)
(13)		Schedule BA Unaffiliated Common Stock	LR008 Other Long-Term Assets Column (5) Line (47)
(14)		Schedule BA Affiliated Common Stock - C-1es	LR008 Other Long-Term Assets Column (5) Line (49.2)
(15)		Common Stock Concentration Factor	LR011 Common Stock Concentration Factor Column (6) Line (6)
(16)		Affiliated Preferred Stock and Common Stock - Holding Company in Excess of Indirect Subsidiaries	LR042 Summary for Affiliated Investments Column (4) Line (7)
(17)		Affiliated Preferred Stock and Common Stock - All Other	LR042 Summary for Affiliated Investments Column (4) Line (13)
(18)		Total (C-1es) - Pre-Tax	Sum of Lines (12) through (17)
(19)		(C-1es) Tax Effort	LR030 Calculation of Tax Effort for Life and Fraternal Risk-Based Capital Column (2) Line (132)
(20)		Net (C-1es) - Post-Tax	Line (18) - Line (19)
(21)		Asset Risk - All Other (C-1d)	
		Bonds after Size Factor	LR002 Bonds Column (2) Line (27) + LR018 Off-Balance Sheet Collateral Column (3) Line (8)
(22)		Mortgages (including part due and unpaid taxes)	LR004 Mortgages Column (6) Line (31)
(23)		Unaffiliated Preferred Stock	LR005 Unaffiliated Preferred and Common Stock Column (5) Line (10) + LR018 Off-Balance Sheet Collateral Column (3) Line (15)
(24)		Affiliated Preferred Stock and Common Stock - Investment Subsidiaries	LR042 Summary for Affiliated Investments Column (4) Line (6)
(25)		Affiliated Preferred Stock and Common Stock - Parent	LR042 Summary for Affiliated Investments Column (4) Line (10)
(26)		Affiliated Preferred Stock and Common Stock - Property and Casualty Insurers not Subject to Risk-Based Capital	LR042 Summary for Affiliated Investments Column (4) Line (11)
(27)		Affiliated Preferred Stock and Common Stock - Life Insurers not Subject to Risk-Based Capital	LR042 Summary for Affiliated Investments Column (4) Line (12)
(28)		Affiliated Preferred Stock and Common Stock - Publicly Traded Insurers Held at Fair Value (excess of statement value over book value)	LR042 Summary for Affiliated Investments Column (4) Line (14)
(29)		Separate Accounts with Guarantees	LR006 Separate Accounts Column (3) Line (7)

Denotes items that must be manually entered on the filing software.

LR031

Company Name CONTROLLED LEVEL RISK-BASED CAPITAL (CONTINUED)

Confidential when Completed

NAIC Company Code

	Source	RBC Requirement
(30) Synthetic GIC's (C-1o)	LR006 Separate Accounts Column (3) Line (8)	
(31) Surplus in Non-Guaranteed Separate Accounts	LR006 Separate Accounts Column (3) Line (13)	
(32) Real Estate (gross of encumbrances)	LR007 Real Estate Column (3) Line (13)	
(33) Schedule BA Real Estate (gross of encumbrances)	LR007 Real Estate Column (3) Line (25)	
(34) Other Long-Term Assets	LR008 Other Long-Term Assets Column (5) Line (56) + LR018 OIE Balance Sheet Collateral Column (3) Line (17) + Line (18)	
(35) Schedule BA Mortgages	LR009 Schedule BA Mortgages Column (6) Line (23)	
(36) Concentration Factor	LR010 Asset Concentration Factor Column (6) Line (62) Grand Total Page	
(37) Miscellaneous	LR012 Miscellaneous Assets Column (2) Line (21)	
(38) Replication Transactions and Mandatory Convertible Securities	LR013 Replication (Synthetic Asset) Transactions and Mandatory Convertible Securities Column (7) Line (9999999)	
(39) Reinsurance	LR016 Reinsurance Column (4) Line (17)	
(40) Total (C-1o) - Pre-Tax	Sum of Lines (21) through (39)	
(41) (C-1o) Tax Effect	LR030 Calculation of Tax Effect for Life and Fraternal Risk-Based Capital Column (2) Line (109) Line (40) - Line (41)	
(42) Net (C-1o) - Post-Tax		
Insurance Risk (C-2)		
(43) Individual & Industrial Life Insurance	LR025 Life Insurance Column (2) Line (20)	
(44) Group & Credit Life Insurance	LR025 Life Insurance Column (2) Line (44) (48)	
(45) Longevity Risk	LR025-A Longevity Risk Column (2) Line (5)	
(46) Total Health Insurance	LR024 Health Claims Reserves Column (4) Line (18)	
(47) Premium Stabilization Reserve Credit	LR026 Premium Stabilization Reserves Column (2) Line (10)	
(48) Total (C-2) - Pre-Tax	$L(45) + L(46) + \text{Greatest of } [\text{Guardrail Factor} * (L(43)+L(44)) , \text{Guardrail Factor} * L(44b) , \text{Square Root of } (L(43) + L(44))^2 + 2 * (\text{Correlation Factor}) * L(43) * L(44)]]$	
(49) (C-2) Tax Effect	LR030 Calculation of Tax Effect for Life and Fraternal Risk-Based Capital Column (2) Line (139) Line (47) - Line (48)	
(49) Net (C-2) - Post-Tax		
Interest Rate Risk (C-3a)		
(50) Total Interest Rate Risk - Pre-Tax	LR027 Interest Rate Risk Column (3) Line (36)	
(51) (C-3a) Tax Effect	LR030 Calculation of Tax Effect for Life and Fraternal Risk-Based Capital Column (2) Line (140) Line (50) - Line (51)	
(52) Net (C-3a) - Post-Tax		
Health/Credit Risk (C-3b)		
(53) Total Health/Credit Risk - Pre-Tax	LR028 Health/Credit Risk Column (2) Line (7)	
(54) (C-3b) Tax Effect	LR030 Calculation of Tax Effect for Life and Fraternal Risk-Based Capital Column (2) Line (141) Line (53) - Line (54)	
(55) Net (C-3b) - Post-Tax		
Market Risk (C-3c)		
(56) Total Market Risk - Pre-Tax	LR027 Interest Rate Risk Column (3) Line (37)	
(57) (C-3c) Tax Effect	LR030 Calculation of Tax Effect for Life and Fraternal Risk-Based Capital Column (2) Line (142) Line (56) - Line (57)	
(58) Net (C-3c) - Post-Tax		

Denotes items that must be manually entered on the filing software.

LR031

Company Name	Confidential when Completed	NAIC Company Code
Business Risk (C-4a)		RBC Requirement
(59) Premium Component		
(60) Liability Component		
(61) Subtotal Business Risk (C-4a) - Pre-Tax		
(62) (C-4a) Tax Effect		
(63) Net (C-4a) - Post-Tax		
Business Risk (C-4b)		
(64) Health Administrative Expense Component of Business Risk (C-4b) - Pre-Tax		
(65) (C-4b) Tax Effect		
(66) Net (C-4b) - Post-Tax		
Total Risk-Based Capital After Covariance Before Basic Operational Risk		
(67) $C-0 + C-4a + \text{Square Root of } [(C-1a + C-3a)^2 + (C-1es + C-3e)^2 + (C-2)^2 + (C-3b)^2 + (C-4b)^2]$		
(68) Gross Basic Operational Risk		
(69) C-4a of U.S. Life Insurance Subsidiaries		
(70) Net Basic Operational Risk		
(71) Primary Security Shortfall Calculated in Accordance With Actuarial Guideline XLVIII Multiplied by 2		
(72) Total Risk-Based Capital After Covariance (Including Basic Operational Risk and Primary Security Shortfall multiplied by 2)		
Authorized Control Level Risk-Based Capital After Covariance Adjustment and Shortfall		
(73) Total Risk-Based Capital After Covariance Times Fifty Percent		
Tax Sensitivity Test		
(74) Tax Sensitivity Test: Total Risk-Based Capital After Covariance		
(75) Tax Sensitivity Test: Authorized Control Level Risk-Based Capital		

Denotes items that must be manually entered on the filing software.

LRO31

PROPOSED 2023 UPDATE 1
LIFE INSURANCE
LR025

Basis of Factors

The factors developed represent surplus needed to provide for life insurance mortality risk, which is defined as adverse variance in life insurance deaths (i.e., insureds dying sooner than expected) over the remaining lifetime of a block of business while appropriately reflecting the pricing flexibility to adjust current mortality rates for emerging experience. The mortality risks included in the development of the factors were volatility, level, trend, and catastrophe. The factors were developed by stochastically simulating the run-off of in force life insurance blocks typical of U.S. life insurers.

The capital need, expressed as a dollar amount, is determined as the greatest present value of accumulated deficiencies at the 95th percentile of the stochastic distribution of scenarios over the remaining lifetime of a block of business while appropriately reflecting the pricing flexibility to adjust current mortality rates. Statutory losses are defined as the after-tax quantification of gross death benefits minus reserves released in excess of the mortality cost expected under the moderately adverse scenario minus mortality margin present in reserves. The after-tax statutory losses are discounted to the present by using 20-year averages for U.S. swap rates. By selecting the largest present value accumulated loss across all projection years, the solved for capital ensures non-negative capital at all projection periods. Earlier period losses are not allowed to be offset by later period gains to reduce capital. The 95th percentile is the commonly accepted statistical safety level used for Life RBC C-2 mortality risk to identify weakly capitalized companies. The after-tax capital needs are translated to a factor expressed as a percentage of the net amount at risk (NAR). The pre-tax factor is determined by taking the after-tax factor divided by (1 minus the tax rate).

The factors are differentiated between individual & industrial life and group & credit life, and by in force block size. Within individual & industrial life, the factors are differentiated into categories by contract type depending on the degree of pricing flexibility. Within group & credit life, the factors are differentiated into categories by the remaining length of the premium rate term by group contract. There are distinct factors for contracts that have remaining premium rate terms 36 months and under and for contracts that have remaining premium rate terms over 36 months. The Federal Employees' Group Life Insurance (FEGLI) and Servicemembers' Group Life Insurance (SGLI) receive a separate factor applied to the amounts in force.

Specific Instructions for Application of the Formula

Lines 2, 5 and 21-~~44-47~~ are not applicable to Fraternal Benefit Societies.

The NAR is derived for each of the factor categories using annual statement sources and company records. In Force and Reserves amounts are net of reinsurance throughout. The In Force amounts throughout derived from company records need to be consistent with the Exhibit of Life Insurance. The Reserves amounts throughout derived from company records need to be consistent with Exhibit 5, Separate Accounts Exhibit, and Schedule S.

The NAR size bands apply to the total amounts for individual & industrial life and group term & credit life. The size bands are allocated proportionately to the NAR for each of the factor categories.- Size band 1 is for NAR amounts up to \$500 million. Size band 2 is for NAR amounts greater than \$500 million and up to \$2.5 billion. Size band 3 is for NAR amounts greater than \$2.5 billion.

Pricing Flexibility for Individual & Industrial Life Insurance and Group & Credit Life Permanent Life Insurance is defined as the ability to materially adjust rates on in force contracts through changing premiums and/or non-guaranteed elements as of the valuation date and within the next 5 policy years and reflecting typical business practices. For the purposes of assessing whether business is categorized as having "Pricing Flexibility", grouping of gross amounts may be done at either the contract level or at a cohort level consistent with grouping for pricing purposes. The categorization for ceded amounts for direct insurers should be based on the terms of each reinsurance treaty. Non-affiliated reinsurers are to assess the flexibility to adjust rates on in force contracts based on the terms of each reinsurance treaty and constraints based on typical business practices. For example, if a non-affiliated

10/14/2023 1/31/2023

reinsurer has historical precedent for changing in force rates, then that may provide support for assigning policies to the category with pricing flexibility. Affiliated reinsurers are to assign the factor category based on the direct policies. In force contracts may move between categories throughout their remaining lifetime if the degree of pricing flexibility changes as of each valuation date. A material rate adjustment is defined as the ability to recover, on a present value basis, the difference in mortality risks provided for in the factors below for contracts with and without pricing flexibility. ~~These differences in factors are shown in the Line (13) table below in the Permanent Life Flexibility Factor and Term Life Flexibility Factor columns.~~ The flexibility factor for each category multiplied by the NAR results in the minimum dollar margin needed for a material rate adjustment, which can then be compared against margins available to adjust rates. In force contracts that have margin available that is greater than or equal to the minimum dollar margin needed may be assigned to the category for policies with pricing flexibility. Insurers may choose to assign contracts to the categories without pricing flexibility if the evaluation of margins is not completed or if the degree of pricing flexibility is uncertain.

Lines (11) and (12) Individual & Industrial Life Policies with Pricing Flexibility In Force and Reserves are derived from company records. Examples of products intended for this category include, but aren't limited to, participating whole life insurance, universal life insurance without secondary guarantees, and yearly renewable term insurance where scheduled premiums may be changed on an annual basis from the date of issue. The table below illustrates the RBC requirement calculation embedded in Line (13) for Individual & Industrial Life Policies with Pricing Flexibility.

Line (13)	<u>Individual & Industrial</u> Life Policies with Pricing Flexibility	(1) Statement Value	Factor	(2) RBC Requirement	<u>Permanent Life</u> <u>Flexibility Factor</u>	<u>Term Life</u> <u>Flexibility Factor</u>
	Allocation of First \$500 Million		X 0.00220 =		0.00230	0.00110
	Allocation of Next \$24,500 Million		X 0.00105 =		0.00120	0.00065
	Allocation of Over \$25,000 Million		X 0.00080 =		0.00085	0.00055
	Total <u>Individual & Industrial</u> Life Policies with Pricing Flexibility Net Amount at Risk					

Lines (14) and (15) Individual & Industrial Term Life Policies without Pricing Flexibility In Force and Reserves are derived from company records. Examples of products intended for this category include, but aren't limited to, level term insurance with guaranteed level premiums and yearly renewable term insurance where scheduled premiums may not be changed. The table below illustrates the RBC requirement calculation embedded in Line (16) for Individual & Industrial Term Life Policies without Pricing Flexibility.

Line (16)	<u>Individual & Industrial</u> Term Life Policies without Pricing Flexibility	(1) Statement Value	Factor	(2) RBC Requirement
	Allocation of First \$500 Million		X 0.00280 =	
	Allocation of Next \$24,500 Million		X 0.00120 =	
	Allocation of Over \$25,000 Million		X 0.00085 =	
	Total <u>Individual & Industrial</u> Term Life Policies without Pricing Flexibility Net Amount at Risk			

Lines (17) and (18) Individual & Industrial Permanent Life Policies without Pricing Flexibility In Force and Reserves are derived from the aggregate amounts derived in lines (1) to (10) minus the amounts recorded in the other individual life categories. Examples of products intended for this category include, but aren't limited to, universal life with secondary guarantees and non-participating whole life insurance. Policies that aren't recorded in the other individual life categories default to this category which has the highest factors. The table below illustrates the RBC requirement calculation embedded in Line (19) for Individual & Industrial Permanent Life Policies without Pricing Flexibility.

10/14/2023/3/1/2023

<u>Line (19)</u>	<u>Individual & Industrial Permanent Life Policies without Pricing Flexibility</u>	<u>Statement Value</u>	<u>Factor</u>	<u>RBC Requirement</u>
		(1)		(2)
	Allocation of First \$500 Million		X 0.00400 =	
	Allocation of Next \$24,500 Million		X 0.00175 =	
	Allocation of Over \$25,000 Million		X 0.00120 =	
	<u>Total Individual & Industrial Permanent Life Policies without Pricing Flexibility Net Amount at Risk</u>			

Lines (35) and (36) Group & Credit Term Life In Force and Reserves with Remaining Rate Terms 36 Months and Under are derived from company records. This category includes group term life contracts where the premium terms have 36 months or fewer until expiration or renewal. Insurers may choose to assign contracts to the category for remaining rate terms over 36 months if the evaluation of remaining rate terms is not completed. The in force amount classified in this category needs to be consistent with the Exhibit of Life Insurance. The reserves amount classified in this category needs to be consistent with Exhibit 5 used for Lines (28) and (29), Separate Accounts Exhibit used for Line (30), and Schedule S used for Lines (31) and (32). Federal Employees' Group Life Insurance (FEGLI) and Servicemembers' Group Life Insurance (SGLI) contracts are excluded. The table below illustrates the RBC requirement calculation embedded in Line (37) for Group & Credit Term Life ~~Net Amount at Risk~~ with Remaining Rate Terms 36 Months and Under Net Amount at Risk.

<u>Line (37)</u>	<u>Group & Credit Term Life with Remaining Rate Terms 36 Months and Under</u>	<u>Statement Value</u>	<u>Factor</u>	<u>RBC Requirement</u>
		(1)		(2)
	Allocation of First \$500 Million		X 0.00140 =	
	Allocation of Next \$24,500 Million		X 0.00055 =	
	Allocation of Over \$25,000 Million		X 0.00040 =	
	<u>Total Group & Credit Term Life</u> Net Amount at Risk with Remaining Rate Terms 36 Months and Under <u>Net Amount at Risk</u>			

Lines (38) and (39) Group & Credit Term Life In Force and Reserves with Remaining Rate Terms Over 36 Months are derived from ~~the aggregate amounts derived in lines (21) to (34) minus the Group & Credit Life In Force and Reserves with Remaining Rate Terms 36 Months and Under in lines (35) and (36) company records~~. This category includes group term life contracts where the premium terms have over 36 months until expiration or renewal. FEGLI and SGLI contracts are excluded. The table below illustrates the RBC requirement calculation embedded in Line (40) for Group & Credit Life Term ~~Net Amount at Risk~~ with Remaining Rate Terms Over 36 Months Net Amount at Risk.

<u>Line (40)</u>	<u>Group & Credit Term Life with Remaining Rate Terms Over 36 Months</u>	<u>Statement Value</u>	<u>Factor</u>	<u>RBC Requirement</u>
		(1)		(2)
	Allocation of First \$500 Million		X 0.00190 =	
	Allocation of Next \$24,500 Million		X 0.00080 =	
	Allocation of Over \$25,000 Million		X 0.00055 =	
	<u>Total Group & Credit Term Life</u> Net Amount at Risk with Remaining Rate Terms Over 36 Months <u>Net Amount at Risk</u>			

10/14/2023 1/31/2023

Lines (41) and (42) Group & Credit Permanent Life Policies with Pricing Flexibility In Force and Reserves are derived from company records. FEGLI and SGLI contracts are excluded. The table below illustrates the RBC requirement calculation embedded in Line (43) for Group & Credit Permanent Life Policies with Pricing Flexibility Net Amount at Risk. The capital factors assigned are the same as Individual & Industrial Permanent Life Policies with Pricing Flexibility.

Line (43)	Group & Credit Permanent Life Policies with Pricing Flexibility	(1) Statement Value	Factor	(2) RBC Requirement
	Allocation of First \$500 Million		X 0.00220 =	
	Allocation of Next \$24,500 Million		X 0.00105 =	
	Allocation of Over \$25,000 Million		X 0.00080 =	
	Total Group & Credit Permanent Life Policies with Pricing Flexibility Net Amount at Risk			

Lines (44) and (45) Group & Credit Permanent Life Policies without Pricing Flexibility In Force and Reserves are derived from the aggregate amounts derived in lines (21) to (34) minus the other Group & Credit life amounts derived in lines (35) to (43). FEGLI and SGLI contracts are excluded. The table below illustrates the RBC requirement calculation embedded in Line (46) for Group & Credit Permanent Life Policies without Pricing Flexibility Net Amount at Risk. The capital factors assigned are the same as Individual & Industrial Permanent Life Policies without Pricing Flexibility.

Line (46)	Group & Credit Permanent Life Policies without Pricing Flexibility	(1) Statement Value	Factor	(2) RBC Requirement
	Allocation of First \$500 Million		X 0.00400 =	
	Allocation of Next \$24,500 Million		X 0.00175 =	
	Allocation of Over \$25,000 Million		X 0.00120 =	
	Total Group & Credit Permanent Life Policies without Pricing Flexibility Net Amount at Risk			

Line (447) FEGLI/SGLI In Force amounts are retrieved from the Exhibit of Life Insurance. -The capital factor assigned is the same as the largest size band for group & credit term life contracts with remaining rate terms 36 months and under.

Line (447)	FEGLI/SGLI In Force	(1) Statement Value	Factor	(2) RBC Requirement
	In Force		X 0.00040 =	

All amounts should be entered as required. The risk-based capital software will calculate the RBC requirement for individual and industrial and for group and credit.

10/14/2023 13/1/2023

Proposed 2023 Update 2

NOTE 37 Life Insurance Net Amount at Risk by Product Characteristics

Refer to LR025 of the RBC instructions for category definitions

A. INDIVIDUAL & INDUSTRIAL LIFE

Line Definitions

- (1) Life In Force Exhibit of Life Insurance Amount of Insurance for Industrial and Ordinary Life, Lines 21 and 22
- (2) Exhibit 5 Life Reserves Exhibit 5 for Industrial and Ordinary Life, Lines 0199997 and 0199998
- (3) Separate Account Life Reserves Separate Accounts, Exhibit 3, Column 3 Line 0199999
- (4) Modified Coinsurance Life Reserves Schedule S, Part 1 Section 1 Column 12 and Part 3 Section 1 Column 14, the portion which relates to policy reserves that, if written on a direct basis, would be included on Exhibit 5.

Table A1

Total Individual & Industrial Life				
	(1) Gross	(2) Assumed	(3) Ceded	(4) Net of Reinsurance (1) + (2) - (3)
(1) Life In Force				
(2) Exhibit 5 Life Reserves				
(3) Separate Account Life Reserves				
(4) Modified Coinsurance Life Reserves				
(5) Life Reserves (2) + (3) + (4)				
(6) Life Net Amount at Risk (1) - (5)				

Table A2

Individual & Industrial Life Policies with Pricing Flexibility				
	(1) Gross	(2) Assumed	(3) Ceded	(4) Net of Reinsurance (1) + (2) - (3)
(1) Life In Force				
(2) Exhibit 5 Life Reserves				
(3) Separate Account Life Reserves				
(4) Modified Coinsurance Life Reserves				
(5) Life Reserves (2) + (3) + (4)				
(6) Life Net Amount at Risk (1) - (5)				

Table A3

Individual & Industrial Term Life Policies without Pricing Flexibility				
	(1) Gross	(2) Assumed	(3) Ceded	(4) Net of Reinsurance (1) + (2) - (3)
(1) Life In Force				
(2) Exhibit 5 Life Reserves				
(3) Separate Account Life Reserves				
(4) Modified Coinsurance Life Reserves				
(5) Life Reserves (2) + (3) + (4)				
(6) Life Net Amount at Risk (1) - (5)				

Table A4

Individual & Industrial Permanent Life Policies without Pricing Flexibility				
	(1) Gross	(2) Assumed	(3) Ceded	(4) Net of Reinsurance (1) + (2) - (3)
(1) Life In Force				
(2) Exhibit 5 Life Reserves				
(3) Separate Account Life Reserves				
(4) Modified Coinsurance Life Reserves				
(5) Life Reserves (2) + (3) + (4)				
(6) Life Net Amount at Risk (1) - (5)				

B. GROUP & CREDIT LIFE EXCLUDING FEGLI/SGLI

Line Definitions

- (1) Life In Force
- (2) Exhibit 5 Life Reserves
- (3) Separate Account Life Reserves
- (4) Modified Coinsurance Life Reserves

Exhibit of Life Insurance Amount of Insurance for Group and Credit Life, Lines 21 and 22; exclude amounts for FEGLI and SGLI reported on lines 43 and 44
 Exhibit 5 for Group and Credit Life, Lines 0199997 and 0199998
 Separate Accounts, Exhibit 3, Column 4 Line 0199999
 Schedule S, Part 1 Section 1 Column 12 and Part 3 Section 1 Column 14, the portion which relates to policy reserves that, if written on a direct basis, would be included on Exhibit 5.

Table B1

Total Group & Credit Life Excluding FEGLI/SGLI				
	(1) Gross	(2) Assumed	(3) Ceded	(4) Net of Reinsurance (1) + (2) - (3)
(1) Life In Force				
(2) Exhibit 5 Life Reserves				
(3) Separate Account Life Reserves				
(4) Modified Coinsurance Life Reserves				
(5) Life Reserves (2) + (3) + (4)				
(6) Life Net Amount at Risk (1) - (5)				

Table B2

Group & Credit Term Life with Remaining Rate Terms 36 Months and Under				
	(1) Gross	(2) Assumed	(3) Ceded	(4) Net of Reinsurance (1) + (2) - (3)
(1) Life In Force				
(2) Exhibit 5 Life Reserves				
(3) Separate Account Life Reserves				
(4) Modified Coinsurance Life Reserves				
(5) Life Reserves (2) + (3) + (4)				
(6) Life Net Amount at Risk (1) - (5)				

Table B3

Group & Credit Term Life with Remaining Rate Terms Over 36 Months				
	(1) Gross	(2) Assumed	(3) Ceded	(4) Net of Reinsurance (1) + (2) - (3)
(1) Life In Force				
(2) Exhibit 5 Life Reserves				
(3) Separate Account Life Reserves				
(4) Modified Coinsurance Life Reserves				
(5) Life Reserves (2) + (3) + (4)				
(6) Life Net Amount at Risk (1) - (5)				

Table B4

Group & Credit Permanent Life Policies with Pricing Flexibility				
	(1) Gross	(2) Assumed	(3) Ceded	(4) Net of Reinsurance (1) + (2) - (3)
(1) Life In Force				
(2) Exhibit 5 Life Reserves				
(3) Separate Account Life Reserves				
(4) Modified Coinsurance Life Reserves				
(5) Life Reserves (2) + (3) + (4)				
(6) Life Net Amount at Risk (1) - (5)				

Table B5

Group & Credit Permanent Life Policies without Pricing Flexibility				
	(1) Gross	(2) Assumed	(3) Ceded	(4) Net of Reinsurance (1) + (2) - (3)
(1) Life In Force				
(2) Exhibit 5 Life Reserves				
(3) Separate Account Life Reserves				
(4) Modified Coinsurance Life Reserves				
(5) Life Reserves (2) + (3) + (4)				
(6) Life Net Amount at Risk (1) - (5)				

Proposed 2023 Update 2
LIFE INSURANCE

	(1) Statement Value	Factor	(2) RBC Requirement
	Annual Statement Source		
(4)	Individual & Industrial Life-Net Amount at Risk		
(5)	Ordinary Life In Force		
(6)	Plus-Industrial Life In Force		
(7)	Total Individual & Industrial Life In Force		
(8)	Ordinary Life Reserves		
(9)	Plus-Industrial Life Reserves		
(10)	Plus-Ordinary Life Separate Accounts		
(11)	Plus-Ordinary & Industrial Life Modified Contingence Assumed Reserve		
(12)	Plus-Ordinary & Industrial Life Modified Contingence Credited Reserve		
(13)	Total Individual & Industrial Life Reserves		
(14)	Total Individual & Industrial Life Net Amount at Risk		
(15)	Individual & Industrial Life Policies with Pricing Flexibility In Force		
(16)	Less-Individual & Industrial Life Policies with Pricing Flexibility In Force-Reserves		
(17)	Total Individual & Industrial Life Policies with Pricing Flexibility Net Amount at Risk		
(18)	Individual & Industrial Term Life Policies without Pricing Flexibility In Force		
(19)	Less-Individual & Industrial Term Life Policies without Pricing Flexibility-Reserves		
(20)	Total Individual & Industrial Permanent Life Policies without Pricing Flexibility Net Amount at Risk		
(21)	Total Individual & Industrial Life		
(22)	Group & Credit Life-Net Amount at Risk		
(23)	Group Life In Force		
(24)	Less-Group-FGLH In Force		
(25)	Less-Group-SGLH In Force		
(26)	Less-Credit-FGLH In Force		
(27)	Less-Credit-SGLH In Force		
(28)	Total Group & Credit Life In Force-Excluding FGLH/SGLH		
(29)	Group Life Reserves		
(30)	Plus-Credit Life Reserves		
(31)	Plus-Group Life Separate Accounts		
(32)	Plus-Group & Credit Life Modified Contingence Assumed Reserve		
(33)	Plus-Group & Credit Life Modified Contingence Credited Reserve		
(34)	Total Group & Credit Life Reserves		
(35)	Total Group & Credit Life Excluding FGLH/SGLH Net Amount at Risk-Excluding FGLH/SGLH		
(36)	Group & Credit Term Life In Force with Remaining Rate Terms-36 Months and Under		
(37)	Less-Group & Credit Term Life Reserves with Remaining Rate Terms-36 Months and Under		
(38)	Group & Credit Term Life with Remaining Rate Terms-36 Months and Under Net Amount at Risk		
(39)	Group & Credit Term Life In Force with Remaining Rate Terms-Over 36 Months		
(40)	Less-Group & Credit Term Life Reserves with Remaining Rate Terms-Over 36 Months		
(41)	Group & Credit Term Life with Remaining Rate Terms-Over 36 Months Net Amount at Risk		
(42)	Group & Credit Permanent Life Policies with Pricing Flexibility In Force		
(43)	Less-Group & Credit Permanent Life Policies with Pricing Flexibility-Reserves		
(44)	Group & Credit Permanent Life Policies with Pricing Flexibility Net Amount at Risk		
(45)	Group & Credit Permanent Life Policies without Pricing Flexibility In Force		
(46)	Less-Group & Credit Permanent Life Policies without Pricing Flexibility-Reserves		
(47)	Group & Credit Permanent Life Policies without Pricing Flexibility Net Amount at Risk		
(48)	FGLH/SGLH Life In Force		
(49)	Total Group & Credit Life		
(50)	Total Life		

† The definitions are specified in the Life Insurance sections of the risk-based capital instructions. The tiered calculation is illustrated in the Life Insurance section of the risk-based capital instructions. ‡ Includes only the portion which relates to policy reserves that, if written on a direct basis, would be included on Exhibit 5. ††† Items that must be manually entered on the filing software.

Proposed 2023 Update 2
LIFE INSURANCE (Clean Version)

		(1)	Factor	(2)
	Annual Statement Source	Statement Value		RBC Requirement
(1)	Individual & Industrial Life			
(2)	Total Individual & Industrial Life Net Amount at Risk	X	†	=
(3)	Total Individual & Industrial Life Policies with Pricing Flexibility Net Amount at Risk	X	†	=
(4)	Total Individual & Industrial Term Life Policies without Pricing Flexibility Net Amount at Risk	X	†	=
(5)	Total Individual & Industrial Permanent Life Policies without Pricing Flexibility Net Amount at Risk			
(6)	Total Individual & Industrial Life			
(6)	Group & Credit Life			
(7)	Total Group & Credit Life Excluding FEGLI/SGLI Net Amount at Risk	X	†	=
(8)	Group & Credit Term Life with Remaining Rate Terms 36 Months and Under Net Amount at Risk	X	†	=
(9)	Group & Credit Life Term Life with Remaining Rate Terms Over 36 Months Net Amount at Risk	X	†	=
(10)	Group & Credit Permanent Life Policies with Pricing Flexibility Net Amount at Risk	X	†	=
(11)	Group & Credit Permanent Life Policies without Pricing Flexibility Net Amount at Risk	X	†	=
(12)	FEGLI/SGLI Life In Force	X	0.0004	=
(13)	Total Group & Credit Life			
(13)	Total Life			

Notes to Financial Statements Item 37, Table A1, Column (4), Line (6)
 Notes to Financial Statements Item 37, Table A2, Column (4), Line (6)
 Notes to Financial Statements Item 37, Table A3, Column (4), Line (6)
 Lines (1) - (2) - (3)
 Lines (2) + (3) + (4)

Notes to Financial Statements Item 37, Table B1, Column (4), Line (6)
 Notes to Financial Statements Item 37, Table B2, Column (4), Line (6)
 Notes to Financial Statements Item 37, Table B3, Column (4), Line (6)
 Notes to Financial Statements Item 37, Table B4, Column (4), Line (6)
 Lines (6) - (7) - (8) - (9)
 Exhibit of Life Insurance Sum of Column 2 and 4 Line 43 and 44 x 1000
 Lines (7) + (8) + (9) + (10) + (11)

Lines (5) + (12)

† The tiered calculation is illustrated in the Life Insurance section of the risk-based capital instructions.

**Proposed 2023 Update 2
PREMIUM STABILIZATION RESERVES**

	Annual Statement Source	(1) Statement Value	Factor	(2) RBC Requirement
<u>Group and Credit Life and Health Reported Premium Stabilization Reserves</u>				
(1)	Stabilization Reserves and Experience Rating Refunds included in Line 3		X	
(2)	Provision for Experience Rating Refunds		X	
(3)	Reserve for Group Rate Credits		X	
(4)	Reserve for Credit Rate Credits		X	
(5)	Premium Stabilization Reserves		X	
(6)	Total of Preliminary Premium Stabilization Reserve Credit			
<u>Group & Credit Life and Health Risk-Based Capital</u>				
(7)	Life			
(8)	Health			
(9)	Maximum Risk-Based Capital			
(10)	Final Premium Stabilization Reserve		X	

Page 3 Column 1 Line 3 in part
 Page 3 Column 1 Line 9.2 in part
 Company Records
 Company Records
 Page 3 Column 1 Line 25 in part
 Sum of Lines (1) through (5)
 LRO25 Life Insurance Column (2) Line ~~(42)~~(48)-(12)
 LRO24 Health Claim Reserves Column (4) Line (16)
 + [LRO24 Column (4) Line (15) x 0.65] + LRO19
 Health Premiums Column (2) Lines (12), (17), (18)
 and (19) + [[LRO19 Column (2) Lines (23), (24),
 and (27)] x 0.65] + [LRO20 Underwriting Risk -
 Experience Fluctuation Risk Column (5) Line (18) -
 Column (4) Line (18) x Line (1.2) / Line (1.3)]
 Lines (7) + (8)
 Column (2) Line (6), but not more than
 Column (1) Line (9)

LRO26

Company Name

Confidential when Completed

NAIC Company Code

Proposed 2023 Update 2
CALCULATION OF TAX EFFECT FOR LIFE AND FRATERNAL RISK-BASED CAPITAL

ASSET RISKS	Source	RBC Amount	Tax Factor	RBC Tax Effect
Bonds				
(001) Long-term Bonds - NAIC 1	LR002 Bonds Column (2) Line (2.8) + LR018 Off-Balance Sheet Collateral Column (3) Line (2.8)	X	0.1680	=
(002) Long-term Bonds - NAIC 2	LR002 Bonds Column (2) Line (3.4) + LR018 Off-Balance Sheet Collateral Column (3) Line (3.4)	X	0.1680	=
(003) Long-term Bonds - NAIC 3	LR002 Bonds Column (2) Line (4.4) + LR018 Off-Balance Sheet Collateral Column (3) Line (4.4)	X	0.1680	=
(004) Long-term Bonds - NAIC 4	LR002 Bonds Column (2) Line (5.4) + LR018 Off-Balance Sheet Collateral Column (3) Line (5.4)	X	0.1680	=
(005) Long-term Bonds - NAIC 5	LR002 Bonds Column (2) Line (6.4) + LR018 Off-Balance Sheet Collateral Column (3) Line (6.4)	X	0.1680	=
(006) Long-term Bonds - NAIC 6	LR002 Bonds Column (2) Line (7) + LR018 Off-Balance Sheet Collateral Column (3) Line (7)	X	0.2100	=
(007) Short-term Bonds - NAIC 1	LR002 Bonds Column (2) Line (10.8)	X	0.1680	=
(008) Short-term Bonds - NAIC 2	LR002 Bonds Column (2) Line (11.4)	X	0.1680	=
(009) Short-term Bonds - NAIC 3	LR002 Bonds Column (2) Line (12.4)	X	0.1680	=
(010) Short-term Bonds - NAIC 4	LR002 Bonds Column (2) Line (13.4)	X	0.1680	=
(011) Short-term Bonds - NAIC 5	LR002 Bonds Column (2) Line (14.4)	X	0.1680	=
(012) Short-term Bonds - NAIC 6	LR002 Bonds Column (2) Line (15)	X	0.2100	=
(013) Credit for Hedging - NAIC 1 Through 5 Bonds	LR014 Hedged Asset Bond Schedule Column (13) Line (0199999)	X	0.1680	†
(014) Credit for Hedging - NAIC 6 Bonds	LR014 Hedged Asset Bond Schedule Column (13) Line (0299999)	X	0.2100	†
(015) Bond Reduction - Reinsurance	LR002 Bonds Column (2) Line (19)	X	0.2100	=
(016) Bond Increase - Reinsurance	LR002 Bonds Column (2) Line (20)	X	0.2100	=
(017) Non-Exempt NAIC 1 U.S. Government Agency	LR002 Bonds Column (2) Line (22)	X	0.1680	=
(018) Bonds Size Factor	LR002 Bonds Column (2) Line (26) - LR002 Bonds Column (2) Line (21)	X	0.1680	=
Mortgages				
(019) In Good Standing				
(020) Residential Mortgages - Insured	LR004 Mortgages Column (6) Line (1)	X	0.1575	=
(021) Residential Mortgages - Other	LR004 Mortgages Column (6) Line (2)	X	0.1575	=
(022) Commercial Mortgages - Insured	LR004 Mortgages Column (6) Line (3)	X	0.1575	=
(023) Total Commercial Mortgages - All Other	LR004 Mortgages Column (6) Line (9)	X	0.1575	=
(024) 90 Days Overdue	LR004 Mortgages Column (6) Line (15)	X	0.1575	=
(025) Farm Mortgages	LR004 Mortgages Column (6) Line (16)	X	0.1575	=
(026) Residential Mortgages - Insured	LR004 Mortgages Column (6) Line (17)	X	0.1575	=
(027) Residential Mortgages - Other	LR004 Mortgages Column (6) Line (18)	X	0.1575	=
(028) Commercial Mortgages - Insured	LR004 Mortgages Column (6) Line (19)	X	0.1575	=
(029) Commercial Mortgages - Other	LR004 Mortgages Column (6) Line (20)	X	0.1575	=
(029) In Process of Foreclosure				
(029) Farm Mortgages	LR004 Mortgages Column (6) Line (21)	X	0.1575	=

† Denotes lines that are deducted from the total rather than added.
Denotes items that must be manually entered on the filing software.

LR030

NAIC Company Code

Confidential when Completed

Company Name

CALCULATION OF TAX EFFECT FOR LIFE AND FRATERNAL RISK-BASED CAPITAL (CONTINUED)

	Source	(1) RBC Amount	Tax Factor	(2) RBC Tax Effect
(030) Residential Mortgages - Insured	L.R004 Mortgages Column (6) Line (22)	X	0.1575	
(031) Residential Mortgages - Other	L.R004 Mortgages Column (6) Line (23)	X	0.1575	
(032) Commercial Mortgages - Insured	L.R004 Mortgages Column (6) Line (24)	X	0.1575	
(033) Commercial Mortgages - Other	L.R004 Mortgages Column (6) Line (25)	X	0.1575	
(034) Due & Unpaid Taxes - Mortgages	L.R004 Mortgages Column (6) Line (26)	X	0.1575	
(035) Mortgage Reduction - Forbearance	L.R004 Mortgages Column (6) Line (27)	X	0.1575	
(036) Mortgage Reduction - Reinsurance	L.R004 Mortgages Column (6) Line (28)	X	0.2100	
(037) Preferred Stock	L.R004 Mortgages Column (6) Line (29)	X	0.2100	
(038) Unaffiliated Preferred Stock NAIC 1	L.R005 Unaffiliated Preferred and Common Stock Column (5) Line (1)	X	0.1575	
(039) Unaffiliated Preferred Stock NAIC 2	L.R005 Unaffiliated Preferred and Common Stock Column (5) Line (9)	X	0.1575	
(040) Unaffiliated Preferred Stock NAIC 3	L.R005 Unaffiliated Preferred and Common Stock Column (5) Line (2)	X	0.1575	
(041) Unaffiliated Preferred Stock NAIC 4	L.R005 Unaffiliated Preferred and Common Stock Column (5) Line (3)	X	0.1575	
(042) Unaffiliated Preferred Stock NAIC 5	L.R005 Unaffiliated Preferred and Common Stock Column (5) Line (4)	X	0.1575	
(043) Unaffiliated Preferred Stock NAIC 6	L.R005 Unaffiliated Preferred and Common Stock Column (5) Line (5)	X	0.1575	
(044) Preferred Stock Reduction-Reinsurance	L.R005 Unaffiliated Preferred and Common Stock Column (5) Line (6)	X	0.2100	
(045) Preferred Stock Increase-Reinsurance	L.R005 Unaffiliated Preferred and Common Stock Column (5) Line (8)	X	0.2100	
(046) Separate Accounts	L.R005 Unaffiliated Preferred and Common Stock Column (5) Line (9)	X	0.1575	
(047) Nonindex-Block Reserve	L.R006 Separate Accounts Column (3) Line (1)	X	0.1575	
(048) Separate Accounts Nonindex Market Reserve	L.R006 Separate Accounts Column (3) Line (2)	X	0.1575	
(049) Separate Accounts Reduction-Reinsurance	L.R006 Separate Accounts Column (3) Line (3)	X	0.1575	
(050) Separate Account Increase-Reinsurance	L.R006 Separate Accounts Column (3) Line (5)	X	0.2100	
(051) Synthetic CIGS	L.R006 Separate Accounts Column (3) Line (6)	X	0.1575	
(052) Separate Account Surplus	L.R006 Separate Accounts Column (3) Line (13)	X	0.1575	
(053) Company Owned Real Estate	L.R007 Real Estate Column (3) Line (3)	X	0.2100	
(054) Forfeited Real Estate	L.R007 Real Estate Column (3) Line (6)	X	0.2100	
(055) Investment Real Estate	L.R007 Real Estate Column (3) Line (9)	X	0.2100	
(056) Real Estate Reduction - Reinsurance	L.R007 Real Estate Column (3) Line (11)	X	0.2100	
(057) Real Estate Increase - Reinsurance	L.R007 Real Estate Column (3) Line (12)	X	0.2100	
(058) Sch Bx Real Estate Excluding Low Income Housing Tax Credits	L.R007 Real Estate Column (3) Line (16)	X	0.2100	
(059) Guaranteed Low Income Housing Tax Credits	L.R007 Real Estate Column (3) Line (17)+ Line (19)	X	0.0000	
(060) Non-Committed and All Other Low Income Housing Tax Credits	L.R007 Real Estate Column (3) Line (18) + Line (20) + Line (21)	X	0.0000	
(061) Sch Bx Real Estate Reduction - Reinsurance	L.R007 Real Estate Column (3) Line (23)	X	0.2100	
(062) Sch Bx Real Estate Increase - Reinsurance	L.R007 Real Estate Column (3) Line (24)	X	0.2100	

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LR030

Company Name

Confidential when Completed

NAIC Company Code

CALCULATION OF TAX EFFECT FOR LIFE AND FRATERNAL RISK-BASED CAPITAL (CONTINUED)

	(1)	Tax Factor	(2)
	RBC Amount	0.1575	RBC Tax Effect
(102) Replications		X	=
(103) Reinsurance	LR013 Replication (Synthetic Asset) Transactions and Mandatory Convertible Securities Column (7) Line (9999999)		=
(104) Investment Affiliates	LR016 Reinsurance Column (4) Line (17)	X 0.2100	=
(105) Investment in Parent	LR042 Summary for Affiliated Investments Column (4) Line (6)	X 0.2100	=
(106) Other Affiliate: Property and Casualty Insurers not Subject to Risk-Based Capital	LR042 Summary for Affiliated Investments Column (4) Line (10)	X 0.2100	=
(107) Other Affiliate: Life Insurers not Subject to Risk-Based Capital	LR042 Summary for Affiliated Investments Column (4) Line (11)	X 0.2100	=
(108) Publicly Traded Insurance Affiliates	LR042 Summary for Affiliated Investments Column (4) Line (12)	X 0.2100	=
(109) Subtotal for C-10 Assets	Sum of Lines (001) through (108), Recognizing the Deduction of Lines (013), (014), (015), (036), (044), (049), (056), (061), (069), (077), (084), (089) and (100)	X 0.2100	=
(110) C-0 Affiliated Common Stock			
(111) Off-Balance Sheet and Other Items	LR017 Off-Balance Sheet and Other Items Column (5) Line (27)	X 0.1575	=
(112) Off-Balance Sheet Items Reduction - Reinsurance	LR017 Off-Balance Sheet and Other Items Column (5) Line (28)	X 0.2100	=
(113) Affiliated US Property - Casualty Insurers	LR017 Off-Balance Sheet and Other Items Column (5) Line (29)	X 0.2100	=
(114) Directly Owned	LR042 Summary for Affiliated Investments Column (4) Line (1)	X 0.2100	=
(115) Affiliated US Life Insurers Directly Owned	LR042 Summary for Affiliated Investments Column (4) Line (2)	X 0.2100	=
(116) Affiliated US Health Insurers Directly and Indirectly Owned	LR042 Summary for Affiliated Investments Column (4) Line (3)	X 0.2100	=
(117) Indirectly Owned	LR042 Summary for Affiliated Investments Column (4) Line (4)	X 0.2100	=
(118) Affiliated US Life Insurers Indirectly Owned	LR042 Summary for Affiliated Investments Column (4) Line (5)	X 0.2100	=
(119) Affiliated Alien Life Insurers - Canadian	LR042 Summary for Affiliated Investments Column (4) Line (8)	X 0.0000	=
(120) Affiliated Alien Life Insurers - All Others	LR042 Summary for Affiliated Investments Column (4) Line (9)	X 0.0000	=
(121) Subtotal for C-0 Affiliated Common Stock	Lines (110)-(111)+(112)+(113)+(114)+(115)+(116)+(117)+(118)+(119)	X 0.2100	=
(122) Common Stock			
(123) Unaffiliated Common Stock	LR005 Unaffiliated Preferred and Common Stock Column (5) Line (17) + LR018 Off-Balance Sheet Collateral Column (3) Line (16)	X 0.2100	=
(124) Credit for Hedging - Common Stock	LR015 Hedged Asset Common Stock Schedule Column (10) Line (0299999)	X 0.2100	=
(125) Stock Reduction - Reinsurance	LR005 Unaffiliated Preferred and Common Stock Column (5) Line (19)	X 0.2100	=
(126) Stock Increase - Reinsurance	LR005 Unaffiliated Preferred and Common Stock Column (5) Line (20)	X 0.2100	=
(127) BA Common Stock Unaffiliated	LR008 Other Long-Term Assets Column (5) Line (47)	X 0.2100	=
(128) BA Common Stock Affiliated - C-1s	LR008 Other Long-Term Assets Column (5) Line (49.2)	X 0.2100	=
(129) Common Stock Concentration Factor	LR011 Common Stock Concentration Factor Column (6) Line (6)	X 0.2100	=
(130) NAIC 01 Working Capital Finance Notes	LR008 Other Long-Term Assets Column (5) Line (51.1)	X 0.1575	=
(131) NAIC 02 Working Capital Finance Notes	LR008 Other Long-Term Assets Column (5) Line (51.2)	X 0.1575	=
(132) Affiliated Preferred Stock and Common Stock - Holding Company in Excess of Indirect Subs	LR042 Summary for Affiliated Investments Column (4) Line (7)	X 0.2100	=
(133) All Other	LR042 Summary for Affiliated Investments Column (4) Line (13)	X 0.2100	=
(134) Total for C-1s Assets	Lines (121)-(122)+(123)+(124)+(125)+(126)+(127)+(128)+(129)+(130)+(131)	X 0.2100	=
(135) Insurance Risk			
(136) Disability Income Premium	LR019 Health Premiums Column (2) Lines (21) through (27)	X 0.2100	=

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Company Name

Confidential when Completed

NAIC Company Code

CALCULATION OF TAX EFFECT FOR LIFE AND FRATERNAL RISK-BASED CAPITAL (CONTINUED)

	(1) RBC Amount	Tax Factor	(2) RBC Tax Effect
(134) Long-Term Care	X	0.2100	=
(135) Individual & Industrial Life Insurance C-2 Risk	X	0.2100	=
(136) Group & Credit Life Insurance C-2 Risk	X	0.2100	=
(136b) Longevity C-2 Risk	X	0.2100	=
(137) Disability and Long-Term Care Health Claim Reserves	X	0.2100	=
(138) Premium Stabilization Credit	X	0.0000	=
(139) Total C-2 Risk			
(140) Interest Rate Risk	X	0.2100	=
(141) Health Credit Risk	X	0.0000	=
(142) Market Risk	X	0.2100	=
(143) Business Risk	X	0.2100	=
(144) Health Administrative Expenses	X	0.0000	=
(145) Total Tax Effect			

Source:
 LR019 Health Premiums Column (2) Line (28) + LR023 Long-Term Care Column (4) Line (7)
 LR025 Life Insurance Column (2) Line (24)+(5)
 LR025 Life Insurance Column (2) Line (43)+(48)+(12)
 LR025-A Longevity Risk Column (2) Line (5)
 LR024 Health Claim Reserves Column (4) Line (9) + Line (15)
 LR026 Premium Stabilization Reserves Column (2) Line (10)
 L(133) + L(134) + L(137) + L(138) + Greatest of [Guardrail Factor * (L(135)+L(136)), Guardrail Factor * L(136b)]
 * L(136b)]
 LR027 Interest Rate Risk Column (3) Line (36)
 LR028 Health Credit Risk Column (2) Line (7)
 LR027 Interest Rate Risk Column (3) Line (37)
 LR029 Business Risk Column (2) Line (40)
 LR029 Business Risk Column (2) Line (57)
 Lines (109) + (120) + (132) + (139) + (140) + (141) + (142) + (143) + (144)

↑ Denotes lines that are deducted from the total rather than added.
 Denotes items that must be manually entered on the filing software.

LR030

NAIC Company Code

Confidential when Completed

Profitability Name
CALCULATION OF AUTHORIZED CONTROL LEVEL RISK-BASED CAPITAL

	Source	(1) RBC Requirement
Insurance Affiliates and Misc. Other Amounts (C-2)		
(1) Affiliated US Property-Casualty Insurers Directly Owned	LR042 Summary for Affiliated Investments Column (4) Line (1)	
(2) Affiliated US Life Insurers Directly Owned	LR042 Summary for Affiliated Investments Column (4) Line (2)	
(3) Affiliated US Health Insurers Directly and Indirectly Owned	LR042 Summary for Affiliated Investments Column (4) Line (3)	
(4) Affiliated US Property-Casualty Insurers Indirectly Owned	LR042 Summary for Affiliated Investments Column (4) Line (4)	
(5) Affiliated US Life Insurers Indirectly Owned	LR042 Summary for Affiliated Investments Column (4) Line (5)	
(6) Affiliated Alien Life Insurers - Canadian	LR042 Summary for Affiliated Investments Column (4) Line (8)	
(7) Affiliated Alien Life Insurers - All Others	LR042 Summary for Affiliated Investments Column (4) Line (9)	
(8) Off-Balance Sheet and Other Items	LR017 Off-Balance Sheet and Other Items Column (5) Line (34)	
(9) Total (C-0) - Pre-Tax	Sum of Lines (1) through (8)	
(10) (C-0) Tax Effect	LR030 Calculation of Tax Effect for Life and Fraternal Risk-Based Capital Column (2) Line (120) Line (9) - Line (10)	
(11) Net (C-0) - Post-Tax		
Asset Risk - Unaffiliated Common Stock and Affiliated Non-Insurance Stock (C-1cs)		
(12) Schedule D Unaffiliated Common Stock	LR005 Unaffiliated Common Stock Column (5) Line (21) + LR018 Off-Balance Sheet Collateral Column (3) Line (16)	
(13) Schedule BA Unaffiliated Common Stock	LR008 Other Long-Term Assets Column (5) line (47)	
(14) Schedule BA Affiliated Common Stock - C-1cs	LR008 Other Long-Term Assets Column (5) line (49,2)	
(15) Common Stock Concentration Factor	LR011 Common Stock Concentration Factor Column (6) Line (6)	
(16) Affiliated Preferred Stock and Common Stock - Holding Company in Excess of Indirect Subsidiaries	LR042 Summary for Affiliated Investments Column (4) Line (7)	
(17) Affiliated Preferred Stock and Common Stock - All Other	LR042 Summary for Affiliated Investments Column (4) Line (13)	
(18) Total (C-1cs) - Pre-Tax	Sum of Lines (12) through (17)	
(19) (C-1cs) Tax Effect	LR030 Calculation of Tax Effect for Life and Fraternal Risk-Based Capital Column (2) Line (132) Line (18) - Line (19)	
(20) Net (C-1cs) - Post-Tax		
Asset Risk - All Other (C-1o)		
(21) Bonds after Size Factor	LR002 Bonds Column (2) Line (27) + LR018 Off-Balance Sheet Collateral Column (3) Line (8)	
(22) Mortgages (including past due and unpaid taxes)	LR004 Mortgages Column (6) Line (31)	
(23) Unaffiliated Preferred Stock	LR005 Unaffiliated Preferred and Common Stock Column (5) Line (10) + LR018 Off-Balance Sheet Collateral Column (3) Line (15)	
(24) Affiliated Preferred Stock and Common Stock - Investment Subsidiaries	LR042 Summary for Affiliated Investments Column (4) Line (6)	
(25) Affiliated Preferred Stock and Common Stock - Parent	LR042 Summary for Affiliated Investments Column (4) Line (10)	
(26) Affiliated Preferred Stock and Common Stock - Property and Casualty Insurers not Subject to Risk-Based Capital	LR042 Summary for Affiliated Investments Column (4) Line (11)	
(27) Affiliated Preferred Stock and Common Stock - Life Insurers not Subject to Risk-Based Capital	LR042 Summary for Affiliated Investments Column (4) Line (12)	
(28) Affiliated Preferred Stock and Common Stock - Publicly Traded Insurers Held at Fair Value (excess of statement value over book value)	LR042 Summary for Affiliated Investments Column (4) Line (14)	
(29) Separate Accounts with Guarantees	LR006 Separate Accounts Column (3) Line (7)	

Denotes items that must be manually entered on the filing software.

LR031

CONFIDENTIAL - UNRATED CONTROL LEVEL RISK-BASED CAPITAL (CONTINUED)

Confidential when Completed

NAIC Company Code

Company Name	Source	RBC Requirement
(30) Synthetic CIG's (C-1o)	LR006 Separate Accounts Column (3) Line (8)	
(31) Surplus in Non-Guaranteed Separate Accounts	LR006 Separate Accounts Column (3) Line (13)	
(32) Real Estate (gross of encumbrances)	LR007 Real Estate Column (5) Line (13)	
(33) Schedule BA Real Estate (gross of encumbrances)	LR007 Real Estate Column (5) Line (25)	
(34) Other Long-Term Assets	LR008 Other Long-Term Assets Column (5) Line (56) + LR018 Off-Balance Sheet Collateral Column (3) Line (17) + Line (18)	
(35) Schedule BA Mortgages	LR009 Schedule BA Mortgages Column (6) Line (23)	
(36) Concentration Factor	LR010 Asset Concentration Factor Column (6) Line (62) Grand Total Page	
(37) Miscellaneous	LR012 Miscellaneous Assets Column (2) Line (21)	
(38) Replication Transactions and Mandatory Convertible Securities	LR013 Replication (Synthetic Asset) Transactions and Mandatory Convertible Securities Column (7) Line (9999999)	
(39) Reinsurance	LR016 Reinsurance Column (4) Line (17)	
(40) Total (C-1o) - Pre-Tax	Sum of Lines (21) through (39)	
(41) (C-1o) Tax Effect	LR030 Calculation of Tax Effect for Life and Fraternal Risk-Based Capital Column (2) Line (109)	
(42) Net (C-1o) - Post-Tax	Line (40) - Line (41)	
Insurance Risk (C-2)		
(43) Individual & Industrial Life Insurance	LR025 Life Insurance Column (2) Line (39) (5)	
(44) Group & Credit Life Insurance	LR025 Life Insurance Column (2) Line (43) (49)+(12)	
(44b) Longevity Risk	LR025-A Longevity Risk Column (2) Line (5)	
(45) Total Health Insurance	LR024 Health Claim Reserves Column (4) Line (18)	
(46) Premium Stabilization Reserve Credit	LR026 Premium Stabilization Reserves Column (2) Line (10)	
(47) Total (C-2) - Pre-Tax	L(45) + L(46) + Greatest of [Grandtotal Factor * L(43)+L(44)], Grandtotal Factor * L(44b), Square Root of [L(43) + L(44)] ² + L(44b) ² + 2 * (Correlation Factor * L(43) + L(44b) * L(44b)]	
(48) (C-2) Tax Effect	LR030 Calculation of Tax Effect for Life and Fraternal Risk-Based Capital Column (2) Line (139)	
(49) Net (C-2) - Post-Tax	Line (47) - Line (48)	
Interest Rate Risk (C-3a)		
(50) Total Interest Rate Risk - Pre-Tax	LR027 Interest Rate Risk Column (3) Line (36)	
(51) (C-3a) Tax Effect	LR030 Calculation of Tax Effect for Life and Fraternal Risk-Based Capital Column (2) Line (140)	
(52) Net (C-3a) - Post-Tax	Line (50) - Line (51)	
Health Credit Risk (C-3b)		
(53) Total Health Credit Risk - Pre-Tax	LR028 Health Credit Risk Column (2) Line (7)	
(54) (C-3b) Tax Effect	LR030 Calculation of Tax Effect for Life and Fraternal Risk-Based Capital Column (2) Line (141)	
(55) Net (C-3b) - Post-Tax	Line (53) - Line (54)	
Market Risk (C-3c)		
(56) Total Market Risk - Pre-Tax	LR027 Interest Rate Risk Column (3) Line (37)	
(57) (C-3c) Tax Effect	LR030 Calculation of Tax Effect for Life and Fraternal Risk-Based Capital Column (2) Line (142)	
(58) Net (C-3c) - Post-Tax	Line (56) - Line (57)	

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LR031

Company Name	Control Level Risk-Based Capital (Continued)	Confidential when Completed	Source	NAIC Company Code	RBC Requirement
(59)	Business Risk (C-4a) Premium Component		LR029 Business Risk Column (2) Lines (12) + (24) + (36)		
(60)	Liability Component		LR029 Business Risk Column (2) Line (39)		
(61)	Subtotal Business Risk (C-4a) - Pre-Tax		Lines (59) + (60)		
(62)	(C-4a) Tax Effect		LR030 Calculation of Tax Effect for Life and Fraternal Risk-Based Capital Column (2) Line (143)		
(63)	Net (C-4a) - Post-Tax		Line (61) - Line (62)		
(64)	Business Risk (C-4b)		LR029 Business Risk Column (2) Line (57)		
(65)	Health Administrative Expense Component of Business Risk (C-4b) - Pre-Tax		LR030 Calculation of Tax Effect for Life and Fraternal Risk-Based Capital Column (2) Line (144)		
(66)	Net (C-4b) - Post-Tax		Line (64) - Line (65)		
(67)	Total Risk-Based Capital After Covariance Before Basic Operational Risk $C-0 + C-4a + \text{Square Root of } [(C-1e + C-3a)^2 + (C-1e + C-3a)^2 + (C-2)^2 + (C-3b)^2 + (C-4b)^2]$		REPORT AMOUNT ON PARENT COMPANY'S RBC IF APPLICABLE $L(11)+L(63) + \text{Square Root of } [(L(42) + L(52))^2 + (L(20) + L(58))^2 + L(49)^2 + L(55)^2 + L(66)^2]$		
(68)	Gross Basic Operational Risk		$0.05 \times L(67)$		
(69)	C-4a of U.S. Life Insurance Subsidiaries		Company Records		
(70)	Net Basic Operational Risk		Line (68) - (Line (63) + Line (69)) (Not less than zero)		
(71)	Primary Security Shortfall Calculated in Accordance With Actuarial Guideline XLVIII Multiplied by 2		LR036 XXX/XXXX Reinsurance Primary Security Shortfall by Cession Column (7) Line (9999999) Multiplied by 2		
(72)	Total Risk-Based Capital After Covariance (Including Basic Operational Risk and Primary Security Shortfall multiplied by 2)		Line (67) + Line (70) + Line (71)		
(73)	Authorized Control Level Risk-Based Capital (After Covariance Adjustment and Shortfall) Total Risk-Based Capital After Covariance Times Fifty Percent		Line (72) x 0.50		
(74)	Tax Sensitivity Test Tax Sensitivity Test: Total Risk-Based Capital After Covariance		$L(9)+L(61) + \text{Square Root of } [(L(40) + L(50))^2 + (L(18) + L(56))^2 + L(47)^2 + L(53)^2 + L(64)^2]$		
(75)	Tax Sensitivity Test: Authorized Control Level Risk-Based Capital		Line (74) x 0.50		

Denotes items that must be manually entered on the filing software.

LR031

PROPOSED 2023 UPDATE 2
LIFE INSURANCE
LR025

Basis of Factors

The factors developed represent surplus needed to provide for life insurance mortality risk, which is defined as adverse variance in life insurance deaths (i.e., insureds dying sooner than expected) over the remaining lifetime of a block of business while appropriately reflecting the pricing flexibility to adjust current mortality rates for emerging experience. The mortality risks included in the development of the factors were volatility, level, trend, and catastrophe. The factors were developed by stochastically simulating the run-off of in force life insurance blocks typical of U.S. life insurers.

The capital need, expressed as a dollar amount, is determined as the greatest present value of accumulated deficiencies at the 95th percentile of the stochastic distribution of scenarios over the remaining lifetime of a block of business while appropriately reflecting the pricing flexibility to adjust current mortality rates. Statutory losses are defined as the after-tax quantification of gross death benefits minus reserves released in excess of the mortality cost expected under the moderately adverse scenario minus mortality margin present in reserves. The after-tax statutory losses are discounted to the present by using 20-year averages for U.S. swap rates. By selecting the largest present value accumulated loss across all projection years, the solved for capital ensures non-negative capital at all projection periods. Earlier period losses are not allowed to be offset by later period gains to reduce capital. The 95th percentile is the commonly accepted statistical safety level used for Life RBC C-2 mortality risk to identify weakly capitalized companies. The after-tax capital needs are translated to a factor expressed as a percentage of the net amount at risk (NAR). The pre-tax factor is determined by taking the after-tax factor divided by (1 minus the tax rate).

The factors are differentiated between individual & industrial life and group & credit life, and by in force block size. Within individual & industrial life, the factors are differentiated into categories by contract type depending on the degree of pricing flexibility. Within group & credit life, the factors are differentiated into categories by the remaining length of the premium rate term by group contract. There are distinct factors for contracts that have remaining premium rate terms 36 months and under and for contracts that have remaining premium rate terms over 36 months. The Federal Employees' Group Life Insurance (FEGLI) and Servicemembers' Group Life Insurance (SGLI) receive a separate factor applied to the amounts in force.

Specific Instructions for Application of the Formula

Lines ~~2, 5 and 21-44-6-11~~ are not applicable to Fraternal Benefit Societies.

The NAR ~~is derived in total and~~ for each of the factor categories ~~using annual statement sources and company records are retrieved from the Notes to the Financial Statements Item 37 and are in Force and Reserves amounts are net of reinsurance throughout. The In Force amounts throughout derived from company records need to be consistent with the Exhibit of Life Insurance. The Reserves amounts throughout derived from company records need to be consistent with Exhibit 5, Separate Accounts Exhibit, and Schedule 5.~~

The NAR size bands apply to the total amounts for individual & industrial life and group term & credit life. The size bands are allocated proportionately to the NAR for each of the factor categories. Size band 1 is for NAR amounts up to \$500 million. Size band 2 is for NAR amounts greater than \$500 million and up to \$25 billion. Size band 3 is for NAR amounts greater than \$25 billion.

Pricing Flexibility for Individual & Industrial Life Insurance and Group & Credit Life Permanent Life Insurance is defined as the ability to materially adjust rates on in force contracts through changing premiums and/or non-guaranteed elements as of the valuation date and within the next 5 policy years and reflecting typical business practices. For the purposes of assessing whether business is categorized as having "Pricing Flexibility", grouping of gross amounts may be done at either the contract level or at a cohort level consistent with grouping for pricing purposes. The categorization for ceded amounts for direct insurers should be based on the terms of each reinsurance treaty. Non-affiliated reinsurers are to assess the flexibility to adjust rates on in force contracts based on the terms of each reinsurance treaty and constraints based on typical business practices. For example, if a non-affiliated

10/14/2023 1/31/2023

reinsurer has historical precedent for changing in force rates, then that may provide support for assigning policies to the category with pricing flexibility. Affiliated reinsurers are to assign the factor category based on the direct policies. In force contracts may move between categories throughout their remaining lifetime if the degree of pricing flexibility changes as of each valuation date. A material rate adjustment is defined as the ability to recover, on a present value basis, the difference in mortality risks provided for in the factors below for contracts with and without pricing flexibility. ~~These differences in factors are shown in the Line (13) table below in the Permanent Life Flexibility Factor and Term Life Flexibility Factor columns.~~ The flexibility factor for each category multiplied by the NAR results in the minimum dollar margin needed for a material rate adjustment, which can then be compared against margins available to adjust rates. In force contracts that have margin available that is greater than or equal to the minimum dollar margin needed may be assigned to the category for policies with pricing flexibility. Insurers may choose to assign contracts to the categories without pricing flexibility if the evaluation of margins is not completed or if the degree of pricing flexibility is uncertain.

~~The table below illustrates the RBC requirement calculation embedded in Line (2) for Individual & Industrial Life Policies with Pricing Flexibility, Lines (11) and (12) Life Policies with Pricing Flexibility in Force and Reserves are derived from company records. Examples of products intended for this category include, but aren't limited to, participating whole life insurance, universal life insurance without secondary guarantees, and yearly renewable term insurance where scheduled premiums may be changed on an annual basis from the date of issue. The table below illustrates the RBC requirement calculation embedded in Line (13) for Life Policies with Pricing Flexibility.~~

<u>Line (42)</u>	<u>Individual & Industrial Life Policies with Pricing Flexibility</u>	<u>Statement Value (1)</u>	<u>Factor</u>	<u>RBC Requirement (2)</u>	<u>Permanent Life Flexibility Factor</u>	<u>Term Life Flexibility Factor</u>
	Allocation of First \$500 Million		X 0.00220 =		0.00230	0.00110
	Allocation of Next \$24,500 Million		X 0.00105 =		0.00120	0.00065
	Allocation of Over \$25,000 Million		X 0.00080 =		0.00085	0.00055
	Total Individual & Industrial Life Policies with Pricing Flexibility Net Amount at Risk					

~~The table below illustrates the RBC requirement calculation embedded in Line (3) for Individual & Industrial Term Life Policies without Pricing Flexibility, Lines (4) and (5) Term Life Policies without Pricing Flexibility in Force and Reserves are derived from company records. Examples of products intended for this category include, but aren't limited to, level term insurance with guaranteed level premiums and yearly renewable term insurance where scheduled premiums may not be changed. The table below illustrates the RBC requirement calculation embedded in Line (16) for Term Life Policies without Pricing Flexibility.~~

<u>Line (463)</u>	<u>Individual & Industrial Term Life Policies without Pricing Flexibility</u>	<u>Statement Value (1)</u>	<u>Factor</u>	<u>RBC Requirement (2)</u>
	Allocation of First \$500 Million		X 0.00280 =	
	Allocation of Next \$24,500 Million		X 0.00120 =	
	Allocation of Over \$25,000 Million		X 0.00085 =	
	Total Individual & Industrial Term Life Policies without Pricing Flexibility Net Amount at Risk			

~~The table below illustrates the RBC requirement calculation embedded in Line (4) for Individual & Industrial Permanent Life Policies without Pricing Flexibility, Lines (17) and (18) Permanent Life Policies without Pricing Flexibility in Force and Reserves are derived from the aggregate amounts derived in Lines (1) to (10) minus the amounts recorded in the other individual life categories. Examples of products intended for this category include, but aren't limited to, universal life with secondary guarantees and non-participating whole life insurance. Policies that aren't recorded in the other individual life categories default to this category which has the highest factors. The table below illustrates the RBC requirement calculation embedded in Line (19) for Permanent Life Policies without Pricing Flexibility.~~

10/14/2023 1/31/2023

<u>Line</u> <u>(494)</u>	<u>Individual & Industrial Permanent Life Policies without Pricing Flexibility</u>	<u>Statement Value</u> <u>(1)</u>	<u>Factor</u>	<u>RBC Requirement</u> <u>(2)</u>
	Allocation of First \$500 Million		X 0.00400 =	
	Allocation of Next \$24,500 Million		X 0.00175 =	
	Allocation of Over \$25,000 Million		X 0.00120 =	
	<u>Total Individual & Industrial Permanent Life Policies without Pricing Flexibility Net Amount at Risk</u>			

The table below illustrates the RBC requirement calculation embedded in Line (7) for Group & Credit Term Life with Remaining Rate Terms 36 Months and Under Net Amount at Risk Lines (35) and (36) Group & Credit Life In Force and Reserves with Remaining Rate Terms 36 Months and Under are derived from company records. This category includes group term life contracts where the premium terms have 36 months or fewer until expiration or renewal. Insurers may choose to assign contracts to the category for remaining rate terms over 36 months if the evaluation of remaining rate terms is not completed. The in force amount classified in this category needs to be consistent with the Exhibit of Life Insurance. The reserves amount classified in this category needs to be consistent with Exhibit 5 used for Lines (28) and (29). Separate Accounts Exhibit used for Line (30), and Schedule S used for Lines (31) and (32). Federal Employees' Group Life Insurance (FELGI) and Servicemembers' Group Life Insurance (SGLI) contracts are excluded. The table below illustrates the RBC requirement calculation embedded in Line (37) for Group & Credit Life Net Amount at Risk with Remaining Rate Terms 36 Months and Under.

<u>Line</u> <u>(37)</u>	<u>Group & Credit Term Life with Remaining Rate Terms 36 Months and Under</u>	<u>Statement Value</u> <u>(1)</u>	<u>Factor</u>	<u>RBC Requirement</u> <u>(2)</u>
	Allocation of First \$500 Million		X 0.00140 =	
	Allocation of Next \$24,500 Million		X 0.00055 =	
	Allocation of Over \$25,000 Million		X 0.00040 =	
	<u>Total Group & Credit Term Life Net Amount at Risk with Remaining Rate Terms 36 Months and Under Net Amount at Risk</u>			

The table below illustrates the RBC requirement calculation embedded in Line (8) for Group & Credit Life Term with Remaining Rate Terms Over 36 Months Net Amount at Risk Lines (38) and (39) Group & Credit Life In Force and Reserves with Remaining Rate Terms Over 36 Months are derived from the aggregate amounts derived in Lines (21) to (34) minus the Group & Credit Life In Force and Reserves with Remaining Rate Terms 36 Months and Under in Lines (35) and (36). This category includes group term life contracts where the premium terms have over 36 months until expiration or renewal. FELGI and SGLI contracts are excluded. The table below illustrates the RBC requirement calculation embedded in Line (40) for Group & Credit Life Net Amount at Risk with Remaining Rate Terms Over 36 Months.

<u>Line</u> <u>(408)</u>	<u>Group & Credit Term Life with Remaining Rate Terms Over 36 Months</u>	<u>Statement Value</u> <u>(1)</u>	<u>Factor</u>	<u>RBC Requirement</u> <u>(2)</u>
	Allocation of First \$500 Million		X 0.00190 =	
	Allocation of Next \$24,500 Million		X 0.00080 =	
	Allocation of Over \$25,000 Million		X 0.00055 =	
	<u>Total Group & Credit Term Life Net Amount at Risk with Remaining Rate Terms Over 36 Months Net Amount at Risk</u>			

10/14/2023 1/31/2023

Risk

The table below illustrates the RBC requirement calculation embedded in Line (9) for Group & Credit Permanent Life Policies with Pricing Flexibility Net Amount at Risk. The capital factors assigned are the same as Individual & Industrial Permanent Life Policies with Pricing Flexibility. FEGLI and SGLI contracts are excluded.

<u>Line (9)</u>	<u>Group & Credit Permanent Life Policies with Pricing Flexibility</u>	<u>(1)</u> <u>Statement Value</u>	<u>Factor</u>	<u>(2)</u> <u>RBC Requirement</u>
	Allocation of First \$500 Million		X 0.00220 =	
	Allocation of Next \$24,500 Million		X 0.00105 =	
	Allocation of Over \$25,000 Million		X 0.00080 =	
	<u>Total Group & Credit Permanent Life Policies with Pricing Flexibility Net Amount at Risk</u>			

The table below illustrates the RBC requirement calculation embedded in Line (10) for Group & Credit Permanent Life Policies without Pricing Flexibility Net Amount at Risk. The capital factors assigned are the same as Individual & Industrial Permanent Life Policies without Pricing Flexibility. FEGLI and SGLI contracts are excluded.

<u>Line (10)</u>	<u>Group & Credit Permanent Life Policies without Pricing Flexibility</u>	<u>(1)</u> <u>Statement Value</u>	<u>Factor</u>	<u>(2)</u> <u>RBC Requirement</u>
	Allocation of First \$500 Million		X 0.00400 =	
	Allocation of Next \$24,500 Million		X 0.00175 =	
	Allocation of Over \$25,000 Million		X 0.00120 =	
	<u>Total Group & Credit Permanent Life Policies without Pricing Flexibility Net Amount at Risk</u>			

Line (411) FEGLI/SGLI In Force amounts are retrieved from the Exhibit of Life Insurance. -The capital factor assigned is the same as the largest size band for group & credit term life contracts with remaining rate terms 36 months and under.

<u>Line (411)</u>	<u>FEGLI/SGLI In Force</u>	<u>(1)</u> <u>Statement Value</u>	<u>Factor</u>	<u>(2)</u> <u>RBC Requirement</u>
			X 0.00040 =	

All amounts should be entered as required. The risk-based capital software will calculate the RBC requirement for individual and industrial and for group and credit.

10/14/2023 1/31/2023



November 16, 2022

Phillip Barlow
Associate Commissioner
Chair, Life Risk-Based Capital (E) Working Group
Washington, D.C Department of
Insurance, Securities and Banking
1050 First Street, NE, 801
Washington, D.C. 20002

Dear Mr. Barlow,

Thank you for allowing the Mortgage Bankers Association (MBA) and the American Council of Life Insurers (ACLI) on behalf of our respective members the time to address the Working Group on the CM6 and CM7 RBC factor normalization. MBA and ACLI submit this letter in response to the questions raised on the October 7, 2022 call to help move this issue forward to approval.

First, Attachment 3 in the October 7, 2022, meeting agenda contained the proposed amendments to forms LR004 and LR009, but the formatting of this document was incorrect and did not show several changes that were being proposed in redline format. As a follow up, please see the attached document that has the full redline changes. The attached document's final version is not different from Attachment 3, but the full redline is more informative. John Waldeck addressed this in his remarks during the discussion.

Second, MBA and ACLI seek to provide context for the limited nature of the investments subject to this change. There is a minimal set of loans in the CM6 and CM7 categories, as shown in the below table.

American Council of Life Insurers | 101 Constitution Ave, NW, Suite 700 | Washington, DC 20001-2133

The American Council of Life Insurers (ACLI) is the leading trade association driving public policy and advocacy on behalf of the life insurance industry. 90 million American families rely on the life insurance industry for financial protection and retirement security. ACLI's member companies are dedicated to protecting consumers' financial wellbeing through life insurance, annuities, retirement plans, long-term care insurance, disability income insurance, reinsurance, and dental, vision and other supplemental benefits. ACLI's 280 member companies represent 94 percent of industry assets in the United States.

acll.com

The Mortgage Bankers Association (MBA) is the national association representing the real estate finance industry, an industry that employs more than 400,000 people in virtually every community in the country. Headquartered in Washington, D.C., the association works to ensure the continued strength of the nation's residential and commercial real estate markets, to expand homeownership, and to extend access to affordable housing to all Americans. MBA promotes fair and ethical lending practices and fosters professional excellence among real estate finance employees through a wide range of educational programs and a variety of publications. Its membership of more than 2,200 companies includes all elements of real estate finance: independent mortgage banks, mortgage brokers, commercial banks, thrifts, REITs, Wall Street conduits, life insurance companies, credit unions, and others in the mortgage lending field. For additional information, visit MBA's website: www.mba.org.

UPB of Life Company CM6 & CM7 Loans as a Percent of Total UPB

	CM6	CM7
12/31/2013	0.02%	0.05%
12/31/2014	0.01%	0.04%
12/31/2015	0.00%	0.08%
12/31/2016	0.00%	0.00%
12/31/2017	0.00%	0.00%
12/31/2018	0.00%	0.00%
12/31/2019	0.00%	0.00%
12/31/2020	0.01%	0.08%
12/31/2021	0.00%	0.04%

Source: MBA Life Company Loan Performance Database

This proprietary MBA database comprises roughly 72% of all life insurance company mortgage loans (representing 100% of the participating companies' portfolios) and is assumed to be consistent with the full population. As indicated, the percentage of CM6 & CM7 loans is very small, at less than 0.1% of total loans for each of the last 9 years. The modification to the CM6 and CM7 RBC factors being requested will have an immaterial impact on Risk Based capital.

Third, there was a request to analyze the applicability of the equity RBC factors for the CM6 and CM7 loans. To understand the applicability of equity RBC factors, it is important to understand the type of loans that are part of the CM6 and CM7 categories and why they behave similarly to equity investments. CM6 and CM7 loans are loans that are not performing (payments not being made). A CM6 loan is in process of evaluation by the lender to determine how it should be handled. If the lender believes it will likely return to performing status (Borrower makes all missed payments and begins making payments again), then they will not pursue their loan remedies to foreclose on the Borrower and will leave it in this status. This means that a CM6 is not currently performing and may or may not become current.

The distinction between CM6 and CM7 is that a CM7 loan is an asset that the Life Company lender has decided will not likely return to a performing status and has decided to foreclose out the borrower and realize on the loan security, and the lender has started that legal process to do so. At the conclusion of this process, the Lender will become the owner of the underlying real estate asset and will hold it in its portfolio as a real estate equity asset. So, a CM7 loan will quickly become an equity investment subject to equity RBC.

The requested change to the RBC factors is to have CM6 loans at an 11.0% RBC charge and CM7 loans at a 13.0% RBC charge. The highest equity RBC charge is 13.0% (for schedule BA assets), and the lowest is 11.0% (for Schedule A assets). Most companies will foreclose on a non-performing loan into a subsidiary entity, which would place the resulting equity asset on Schedule BA. The proposed charge for CM7 mortgages is consistent with the highest 13.0% equity RBC charge because after a likely foreclosure, this is the RBC charge it will be subject to.

When a loan is transitioned to become in the process of foreclosure, the lender will evaluate the value of the underlying real estate asset and impair the mortgage investment to be equal to the value of the

underlying real estate asset. In essence, the resulting STAT book value of the mortgage is the same as if the lender acquired the underlying real estate as an equity investment. Applying the same RBC charge just prior to foreclosure and after foreclosure means that the life company will have consistent risk-based capital through this transition. Prior to the change of the equity RBC from 23% to 13% (for schedule BA), the RBC charges for CM7 and equity RBC were consistent, and the requested change in RBC factors for CM6 and CM7 mortgages maintains this consistency.

The analysis done for the change in equity RBC factors is appropriate for the support of the change in the CM7 RBC factor because the CM7 mortgage asset is, as described above, soon to become an equity investment by the life company. Having the CM6 RBC factor aligned with the lowest equity RBC factor of 11% (for Schedule A assets) is appropriate because these investments may, but are not yet assumed to become an equity investment. The slight discount in the RBC factor reflects the higher likelihood of a CM6 mortgage asset returning to performing loan status.

Given the immaterial portion of life insurers' investments rated CM6 or CM7 and the logical consistency with equity RBC treatment for these assets, we believe the requested change is appropriate and consistent with best RBC practices.

Thank you for considering this request. If you have any questions, please do not hesitate to contact Mike Monahan, Senior Director of Accounting Policy, ACLI (MikeMonahan@acli.com) or Stephanie Milner, Associate Vice President, Commercial & Multifamily Policy, MBA (smilner@mba.org).

Sincerely,



Mike Monahan, American Council of Life Insurers
Mortgage Bankers Association

cc: Dave Fleming, NAIC Senior Insurance Reporting Analyst

**Capital Adequacy (E) Task Force
RBC Proposal Form**

- Capital Adequacy (E) Task Force Health RBC (E) Working Group Life RBC (E) Working Group
 Catastrophe Risk (E) Subgroup Investment RBC (E) Working Group Longevity Risk (A/E) Subgroup
 C3 Phase II/ AG43 (E/A) Subgroup P/C RBC (E) Working Group

		DATE: July 8, 2022	<u>FOR NAIC USE ONLY</u>
CONTACT PERSON:	Grant Carlson	Mike Monahan	Agenda Item # _____
TELEPHONE:	(202) 557-2765	(202) 624-2324	Year _____
EMAIL:	gcarlson@mba.org	mikemonahan@acli.com	<u>DISPOSITION</u>
ON BEHALF OF:	Mortgage Bankers Association	American Council of Life Insurers	<input type="checkbox"/> ADOPTED _____
NAME:	Mike Flood	Mike Monahan	<input type="checkbox"/> REJECTED _____
TITLE:	Senior Vice President, Commercial and Multifamily	Senior Director, Accounting Policy	<input type="checkbox"/> DEFERRED TO _____
AFFILIATION:	Mortgage Bankers Association	American Council of Life Insurers	<input type="checkbox"/> REFERRED TO OTHER NAIC GROUP _____
ADDRESS:	1919 M Street, NW Washington, DC 20036	101 Constitution Ave, NW Washington, DC 20001	<input type="checkbox"/> EXPOSED _____
			<input type="checkbox"/> OTHER (SPECIFY) _____

IDENTIFICATION OF SOURCE AND FORM(S)/INSTRUCTIONS TO BE CHANGED

- Health RBC Blanks Property/Casualty RBC Blanks Life and Fraternal RBC Instructions
 Health RBC Instructions Property/Casualty RBC Instructions Life and Fraternal RBC Blanks
 OTHER _____

DESCRIPTION OF CHANGE(S)

This proposal would make the following two related changes.

1. Align the CM6 and CM7 Life RBC factors for non-performing commercial and farm mortgages with the RBC factors for Schedule A and Schedule BA investments in real estate as those factors were adjusted in 2021; and
2. Adopt the same formula for calculating RBC amounts for non-performing and performing residential, commercial and farm mortgages.

REASON OR JUSTIFICATION FOR CHANGE **

1. Revising CM6 and CM7 factors would re-align the factors for non-performing mortgages with the factors for Schedule A and Schedule BA real estate investments.

Historical alignment and the 2021 change

Prior to the 2021, the 23% factor for CM7 In Process of Foreclosure commercial and farm mortgages was perfectly aligned with the 23% factor for Schedule BA real estate assets; and the 18% factor for CM6 90-Days Delinquent commercial and farm mortgages was roughly aligned with the 15% factor for Schedule A real estate assets.

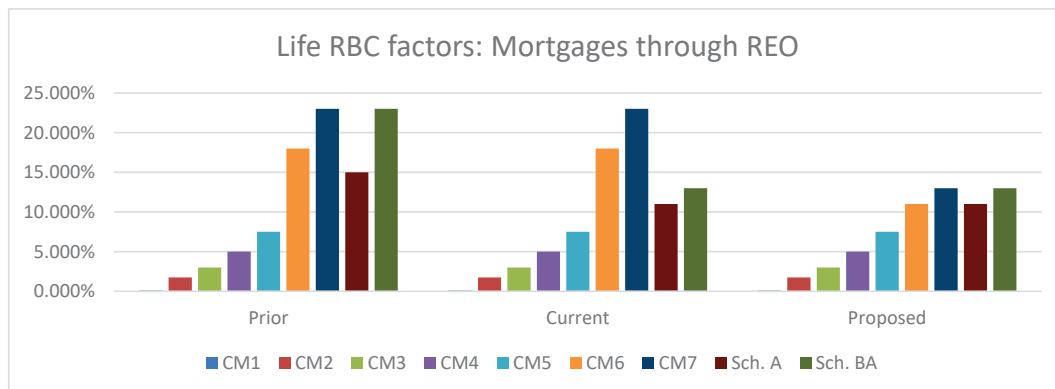
That alignment made sense as a matter of risk because the worst-case path for a non-performing mortgage loan results in the asset becoming a real estate equity investment on the insurer’s balance sheet. In 2021, however, the factor assigned to Schedule A real estate investments dropped from 15% to 11%, and the factor for Schedule BA real estate investments dropped from 23% to 13%. As a result, the 18% and 23% factors for CM6 and CM7 mortgage are no longer aligned with the factors for real estate investments.

The proposal

The proposal is to adjust the factor for CM6 mortgages from 15% to 11% and adjust the factor for CM7 mortgages from 23% to 13%. The changes necessary to implement this proposal are reflected in the attached mark-up of LR004 and LR009 RBC Reporting Instructions.

Impacts

The table below illustrates the relationships between CM6 and CM7 factors and Schedule A and Schedule BA real estate assets, historically, currently, and as proposed.



2. Adopting the same formula for calculating RBC amounts for non-performing and performing residential, commercial and farm mortgages would ensure that the effective RBC factor for non-performing residential, commercial and farm mortgages would not be less than the nominal RBC charge.

As we considered the proposal to align the factors for delinquent mortgages and for real estate investments, we also revisited the formula for computing RBC for non-performing mortgages. Based on that consideration, we concluded that there is no reasonable basis for continuing to use a different calculation formula for performing and non-performing mortgages.

The current state: non-performing mortgages

The formula for applying RBC factors to non-performing mortgages both adds in and backs out any applicable write-downs, as follows:

$$RBC_{non-perf} = [(STAT\ Book\ Value + \underline{STAT\ Write-downs} - STAT\ Invol.\ Reserves) \times CM\ 6-7\ Charge] - \underline{STAT\ Write-downs}$$

Because this formula can result in very low and even negative RBC amounts for non-performing loans, it is supplemented by a requirement that the resulting RBC amount cannot be lower than the applicable CM1-5 charge for the mortgage if the investment was performing.

The current state: performing mortgages

The formula for applying RBC factors to performing mortgages is as follows:

$$RBC_{perf} = (STAT\ Book\ Value - STAT\ Invol.\ Reserves) \times CM\ 1-5\ Charge$$

There is no need for a backstop to this formula because the effective RBC factor for a performing loan is always the same as the nominal RBC charge for the applicable CM category.

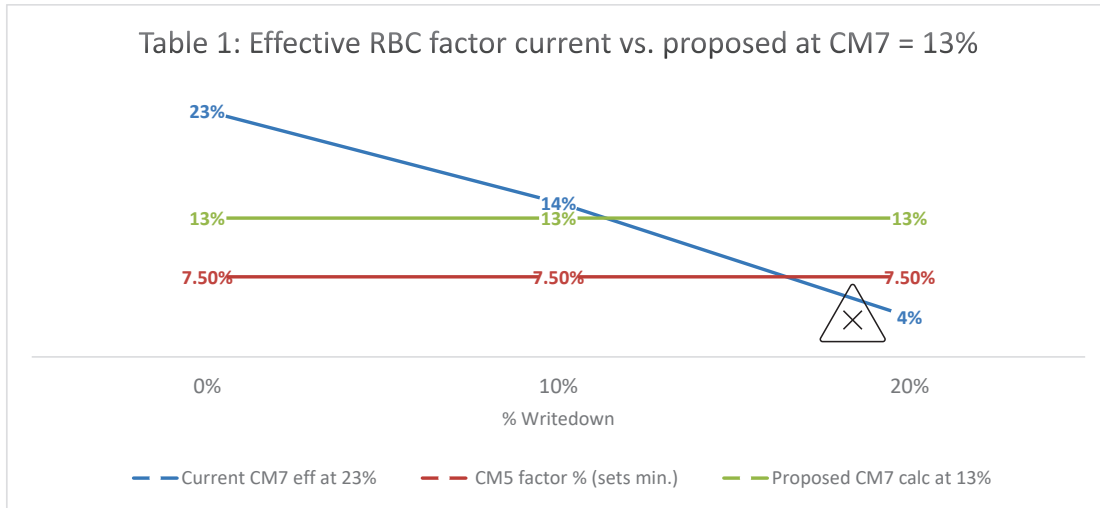
The proposal

The proposal would apply the same formula for both performing and non-performing mortgages. The changes necessary to implement this proposal are reflected in the attached mark-up of LR004 and LR009 RBC Reporting Instructions.

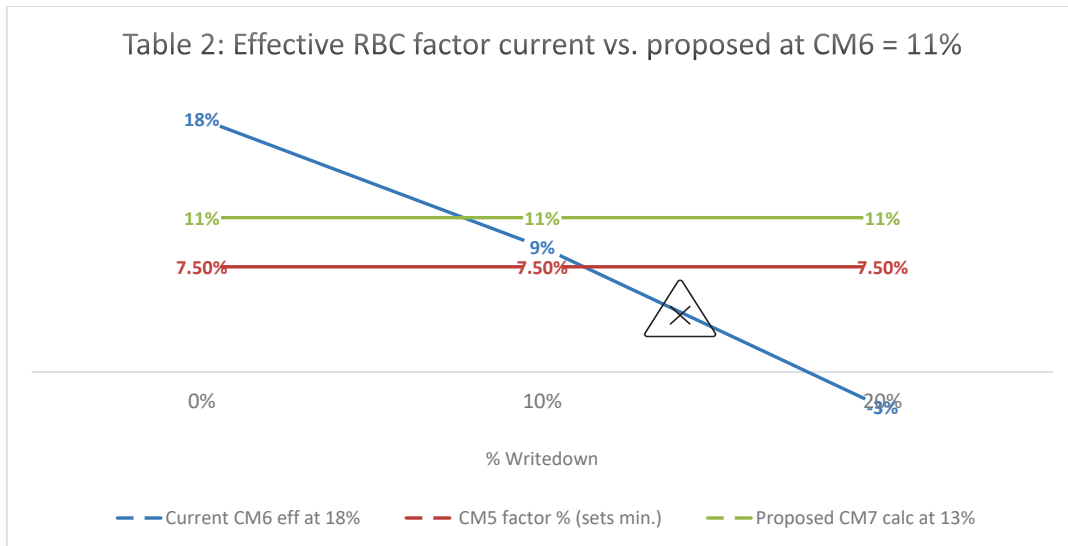
Impacts

Under the proposal, the RBC charge for some non-performing mortgages would increase and the RBC charge for other non-performing mortgages would decrease, depending on the amount of any write-downs.

In Table 1, the blue and brown lines illustrate that, for a CM7 mortgage under the current state, the effective RBC factor would range from 23% to 7.5% of the statutory book value less involuntary reserves (assuming the performing loan rating would be CM5), depending on the amount of any write-down. The green line in the table illustrates that, under the proposal, the effective RBC factor would be equal to the RBC charge for a CM7 mortgage (as adjusted in part 1 of this proposal) without regard to write-downs.



In Table 2, the blue and brown lines illustrate that, for a CM6 mortgage under the current state, the effective RBC factor would range from 18% to 7.5% of the statutory book value less involuntary reserves (assuming the performing loan rating would be CM5), depending on the amount of any write-down. The green line in the table illustrates that, under the proposal, the effective RBC factor would be equal to the RBC charge for a CM6 mortgage (as adjusted in part 1 of this proposal) without regard to write-downs.



Both tables illustrate that adopting the performing mortgage loans formula and the proposed CM6 and CM7 factors would reduce the required RBC amount for non-performing mortgages with smaller levels of write-downs but would increase required RBC amounts for non-performing mortgages with larger write-downs.

Attachment: Suggested mark-up of Instructions LR004 and LR009.

Notes to the mark-up:

- The attached mark-up adds the previously approved instructions for reporting 2020 NOI. See [Guidance for Troubled Debt Restructurings for December 31, 2020 and Interim Risk-Based Capital Filings \(where required\)](#) (October 9, 2020, Revised February 11, 2021).
- The attached mark-up also reflects a suggested deletion of the version number of the CREFC Methodology for Analyzing and Reporting Property Income Statements, to avoid the ongoing need to update the Instructions to reflect each new versions of that methodology. This is not part of the proposal described above, but the Life Risk-Based Capital Working Group may want to consider it.

Additional Staff Comments:

** This section must be completed on all forms.

Revised 2-2019

MORTGAGES

LR004

Basis of Factors

Mortgages in Good Standing

The pre-tax factors for commercial mortgages were developed based on analysis using the Commercial Mortgage Metrics model of Moody's Analytics and documented in a report from the American Council of Life Insurers on March 27, 2013. The factors provide for differing levels of risk, the levels determined by a contemporaneous debt service coverage ratio and the contemporaneous loan-to-value. The 0.14 percent pre-tax factor on insured and guaranteed mortgages represents approximately 30-60 days interest lost due to possible delay in recovery on default. The pre-tax factor of 0.68 percent for residential mortgages reflects a significantly lower risk than commercial mortgages. The pre-tax factors were developed by dividing the post-tax factor by 0.7375 (0.7375 is calculated by taking 1.0 less the result of 0.75 multiplied by 0.35). The pre-tax factors are not changing for 2018 due to tax reform.

Mortgages 90 Days Overdue, Not in Process of Foreclosure

The category pre-tax factor for commercial and farm mortgages of ~~48~~ 11 percent is based on ~~data taken from the Society of Actuaries' "Commercial Mortgage Credit Risk Study," the 11 percent factor for real estate investments reported on Schedule A.~~ For insured and guaranteed or residential mortgages, factors are set at twice the level for those "in good standing" to reflect the increased likelihood of default losses.

Mortgages in Process of Foreclosure

~~The category pre-tax factor of 13 percent for farm mortgages in process of foreclosure is based on the 13 percent factor for real estate investments reported on Schedule BA#re-considered to be as risky as NAIC 5 bonds and are assigned the same category pre-tax factor of 23 percent for commercial and farm mortgages.~~

Due and Unpaid Taxes on Overdue Mortgages and Mortgages in Foreclosure

The factor for due and unpaid taxes on overdue mortgages and mortgages in foreclosure is 100 percent.

Specific Instructions for Application of the Formula

Column (1)

Insured or guaranteed mortgages should be reported separately from residential and commercial mortgages. Insured or guaranteed loans include only those mortgage loans insured or guaranteed by the Federal Housing Administration, under the National Housing Act (Canada) or by the Veterans Administration (exclusive of any portion insured by FHA). Mortgage loans guaranteed by another company (affiliated or unaffiliated) are not to be included in the insured or guaranteed category.

Except for Lines (1) through (3), (17) through (19), (22) through (24), (26) and (27), calculations are done on an individual mortgage basis and then the summary amounts are entered in this column for each class of mortgage investment. ~~Refer to the mortgage calculation worksheet A (Figure 1) for how the individual mortgage calculations are completed for Other Than In Good Standing mortgages on Lines (4) through (25). Refer to the mortgage calculation worksheet – company developed (Figure 23) for how the individual mortgage calculations are completed for In Good Standing – Commercial mortgages on Lines (4) through (8) and for In Good Standing – Farm mortgages on Lines (10) through (14) and for Other Than In Good Standing mortgages on Lines (16), (20), (21), and (25). Line (28) should equal Page 2, Column 3, Lines 3.1 plus 3.2, plus Schedule B, Part 1 Footnotes 3 and 4, first of the two amounts in the footnotes.~~

Column (2)

Companies are permitted to reduce the book/adjusted carrying value of mortgage loans reported in Schedule B by any involuntary reserves. Involuntary reserves are equivalent to valuation allowances specified in SSAP No. 37 paragraph 16. These reserves are held as an offset for a particular troubled mortgage loan that would be required to be written down if

10/15/2021

10/15/2021

the impairment was permanent.

Column (3)

Column (3) is calculated as the net of Column (1) less Column (2).

Column (4)

~~Summary amounts of the individual mortgage calculations are entered in this column for each class of mortgage investments. Refer to the mortgage calculation worksheet (Figure 1). Cumulative writedowns include the total amount of writedowns, amounts non-admitted and involuntary reserves that have been taken or established with respect to a particular mortgage. No longer used. Place "XXX" in any blanks for this column.~~

Column (5)

~~For Lines (1) and (3), the pre-tax factor is equal to 0.0014
For Lines (2), the pre-tax factor is equal to 0.0068
For Lines (4) and (10), the pre-tax factor is equal to 0.0090
For Lines (5) and (11), the pre-tax factor is equal to 0.0175
For Lines (6) and (12), the pre-tax factor is equal to 0.0300
For Lines (7) and (13), the pre-tax factor is equal to 0.0500
For Lines (8) and (14), the pre-tax factor is equal to 0.0750
For Lines (16) and (20), the pre-tax factor is equal to 0.1100
For Lines (17) and (19), the pre-tax factor is equal to 0.0027
For Lines (18), the pre-tax factor is equal to 0.0140
For Lines (21) and (25), the pre-tax factor is equal to 0.1300
For Lines (22) and (24), the pre-tax factor is equal to 0.0054
For Lines (23), the pre-tax factor is equal to 0.0270~~

~~For Lines (26) and (27), the pre-tax factor is 1.0. For Lines (16) through (25), the average factor column is calculated as Column (6) divided by Column (3).~~

Column (6)

~~For Lines (4) through (8), (10) through (14), and (16), (20), (21) and (25), summary amounts are entered for Column (6) based on calculations done on an individual mortgage basis. Refer to the mortgage calculation worksheets (Figure 1) and (Figure 2). For Lines (1) through (3), (17) through (19), (22) through (24), (26) and (27), the RBC subtotal is multiplied by the factor to calculate Column (6).~~

(Figure 1)

(1)	(2)	(3)	(4)	(5)	(6)	(7)	(7a)	(8)	(9)	(10)
	Book/Adjusted Carrying Value	Involuntary Reserve Adjustment [§]	RBC Subtotal [¶]	Cumulative Writedowns*	Category Factor	In-Good Standing Factor	In-Good Standing Category	Col(6)+X [Col (4)+(5)] -Col(5)	Col(4)X Col(7)	RBC Requirement [‡]
(11) All Mortgages Without Cumulative Writedowns				XXXX	‡	‡	‡			
All Mortgages With Cumulative Writedowns:										
(2)										
(3)										
(4)										
(5)										
(6)										
(7)										
(8)										
(9)										
(10)										
(11)										
(12)										
(13)										
(14)										
(15)										
Total Mortgages										

This worksheet is prepared on a loan-by-loan basis for each of the mortgage categories listed in (Figure 2) that are applicable. The Column (2), (3), (5) and (10) subtotals for each category are carried over and entered in Columns (1), (2), (4) and (6) of the Mortgages (LR004) in the risk-based capital formula. Small mortgages aggregated into one line on Schedule B can be treated as one mortgage on this worksheet. NOTE: This worksheet will be available in the risk-based capital filing software.

- ‡ See (Figure 2) for factors to use in the calculation. The In-Good Standing Factor will be based on the CM category developed in the company-generated worksheet (Figure 2) and reported in Column 7a for Commercial or Farm Mortgages.
- ‡ The RBC Requirement column is calculated as the greater of Column (8) or Column (9), but not less than zero.
- § Involuntary reserves are reserves held as an offset to a particular asset that is clearly a troubled asset and are included on Page 3, Line 25 of the annual statement.
- ¶ Column (4) is calculated as Column (2) less Column (3).
- * Cumulative writedowns include the total amount of writedowns, amounts non-admitted and involuntary reserves that have been taken or established with respect to a particular mortgage.

(Figure 12)

The mortgage factors are used in conjunction with the mortgage worksheets (Figures 1 and 2) to calculate the RBC Requirement for each individual mortgage. ~~The factors are used in Columns (6), (7) and (7a) of the mortgage worksheet and are dependent on which of the 25 mortgage categories below the mortgage falls into.~~ The following factors are used for each category of mortgages:

LR004 Line Number	Mortgage Factors	Category Factor ‡	In-Good Standing Factor	MEA Factor
	<u>In Good Standing</u>			
(1)	Residential Mortgages-Insured or Guaranteed	0.0014N/A‡	0.0014	N/A
(2)	Residential Mortgages-All Other	0.0068N/A‡	0.0068	N/A
(3)	Commercial Mortgages-Insured or Guaranteed	0.0014N/A‡	0.0014	N/A
(4)	Commercial Mortgages-All Other – Category CM1	0.0090N/A‡	0.0090	N/A‡
(5)	Commercial Mortgages – Category CM2	0.0175N/A‡	0.0175	N/A‡
(6)	Commercial Mortgages – Category CM3	0.0300N/A‡	0.0300	N/A‡
(7)	Commercial Mortgages – Category CM4	0.0500N/A‡	0.0500	N/A‡
(8)	Commercial Mortgages – Category CM5	0.0750N/A‡	0.0750	N/A‡
(10)	Farm Mortgages – Category CM1	0.0090N/A‡	0.0090	N/A‡
(11)	Farm Mortgages – Category CM2	0.0175N/A‡	0.0175	N/A‡
(12)	Farm Mortgages – Category CM3	0.0300N/A‡	0.0300	N/A‡
(13)	Farm Mortgages – Category CM4	0.0500N/A‡	0.0500	N/A‡
(14)	Farm Mortgages – Category CM5	0.0750N/A‡	0.0750	N/A‡
	<u>90 Days Overdue, Not in Process of Foreclosure</u>			
(16)	Farm Mortgages – Category CM6	0.18000.1100	‡	N/A‡
(17)	Residential Mortgages-Insured or Guaranteed	0.0027	0.0014	-1.0 N/A
(18)	Residential Mortgages-All Other	0.0140	0.0068	-1.0 N/A
(19)	Commercial Mortgages-Insured or Guaranteed	0.0027	0.0014	-1.0 N/A
(20)	Commercial Mortgages-All Other – Category CM6	0.18000.1100	‡	N/A‡
	<u>In Process of Foreclosure</u>			
(21)	Farm Mortgages – Category CM7	0.23000.1300	‡	N/A‡
(22)	Residential Mortgages-Insured or Guaranteed	0.0054	0.0014	-1.0 N/A
(23)	Residential Mortgages-All Other	0.0270	0.0068	-1.0 N/A
(24)	Commercial Mortgages-Insured or Guaranteed	0.0054	0.0014	-1.0 N/A
(25)	Commercial Mortgages-All Other – Category CM7	0.23000.1300	‡	N/A‡

‡-The category factor is a factor used for a particular category of mortgage loans that are not in good standing.
 †-The RBC Requirement for mortgage loans in good standing or restructured are not calculated on Figure (1). These requirements are calculated on Mortgage Worksheet (company developed) (Figure 3) and transferred to LR004 Mortgage Loans Lines (4) through (8) and (10) through (14). In addition, for Commercial and Farm mortgage loans 90 days past due or In Process of Foreclosure, the CM category is determined in Mortgage Worksheet (company developed) and transferred to Worksheet A.

The Company should develop this worksheet on a loan-by-loan basis for each commercial mortgage – other or farm loan held in Annual Statement Schedule B. This worksheet columns (7) and (9) subtotals for each category are to be carried over and entered in Columns (1) and (2) of Mortgages (LR004) in the risk-based capital formula lines (4) – (8), and (10) – (14), (16), (20), (21), and (25). Small mortgages aggregated into one line on Schedule B can be treated as one mortgage on this worksheet. ~~Accounts in Columns (7)-(9) and (12) are carried individually to Worksheet A columns (2), (3) and (7a) for loans that are 90 Days Past Due and In Process of Foreclosure.~~ NOTE: This worksheet will not be available in the risk-based capital filing software and needs to be developed by the company.

#	Column Heading	Description / explanation of item
		Price Index current is the value on 9/30 of the current year for the National Council of Real Estate Investor Fiduciaries Price Index for the United States.
(1)	Name / ID	Identify each mortgage included as in good standing.
(2)	Date of Origination	Enter the year and month that the loan was originated. If the loan has been restructured, extended, or otherwise re-written, enter that new date.
(3)	Maturity Date	Enter earlier of maturity of the loan, or the date the lender can call the loan.
(4)	Property Type	Enter 1 for mortgages with an Office, Industrial, Retail or multifamily property as collateral. Enter 2 for mortgages with a Hotel and Specialty Commercial as property type. For properties that are multiple use, use the property type with the greatest square footage in the property. Enter 3 for Farm Loans.
(5)	Farm Sub-type	If Property Type=3 (Farm Loans), then you must enter a Sub Category: 1=Timber, 2=Farm and Ranch, 3=Agribusiness Single Purpose, 4=Agribusiness All Other (See Note 8).
(6)	Postal Code	Enter zip code of property for US. If multiple properties or zip codes, enter multiple codes. If foreign address, use postal code. If not available, N/A.
(7)	Book / Adjusted Carrying Value	Enter the value that the loan is carried at on the company ledger.
(8)	Statutory Write-downs	Enter the value of any write-downs taken on this loan due to permanent impairment.
(9)	Involuntary Reserve	Enter the amount of any involuntary reserve amount. Involuntary reserves are reserves that are held as an offset to a particular asset that is clearly a troubled asset and are included on Page 3 Line 25 of the Annual Statement.
(10)	Original Loan Balance?	Enter the loan balance at the time of origination of the loan.
(11)	Principal Balance to Co.	Enter the value of the loan balance owed by the borrower.
(12)	Balloon Payment at Maturity	Enter the amount of any balloon or principal payment due at maturity.
(13)	Principal Balance Total	Enter the total amount of mortgage outstanding including debt that is senior to or pari passu with the company's mortgage (Note 2)
(14)	NOI Second Prior	Enter the NOI from the year prior to the value in (15). See Note 1.
(15)	NOI Prior	Enter the NOI from the prior year to the value in (16). See Note 1.
(16)	NOI	Enter the Net Operating Income for the most recent 12 month fiscal period with an end-date between July 1 of the year prior to this report and June 30 of the year of this report. The NOI should be reported following the guidance of the Commercial Real Estate Finance Council Investor Reporting Profile v.5.0. Section VII. See Notes 1, 3, 4, 5, and 6 below.

10/15/2021

(17)	Interest Rate	Input	Enter the annual interest rate at which the loan is accruing. -If the rate is floating, enter the larger of the current month rate or the average rate of interest for the prior 12 months, or -If the rate is fixed by the contract, not level over the year, but level for the next 12 months, use current rate. If the 'Total Loan Balance' consists of multiple loans, use an average loan interest rate weighted by principal balance.
(18)	Trailing 12 Month Debt Service	Input	Enter actual 12 months debt service for prior 12 months
(19)	Original Property Value	Input	Enter the Property Value at the time of origination of the loan. (Note 9)
(20)	Property Value	Input	Property Value is the value of the Property at time of loan origination, or at time of revaluation due to impairment underwriting, restructuring, extension, or other re-writing. (Note 9)
(21)	Year of Valuation	Input	Year of the valuation date defining the value in (20). This will be either the date of origination, or time of restructuring, refinance, or other event which precipitates a new valuation.
(22)	Quarter of Valuation	Input	Calendar quarter of the valuation date defining the value in (20).
(23)	Credit Enhancement	Input	Enter the full dollar amount of any credit enhancement. (see Note 5)
(24)	Senior Debt?	Input	Enter yes if senior position, no if not. (see Note 7.)
(25)	Construction Loan?	Input	Enter 'Yes' if this is a construction loan. (see Note 4.)
(26)	Construction – not in balance?	Input	Enter 'Yes' if this is a construction loan that is not in balance. (see Note 4)
(27)	Construction – Issues?	Input	Enter 'Yes' if this is a construction loan with issues. (see Note 4)
(28)	Land Loan?	Input	Enter 'Yes' if this is a loan on non-income producing land. (see Note 6)
(29)	90 days past due?	Input	Enter 'Yes' if payments are 90 days past due.
(30)	In process of foreclosure?	Input	Enter 'Yes' if the loan is in process of foreclosure.
(31)	Is current payment lower than a payment based on the loan interest?	Input	Yes / No
(32)	Is loan interest a floating rate?	Input	Yes / No
(33)	If not floating, does loan reset during term?	Input	Yes / No - Some fixed rate loans define in the loan document a change to a new rate during the life of the loan, which may be a pre-determined rate or may be the then current market rate. Generally any such changes are less frequent than annual.
(34)	Is negative amortization allowed?	Input	Yes / No
(35)	Amortization type?	Input	1 = fully amortizing 2 = amortizing with balloon 3 = full I/O 4 = partial I/O, then amortizing
(36)	Rolling Average NOI	Computation	For 2013 – 100% of NOI For 2014 – 65% NOI + 35% NOI Prior For 2015 – 50% NOI + 30% NOI Prior + 20% NOI 2 nd Prior For loans originated or valued within the current year, use 100% NOI. For loans originated 2013 or later and within 2 years, use 65% NOI and 35% NOI Prior

10/15/2021

(37)	RBC Debt Service	Computation	This amount is the amount of 12 monthly principal and interest payments required to amortize the Total Loan Balance (13) using a Standardized Amortization period of 300 months and the Annual Loan Interest Rate (17).
(38)	RBC DCR	Computation	This is the ratio of the Net Operating Income (36) divided by the RBC Debt Service (37) rounded down to 2 decimal places. See Note 3 below for special circumstances.
(39)	NCREIF Price Index at Valuation	Computation	The value of the NCREIF Price Index on the last day of the calendar quarter that includes the date defined in (21) and (22).
(40)	Contemporaneous Property Value	Computation	The Property Value (20) times the ratio (rounded to 4 decimal places) of the Price Index current to the Price Index at valuation (39).
(41)	RBC LTV	Computation	The Total Loan Value (13) divided by the Contemporaneous Value (40) rounded to the nearest percent.
(42)	CM Category	Computation	The risk category determined by either being not in good standing (either 90 Days Past Due or In Process of Foreclosure) or the loan being in good standing or restructured and applying the DCR (38) and the LTV (41) to the criteria in Figure (34), Figure (45) or Figure (56). See Notes 2, 3, 4, 5, and 6 below for special circumstances.

Note 1: Net Operating Income (NOI): The majority of commercial mortgage loans require the borrower to provide the lender with at least annual financial statements. The NOI would be determined at the RBC calculation date based on the most recent annual period from financial statements provided by the borrower and analyzed based on accepted industry standards. The most recent annual period is determined as follows:

- If the borrower reports on a calendar year basis, the statements for the calendar year ending December 31 of the year prior to the RBC calculation date will be used. For example, if the RBC calculation date is 12/31/2012, the most recent annual period is the calendar year that ends 12/31/2011.
- If the borrower reports on a fiscal year basis, the statements for the fiscal year that ends after June 30 of the prior calendar year and no later than June 30 of the year of the RBC calculation date will be used. For example, if the RBC calculation date is 12/31/2012, the most recent annual period is the fiscal year that ends after 6/30/2011 and no later than 6/30/2012.
- The foregoing time periods are used to provide sufficient time for the borrower to prepare the financial statements and provide them to the lender, and for the lender to calculate the NOI.

The accepted industry standards for determining NOI were developed by the Commercial Mortgage Standards Association now known as CRE Financial Council (CREFC). The company must develop the NOI using the standards provided by the CREFC Methodology for Analyzing and Reporting Property Income Statements ~~v.5.4~~ (www.crefc.org/irp). These standards are part of the CREFC Investor Reporting Package (CREFC IRP Section VII.) developed to support consistent reporting for commercial real estate loans owned by third party investors. This guidance would be a standardized basis for determining NOI for RBC.

The NOI will be adjusted to use a 3 year rolling average for the DSC calculation. For 2013, a single year of NOI will be used. For 2014, 2 years will be used, weighted 65% most recent year and 35% prior year. Thereafter, 3 years will be used weighted 50% most recent year, 30% prior year, and 20% 2nd prior year. This will apply when there is a history of NOI values. For new originations, including refinancing, the above schedule would apply by duration from origination. For the special circumstances listed below, the specific instructions below will produce the NOI to be used, without further averaging.

For purposes of the NOI inputs at (14), (15), (16), and the computation of a Rolling Average NOI at (36), an insurer may report 2020 NOI (i.e., NOI for any 12-month fiscal period ending after June 30, 2020 but not later than June 30, 2021) as the greater of: (1) actual NOI as determined under the CREFC-C IRP Standards or (2) 85% of NOI determined for the immediate preceding fiscal year's annual report. This guidance with respect to 2020 NOI applies to the application of the 2020 NOI in risk-based capital reporting for 2021, 2022, and 2023. In cases where an insurer reports 85% of 2019 NOI as the 2020 NOI input, the insurer should retain information about actual 2020 NOI in its workpapers so that the information can be readily available to regulators.

Note 2: The calculation of debt service coverage and loan to value will include all debt secured by the property that is (1) senior to or pari passu with the insurer's investment; and (2) any debt subordinate to the insurer's investment that is not (a) subject to an intercreditor, standstill or subordination agreement with the insurer provided that the agreement does

10/15/2021

not grant the subordinate debt holder any rights that would materially affect the rights of the insurer and provided that the subordinate debt holder is prohibited from taking any action against the borrower that would materially affect the insurer's priority lien position with respect to the property without the prior written consent of the insurer, or (b) subject to governing laws that provide that the insurer's investment holds a senior position to the subordinated debt holder and provide substantially similar protections to the insurer as in (2)(a) above.

Note 3: *Unavailable Operating Statements*

There are a variety of situations where the most recent annual period's operating statement may not be available to assist in determining NOI. These situations will occur in distinct categories and each category requires special consideration. The categories are:

1. Loans on owner occupied properties
 - a. For properties where the owner is the sole or primary tenant (50% or more of the rentable space), property level operating statements may not be available or meaningful. If the property is occupied and the loan, taxes and insurance are current, it will be acceptable to derive income and a reasonable estimate of expenses from the most recent appraisal or equivalent and additional known actual expenses (e.g., real estate taxes and insurance).
 - b. For properties where the owner is a minority tenant (49% or less of the rentable space), the owner-occupied space should be underwritten at the average rent per square foot of the arm's length tenant leases. This income estimate should be added to the other tenant leases and combined with a reasonable estimate of expenses based on the most recent appraisal or equivalent and additional known actual expenses (e.g., real estate taxes and insurance).
2. Borrower does not provide the annual operating statement
 - a. Borrower refuses to provide the annual operating statements
 - i. If the leases are in place and evidenced by estoppels and inspections, NOI would be derived from normalized underwriting in accordance with the CREFC Methodology for Analyzing and Reporting Property Income Statements.
 - ii. If there is evidence from inspection that the property is occupied, but there is no evidence of in place leases (e.g., lease documents or estoppels), NOI would be set equal to the lesser of calculated debt service (DSC=I.0) or the NOI from the normalized underwriting.
 - iii. If there is no evidence from inspection that the property is occupied and no evidence of in place leases (e.g., lease documents or estoppels), assume NOI = \$0.
 - b. If the borrower does not have access to a complete previous year operating statement, determine NOI based on the CREFC guidelines for analyzing a partial year income statement.

Note 4: Construction loans:

Construction loans would be categorized as follows, based on a determination by the loan servicer whether the loan is in balance and whether construction issues exist:

- a. In balance, no construction issues: DSC = 1.0, LTV determined as usual
- b. Not in Balance, no construction issues: CM4
- c. Construction issues: CM5

A loan is "*in balance*" if the committed amount of the construction loan plus any lender held reserves and unfunded borrower equity is sufficient to cover the remaining costs of the development project, including debt service not anticipated to be paid from property operations.

A "*construction issue*" is a problem that may reasonably jeopardize the completion of the project. Examples of construction issues include the abandonment of construction and construction defects that are not being addressed.

10/15/2021

Note 5: Credit enhancements: Where the loan payments are secured by a letter of credit from an investment grade financial institution or an escrow account held at an investment grade financial institution, NOI less than the debt service may be increased by these amounts until it is equal to but not exceeding the debt service. These situations are typically short term in nature and are intended to bridge the lease-up following renovation or loss of a major tenant.

Note 6: Non-income-producing land: NOI = \$0

Note 7: Non-senior financing:

- a. The company should first calculate DSC and LTV for non-senior financing using the standardized debt service and aggregate LTV of all financing *pari passu* and senior to the position held by the company.
- b. The non-senior piece should then be assigned to the next riskier RBC category. For example, if the DSC and LTV metrics determined in (a) indicate a category of CM2, the non-senior piece would be assigned to category CM3. However, it would not be required to assign a riskier category than CM5 if the loan is not at least 90-days delinquent or in foreclosure.

Note 8: Definitions of each type of Farm Mortgage:

Timber: A loan is classified as a timber loan if more than 50% of the collateral market value (land and timber) of the security is attributable to land supporting a timber crop that is or will be of commercial value.

Farm & Ranch: Farm and ranch land utilized in the production of agricultural commodities of all kinds, including grains, cotton, sugar, nuts, fruits, vegetables, forage crops, and livestock of all kinds, including, beef, swine, poultry, fowl and fish. Loans included in this category are those in which agricultural land accounts for more than 50% of total collateral market value.

Agribusiness Single Purpose: Specialized collateral utilized in the production, further processing, adding value or manufacturing of an agricultural commodity or forest product. In order for a loan to be classified as such, the market value of the single-purpose (special use) collateral would account for more than 50% of total collateral market value.

This collateral is generally not multi-functional and can only be used for a specific production, manufacturing and/or processing function within a specific sub-sector of the food or agribusiness industry and whereby such assets are not strategically important in nature to the overall industry capacity. These assets can be shut down or replicated easily in other locations, or existing plants can be expanded to absorb shuttered capacity. The assets are not generally limited in nature by environmental or operational permits and/or regulatory requirements. An example would be a poultry processing plant located in the Southeast of the United States where there is excess capacity inherent to the industry and production capacity is easily replaceable.

Other loans included in this category are those collateralized by single purpose (special use) confinement livestock production facilities in which the special use facilities account for more than 50% of total collateral market value.

Agribusiness All Other: Multiple-use collateral utilized in the production, further processing, adding value or manufacturing of an agricultural commodity or forest product. In order for a loan to be classified as such, the market value of any single use portion may not be greater than 50% of total collateral market value.

This collateral is multi-functional in nature, adaptable to other manufacturing, processing, or servicing food or agribusiness industries or sub-industries. Assets could also be very strategic in nature and not easily replaceable either due to cost, location, environmental permitting and/or government regulations. These assets may be single purpose in nature, but so vital to the industry capacity needs that they will be generally purchased by another like processing company or strategic or financial buyer. An example of these types of assets are strategically located and highly automated cold storage facilities whereby they can be used for dry storage, distribution centers or converted into

10/15/2021

warehouse or other type uses. Another example may be a cheese processing plant that is strategically located within the heart of the dairy industry, limited permits, environmental restrictions that would limit added capacity, or high barriers to entry to build a like facility within the industry. For example, one of the largest cheese plants in the industry is located in California and it is not easily replicated within the cheese processing industry due to its location, capacity, costs, access to fluid milk supply and related feed and water, as well as highly regulated environmental and government restrictions.

Other loans included in this category are those in which more than 50% of the collateral market value is accounted for by chattel assets or other assets related to the business and financial operations of agribusinesses, including inventories, accounts, trade receivables, cash and brokerage accounts, machinery, equipment, livestock and other assets utilized for or generated by agribusiness operations.

Note 9. The origination value is developed during the underwriting process using appropriate appraisal standards.

- a. If values were received from a qualified third-party appraiser, those values must be used.
- b. If the company performs internal valuations using standards comparable to an external appraisal, then the internal valuation may be used.

(Figure 3-4)

For Office, Industrial, Retail and Multi-family:

RISK CATEGORY	DSC LIMITS		LTV LIMITS
CM1	1.50 ≤ DSC	and	LTV < 85%
CM2	0.95 ≤ DSC < 1.50	and	LTV < 75%
CM2	1.15 ≤ DSC < 1.50	and	75% ≤ LTV < 100%
CM2	1.50 ≤ DSC	and	85% ≤ LTV < 100%
CM2	1.75 ≤ DSC	and	100% ≤ LTV
CM3	DSC < 0.95	and	LTV < 85%
CM3	0.95 ≤ DSC < 1.15	and	75% ≤ LTV < 100%
CM3	1.15 ≤ DSC < 1.75	and	100% ≤ LTV
CM4	DSC < 0.95	and	85% ≤ LTV < 105%
CM4	0.95 ≤ DSC < 1.15	and	100% ≤ LTV
CM5	DSC < 0.95	and	105% ≤ LTV
CM6	Loans 90 days past due but not yet in process of foreclosure		
CM7	Loans in process of foreclosure		

For Hotels and Specialty Commercial:

(Figure 45)

RISK CATEGORY	DSC LIMITS	LTV LIMITS
CM1	1.85 ≤ DSC	LTV < 60%
CM2	1.45 ≤ DSC < 1.85	LTV < 70%
CM2	1.85 ≤ DSC	60% ≤ LTV < 115%
CM3	0.90 ≤ DSC < 1.45	≤ LTV < 80%
CM3	1.45 ≤ DSC < 1.85	70% ≤ LTV
CM3	1.85 ≤ DSC	115% ≤ LTV
CM4	DSC < 0.90	LTV < 90%
CM4	0.90 ≤ DSC < 1.10	80% ≤ LTV < 90%
CM4	1.10 ≤ DSC < 1.45	80% ≤ LTV
CM5	1.10 ≤ DSC	90% ≤ LTV
CM6	Loans 90 days past due but not yet in process of foreclosure	
CM7	Loans in process of foreclosure	

Farm Mortgages (Agricultural Loans):

(Figure 56)

	Timber	Farm & Ranch	Agribusiness Single Purpose	Agribusiness All Other
CM1	LTV ≤ 55%	LTV ≤ 60%		LTV ≤ 60%
CM2	55% < LTV ≤ 65%	60% < LTV ≤ 70%	LTV ≤ 60%	60% < LTV ≤ 70%
CM3	65% < LTV ≤ 85%	70% < LTV ≤ 90%	60% < LTV ≤ 70%	70% < LTV ≤ 90%
CM4	85% < LTV ≤ 105%	90% < LTV ≤ 110%	70% < LTV ≤ 90%	90% < LTV ≤ 110%
CM5	105% < LTV	110% < LTV	90% < LTV	110% < LTV
CM6	Loans 90 days past due but not yet in process of foreclosure			
CM7	Loans in process of foreclosure			

SCHEDULE BA MORTGAGES

LR009

Basis of Factors

For Affiliated Mortgages, Line 12999999, the factors used are the same as for commercial mortgages and are defined in Figure 9. Risk categories and factors are determined using a company generated worksheet ~~for In Good Standing (Figure 10) and (Figure 9) for Past Due or In Process of Foreclosure.~~

For Unaffiliated Mortgages, Line 11999999, the factors used are the same as for commercial mortgages and are defined in Figure 9. Risk categories and factors are determined as follows:

- 1) For Investments that contain covenants whereby factors of maximum LTV and minimum DSC, or equivalent thresholds must be complied with and it can be determined that the Investments are in compliance, these investments would use the process for directly held mortgages using the maximum LTV and minimum DSC using the company generated worksheet and transferred to LR009 line (2) for mortgages with covenants that are in compliance.
- 2) Investments that are defeased with government securities will be assigned to CM1 and transferred to LR009 line (3).
- 3) Other investments comprised primarily of senior debt will be assigned to CM2 and transferred to LR009 line (4).
- 4) All other investments in this category will be assigned CM3 and transferred to LR009 line (5). This would include assets such as a mortgage fund that invests in mezzanine or sub debt, or investments that cannot be determined to be in compliance with the covenants.

Specific Instructions for Application of the Formula

Column (1)

Except for Lines (1), (12), and (16), calculations are done on an individual mortgage basis and then the summary amounts are entered in this column for each class of mortgage investment. Refer to the Schedule BA mortgage calculation worksheets ~~(Figure 9) and (Figure 10)~~ for how the individual mortgage calculations are completed. Line (20) should equal Schedule BA Part 1, Column 12, Line 11999999 plus Line 12999999.

Column (2)

Companies are permitted to reduce the book/adjusted carrying value of mortgage loans reported in Schedule BA by any involuntary reserves. Involuntary reserves are equivalent to valuation allowances specified in the codification of statutory accounting principles. They are non-AVR reserves reported on Annual Statement Page 3, Line 25. These reserves are held as an offset for a particular troubled Schedule BA mortgage loan that would be required to be written down if the impairment was permanent.

Column (3)

Column (3) is calculated as the net of Column (1) less Column (2).

Column (4)

~~No longer used. Place "XXX" in any blanks for this column. For Lines (12) through (14) and Lines (16) through (19), summary amounts of the individual mortgage calculations are entered in this column for each class of mortgage investments. Refer to the Schedule BA mortgage calculation worksheet (Figure 9).~~

Column (5)

For Line (1), the pre-tax factor is 0.0014.

~~For Line (2), the average factor column is calculated as Column (6) divided by Column (3).~~

~~For Line (3), the pre-tax factor is 0.0090.~~

~~For Line (4), the pre-tax factor is 0.0175.~~

~~For Line (5), the pre-tax factor is 0.0300.~~

10/15/2021

For Line (6), the pre-tax factor is 0.0090.
 For Line (7), the pre-tax factor is 0.0175.
 For Line (8), the pre-tax factor is 0.0300.
 For Line (9), the pre-tax factor is 0.0500.
 For Line (10), the pre-tax factor is 0.0750.
 For Line (12), the pre-tax factor is 0.0027.
 For Lines (13) through (14), the pre-tax factor is 0.1100.
 For Line (15), the pre-tax factor is 0.0054.
 For Lines (13) through (14), the pre-tax factor is 0.1300.

See Figure 9 for computation of appropriate factors.

Column (6)

For Lines (1), (3) through (10), (12) through (14), and (16) through (18), the RBC subtotal in Column (3) is multiplied by the average factor to calculate Column (6). The categories and subtotals will be determined in the company developed worksheet Figure (10).

For Lines (4) through (4) and Lines (16) through (18), summary amounts are entered for Column (6) based on calculations done on an individual mortgage basis as determined in the company developed worksheet Figure (10). Refer to the Schedule BA mortgage calculation worksheet (Figure 8).

(Figure 8)

Schedule BA Mortgage Worksheet A
Other Than In-Good Standing

(1) Name/ID	(2) Book/Adjusted Carrying Value	(3) Involuntary Reserve Adjustments	(4) RBC Subtotal	(5) Cumulative Write-downs	(6) Category Factor	(7) In-Good Standing Factor	(7a) In-Good Standing Category	(8) Col(6) X [Col (4)+(5)] -Col(8)	(9) Col(4) X Col(7)	(10) RBC Requirement
	90-Days-Overdue-Insured-or-Guaranteed				‡	‡	‡			
(1)	All Mortgages Without Cumulative Write-downs			XXX	0.0027	0.0014	N/A			
(2)	With Cumulative Write-downs				0.0027	0.0014	N/A			
(3)	Total				0.0027	0.0014	N/A			
	90-Days-Overdue-Unaffiliated									
(4)	All Mortgages Without			XXX	0.1800	‡	‡			

10/15/2021

Construction Loan out of Balance (26)	Construction Loan Issues (27)	Land Loan (28)	90 Days Past Due (29)	In Process of Foreclosure? (30)	Current payment lower than based on Loan Interest? (31)	Is loan interest floating? (32)	Is fixed rate reset during term? (33)
Is negative amortization allowed? (34)	Amortization Type (35)	Schedule BA mortgage? (36)	Affiliated Mortgage (37)	Covenant – Max LTV (39)	Covenant – Min DCR (40)	Loan Covenants in compliance? (41)	Deceased with government securities? (42)

Primarily Senior positions? (43)	Rolling Average NOI (44)	RBC DCR (45)	Price Index at Valuation (46)	Contemporaneous Property Value (47)	RBC - Loan to Value Ratio (48)	RBC Risk Category (49)
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This worksheet is prepared on a loan-by-loan basis for each commercial mortgage – other or farm loan held in Schedule BA. The Column (7) and (9) subtotals for each category are carried over and entered in Columns (1) and (2) of the Mortgages (LR009) in the risk-based capital formula lines (2) – (10), (13) – (14), and (17) – (18). Small mortgages aggregated into one line on Schedule BA can be treated as one mortgage on this worksheet. ~~Amounts in Columns (7), (9) and (49) are entered individually to Worksheet-A columns (2), (3) and (7) for loans that are 90 Days Past Due and in Process of Foreclosure.~~ NOTE: This worksheet will not be available in the risk-based capital filing software and must be developed by the Company.

Column #	Heading	Description / Explanation of Item
(1)	Name / ID	Price Index current is the value on 9/30 of the current year for the National Council of Real Estate Investor Fiduciaries Price Index for the United States.
(2)	Date of Origination	Identify each mortgage included as in good standing.
(3)	Maturity Date	Enter the year and month that the loan was originated. If the loan has been restructured, extended, or otherwise re-written, enter that new date.
(4)	Property Type	Enter earlier of maturity of the loan, or the date the lender can call the loan.
(5)	Farm Sub-type	Enter 1 for mortgages with an Office, Industrial, Retail or multifamily property as collateral. Enter 2 for mortgages with a Hotel and Specialty Commercial as property type. For properties that are multiple use, use the property type with the greatest square footage in the property. Enter 3 for Farm Loans.
(6)	Postal Code	Sub-category – If Property Type=3 (Farm Loans), then you must enter a Sub Category: 1=Timber, 2=Farm and Ranch, 3=Agribusiness Single Purpose, 4=Agribusiness All Other. (See Note 8)
(7)	Book / Adjusted Carrying	Enter zip code of property for US properties. If multiple properties or zip codes, enter multiple codes. If foreign, enter postal code. If not available, N/A. Enter the value that the loan is carried at on the company ledger.

10/15/2021

	Value		
(8)	Statutory Writedowns	Input	Enter the value of any writedowns taken on this loan due to permanent impairment.
(9)	Involuntary Reserve	Input	Enter the amount of any involuntary reserve amount. Involuntary reserves are reserves that are held as an offset to a particular asset that is clearly a troubled asset and are included on Page 3 Line 25 of the Annual Statement.
(10)	Original Loan Balance?	Input	Enter the loan balance at the time of origination of the loan.
(11)	Principal Balance to Co.	Input	Enter the value of the loan balance owed by the borrower.
(12)	Balloon Payment at Maturity	Input	Enter the amount of any balloon or principal payment due at maturity.
(13)	Principal Balance Total	Input	Enter the total amount of mortgage outstanding that is senior to or pari passu with the company's mortgage
(14)	NOI Second Prior	Input	Enter the NOI from the year prior to the value in (15). See Note 1.
(15)	NOI Prior	Input	Enter the NOI from the prior year to the value in (16). See Note 1.
(16)	NOI	Input	Enter the Net Operating Income for the most recent 12 month fiscal period with an end-date between July 1 of the year prior to this report and June 30 of the year of this report. The NOI should be reported following the guidance of the Commercial Real Estate Finance Council Investor Reporting Profile v.5.0. Section VII. See Notes 1, 2, 3, 4, 5 and 6 below.
(17)	Interest Rate	Input	Enter the annual interest rate at which the loan is accruing. -If the rate is floating, enter the larger of the current month rate or the average rate of interest for the prior 12 months, or -If the rate is fixed by the contract, not level over the year, but level for the next 12 months, use current rate. If the 'Total Loan Balance' consists of multiple loans, use an average loan interest rate weighted by principal balance. Enter actual 12 months debt service for prior 12 months.
(18)	Trailing 12 Month Debt Service	Input	Enter the loan balance at the time of origination of the loan.
(19)	Original Property Value	Input	The value of the Property at time of loan origination, or at time of revaluation due to impairment underwriting, restructure, extension, or other re-writing.
(20)	Property Value	Input	Year of the valuation date defining the value in (20). This will be either the date of origination, or time of restructure, refinace, or other event which precipitates a new valuation.
(21)	Year of Valuation	Input	Calendar quarter of the valuation date defining the value in (20).
(22)	Quarter of Valuation	Input	Enter the full dollar amount of any credit enhancement. (see Note 5)
(23)	Credit Enhancement	Input	Enter 'Yes' if senior position, 'No' if not. (see Note 7)
(24)	Senior Loan?	Input	Enter 'Yes' if this is a construction loan. (see Note 4)
(25)	Construction Loan?	Input	Enter 'Yes' if this is a construction loan that is not in balance. (see Note 4)
(26)	Construction - not in balance	Input	Enter 'Yes' if this is a construction loan with issues. (see Note 4)
(27)	Construction - Issues	Input	Enter 'Yes' if this is a loan on non-income producing land. (see Note 6)
(28)	Land Loan?	Input	Enter 'Yes' if payments are 90 days past due.
(29)	90 days past due?	Input	Enter 'Yes' if the loan is in process of foreclosure.
(30)	In process of foreclosure?	Input	Yes / No
(31)	Is current payment lower than a payment based on the Loan Interest?	Input	Yes / No
(32)	Is loan interest a floating	Input	Yes / No

10/15/2021

	rate?			
(33)	If not floating, does loan reset during term?	Input	Yes / No - Some fixed rate loans define in the loan document a change to a new rate during the life of the loan, which may be a predetermined rate or may be the then current market rate. Generally any such changes are less frequent than annual.	Yes / No
(34)	Is negative amortization allowed?	Input		Yes / No
(35)	Amortization type?	Input	1 = fully amortizing 2 = amortizing with balloon 3 = full I/O 4 = partial I/O, then amortizing	Yes / No
(36)	Schedule BA mortgage?	Input		Yes / No
(37)	Affiliated Mortgage?	Input		Yes / No
(38)	Covenant Max LTV	Input	For mortgage investments with covenants, what is the maximum LTV allowed?	Yes / No
(39)	Covenant Min DCR	Input	For mortgage investments with covenants, what is the minimum DCR allowed?	Yes / No
(40)	Covenants in compliance?	Input	Yes / No – for mortgage investments with covenants, is the investment in compliance with the covenants?	Yes / No
(41)	Defeased with government securities	Input	Yes / No – has the mortgage loan been defeased using government securities?	Yes / No
(42)	Primarily Senior Mortgages	Input	Is the mortgage pool primarily senior mortgage instruments? {If yes, assign to CM2}	Yes / No
(43)	Rolling Average NOI	Computation	For 2012 – 100% of NOI For 2014 – 65% NOI + 35% NOI Prior For 2015 – 50% NOI + 30% NOI Prior + 20% NOI 2 nd Prior For loans originated or valued within the current year, use 100% NOI. For loans originated 2012 or later and within 2 years, use 65% NOI and 35% NOI Prior.	Yes / No
(44)	RBC Debt Service	Computation	RBC Debt Service Amount is the amount of 12 monthly principal and interest payments required to amortize the Total Loan Balance (13) using a Standardized Amortization period of 300 months and the Annual Loan Interest Rate (17).	Yes / No
(45)	RBC - DCR	Computation	Debt Coverage Ratio is the ratio of the Net Operating Income (43) divided by the RBC Debt Service (44) rounded down to 2 decimal places. See Note 3 below for special circumstances. For loan pools with covenants, this will be the minimum DCR by covenant.	Yes / No
(46)	NCREIF Index at Valuation	Computation	Price index is the value of the NCREIF Price Index on the last day of the calendar quarter that includes the date defined in (21) and (22).	Yes / No
(47)	Contemporaneous Property Value	Computation	Contemporaneous Value is the Property Value (11) times the ratio (rounded to 4 decimal places) of the Price Index current to the Price Index (46).	Yes / No
(48)	RBC - LTV	Computation	The Loan to Value ratio is the Loan Value (13) divided by the Contemporaneous Value (47) rounded to the nearest percent. For Loan Pools with covenants, this will be the max LTV by covenant.	Yes / No
(49)	CM Category	Computation	Commercial Mortgage Risk category is the risk category determined by either being not in good standing (either 90 Days Past Due or In Process of Foreclosure) or the loan being in good standing and by applying the DCR (45) and the LTV (48) to the criteria in Figure (11), Figure (12) or Figure (13). See Notes 2, 3, 4, 5, and 6 below for special circumstances. If (41) = yes, CM1. If (42) = yes, CM2. If no LTV and DCR, and (41) = no and (42) = no, CM3.	Yes / No

10/15/2021

Note 1: Net Operating Income (NOI): The majority of commercial mortgage loans require the borrower to provide the lender with at least annual financial statements. The NOI would be determined at the RBC calculation date based on the most recent annual period from financial statements provided by the borrower and analyzed based on accepted industry standards. The most recent annual period is determined as follows:

- If the borrower reports on a calendar year basis, the statements for the calendar year ending December 31 of the year prior to the RBC calculation date will be used. For example, if the RBC calculation date is 12/31/2012, the most recent annual period is the calendar year that ends 12/31/2011.
- If the borrower reports on a fiscal year basis, the statements for the fiscal year that ends after June 30 of the prior calendar year and no later than June 30 of the year of the RBC calculation date will be used. For example, if the RBC calculation date is 12/31/2012, the most recent annual period is the fiscal year that ends after 6/30/2011 and no later than 6/30/2012.
- The foregoing time periods are used to provide sufficient time for the borrower to prepare the financial statements and provide them to the lender, and for the lender to calculate the NOI.

The accepted industry standards for determining NOI were developed by the Commercial Mortgage Standards Association now known as CRE Financial Council (CREFC). The company must develop the NOI using the standards provided by the CREFC Methodology for Analyzing and Reporting Property Income Statements ~~v. 5.1~~ (www.crefc.org/irp). These standards are part of the CREFC Investor Reporting Package (CREFC IRP Section VII.) developed to support consistent reporting for commercial real estate loans owned by third party investors. This guidance is a standardized basis for determining NOI for RBC.

The NOI will be adjusted to use a 3-year rolling average for the DSC calculation. For 2013, a single year of NOI will be used. For 2014, 2 years will be used, weighted 65% most recent year and 35% prior year. Thereafter, 3 years will be used weighted 50% most recent year, 30% prior year, and 20% 2nd prior year. This will apply when there is a history of NOI values. For new originations, including refinancing, the above schedule would apply by duration from origination. For the special circumstances listed below, the specific instructions below will produce the NOI to be used, without further averaging.

For purposes of the NOI inputs at (14), (15), (16), and the computation of a Rolling Average NOI at (43), an insurer may report 2020 NOI (i.e., NOI for any 12-month fiscal period ending after June 30, 2020 but not later than June 30, 2021) as the greater of: (1) actual NOI as determined under the CREFC-C IRP Standards or (2) 85% of NOI determined for the immediate preceding fiscal year's annual report. This guidance with respect to 2020 NOI in risk-based capital reporting for 2021, 2022, and 2023. In cases where an insurer reports 85% of 2019 NOI as the 2020 NOI input, the insurer should retain information about actual 2020 NOI in its workpapers so that the information can be readily available to regulators.

Note 2: The calculation of debt service coverage and loan to value will include all debt secured by the property that is (1) senior to or pari passu with the insurer's investment; and (2) any debt subordinate to the insurer's investment that is not (a) subject to an intercreditor, standstill or subordination agreement with the insurer provided that the agreement does not grant the subordinate debt holder any rights that would materially affect the rights of the insurer and provided that the subordinate debt holder is prohibited from taking any action against the borrower that would materially affect the insurer's priority lien position with respect to the property without the prior written consent of the insurer, or (b) subject to governing laws that provide that the insurer's investment holds a senior position to the subordinated debt holder and provide substantially similar protections to the insurer as in (2)(a) above.

Note 3: *Unavailable Operating Statements:*

There are a variety of situations where the most recent annual period's operating statement may not be available to assist in determining NOI. These situations will occur in distinct categories and each category requires special consideration. The categories are:

1. Loans on owner occupied properties

10/15/2021

- a. For properties where the owner is the sole or primary tenant (50% or more of the rentable space), property level operating statements may not be available or meaningful. If the property is occupied and the loan, taxes and insurance are current, it will be acceptable to derive income and a reasonable estimate of expenses from the most recent appraisal or equivalent and additional known actual expenses (e.g., real estate taxes and insurance).
 - b. For properties where the owner is a minority tenant (49% of less of the rentable space), the owner-occupied space should be underwritten at the average rent per square foot of the arm's length tenant leases. This income estimate should be added to the other tenant leases and combined with a reasonable estimate of expenses based on the most recent appraisal or equivalent and additional known actual expenses (e.g., real estate taxes and insurance).
2. Borrower does not provide the annual operating statement
- a. Borrower refuses to provide the annual operating statements
 - i. If the leases are in place and evidenced by estoppels and inspections, NOI would be derived from normalized underwriting in accordance with the CREFC Methodology for Analyzing and Reporting Property Income Statements.
 - ii. If there is evidence from inspection that the property is occupied, but there is no evidence of in place leases (e.g., lease documents or estoppels), NOI would be set equal to the lesser of calculated debt service (DSC=I.0) or the NOI from the normalized underwriting.
 - iii. If there is no evidence from inspection that the property is occupied and no evidence of in place leases (e.g., lease documents or estoppels), assume NOI = \$0.
 - b. If the borrower does not have access to a complete previous year operating statement, determine NOI based on the CREFC guidelines for analyzing a partial year income statement.

Note 4: Construction loans

Construction loans would be categorized as follows, based on a determination by the loan servicer whether the loan is in balance and whether construction issues exist:

- a. In balance, no construction issues: DSC = 1.0, LTV determined as usual
- b. Not in Balance, no construction issues: CM4
- c. Construction issues: CM5

A loan is "in balance" if the committed amount of the construction loan plus any lender held reserves and unfunded borrower equity is sufficient to cover the remaining costs of the development project, including debt service not anticipated to be paid from property operations.

A "construction issue" is a problem that may reasonably jeopardize the completion of the project. Examples of construction issues include the abandonment of construction and construction defects that are not being addressed.

Note 5: Credit enhancements: Where the loan payments are secured by a letter of credit from an investment grade financial institution or an escrow account held at an investment grade financial institution, NOI less than the debt service may be increased by these amounts until it is equal to but not exceeding the debt service. These situations are typically short term in nature, and are intended to bridge the lease-up following renovation or loss of a major tenant.

Note 6: Non-income-producing land: NOI = \$0

Note 7: Non-senior financing

10/15/2021

- a. The company should first calculate DSC and LTV for non-senior financing using the standardized debt service and aggregate LTV of all financing *pari passu* and senior to the position held by the company.
- b. The non-senior piece should then be assigned to the next riskier RBC category. For example, if the DSC and LTV metrics determined in (a) indicate a category of CM2, the non-senior piece would be assigned to category CM3. However, it would not be required to assign a riskier category than CM5 if the loan is not at least 90-days delinquent or in foreclosure.

Note 8: Definitions of each type of Farm Mortgage:

Timber: A loan is classified as a timber loan if more than 50% of the collateral market value (land and timber) of the security is attributable to land supporting a timber crop that is or will be of commercial value.

Farm & Ranch: Farm and ranch land utilized in the production of agricultural commodities of all kinds, including grains, cotton, sugar, nuts, fruits, vegetables, forage crops and livestock of all kinds, including, beef, swine, poultry, fowl and fish. Loans included in this category are those in which agricultural land accounts for more than 50% of total collateral market value.

Agribusiness Single Purpose: Specialized collateral utilized in the production, further processing, adding value or manufacturing of an agricultural commodity or forest product. In order for a loan to be classified as such, the market value of the single-purpose (special use) collateral would account for more than 50% of total collateral market value.

This collateral is generally not multi-functional and can only be used for a specific production, manufacturing and/or processing function within a specific sub-sector of the food or agribusiness industry and whereby such assets are not strategically important in nature to the overall industry capacity. These assets can be shut down or replicated easily in other locations, or existing plants can be expanded to absorb shuttered capacity. The assets are not generally limited in nature by environmental or operational permits and/or regulatory requirements. An example would be a poultry processing plant located in the Southeast of the United States where there is excess capacity inherent to the industry and production capacity is easily replaceable.

Other loans included in this category are those collateralized by single purpose (special use) confinement livestock production facilities in which the special use facilities account for more than 50% of total collateral market value.

Agribusiness All Other: Multiple-use collateral utilized in the production, further processing, adding value or manufacturing of an agricultural commodity or forest product. In order for a loan to be classified as such, the market value of any single use portion may not be greater than 50% of total collateral market value.

This collateral is multi-functional in nature, adaptable to other manufacturing, processing, or servicing food or agribusiness industries or sub-industries. Assets could also be very strategic in nature and not easily replaceable either due to cost, location, environmental permitting and/or government regulations. These assets may be single purpose in nature, but so vital to the industry capacity needs that they will be generally purchased by another like processing company or strategic or financial buyer. An example of these types of assets are strategically located and highly automated cold storage facilities whereby they can be used for dry storage, distribution centers or converted into warehouse or other type uses. Another example may be a cheese processing plant that is strategically located within the heart of the dairy industry, limited permits, environmental restrictions that would limit added capacity, or high barriers to entry to build a like facility within the industry. For example, one of the largest cheese plants in the industry is located in California and it is not easily replicated within the cheese processing industry due to its location, capacity, costs, access to fluid milk supply and related feed and water, as well as highly regulated environmental and government restrictions.

Other loans included in this category are those in which more than 50% of the collateral market value is accounted for by chattel assets or other assets related to the business and financial operations of agribusinesses, including inventories, accounts, trade receivables, cash and brokerage accounts, machinery, equipment, livestock and other assets utilized for or generated by agribusiness operations.

10/15/2021

For Office, Industrial, Retail and Multi-family

(Figure 11)

Risk Category	DSC Limits	LTV Limits
CM1	1.50 ≤ DSC	and LTV < 85%
CM2	0.95 ≤ DSC < 1.50	and LTV < 75%
CM2	1.15 ≤ DSC < 1.50	and 75% ≤ LTV < 100%
CM2	1.50 ≤ DSC	and 85% ≤ LTV < 100%
CM2	1.75 ≤ DSC	and 100% ≤ LTV
CM3	DSC < 0.95	and LTV < 85%
CM3	0.95 ≤ DSC < 1.15	and 75% ≤ LTV < 100%
CM3	1.15 ≤ DSC < 1.75	and 100% ≤ LTV
CM4	DSC < 0.95	and 85% ≤ LTV < 105%
CM4	0.95 ≤ DSC < 1.15	and 100% ≤ LTV
CM5	DSC < 0.95	and 105% ≤ LTV
CM6	Loans 90 days past due but not yet in process of foreclosure	
CM7	Loans in process of foreclosure	

For Hotels and Specialty Commercial

(Figure 12)

Risk category	DSC limits	LTV limits
CM1	1.85 ≤ DSC	and LTV < 60%
CM2	1.45 ≤ DSC < 1.85	and LTV < 70%
CM2	1.85 ≤ DSC	and 60% ≤ LTV < 115%
CM3	0.90 ≤ DSC < 1.45	and ≤ LTV < 80%
CM3	1.45 ≤ DSC < 1.85	and 70% ≤ LTV
CM3	1.85 ≤ DSC	and 115% ≤ LTV
CM4	DSC < 0.90	and LTV < 90%
CM4	0.90 ≤ DSC < 1.10	and 80% ≤ LTV < 90%
CM4	1.10 ≤ DSC < 1.45	and 80% ≤ LTV
CM5	1.10 ≤ DSC	and 90% ≤ LTV
CM6	Loans 90 days past due but not yet in process of foreclosure	
CM7	Loans in process of foreclosure	

For Farm Loans:

(Figure 13)

Timber	Farm & Ranch	Agribusiness Single Purpose	Agribusiness All Other

10/15/2021

CM1	LTV <= 55%	LTV <= 60%	LTV <= 60%	LTV <= 60%
CM2	55% < LTV <= 65%	60% < LTV <= 70%	LTV <= 60%	60% < LTV <= 70%
CM3	65% < LTV <= 85%	70% < LTV <= 90%	60% < LTV <= 70%	70% < LTV <= 90%
CM4	85% < LTV <= 105%	90% < LTV <= 110%	70% < LTV <= 90%	90% < LTV <= 110%
CM5	105% < LTV	110% < LTV	90% < LTV	110% < LTV
CM6	Loans 90 days past due but not yet in process of foreclosure			
CM7	Loans in process of foreclosure			

Draft: 8/10/23

Health Risk-Based Capital (E) Working Group
Virtual Meeting
July 25, 2023

The Health Risk-Based Capital (E) Working Group of the Capital Adequacy (E) Task Force met July 25, 2023. The following Working Group members participated: Steve Drutz, Chair (WA); Matthew Richard, Vice Chair, Aaron Hodges, and Caroline Choi (TX); Wanchin Chou and Sarah Mu (CT); Benjamin Ben (FL); Chut Tee (KS); Debbie Doggett (MO); Lindsay Crawford and Michael Muldoon (NE); and Tom Dudek and Matt Ryan (NY). Also participating was: Tom Botsko (OH).

1. Adopted its May 17 and April 17 Minutes

Drutz said the Working Group met May 17 and April 17. During these meetings, the Working Group took the following action: 1) adopted its Spring National Meeting minutes; 2) referred proposal 2023-01-CA to the Capital Adequacy (E) Task Force for exposure; 3) heard an update from the American Academy of Actuaries (Academy) on the health care receivables and H2-underwriting risk review projects; 4) discussed pandemic risk; and 5) exposed the proposal on the health test language for a 45-day public comment period ending June 30.

Chou made a motion, seconded by Doggett, to adopt the Working Group's May 17 (Attachment Three-A) and April 17 (Attachment Three-B) minutes. The motion passed unanimously.

2. Adopted its 2023 Health Risk-Based Capital Newsletter

Drutz said the 2023 health risk-based capital newsletter includes all proposals that the Working Group adopted for year-end 2023, along with editorial changes to the health risk-based capital (RBC) forecasting and instructions publication. He said the purpose of this adoption is to consider the content of the newsletter, and the format will later be revised. The adopted version of the newsletter will be posted to the Working Group's web page, with the final formatted version posted around Sept. 1.

Dudek made a motion, seconded by Chou, to adopt the Working Group's 2023 health risk-based capital newsletter (Attachment Three-C). The motion passed unanimously.

3. Adopted its 2022 Health RBC Statistics

Drutz said the 2022 health RBC statistics were run July 5. There were 1,143 health RBC filings loaded onto the NAIC database, up from 1,095 in 2021. Twenty-eight companies triggered an action level in 2022, of which six were in a company action level, 10 were in a regulatory action level, and 12 were in a mandatory control level. There were 13 companies that triggered the trend test. The authorized control level and total adjusted capital amounts increased from 2021 to 2022. Chou said that the number of companies in an action level rose from 12 to 28 and asked if there were any significant reasons for the change. Drutz asked NAIC staff to review the companies at an action level and try to identify the cause of the action level. He said the Working Group could review this during its next meeting. Botsko said the number of companies that filed on the health blank grew by about 48 over the prior year and asked if it would be possible to identify how many new companies triggered an action level. Drutz agreed and said this was also something that could be investigated further. Jim Braue (UnitedHealth Group—UHG) suggested incorporating the operational risk component into the statistical report in future years. Crystal Brown (NAIC) said this could be added to the report beginning with 2023, but it would not include previous years because the report is run at a specific point in time, as the numbers can fluctuate due to

amendments and late filings. The Working Group agreed to incorporate this into the report. Botsko asked that it also be added to the life and property/casualty (P/C) statistics beginning with 2023.

Doggett made a motion, seconded by Dudek, to adopt the 2022 health RBC statistics (Attachment Three-D). The motion passed unanimously.

4. Exposed Proposal 2023-11-HI

Drutz said proposal 2023-11-H was developed to include Medicare and Medicaid fee-for-service and other risk revenue amounts in column (1), lines (4) and (10) on pages XR013 and XR014. This change creates consistency across column (1), lines (2), (3), (4), (7), and (10) since Medicare and Medicaid premiums and claims are already included in column (1), line (2), (3), and (7). Brown said that only page XR014 is referenced in the proposal because it references the annual statement pulls for the calculation used on XR013.

Hearing no objections, the Working Group agreed to expose proposal 2023-11-H for a 30-day public comment period ending Aug. 24.

5. Referred the Health Test Proposal to Blanks (E) Working Group

Drutz said the health test language proposal was exposed to all RBC working groups for a 45-day comment period that ended June 30. The Working Group received one comment letter from the New York Department of Financial Services (DFS). Ryan said the New York DFS believes any insurer that writes life business should file on the life blank and be regulated by the Life Bureau, and the Health Bureau agreed. He said the main concern is that the New York DFS has some domestics that cede a large portion of their life business. As a result, the net basis approach makes it appear that the company has a majority of health business when it actually has a significant amount of life business. He said that in those situations, they would want those companies to be filed on a life blank.

Drutz said the ad hoc group considered either an all-net or all-gross basis for the premium and reserve ratios due to the inconsistencies in the current calculation, where both net and gross basis amounts are included in the calculation of the reserve ratio. The ad hoc group also discussed lowering the 95% ratio to capture more companies. However, the group determined it best to leave the ratios at 95% and use an all-net basis. The group determined that if needed, it could re-evaluate in the future, given that more data is being captured on health business in the life blank and that the health blank includes the life supplement. Drutz said the ad hoc group intended to fix the ratio, but New York DFS' comments are strong arguments for using an all-gross basis. He noted that points have been made for both raising and lowering the ratio thresholds, and as a result, the group may need to consider revisions to the threshold in the future.

Doggett made a motion, seconded by Chou, to refer the health test proposal to the Blanks (E) Working Group (Attachment Three-E). The motion passed unanimously.

6. Received an Update from the Academy on the Health Care Receivables Project

Kevin Russell (American Academy of Actuaries—Academy) said Other Health Care Receivables included in line 06xxxxx on Exhibit 3 are part of incurred claims. He said those and four additional types of health care receivables (pharmaceutical rebates receivable, claim overpayment receivables, capitation arrangement receivables, and risk-sharing receivables) enter the calculation of incurred claims on the U&I Exhibit Part 2 line 6. He said loans and advances to providers are another type of health care receivable, but they are excluded from incurred claims if not yet expensed. He said the Academy has concerns that some filing companies may be using the other health

care receivables line when another would be more appropriate—either a different type of health care receivable or some other type of receivable (one that is not a health care receivable). He said that because of differences in receivable factors, this is affecting the calculation of RBC. Russell said the Academy is looking at other health care receivables where the filing company provided a name of the debtor or a description of the receivable in that field. He noted that many filing companies do not provide a description of the receivable, so the Academy is grateful for those that did. Russell said the Academy is looking for the Working Group's approval for NAIC staff to contact the filing companies to ask questions related to the other health care receivable amounts. He said the expectation is that their answers will help guide improvements to the Instructions for filing or improvements to guidance. Russell said the Academy would provide recommendations on the questions to ask particular companies, and NAIC staff would contact the filing companies and compile their responses.

Drutz said the plan is to notify all states that the Working Group may be contacting some of their companies and is just looking for additional clarity and understanding of the reporting.

The Working Group approved the Academy's request to reach out to the filing companies. It directed NAIC staff to work with the Academy to begin reaching out to the companies for further clarification on the questions.

7. Received an Update from the Academy on the H2 – Underwriting Risk Review

Derek Skoog (Academy) said the Health Solvency Work Group is working on getting a better understanding of the definitions for claims and revenue in the health RBC formula. He summarized the Academy's letter regarding the nuances identified (Attachment Three-F). He said proposal 2023-11-H does help to address nuance 1 and 2. He said there are a couple of questions the proposal does not address, including: 1) how we should think about the fee for service revenue in the context of the RBC formula; and 2) whether the fee for service revenue should be netted. He said the annual statement instructions define the fee for service at a high level. He said the Academy noted that the reporting conventions appeared varied for those issuers who report a substantial portion of fee for service revenue. He said the Academy has looked at historical loss ratios by line of business, and a change to the calculation could result in a significant change.

Skoog noted one caveat is that few issuers report fee for service revenue, and it appears more unique to provider-sponsored plans. He said that when an issuer reports fee for service revenue, it tends to be a pretty material portion of the total revenue. He said the reason the Academy feels this is important is that there was a case where an issuer reported a substantial amount of fee for service revenue to its total revenue, and when it is netted out (fee for service revenue is not included in revenue nor claims), the observed loss ratio is very high. When it is not netted out, it is still high but has a more reasonable loss ratio.

Skoog said the Academy's view is to look at this on a gross basis and not net out the fee for service revenue. He said using Total Revenue (Line 7) in the Analysis of Operations would allow for a more simplistic approach to the calculation. He also noted that using line 7 would include aggregate write-in revenues (health and non-health). He said line 6 for aggregate write-in revenue for non-health was basically blank across the entire industry, and aggregate write-in revenue for health comprised a tiny portion of total revenue. He asked the medical loss ratio should use total revenue as the denominator or continue to use the nuanced view of net premium revenue plus unearned premium revenue plus fee for service revenue plus risk revenue but not include aggregate write-ins. Skoog asked if the Working Group preferred a net or gross-basis approach for total revenue. He said that from a results perspective, it does not appear to have too much of an impact.

Braue said the fee for service business is where the reporting entity is basically acting like a provider or provider intermediary. They are being paid directly for specific services, and it is not a prepaid sort of coverage like the

premium and other risk revenue are. He asked that given that, while it might be that the entity is reflecting the potential gains from that business in its pricing, in terms of potential fluctuation in the results (not an RBC concern), wouldn't there be a much different pattern of fluctuation for that fee for service business versus the prepaid business. Skoog said that is what the Academy was expecting. However, based on the filings, the results in practice did not match that intuition. He said that it appeared after looking at several issuers that there was some relationship where they were pricing this into the products, but it was not obviously clear without reaching out to the issuer directly.

Braue asked if some are reporting losses on the fee for service business itself. Skoog said it is hard to parse that out because the fee-for-service component is included in other lines, and one does not see a stand-alone amount for fee-for-service profit or losses. Braue said he thought that the entity was supposed to report the number of claims netted against the revenue on that line. Skoog said companies are not doing that particularly well.

Drutz suggested meeting in regulator-to-regulator session to discuss specific companies to address the Academy's questions and possibly contacting specific companies to request additional clarification on the reporting.

The Working Group agreed to move forward with a regulator-to-regulator meeting and to expose the Academy letter for 30 days.

Hearing no objections, the Working Group agreed to expose the Academy letter for a 30-day public comment period ending Aug. 24.

8. Adopted its Updated Working Agenda

Drutz said its working agenda was revised to incorporate the following changes: 1) line X1 was updated to reference the adoption of proposal 2022-16-CA; 2) line X3 was updated to reference the adoption of proposal 2023-01-CA; 3) line X4 was updated to include the work with the Academy on the health care receivables; and 4) lines X5 and X10 were deleted because these items have been completed.

Dudek made a motion, seconded by Chou, to adopt its revised working agenda (*see NAIC Proceedings – Summer 2023, Capital Adequacy (E) Task Force, Attachment Seven*). The motion passed unanimously.

9. Received an Update on the Excessive Growth Charge Ad Hoc Group

Drutz said the Excessive Growth Charge Ad Hoc Group has continued to meet and move forward on its work of evaluating the existing health RBC excessive growth charge. He said the group has performed an extensive analysis of various data pieces, and based on the analysis to date, it appears that the current excessive growth charge is working at a reasonable level in identifying companies that incur an underwriting loss in the following year after revenue growth in excess of 10% is reported in the current year. He said there seem to be some limitations with the current charge in that it has a very narrow focus because the trigger is based on the RBC charge and does not seem to identify all companies that incur an underwriting loss in the following year. The group continues to meet generally monthly to determine the best approach to move forward. The group will continue to provide the Working Group with updates.

10. Discussed Pandemic Risk

Drutz said the Working Group has discussed pandemic risk and its effect on the health RBC formula in the last several meetings. During its April 17 meeting, the Working Group discussed some of the questions to think about, and some suggestions were made to look at any work done by the Society of Actuaries (SOA) on the COVID-19

public health emergency (PHE) and evaluate the RBC filings from 2020 to 2022. He suggested asking NAIC staff to: 1) reach out to the SOA on any work it has done on pandemic risk; 2) reach out to modeling firms to see if any model pandemic risk; 3) look at the templates for the calculation used by Solvency II; and 4) review the RBC filings from 2020 to 2022 to see if there are any discernable differences from year to year. Chou suggested also looking at the exposure by the Life Actuarial (A) Task Force on the historical mortality index, which included a discussion on pandemic risk.

Having no further business, the Health Risk-Based Capital (E) Working Group adjourned.

SharePoint/NAIC Support Staff Hub/Committees/E CMTE/CADTF/2023-2-Summer/HRBCWG/7-25-23 minutesTPR.docx

Draft: 7/10/23

Health Risk-Based Capital (E) Working Group
Virtual Meeting
May 17, 2023

The Health Risk-Based Capital (E) Working Group of the Capital Adequacy (E) Task Force met May 17, 2023. The following Working Group members participated: Steve Drutz, Chair (WA); Matthew Richard, Vice Chair, and Aaron Hodges (TX); Wanchin Chou and Sarah Mu (CT); Benjamin Ben (FL); Danielle Smith and Debbie Doggett (MO); and Tom Dudek (NY).

1. Exposed the Health Test Proposal

Drutz said the Working Group established the Health Test Ad Hoc Group in 2018 to review the existing health test language in the Annual Statement Instructions for all lines of business. He said the Working Group initially identified the concern when pulling the data for the Health Care Receivables (HCR) factor review. In 2016, approximately 28% of the overall health premiums were reported on the life blank, and 72% reported on the health blank, with less than 1% reported in the property/casualty (P/C) blank.

Drutz said in 2016, the life blank did not provide the same level of detail on health business and risks as the health blank. He said the following concerns were identified from a risk-based capital (RBC) perspective: 1) factor development; and 2) differences between the formulas. From a factor development perspective, only the data contained within the health blank could be used due to inconsistencies between the blanks. An example is HCRs, for which the factors are developed from data in Exhibit 3, Exhibit 3a, and Underwriting and Investment (U&I) Part 2B of the annual statement. These schedules were previously only available in the Health Annual Statement Blank. Drutz noted that there are also formula differences to consider; i.e., the health formula is driven primarily by the Underwriting Risk component, which in 2018 made up approximately 60–70% of the overall risk within the formula, while the life formula was driven more by asset risk. He also noted that the risk components are not accounted for identically between the health and life formulas. An example is that the health formula includes an excessive growth and HCR charge not included in the life RBC formula.

Drutz said prior to the establishment of the Ad Hoc Group, the Working Group reached out to other NAIC groups, such as the Financial Analysis (E) Working Group, the Financial Stability (E) Task Force, and the Blanks (E) Working Group to garner their feedback. From a financial analysis perspective, issues identified as concerns were group analysis and health insurance industry research and reporting. The Working Group established the Ad Hoc Group to consider the health test language, as it was included in the Annual Statement Instructions in 2018. The Ad Hoc Group was made up of state insurance regulators, industry, and NAIC staff. The health test language at the time the Ad Hoc Group was developed was as follows:

An entity is deemed to have passed the current test if:

The values for the premium and reserve ratios in the Health Statement Test equal or exceed 95% for both the reporting and prior year AND The entity passing Health Statement Test is licensed and actively issuing and/or renewing business in five states or less AND At least seventy-five percent (75%) of the entity's current year premiums are written in its domiciliary state OR The values for the premium and reserve ratios in the Health Statement Test equal 100% for both the reporting and prior year, regardless of the number of states in which the entity is licensed.

Drutz said the Ad Hoc Group considered two approaches: 1) a bright line test, which was rules-based and maintained the current “test” concept. That is, if the test is passed, the presumption is that the insurer would switch to the health blank unless the state insurance regulator vetoed that move. Additional tests and considerations would be outlined to determine if special consideration should be given to the reporting entity moving to the health blank (e.g., separate accounts, large book of long-term care (LTC) business, etc.); or 2) an analysis/risk-based approach that would change the “test” concept to become an “analysis” process. The “test” would instead provide metrics to the state insurance regulator. When a metric exceeds the guideline, the state insurance regulator should consider whether the insurer should be reporting on the health blank. Drutz said the Ad Hoc Group always maintained that with either approach, the full authority and discretion in determining the blank to be filed by the reporting entity would remain with the domiciliary state. He said the Ad Hoc Group ultimately agreed to move forward and maintain a bright line test approach.

Drutz said the Phase 1 proposal was developed and exposed by the Working Group in December 2021. The primary components of this proposal included the following revisions: 1) removal of the requirements for licensed and actively writing in five states or less; 75% of current premiums are written in the domiciliary state; and the “or” statement for the premium and reserve ratio equal to 100%; 2) added a clarifying sentence to the Life and P/C portion of the Health Test language instructions that companies that report separate accounts or protected cells are not subject to the results of the health test but should continue to report on the existing blank; and 3) the General Interrogatory references for Life were updated to pull from the current Analysis of Operations by Line of Business—Accident and Health instead of the Life RBC.

Drutz said the Ad Hoc Group also discussed the premium and reserve ratios during the Phase 1 work. At one point, consideration was given to removing the reserve ratio as a requirement. Drutz said the Ad Hoc Group determined to maintain the existing 95% premium and reserve ratios for the time being and evaluate any changes to this requirement as part of Phase 2. The Working Group referred the Phase 1 proposal to the Blanks (E) Working Group in February 2022, and it was adopted for year-end 2022 reporting by the Blanks (E) Working Group.

Drutz said the Ad Hoc Group began its review of the premium and reserve ratios after the referral of the Phase 1 proposal. The primary discussion revolved around the reserve ratio. The focus of consideration and discussion by the Ad Hoc Group was on asset valuation reserve (AVR)/interest maintenance reserve (IMR), the actuarial opinion and asset adequacy testing (AAT), and the reserve ratio calculation itself. He said a question was raised on AAT when a reporting entity transitions from the life blank to the health blank and if the entity must continue to submit a Statement of Actuarial Opinion (SAO) based on asset adequacy analysis. The Ad Hoc Group worked closely with the Health Actuarial (B) Task Force and identified that there was not a general requirement that would require a health insurer to perform AAT, but there were other requirements that could compel such an analysis. The Ad Hoc Group also worked with the Working Group to draft a referral letter to ask the Health Actuarial (B) Task Force to consider adding a sentence to *Actuarial Guideline LI—The Application of Asset Adequacy Testing to Long-Term Care Insurance Reserves* (AG 51) that says AAT must be completed regardless of statement type if such requirements are met.

Drutz said the discussion around calculating the life reserve ratio was multi-faceted. He said the initial concern identified in the existing calculation was that the numerator pulled from Exhibits 5, 6, and 8, while the denominator pulled from the Liabilities page. The Ad Hoc Group noted that using the varying schedules between the numerator and denominator was a less straightforward approach to the calculation. Drutz said the Ad Hoc Group started its initial review by identifying equivalent lines in Exhibits 5, 6, or 8 to the Liabilities reference in the denominator. After identifying these, the Ad Hoc Group recalculated the results to ensure consistency. However, as the Ad Hoc Group worked through this exercise, it identified an inconsistency in the lines used in the calculation. Some were reported on a net basis, while others were reported on a gross basis. As a result, the Ad Hoc Group identified and analyzed the results of the reserve ratio to be calculated on an all-net or all-gross basis. It

determined that there was no material effect to one over the other, and it moved forward with a net basis approach, which will keep the premium and reserve ratio on a net basis.

Drutz said based on the analysis of the Ad Hoc Group, a Phase 2 proposal was drafted. This proposal includes revisions to the General Interrogatories, Part 2, Health Test Premium and Reserve Ratio calculations for life, property, and health. The changes reflected in this proposal were to clarify and create greater transparency in the calculation of both the numerator and the denominator in both the premium and reserve calculation. In both the premium and reserve ratios, the numerator and the denominator were calculated using separate schedules. Drutz said the changes align the denominator to pull from the same schedules as the numerator where possible. For example, the denominator in the calculation of the reserve ratio in the life general interrogatories was calculated using the Liabilities page, but the numerator utilized Exhibits 6 and 8. For greater transparency, the Ad Hoc Group then utilized those same schedules to now calculate the denominator. He said the current calculation of the reserve ratio utilizes both gross and net amounts, creating inconsistencies in the calculation. It was concluded that the net basis was the best way to move forward. This allowed for both the premium and reserve ratio to be calculated on a net basis. Drutz said additional clarifying instructions were also incorporated into the health test language on the timing of when a company would move if it has passed the test.

Drutz said the Ad Hoc Group also discussed whether the 95% ratio should be lowered, but it determined that no changes should be made at this time due to the extensive changes in the life and property annual statement filings for capturing health data. He said the Ad Hoc Group felt that all health data changes should be implemented, as well as the proposed health test changes, and then re-evaluated in a few years.

Hearing no objections, the Working Group exposed the proposal to the Health Risk-Based Capital (E) Working Group, the Property and Casualty Risk-Based Capital (E) Working Group, and the Life Risk Based-Capital (E) Working Group for a 45-day public comment period ending June 30.

2. Discussed Other Matters

Drutz said proposal 2022-09-CA was adopted for year-end 2023 reporting, and it revises the affiliated investment portion of the health RBC formula. He said as NAIC staff worked through the implementation of the changes, it was found that some clarifications were needed in the form of editorial changes, specifically for indirectly owned alien insurance subsidiaries and affiliates. He said the Working Group will work with the Capital Adequacy (E) Task Force on these editorial changes.

Having no further business, the Health Risk-Based Capital (E) Working Group adjourned.

SharePoint/NAIC Support Staff Hub/Member Meetings/

Draft: 7/10/23

Health Risk-Based Capital (E) Working Group
Virtual Meeting
April 17, 2023

The Health Risk-Based Capital (E) Working Group of the Capital Adequacy (E) Task Force met April 17, 2023. The following Working Group members participated: Steve Drutz, Chair (WA); Matthew Richard, Vice Chair (TX); Wanchin Chou, Qing He, and Sarah Mu (CT); Frances Tay and Benjamin Ben (FL); Tish Becker (KS); Danielle Smith and Debbie Doggett (MO); Lindsay Crawford, Michael Muldoon, and Margaret Garrison (NE); and Tom Dudek (NY).

1. Adopted its Spring National Meeting Minutes

Chou made a motion, seconded by Muldoon, to adopt the Working Group's March 18 minutes (*see NAIC Proceedings – Spring 2023, Capital Adequacy (E) Task Force, Attachment Three*). The motion passed unanimously.

2. Referred Proposal 2023-01-CA to the Capital Adequacy (E) Task Force for Exposure

Drutz said the intent is to refer proposal 2023-01-CA to the Capital Adequacy (E) Task Force for exposure, which the Working Group exposed at the Spring National Meeting for 20 days. No comments were received. Drutz said the purpose of the proposal was to clarify the instructions for stop loss business in the health risk-based capital (RBC) formula and align the life and property/casualty (P/C) RBC formulas with these changes. The following minor editorial changes were made to the proposal: 1) the "i.e." references were replaced with "e.g."; 2) the reference to "treaty" in the example provided under the Calendar Year was corrected to "contract"; and 3) the proposal number on the proposal form was corrected.

Hearing no objections, the Working Group agreed to refer proposal 2023-01-CA to the Capital Adequacy (E) Task Force for exposure.

3. Received an Update from the Academy on the Health Care Receivables Project

Kevin Russell (American Academy of Actuaries—Academy) provided an overview and update to the Working Group on the status of the health care receivable (HCR) factor review project. He provided a brief history, noting that Exhibit 3A was implemented in the Health Annual Statement Blank in 2013, which provides a follow-up study on HCRs, and an analogous exhibit was implemented in the Life, Accident and Health (A&H)/Fraternal Annual Statement Blank in 2021. He said the original RBC factor for all types of HCRs was 0.05. He said in 2016, the Academy recommended a change to the factors based on an analysis of amounts collected against receivables compared to admitted receivable assets. He said there was a separate analysis of drug rebates versus the other five types combined. For drug rebates, the 0.05 factor provides a likelihood of between 90% and 95% that the collected amounts would cover the admitted asset plus the amount added to the H3 credit risk calculation. Russell noted that the second largest category of receivables is claim overpayment receivables, and a separate analysis was considered but rejected in favor of including them with the other four types. The Academy recommended the following current factors: 0.05 for drug rebates and 0.19 for all other HCRs.

Russell noted that HCRs have been changing over the years, and drug rebate receivables continue to be the largest portion and still growing; i.e., 48% in 2014 and 65% in 2021. He said claim overpayment receivables have always been the second largest, but their percentage is shrinking—20% in 2014 to 14% in 2021—and risk-sharing receivables are growing as a percentage—3% in 2014 to 7% in 2021.

Russell said the Academy has looked at the 2018–2021 data provided for the Other HCRs, and less than one-third of the Other HCR (for 2018 through 2021) dollars have any description. He said a good amount have descriptions consistent with expectations, such as government programs (e.g., Medicare, Medicaid, and the Children’s Health Insurance Program [CHIP]). However, there is a good amount where the descriptions do not seem to be appropriate for items that become a portion of incurred claims via the Underwriting and Investment (U&I) Exhibit Part 2. Examples are: 1) Reinsurance – Reinsurance receivables are part of the H3 Credit Risk but in a different section than HCRs; reinsurance is separately accounted for on the U&I Exhibit Part 2; 2) Interest – Investment income receivables are part of the H3 Credit Risk but in a different section than HCRs; and 3) Admin Fee – The H4 Business Risk covers administrative expenses. Russell said the Academy is considering making inquiries through the NAIC to better understand why these receivables are being reported as such, and the goal would be to produce recommendations to improve instruction clarity or provide additional guidance.

Russell said the Academy is investigating the following questions: 1) whether performance is better for drug rebates compared to the other five categories of HCRs for the filing companies whose receipts do not cover their accrual; 2) whether company performance has improved over time for the filing companies whose receipts do not cover their accrual (an outlier poor performance year might be excluded from the analysis to produce new recommended factors); 3) whether larger companies perform better than smaller ones for the filing companies whose receipts do not cover their accrual (this could indicate that smaller factors could be appropriate for larger receivable amounts, similar to the treatment of the Experience Fluctuation Risk component of the H2 Underwriting Risk).

David Quinn (Academy) shared a graphical representation of the initial analysis results with the Working Group (Attachment Three-B1). He said the density plots show how well companies collected if they did not collect at least 100%. Taller peaks towards 100% are desirable, while masses above 0% could be poor reporting or failure to collect on the receivable. The left-side charts are by year. The overlapping suggests that reporting is consistent across years. The right-side charts are by company size measured by total HCR dollars. The medium and large tiers are defined by \$1 million and \$10 million, respectively. Each tier is noticeably different in its distribution and thus may have different H3 risks as a function of size. Quinn said larger HCR companies typically did better than smaller ones, which has given rise to the consideration of using a tiered factor approach.

Muldoon said it is interesting that claims overpayment appears to be a much bigger group getting no collections in the prior year, and it could have been estimated erroneously, or there is a dispute with a company that thinks they have made overpayments, but the provider disagrees. Quinn agreed that this is very plausible, and he said it could be the size, as fewer companies hold this type of receivable, so there is more volatility from a small sample size. Russell said the receivable is set up, but the collection often does not come as a separate payment against the accruals. Rather, it comes as an offset made against future claim payments. This may be difficult for companies to quantify because it looks like an adjustment to a claim. He said a large portion is not reporting any collections against the accruals made, and this may be an inquiry to be made.

Drutz asked if the items identified in the analysis as questionable or incorrect were omitted from the analysis. Russell said they were not omitted, and in many cases, they had recoveries reported. The question was the propriety of the receivable type that they were reported as and if it was truly an HCR or some other type of receivable. Drutz asked if the clarification of the Annual Statement Instructions provided any improvement in the data integrity in the last several years. Russell said the Academy did not see much difference in the data integrity in the last four years.

Robin Marcotte (NAIC) asked if it was not a true reinsurance recoverable but instead perhaps related to Medicare or Medicaid. Russell said that is something that has been considered, and it is not uncommon on the Medicaid side for states to keep out of their managed care capitations; i.e., claims in excess of \$500,000 for the plan year.

Russell said the state may ask the health plan to pay the whole claim and then submit a stop loss request back to the state, so the HCR could be mislabeled.

The Working Group agreed that it wants the Academy to continue its work on the HCR factor review and prepare a list of possible inquiries.

4. Received an Update from the Academy on the H2 – Underwriting Risk Review

Derek Skoog (Academy) said the Health Solvency Work Group has been working in several different subgroups to advance the following topics: 1) redesigning the structure of the underwriting risk formula; 2) data analysis; and 3) redesigning the managed care credit. He said the Work Group continues to work towards providing more analyses related to where it is seeing volatility in the performance of various lines of business over time and what that may imply for initial underwriting risk factors and structural changes.

5. Discussed Pandemic Risk

Drutz said the Working Group agreed to begin discussing pandemic risk at the Spring National Meeting, and he asked if state insurance regulators consider it to be a missing risk. Muldoon said he has not seen any definitive studies about the impact on RBC because of the pandemic. He said in 2020, the government stepped in and shut down all elective surgeries, and because health companies did not have to cover them, many had a big underwriting gain; however, many companies experienced an increase in telehealth and mental health services, as well as the COVID-19 vaccine. He asked if the assumption is that there would be the same type of government action to step in when the next pandemic hits, and if so, the risk of many health companies becoming insolvent could be minimized. He said he was not clear on what could be changed in the RBC at this time. Drutz noted the limited hospital space during the pandemic, and he asked how the limited space could affect the risk. He also noted the pent-up demand for medical care following the worst of the pandemic, and he asked if this demand could have a bigger effect than the pandemic. He said there appeared to be more volatility for some carriers in 2021 and 2022 because of this pent-up demand.

Drutz asked if anyone has any knowledge or information on modeling pandemic risk and if any industry participants model for pandemic risk. Muldoon said Nebraska has not seen much on modeling pandemic risk in its reviews of companies. Drutz asked if anyone has any information related to the Solvency II requirements for modeling pandemic risk. Richard said he has seen some requirements for Solvency II for the United Kingdom (UK). He said the approach was as follows: if the number of policyholders is X, assume X percent will have an office visit, X will have a more severe case, and X will have a higher severity case. Then, there is an assumed frequency for each of the three levels of severity multiplied by the corresponding costs. Richard said the templates for the calculation are all public through the European Insurance and Occupational Pensions Authority (EIOPA).

Drutz asked if the Working Group feels it should dive deeper into pandemic risk, and if so, if there are any thoughts on how to begin this work or questions to consider. Muldoon suggested looking at what work the Society of Actuaries (SOA) is still doing with its monitoring spreadsheets. He also suggested looking at the RBC filings from 2020–2022 to see if any discernable differences were noted. Drutz suggested looking to see if there was a general decline in RBC results. Muldoon also suggested segregating the companies into groups, such as major medical.

The Working Group agreed to begin looking at pandemic risk.

6. Discussed Other Matters

Drutz said the Health Test Ad Hoc Group met April 12, and a question was raised on the proposal's effective date and when a company would move if they passed the health test based on the language currently included in it. The Ad Hoc Group determined that that language was not overly clear, and it would be beneficial to look at it further. As a result, the Ad Hoc Group will meet again April 26 to look at clarifications for the language on "Passing the Test" and "Failing the Test."

Drutz said the Capital Adequacy (E) Task Force established an ad hoc group at the Spring National Meeting to review or analyze current non-investment charges, missing risks, and modernizing asset concentration instructions. He said if anyone has any thoughts on non-investment charges or missing risks in the health RBC formula, they should reach out to him or Crystal Brown (NAIC).

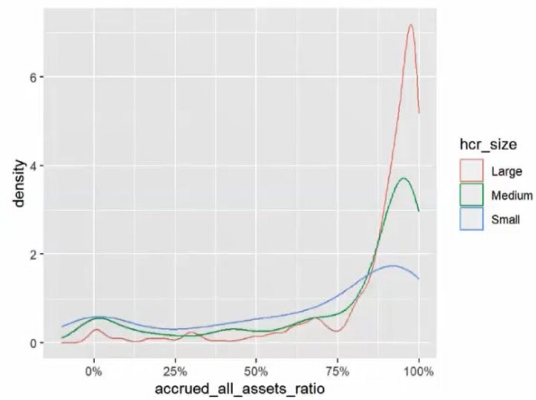
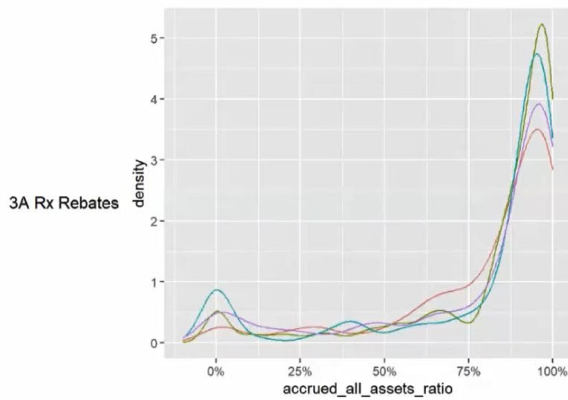
Having no further business, the Health Risk-Based Capital (E) Working Group adjourned.

SharePoint/NAIC Support Staff Hub/Member Meetings/

Rx Rebates

```
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##   year accrued_all_assets_ratio
##   <chr>      <dbl>
## 1 2018          0.887
## 2 2019          0.923
## 3 2020          0.926
## 4 2021          0.923
```

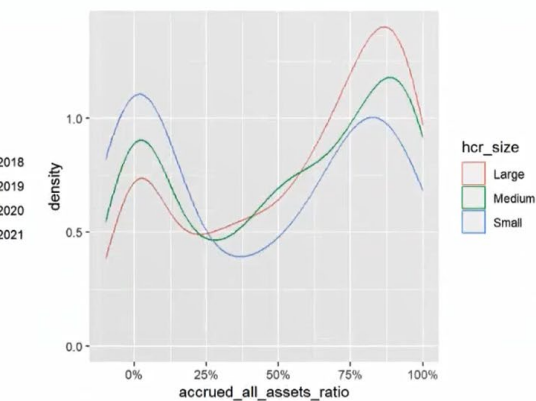
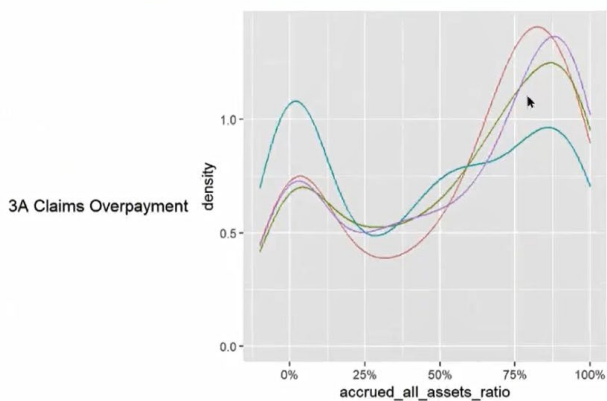
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## 2 Medium   0.921  303
## 3 Small    0.803  176
```



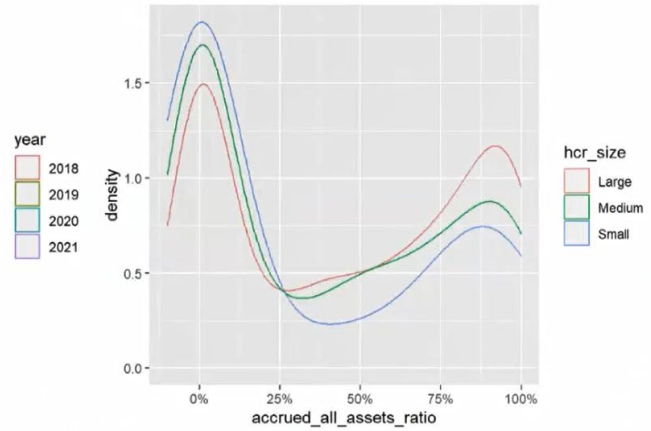
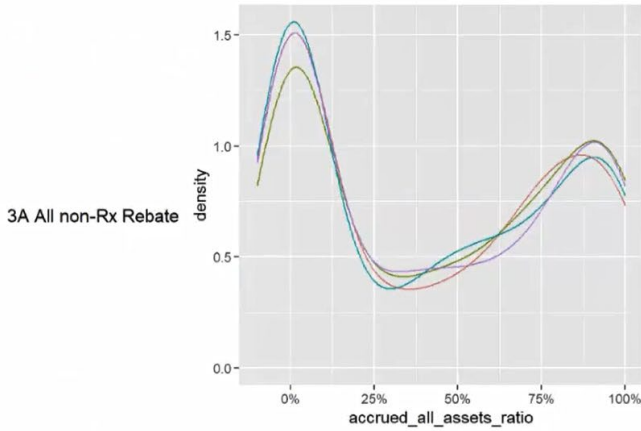
Claim Overpayments

```
## # A tibble: 4 x 2
##   year accrued_all_assets_ratio
##   <chr>      <dbl>
## 1 2018          0.711
## 2 2019          0.660
## 3 2020          0.509
## 4 2021          0.685
```

```
## # A tibble: 3 x 3
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##   <chr>      <dbl> <int>
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## 2 Medium   0.589  213
## 3 Small    0.475   85
```



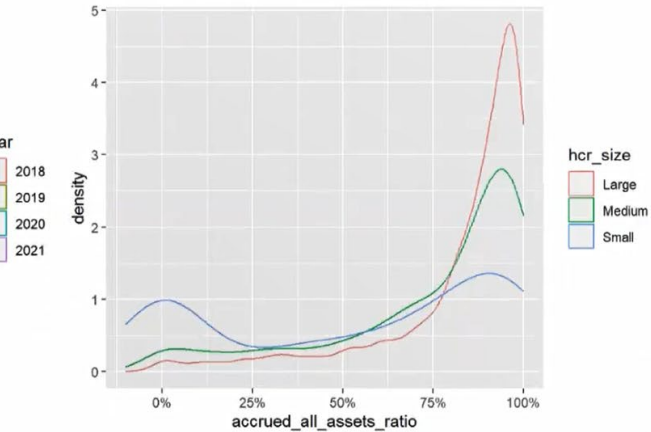
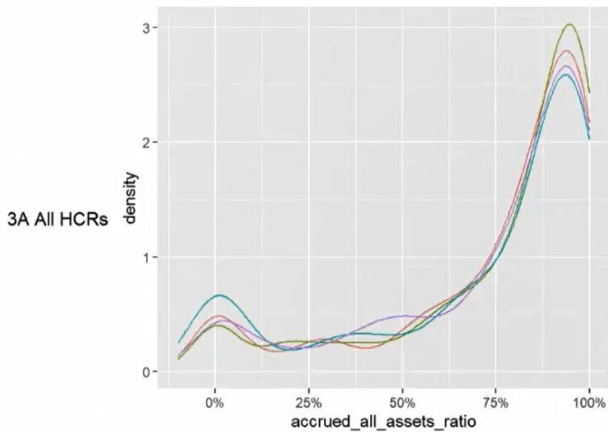
```
## # A tibble: 3 x 3
##   hcr_size median count
##   <chr>      <dbl> <int>
## 1 Large     0.494  889
## 2 Medium   0.283  454
## 3 Small     0      179
```

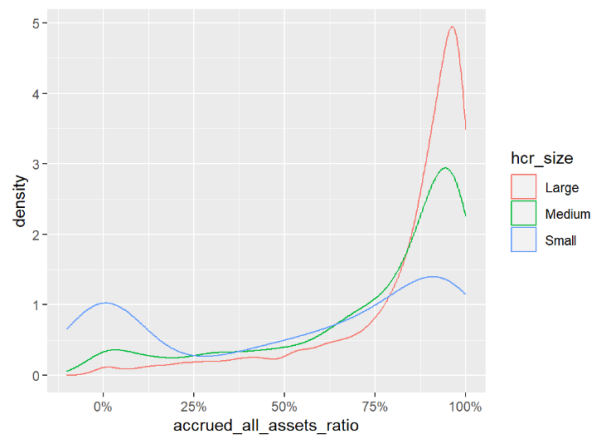
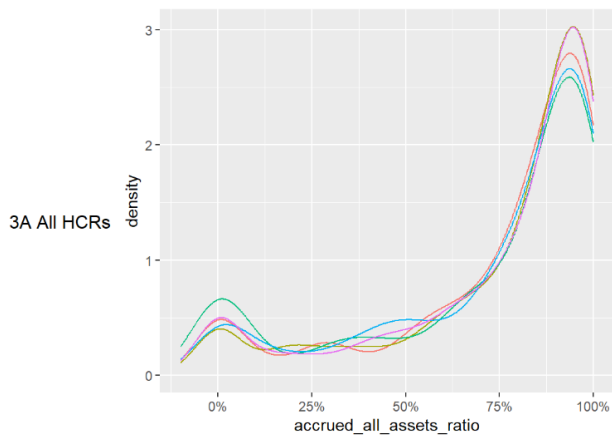
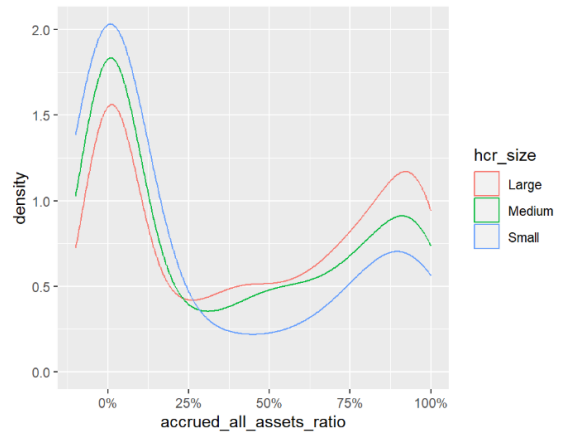
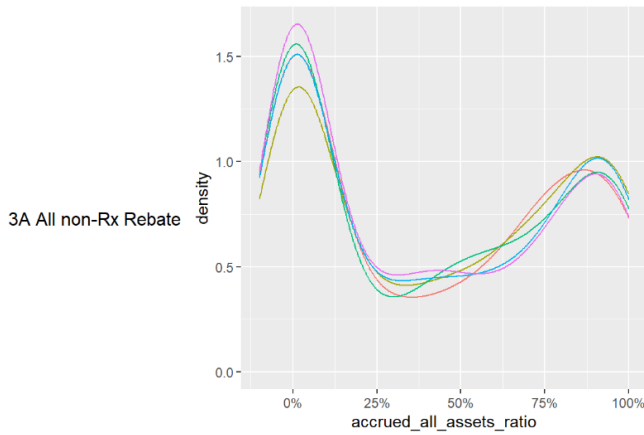
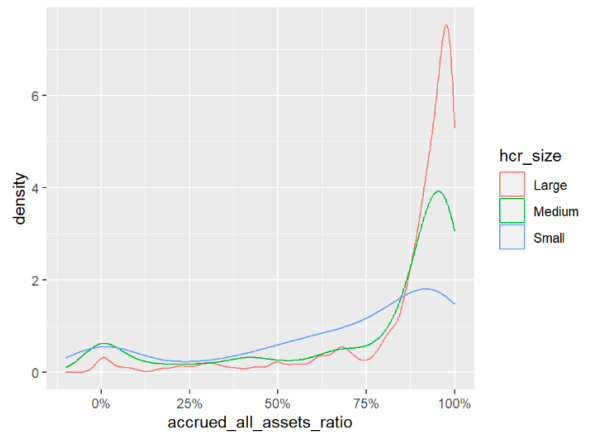
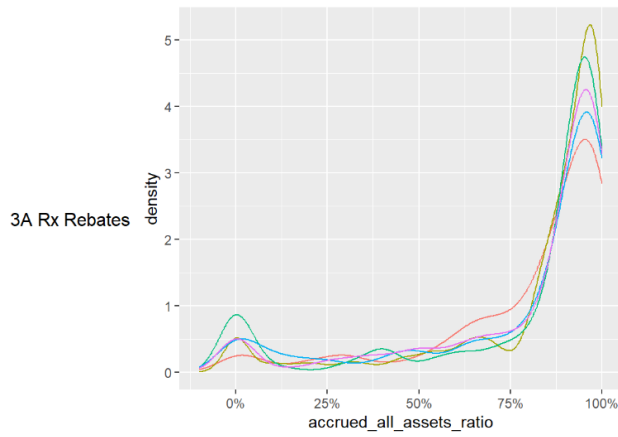


All HCR

```
## # A tibble: 4 x 2
##   year accrued_all_assets_ratio
##   <chr>      <dbl>
## 1 2018          0.865
## 2 2019          0.880
## 3 2020          0.869
## 4 2021          0.871
```

```
## # A tibble: 3 x 3
##   hcr_size median count
##   <chr>      <dbl> <int>
## 1 Large     0.908  455
## 2 Medium   0.863  389
## 3 Small     0.682  253
```







Newsletter Items for Adoption for 2023 for Health RBC:

Date: July 2023

Volume: 25.1

Page 1: Intro Section:

What Risk-Based Capital Pages Should Be Submitted?

For the year-end 2023 health risk-based capital (RBC) filing, submit hard copies of pages **XR001 through XR027** to any state that requests a hard copy in addition to the electronic filing. Beginning with year-end 2007, a hard copy of the RBC filings was not required to be submitted to the NAIC. Other pages, outside of pages XR001 through XR027, do not need to be submitted. Those pages would need to be retained by the company as documentation.

Page 1+: Items Adopted for 2023:

Modification to the Affiliated Investment Structure and Instructions

The Capital Adequacy (E) Task Force adopted proposal 2022-09-CA during its March 23 meeting to revise the instructions and structure of the Affiliated Investment pages (pages XR002-XR004) to provide consistent treatment of affiliated investments between the Health, Life, and Property/Casualty (P/C) RBC formulas. The Capital Adequacy (E) Task Force adopted proposal 2022-09-CA (MOD) during its June 30 call. The modified proposal clarified the examples provided for the Indirectly Owned Alien Insurance Affiliates/Subsidiaries section within the instructions and added a footnote for the "% Owned" column within the blank.

Preferred Stock Instructions

The Capital Adequacy (E) Task Force adopted proposal 2022-10-H during its Dec. 14, 2022, meeting to delete the reference to bond factors and revise for consistency with the P/C RBC preferred stock instructions.

Underwriting Risk - Annual Statement - Analysis of Operations References

The Capital Adequacy (E) Task Force adopted proposal 2022-11-H during its Dec. 14, 2022,

Washington, DC 444 North Capitol Street NW, Suite 700, Washington, DC 20001-1509 p | 202 471 3990 f | 816 460 7493

Kansas City 1100 Walnut Street NW, Suite 1500, Kansas City, MO 64106-2197 p | 816 842 3600 f | 816 783 8175

New York One New York Plaza, Suite 4210, New York, NY 20004 p | 212 398 9000 f | 212 382 4207

www.naic.org

meeting. The purpose of this proposal was to update the annual statement source descriptions and align the lines of business on pages XR013 and XR014 with the changes in the Annual Statement Analysis of Operations based on Blanks proposal 2021-17BWGMOD.

Trend Test Instructions

The Capital Adequacy (E) Task Force adopted proposal 2022-14-H during its March 23 meeting to remove the informational-only trend test instructions.

Renumbering of Page XR008

The Capital Adequacy (E) Task Force adopted proposal 2022-15-H during its March 23 meeting to renumber the lines on page XR008 so it starts with line number 1.

Underwriting Risk Factors - Investment Income Adjustment

The Capital Adequacy (E) Task Force adopted proposal 2022-16-CA during its June 30 meeting. This proposal updated the comprehensive medical, Medicare supplement, and dental and vision factors to include a 5% investment yield adjustment. The revised factors are:

	Comprehensive Medical	Medicare Supplement	Dental & Vision
\$0-\$3 Million	0.1434	0.0980	0.1148
\$3-\$25 Million	0.1434	0.0603	0.0711
Over \$25 Million	0.0838	0.0603	0.0711

Stop Loss Premiums

The Capital Adequacy (E) Task Force adopted proposal 2023-01-CA during its June 30 meeting. This proposal clarifies the instructions for stop loss premiums in the Underwriting Risk - Experience Fluctuation Risk, Other Underwriting Risk, and Stop Loss Interrogatories.

Page 2+: Editorial Changes:

1. An editorial change was made to the Annual Statement Source column on page XR014 for the following:
 - a. Column (1), Line (7) was updated to reference "Pg. 7, Col. 2+3+8+9, Line 17."
 - b. Column (7), Line (2) was updated to reference "Pg. 7, Col. 8, Lines 1+2."
 - c. Column (7), Line (3) was updated to reference "Pg. 7, Col. 9, Lines 1+2."
2. An editorial change was made to the instructions for Affiliated Investments to remove the reference "and Line 93999999" from the end of the following sentence: "The total of all reported affiliate/subsidiary stock should equal the amounts reported on Schedule D, Part 2, Section 1, Line 4409999999 plus Schedule D, Part 2, Section 2, Line 5979999999 and should also equal Schedule D, Part 6, Section 1, Line 09999999 plus Line 18999999."
3. An editorial change was made to the Annual Statement Source on page XR023, Lines (5) and (13), to update the line reference to Line 7.
4. An editorial change was made to remove the page number reference from the electronic-only stop loss tables on page XR015 of the forecasting file.

Last Page: RBC Forecasting & Warning:**Risk-Based Capital Forecasting and Instructions**

The Health RBC forecasting spreadsheet calculates RBC using the same formula presented in the *2023 NAIC Health Risk-Based Capital Report Including Overview & Instructions for Companies*, and it can be downloaded from the NAIC Account Manager. The *2023 NAIC Health Risk-Based Capital Report Including Overview & Instructions for Companies* publication is available for purchase in an electronic format through the NAIC Publications Department. This publication is available for purchase on or about Nov. 1 each year. The User Guide is no longer included in the Forecasting & Instructions.

WARNING: The RBC forecasting spreadsheet CANNOT be used to meet the year-end RBC electronic filing requirement. RBC filing software from an annual statement software vendor should be used to create the electronic filing. If the forecasting worksheet is sent instead of an electronic filing, it will not be accepted, and the RBC will not have been filed.

Last Page: 2023 National Association of Insurance Commissioners:

2023 NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

Health Risk-Based Capital Newsletter Volume 25.1. Published annually or whenever needed by the NAIC for state insurance regulators, professionals, and consumers.

Direct correspondence to: Crystal Brown, RBC Newsletters, NAIC, 1100 Walnut Street, Suite 1500, Kansas City, MO 64106-2197. Phone: 816-783-8146. Email: cbrown@naic.org.

NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

Aggregated Health Risk-Based Capital Data
2022 Data as of 7/5/2023

	2022	2021	2020	2020	2019	2018	2018	2017	2017
	<u>Health RBC</u>	<u>Health RBC</u>	<u>Health RBC</u>	<u>Health RBC</u>	<u>Health RBC</u>	<u>Health RBC</u>	<u>Health RBC</u>	<u>Health RBC</u>	<u>Health RBC</u>
		<u>Fees</u>	<u>Excluding ACA</u>	<u>Excluding ACA</u>	<u>Fees</u>	<u>Excluding ACA</u>	<u>Fees</u>	<u>Excluding ACA</u>	<u>Fees</u>
Companies that have an RBC loaded on the database	1143	1095	1067	1,012	1,012	965	965	937	937
Companies with action levels:									
Percentage of total RBC's loaded	2.45%	1.10%	1.41%	3.06%	1.48%	1.87%	1.87%	4.48%	2.24%
Company Action Level - Trend Test	13	15	12	27	14	13	13	23	12
Regulatory Action Level	6	5	4	14	3	4	4	24	10
Authorized Control Level	10	2	3	5	3	5	5	10	5
Mandatory Control Level	12	3	6	9	7	7	7	8	6
Total H0 (H0 - Asset Risk - Affiliates w/RBC)	6,291,267,994	6,077,847,595	5,192,392,682	4,782,424,393	4,782,424,393	4,487,634,571	4,487,634,571	4,332,880,131	4,332,880,131
Total H1 (H1 - Asset Risk - Other)	14,838,262,774	15,015,094,709	11,292,103,225	9,743,938,557	9,743,938,557	8,589,245,210	8,589,245,210	8,315,790,867	8,315,790,867
Total H2 (H2 - Underwriting Risk)	58,513,470,158	52,350,782,394	45,819,164,666	44,037,638,071	44,037,638,071	40,572,604,055	40,572,604,055	38,787,031,590	38,787,031,590
Total H3 (H3 - Credit Risk)	5,526,140,601	4,782,549,718	4,199,732,859	3,626,933,231	3,626,933,231	3,408,004,022	3,408,004,022	3,143,155,975	3,143,155,975
Total H4 (H4 - Business Risk)	8,609,609,597	7,882,405,838	7,481,764,896	6,571,143,274	6,571,143,274	6,468,297,728	6,468,297,728	5,739,438,653	5,739,438,653
Total RBC Before Covariance	93,778,751,124	86,088,680,244	73,985,158,328	68,762,077,526	68,762,077,526	63,525,815,586	63,525,815,586	60,318,297,216	60,318,297,216
Total Adjusted Capital	220,326,411,094	211,045,740,619	193,859,548,232	180,286,143,771	171,305,834,767	156,736,204,863	156,736,204,863	142,062,265,048	142,062,265,048
ACA Fees			6,758,224	11,039,690,995	3,172,155			9,892,443,636	
Authorized Control Level RBC *	36,522,419,595	33,256,637,840	28,853,148,695	27,216,649,996	27,216,654,287	25,020,328,688	25,020,329,600	23,228,424,178	23,228,428,544
Aggregate RBC %	60.3%	63.5%	67.2%	54.8%	62.9%	62.6%	62.6%	52.6%	61.2%
Median RBC %	62.8%	63.3%	70.6%	64.0%	67.2%	66.8%	66.8%	60.9%	64.0%
# of Companies with an RBC Ratio of >10,000%	148	121	143	156	156	134	134	112	112
# of Companies with an RBC Ratio of < 10,000% & > 1,000%	232	243	259	202	215	224	224	201	213
# of Companies with an RBC Ratio of < 1,000% & > 500%	333	356	320	257	282	267	267	237	251
# of Companies with an RBC Ratio of < 500% & > 300%	341	301	278	267	285	256	255	247	268
# of Companies with an RBC Ratio of < 300% & > 250%	35	32							
# of Companies with an RBC Ratio of < 250% & > 200%	25	28							
# of Companies with an RBC Ratio of < 300% & > 200%	28	12	14	31	15	18	18	42	21
# of Companies with an RBC Ratio of < 200% & > 0%	1	2	1	0	0	0	0	1	1
Total Companies with RBC	1,143	1,095	1,067	1,012	1,012	965	965	937	937
Total Revenue	988,270,459,614	888,638,436,244	806,712,759,846	731,800,228,651	731,800,228,651	689,327,716,795	689,327,716,795	643,856,047,265	643,856,047,265
Underwriting Deductions	973,220,456,829	873,463,482,222	774,563,533,665	715,077,656,883	715,077,656,883	668,916,360,940	668,916,360,940	625,985,270,784	625,985,270,784
Aggregate Premium	285,669,735,439	278,391,052,611	277,819,028,596	268,818,431,635	268,818,431,635	271,400,290,484	271,400,290,484	262,662,393,744	262,662,393,744
Aggregate Net Incurred Claims	806,428,955,513	721,841,094,774	622,491,724,778	585,439,850,066	585,439,850,066	541,009,426,163	541,009,426,163	511,376,831,853	511,376,831,853

* Authorized Control Level RBC amount reported in the Health RBC Excluding ACA Fees column is pulled from Line (18), page XR02B, and the Authorized Control Level RBC amount reported in the Health RBC column is pulled from Line (4), page XR02Z.

Source: NAIC Financial Data Repository

NAIC BLANKS (E) WORKING GROUP

Blanks Agenda Item Submission Form

<p style="text-align: right;">DATE: <u>5-17-23</u></p> <p>CONTACT PERSON: <u>Crystal Brown</u></p> <p>TELEPHONE: <u>816-783-8146</u></p> <p>EMAIL ADDRESS: <u>cbrown@naic.org</u></p> <p>ON BEHALF OF: <u>Health Risk-Based Capital (E) Working Group</u></p> <p>NAME: <u>Steve Drutz</u></p> <p>TITLE: <u>Chair</u></p> <p>AFFILIATION: <u>WA Office of Insurance Commissioner</u></p> <p>ADDRESS: _____</p>	<p style="text-align: center;">FOR NAIC USE ONLY</p> <p>Agenda Item # _____</p> <p>Year <u>2024</u></p> <p>Changes to Existing Reporting []</p> <p>New Reporting Requirement []</p> <hr/> <p style="text-align: center;">REVIEWED FOR ACCOUNTING PRACTICES AND PROCEDURES IMPACT</p> <p>No Impact []</p> <p>Modifies Required Disclosure []</p> <hr/> <p style="text-align: center;">DISPOSITION</p> <p>[] Rejected For Public Comment</p> <p>[] Referred To Another NAIC Group</p> <p>[] Received For Public Comment</p> <p>[] Adopted Date _____</p> <p>[] Rejected Date _____</p> <p>[] Deferred Date _____</p> <p>[] Other (Specify) _____</p>
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BLANK(S) TO WHICH PROPOSAL APPLIES

- | | | |
|---|---|--------------------------------------|
| <input checked="" type="checkbox"/> ANNUAL STATEMENT | <input checked="" type="checkbox"/> INSTRUCTIONS | <input type="checkbox"/> CROSSCHECKS |
| <input type="checkbox"/> QUARTERLY STATEMENT | <input type="checkbox"/> BLANK | |
| <input checked="" type="checkbox"/> Life, Accident & Health/Fraternal | <input type="checkbox"/> Separate Accounts | <input type="checkbox"/> Title |
| <input checked="" type="checkbox"/> Property/Casualty | <input type="checkbox"/> Protected Cell | <input type="checkbox"/> Other _____ |
| <input checked="" type="checkbox"/> Health | <input type="checkbox"/> Health (Life Supplement) | |

Anticipated Effective Date: _____

IDENTIFICATION OF ITEM(S) TO CHANGE

Revise the Health Test Language and General Interrogatories.

REASON, JUSTIFICATION FOR AND/OR BENEFIT OF CHANGE**

The purpose of this change is to clarify and create better transparency in the calculation of the premium and reserve ratios in the health test.

NAIC STAFF COMMENTS

Comment on Effective Reporting Date: _____

Other Comments:

** This section must be completed on all forms.

Revised 7/18/202

INSTRUCTIONS**GENERAL**

The annual statement is to be completed in accordance with the *Annual Statement Instructions* and *Accounting Practices and Procedures Manual* except to the extent that state law, rules or regulations are in conflict with these publications. In cases of conflict, the life, accident and health annual statement will be filed pursuant to such state's filing requirements. The domiciliary state's insurance regulatory authority shall maintain full discretion in determining which NAIC annual statement blank must be filed. The annual statement blank filed with the domiciliary state shall be the blank submitted to, and maintained by, the NAIC, and barring conflict as described above, should be filed with all jurisdictions in which the reporting entity is licensed.

1. Health Statement Test:

If a reporting entity is licensed as a life and health insurer and completes the life, accident and health annual statement for the reporting year, the reporting entity must complete the Health Statement Test. However, a reporting entity that is required to also file the Separate Accounts Statement is not subject to the results of the Health Statement Test, and should continue to complete the life, accident and health/fraternal blank.

The Health Statement Test is designed to determine whether a reporting entity reports predominantly health lines of business. Health lines include hospital or medical policies or certificates, comprehensive major medical expense insurance and managed care contracts and exclude other health coverage such as credit insurance, disability income coverage, automobile medical coverage, workers' compensation, accidental death and dismemberment policies and long-term care policies.

Passing the Test:

A reporting entity is deemed to have passed the Health Statement Test if:

The values for the premium and reserve ratios in the Health Statement Test equal or exceed 95% for both the reporting and prior year.

If a reporting entity is a) licensed as a life and health insurer; b) completes the Life, Accident and Health annual statement for the reporting year; and c) passes the Health Statement Test (as described above), the reporting entity must complete the health statement beginning with the first quarter's statement for the second year following the reporting year in which the reporting entity passes the Health Statement Test and must also file the corresponding risk-based capital report and the life supplements for that year-end. **For example, if the reporting entity reports premium and reserve ratios of 95% or greater in 20X1 and again reports premium and reserve ratios of 95% or greater in 20X2, the reporting entity is deemed to have passed the Health Statement Test as of 20X2. Therefore, the reporting entity would begin completing the health statement in the first quarter of 20X4. (As noted above, the domiciliary state regulator maintains full discretion in determining which annual statement blank must be filed and when the reporting entity is to move.)**

	<u>20X1</u>	<u>20X2</u>	<u>20X3</u>	<u>20X4</u>
<u>Premium Ratio</u>	<u>95% or greater</u>	<u>95% or greater</u>	<u>Work with domestic regulators to move effective Quarter 1 20X4</u>	<u>Move to Orange Blank Quarter 1</u>
<u>Reserve Ratio</u>	<u>95% or greater</u>	<u>95% or greater</u>		

As noted above, the domiciliary state regulator maintains full discretion in determining which annual statement blank must be filed and when the reporting entity is to move.

Variations from following these instructions:

If a reporting entity's domestic regulator requires the reporting entity to complete an annual statement form and risk-based capital report that differs from these instructions, the domestic regulator shall notify the reporting entity in writing by June 1 of the year following the reporting year in which a Health Statement Test is submitted.

PART 2 – LIFE ACCIDENT HEALTH COMPANIES/FRATERNAL BENEFIT SOCIETIES INTERROGATORIES

Life and Accident Health Companies/Fraternal Benefit Societies:

- This General Interrogatory is designed to determine whether a reporting entity reports predominantly health lines of business. Health lines include hospital or medical policies or certificates, comprehensive major medical expense insurance and managed care contracts and exclude other health coverage such as credit insurance, disability income coverage, automobile medical coverage, workers compensation, accidental death and dismemberment policies and long-term care policies.

All reporting entities should file the test; however, a reporting entity that is required to also file the Separate Accounts Statement is not subject to the results of the Health Statement Test, and should continue to complete the life, accident and health/fraternal blank.

Premium and reserve information is obtained from the annual statement sources referenced on the form ~~or from the related risk-based capital report for the corresponding premium descriptions~~ relating to the current and prior reporting periods. The premium and reserve ratios are calculated on the net basis reporting.

Item	Description	Reporting Year Annual Statement Data	Prior Year Annual Statement Data
2.1	Premium Numerator	<p>Health Premium values listed in the Analysis of Operations by Lines of Business – Accident and Health:</p> <p><u>The sum of Line 1, Columns 2-9 (Column 9 Medicaid should include Medicaid Pass-Through Payments Reported as Premium) plus</u></p> <p><u>Line 1, Column 13 in part (include only Medicare Part D and Stop Loss and Minimum Premium exclude credit insurance, disability income coverage, automobile medical coverage, workers' compensation, accidental death and dismemberment policies and long-term care policies) of the reporting year's annual statement.</u></p>	<p><u>Health Premium values listed in the Analysis of Operations by Lines of Business – Accident and Health:</u></p> <p><u>The sum of Line 1, Columns 2-9 (Column 9 Medicaid should include Medicaid Pass-Through Payments Reported as Premium) plus Line 1, Column 13 in part (exclude credit insurance, disability income coverage, automobile medical coverage, workers' compensation, accidental death and dismemberment policies and long-term care policies) of the prior year's annual statement.</u></p> <p>Health Premium values listed in the statement value column (Column 1) of the reporting year's Life RBC report:</p> <p>Individual Lines: Usual and Customary Major Medical and Hospital Medicare Supplement Medicare Part D Dental and Vision</p> <p>Group Lines: Usual and Customary Major Medical and Hospital Medicare Supplement Medicare Part D Stop Loss and Minimum Premium Dental and Vision Federal Employee Health and Benefit Plan</p>
2.2	Premium Denominator	<p>Premium and Annuity Considerations (Page 4, Line 1) of the reporting year's annual statement <u>Analysis of Operations by Lines of Business – Summary, Column 1, Line 1 of the reporting year's annual statement.</u></p>	<p>Analysis of Operations by Lines of Business – Summary, Column 1, Line 1 <u>Premium and Annuity Considerations (Page 4, Line 1) of the prior year's annual statement</u></p>
2.3	Premium Ratio	2.1/2.2	2.1/2.2
2.4(a)	Reserve Numerator	Net A&H Policy and Contract Claims	Net A&H Policy and Contract Claims

LAH/Fraternal 2023

		without Credit Health (Exhibit 8, Part 1, Line 4.4, Column 9 and Column 11 (excluding Dread Disease, Disability Income and Long-Term Care)) plus Aggregate Reserves for A&H Policies without Credit Health (Exhibit 6, Column 1 less Columns 10, 11, 12 and Dread Disease included in Column 13) for <u>Total (Net) Unearned Premiums</u> (Line 17) or the reporting year's annual statement, and <u>Future Contingent Benefits</u> (Line 4)	without Credit Health (Exhibit 8, Part 1, Line 4.4, Columns 9 and 11 <u>(excluding Dread Disease, Disability Income and Long-Term Care)</u>) plus Aggregate Reserves for A&H Policies without Credit Health (Exhibit 6, Column 1 less Columns <u>10, 11, 12 and Dread Disease included in Column 13</u>) for <u>Unearned Premiums Total (Net)</u> (Line 17) of the prior year's annual statement, and <u>Future Contingent Benefits</u> (Line 4)
2.5	Reserve Denominator	Aggregate Reserve (Page 3, Column 1, Lines 1+2+4.1+4.2 Exhibit 5, Column 2, Line 9999999 plus Exhibit 6, Column 1, Line 9999999 plus Exhibit 6, Column 1, Line 17 plus Exhibit 8, Part 1, Column 1, Line 4.4) of the reporting year's annual statement, minus additional actuarial reserves (Exhibit 6, Column 1, Lines 3+11 plus Exhibit 5, Misc. Reserves Section, Line 0799999)	Aggregate Reserve (<u>Exhibit 5, Column 2, Line 9999999 plus Exhibit 6, Column 1, Line 9999999 plus Exhibit 6, Column 1, Line 17 plus Exhibit 8, Part 1, Column 1, Line 4.4</u> of the prior year's annual statement. Page 3, Column 1, Lines 1+2+4.1+4.2) minus additional actuarial reserves (Exhibit 6, Column 1, Lines 3+11 plus Exhibit 5, Misc. Reserves Section, Line 0799999)
2.6	Reserve Ratio	2.4/2.5	2.4/2.5

(a) Alternative Reserve Numerator – Company records may be used to adjust the reserve numerator to provide consistency between the values reported in the reserve numerator (2.4) and the premium numerator (2.1).

INSTRUCTIONS**For Completing Health Annual Statement Blank****GENERAL**

The annual statement is to be completed in accordance with the *Annual Statement Instructions* and *Accounting Practices and Procedures Manual* except to the extent that state law, rules or regulations are in conflict with these publications. In cases of conflict, the health annual statement will be filed pursuant to such state's filing requirements. The domiciliary state's insurance regulatory authority shall maintain full discretion in determining which NAIC annual statement blank must be filed. The annual statement blank filed with the domiciliary state shall be the blank submitted to, and maintained by, the NAIC, and barring conflict as described above, should be filed with all jurisdictions in which the reporting entity is licensed.

1. Health Statement Test:

If a reporting entity completes the health annual statement for the reporting year, the reporting entity must complete the Health Statement Test.

The Health Statement Test is designed to determine whether a reporting entity reports predominantly health lines of business. Health lines include hospital or medical policies or certificates, comprehensive major medical expense insurance and managed care contracts and exclude other health coverage such as credit insurance, disability income coverage, automobile medical coverage, workers' compensation, accidental death and dismemberment policies and long-term care policies.

Passing the Test:

A reporting entity is deemed to have passed the Health Statement Test if the values for the premium and reserve ratios in the Health Statement Test equal or exceed 95% for both the reporting and prior year and will continue to report on the Health Statement

Failing the Test:

If a reporting entity, licensed as a life, accident and health or property and casualty insurer in its domiciliary state, is required to file the health annual statement for the reporting year and does not pass the Health Statement Test in the reporting year, it will revert to the annual statement form and risk-based capital report associated with the type of license held in its domestic state in the first quarter of the second year following the reporting year. For example, if the reporting entity reports a premium or reserve ratio below 95% in 20X1, the reporting entity is deemed to have not passed the Health Statement Test. Therefore, the reporting entity would revert to the annual statement form and risk-based capital report associated with the type of license held in its domestic state in the first quarter of 20X3. However, if the reporting entity reports premium and reserve ratios of 95% or greater in 20X2, it should work with its domiciliary regulator to determine the appropriate blank to file on to avoid movement back and forth between blanks. (As noted above, the domiciliary state regulator maintains full discretion in determining which annual statement blank must be filed and when the reporting entity is to move.)

If a reporting entity, licensed as a health insurer in its domiciliary state, is required to file the health annual statement for the reporting year and does not pass the Health Statement Test in the reporting year, it should continue to file the health annual statement.

Variances from following these instructions:

If a reporting entity's domestic regulator requires the reporting entity to complete an annual statement form and risk-based capital report that differs from these instructions, the domestic regulator shall notify the reporting entity in writing by June 1 of the year following the reporting year in which a Health Statement Test is submitted.

PART 2 – HEALTH INTERROGATORIES

2. This General Interrogatory is designed to determine whether a reporting entity reports predominantly health lines of business. Health lines include hospital or medical policies or certificates, comprehensive major medical expense insurance and managed care contracts and exclude other health coverage such as credit insurance, disability income coverage, automobile medical coverage, workers' compensation, accidental death and dismemberment policies and long-term care policies.

All reporting entities should file the test.

Premium and reserve information is obtained from the annual statement sources referenced on the form ~~or from the related risk-based capital report for the corresponding premium descriptions~~ relating to the current and prior reporting periods. The premium and reserve ratios are calculated on the net basis reporting.

Item	Description	Reporting Year Annual Statement Data	Prior Year Annual Statement Data
2.1	Premium Numerator	Health Premium values listed in the Analysis of Operations by Lines of Business, Line 1 plus Line 2, Column 2 through Column 89 plus Line 1 plus Line 2, Column 913 in part (excluding credit A&H and dread disease coverage, LTC, Disability Income) of the reporting year's annual statement.	Health Premium values listed in the Analysis of Operations by Line of Business, Line 1 plus Line 2, Column 1-2 through Column 9 plus Line 1 plus Line 2, Column 139 (in part (excluding for credit A&H and dread disease coverage, LTC, Disability Income) Column 10 of the reporting prior year's annual statement.
2.2	Premium Denominator	Analysis of Operations by Lines of Business Net Premium Income (Page 4, Line 2, Column 2) Column 1, Line 1 plus Line 2 of the reporting year's annual statement.	Net Premium Income (Page 4, Line 2, Column 2) Analysis of Operations by Lines of Business, Column 1, Line 1 plus Line 2 of the prior year's annual statement.
2.3	Premium Ratio	2.1/2.2	2.1/2.2
2.4 (a)	Reserve Numerator	Health Reserve – Underwriting and Investment Exhibit, Part 2B (Column 3 + 4, Line 13 minus (Lines 9, 10, 11 and any dread disease coverage reported in Line 12) plus Line 16)13 minus Line 11) exclude Line 10 health care receivables, dread disease coverage, and credit A&H) + Part 2D (Line 8+14, Column 1 minus (Columns 910, 11, 12 and any dread disease coverage reported in Column 13))include stand-alone health care related plans only (i.e. stand-alone prescription drug plans, etc.), exclude dread disease coverage, credit A&H, LTC, Disability Income, etc. of the reporting year's annual statement.	Health Reserve – Underwriting and Investment Exhibit, Part 2B (Column 3 + 4, Line 13 minus (Lines 9, 10, 11 and any dread disease coverage reported in Line 12) plus Line 16) 13 minus Line 11) exclude Line 10 health care receivables, dread disease coverage, and credit A&H + Part 2D (Line 8+14, Column 1 minus Columns 10, 11, 12 and any dread disease coverage reported in Column 139) include stand-alone health care related plans only (i.e. stand-alone prescription drug plans, etc.), exclude dread disease coverage, credit A&H, LTC, Disability Income, etc. of the reporting prior year's annual statement.
2.5	Reserve Denominator	Underwriting and Investment Exhibit, Part 2A, Col. 1, Line 4.4 plus Underwriting and Investment Exhibit, Part 2, Column 1, Line 5 plus Underwriting and Investment Exhibit, Part 2D, Col. 1, Lines 8+14 plus Page 3, Column 3, Lines 5 + 6 Claims Unpaid and Aggregate Reserves (Page 3, Column 3, Lines 1 + 2 + 4 + 7) of the reporting year's annual statement.	Underwriting and Investment Exhibit, Part 2A, Col. 1, Line 4.4 plus Underwriting and Investment Exhibit, Part 2, Column 1, Line 5 plus Underwriting and Investment Exhibit, Part 2D, Col. 1, Lines 8+14 plus Page 3, Column 3, Lines 5 + 6Claims Unpaid and Aggregate Reserves (Page 3, Column 3, Lines 1 + 2 + 4 + 7) of the prior year's annual statement.
2.6	Reserve Ratio	2.4/2.5	2.4/2.5

- (a) Alternative Reserve Numerator – Alternative Reserve Numerator – Company records may be used to adjust the reserve numerator to provide consistency between the values reported in the reserve numerator (2.4) and the premium numerator (2.1).

INSTRUCTIONS**For Completing Property and Casualty Annual Statement Blank****GENERAL**

The annual statement is to be completed in accordance with the *Annual Statement Instructions* and *Accounting Practices and Procedures Manual* except to the extent that state law, rules or regulations are in conflict with these publications. In cases of conflict, the property and casualty annual statement will be filed pursuant to such state's filing requirements. The domiciliary state's insurance regulatory authority shall maintain full discretion in determining which NAIC annual statement blank must be filed. The annual statement blank filed with the domiciliary state shall be the blank submitted to, and maintained by, the NAIC, and barring conflict as described above, should be filed with all jurisdictions in which the reporting entity is licensed.

1. Health Statement Test:

If a reporting entity is licensed as a property and casualty insurer and completes the property and casualty annual statement for the reporting year, the reporting entity must complete the Health Statement Test. However, a reporting entity that is required to also file the Protected Cell Statement is not subject to the results of the Health Statement Test and should continue to complete the property blank.

The Health Statement Test is designed to determine whether a reporting entity reports predominantly health lines of business. Health lines include hospital or medical policies or certificates, comprehensive major medical expense insurance and managed care contracts and exclude other health coverage such as credit insurance, disability income coverage, automobile medical coverage, workers' compensation, accidental death and dismemberment policies and long-term care policies.

Passing the Test:

A reporting entity is deemed to have passed the Health Statement Test if:

The values for the premium and reserve ratios in the Health Statement Test equal or exceed 95% for both the reporting and prior year.

If a reporting entity is a) licensed as a property and casualty insurer; b) completes the property and casualty annual statement for the reporting year; and c) passes the Health Statement Test (as described above), the reporting entity must complete the health statement beginning with the first quarter's statement for the second year following the reporting year in which the reporting entity passes the Health Statement Test and must also file the corresponding risk-based capital report and the property/casualty supplements for that year-end. For example, if the reporting entity reports premium and reserve ratios of 95% or greater in 20X1 and again reports premium and reserve ratios of 95% or greater in 20X2, the reporting entity is deemed to have passed the Health Statement Test as of 20X2. Therefore, the reporting entity would begin completing the health statement in the first quarter of 20X4. (As noted above, the domiciliary state regulator maintains full discretion in determining which annual statement blank must be filed and when the reporting entity is to move.)

	<u>20X1</u>	<u>20X2</u>	<u>20X3</u>	<u>20X4</u>
<u>Premium Ratio</u>	<u>95% or greater</u>	<u>95% or greater</u>	<u>Work with domestic</u>	<u>Move to Orange</u>
<u>Reserve Ratio</u>	<u>95% or greater</u>	<u>95% or greater</u>	<u>regulator to move</u>	<u>Blank Quarter 1</u>
			<u>effective Quarter 1</u>	
			<u>20X4</u>	

As noted above, the domiciliary state regulator maintains full discretion in determining which annual statement blank must be filed and when the reporting entity is to move.

Variances from following these instructions:

If a reporting entity's domestic regulator requires the reporting entity to complete an annual statement form and risk-based capital report that differs from these instructions, the domestic regulator shall notify the reporting entity in writing by June 1 of the year following the reporting year in which a Health Statement Test is submitted.

PART 2 – PROPERTY AND CASUALTY INTERROGATORIES

2. This General Interrogatory is designed to determine whether a reporting entity reports predominantly health lines of business. Health lines include hospital or medical policies or certificates, comprehensive major medical expense insurance and managed care contracts and exclude other health coverage such as credit insurance, disability income coverage, automobile medical coverage, workers compensation, accidental death and dismemberment policies and long-term care policies.

All reporting entities should file the test; however, a reporting entity that is required to also file the Protected Cell Statement is not subject to the results of the Health Statement Test and should continue to complete the property blank.

Premium and reserve information is obtained from the annual statement sources referenced on the form ~~or from the related risk based capital report for the corresponding premium descriptions~~ relating to the current and prior reporting periods. The premium and reserve ratios are calculated on the net basis reporting.

Item	Description	Reporting Year Annual Statement Data	Prior Year Annual Statement Data
2.1	Premium Numerator	<p>Health Premium values listed in the Net Premiums Written<u>Earned During Year</u> column (Column 46) of the reporting year's U&I Part 1B:</p> <p>Lines 13.1 and 13.2</p> <p>Lines 15.1, 15.2, 15.4, 15.6, and 15.8</p> <p>Line 15.5 (should include Medicare Pass-Through Payments Reported as Premium)</p> <p>Line 15.9 in part (exclude credit insurance, disability income coverage, automobile medical coverage, workers' compensation, accidental death and dismemberment policies and long-term care policies<u>include only Medicare Part D and Stop Loss and Minimum Premium</u>)</p>	<p>Health Premium values listed in the <u>Premiums Earned During Year column (Column 4) of the reporting year's U&I Part 1:</u></p> <p><u>Lines 13.1 and 13.2</u></p> <p><u>Lines 15.1, 15.2, 15.4, 15.6, and 15.8</u></p> <p><u>Line 15.5 (should include Medicare Pass-Through Payments Reported as Premium)</u></p> <p><u>Line 15.9 in part (exclude credit insurance, disability income coverage, automobile medical coverage, workers' compensation, accidental death and dismemberment policies and long-term care policies)</u></p> <p>Health Premium values as listed in the statement value column (Column 1) of the prior year's P&C RBC report:</p> <p><u>Individual Lines</u></p> <p>Usual and Customary Major Medical and Hospital Medicare Supplement Medicare Part D Dental and Vision</p> <p><u>Group Lines</u></p> <p>Usual and Customary Major Medical and Hospital Medicare Supplement Medicare Part D Stop Loss and Minimum Premium Dental and Vision Federal Employee Health and Benefit Plan</p>
2.2	Premium Denominator	<p>Premiums Earned (Page 4, Line 1) of the reporting year's annual statement<u>Underwriting and Investment Exhibit, Part 1, Column 4, Line 35</u></p>	<p><u>Underwriting and Investment Exhibit, Part 1, Column 4, Line 35</u>Premium Earned (Page 4, Line 1) of the prior year's annual statement</p>
2.3	Premium Ratio	<p><u>2.1/2.2</u></p>	<p><u>2.1/2.2</u></p>
2.4(a)	Reserve Numerator	<p>Part 2A, Unpaid Losses and Loss Adjustment Expenses (Columns 8+9, Lines 13+15 (excluding Line 15.3 Disability Income, Line 15.7 Long-Term Care), Line 15.9 in part (include only Medicare Part D and Stop Loss and Minimum Premium)) plus Part 1A, Recapitulation of all Premiums (Columns 1+2, Lines 13+15 (excluding Line 15.3 Disability Income, Line 15.7 Long-Term Care), Line 15.9 in part (include only Medicare Part D and Stop Loss and Minimum Premium)) of the reporting</p>	<p>Part 2A, Unpaid Losses and Loss Adjustment Expenses (Columns 8+9, Lines 13+15) (excluding Line 15.3 Disability Income, Line 15.7 Long-Term Care), <u>Line 15.9 in part (include only Medicare Part D and Stop Loss and Minimum Premium))</u> plus Part 1A, Recapitulation of all Premiums (Columns 1+2, Lines 13+15 (excluding Line 15.3 Disability Income, Line 15.7 Long-Term Care), <u>Line 15.9 in part (include only Medicare Part D and Stop Loss and</u></p>

		year's annual statement.	<u>Minimum Premium))</u> of the prior year's annual statement.
2.5	Reserve Denominator	Unpaid Loss and LAE (Page 3, Column 1, Lines 1+2+3) Part 2A, Unpaid Losses and Loss Adjustment Expenses, (Line 35, Columns 8+9) plus Part 1A, Recapitulation of all Premiums (Line 35, Columns 1+2) of the reporting year's annual statement.	Part 2A, Unpaid Losses and Loss Adjustment Expenses, (Line 35, Columns 8+9) Unpaid Loss and LAE (Page 3, Column 1, Lines 1+2+3) plus Part 1A, Recapitulation of all Premiums (Line 35, Columns 1+2) of the prior year's annual statement.
2.6	Reserve Ratio	2.4/2.5	2.4/2.5

- (a) Alternative Reserve Numerator – Company records may be used to adjust the reserve numerator to provide consistency between the values reported in the reserve numerator (2.4) and the premium numerator (2.1).



July 13, 2023

Steve Drutz
Chair, Health Risk-Based Capital (E) Working Group
National Association of Insurance Commissioners (NAIC)

Re: Request for Comprehensive Review of the H2—Underwriting Risk Component and Managed Care Credit Calculation in the Health Risk-Based Capital Formula

Dear Chair Drutz:

On behalf of the Health Underwriting Risk Factors Analysis Work Group of the Health Solvency Subcommittee of the American Academy of Actuaries (Work Group),¹ I appreciate the opportunity to provide these updates to the National Association of Insurance Commissioners (NAIC) Health Risk-Based Capital (E) Working Group in response to the request to comprehensively review the H2—Underwriting Risk Component and the Managed Care Credit Calculation in the Health Risk-Based Capital (HRBC) formula.

As part of the work group's review of the H2—Underwriting Risk Component, we identified several components of the current formula that merit discussion within the NAIC HRBC Working Group. We have described the issues below and would appreciate the opportunity to discuss them with the Working Group at the July 25, 2023, NAIC HRBC Working Group meeting.

For background, the critical source of the Experience Fluctuation Risk (EFR) formula within Underwriting Risk is the Analysis of Operations by Lines of Business (page 7 of the annual statutory financial statements). The page includes a buildup of underwriting gain/(loss), starting with net premium income, adding various other sources of revenue, then subtracting claims and administrative expenses. Some lines within the exhibit, including Fee-for-service and Risk revenue, are not broadly applicable, and the proportion of filers that utilize these fields is relatively small. Still, they often make up a material portion of revenue for those filers.

Those smaller components of the Analysis of Operations by Lines of Business have nuanced treatment within the current EFR formula that is likely not broadly understood. This nuanced treatment includes:

Nuance #1: Fee-for-service revenue is netted against incurred claims for Comprehensive Major Medical but not Medicare or Medicaid.

- The RBC instructions do not include the rationale for the distinction between lines of business.
- We do not see an intuitive rationale for the distinction and believe it may have been an inadvertent drafting error.

¹ The American Academy of Actuaries is a 19,500-member professional association whose mission is to serve the public and the U.S. actuarial profession. For more than 50 years, the Academy has assisted public policymakers on all levels by providing leadership, objective expertise, and actuarial advice on risk and financial security issues. The Academy also sets qualification, practice, and professionalism standards for actuaries in the United States.

Nuance #2: The fee-for-service revenue netting can result in erratic net loss ratio experience for health plans with significant fee-for-service revenue levels.

- After investigating several instances of health plans reporting fee-for-service revenue, it appears that filer understanding of the field is mixed.
- Additionally, if health plans report a significant amount of fee-for-service revenue, the net loss ratio may look problematic:
 - For example, we observed a health plan with an approximately 100% gross loss ratio and a 140% net loss ratio; the gross loss ratio is more likely to resemble the “priced” loss ratio.
 - The risk charge is effectively applied to the net claims level, which is tantamount to a managed care credit discount of 1.0.

Nuance #3: Other Health Risk Revenue is included in the revenue calculation for Comprehensive Major Medical but not for Medicare or Medicaid.

- The RBC instructions do not include a rationale for the distinction between lines of business.
- We do not see an intuitive rationale for the distinction and believe it may have been an inadvertent drafting error.

Nuance #4: Aggregate write-in revenue (health and non-health) is excluded from the calculation.

- “Aggregate write-ins for other health care related revenues” is commonly populated and often represents pass-through revenue related to Aggregate write-ins for other hospital and medical (line 14), which is included in line 17.
- “Aggregate write-ins for other non-health care revenues” are infrequently populated and generally immaterial.

These nuances may need to be addressed within the existing formula but should be considered as part of any significant change to the EFR formula. For simplicity, one option to change the formula may be to use lines 7 and 17 for revenue and claims for each applicable line of business; however, we welcome additional suggestions based on feedback from the Working Group.

If you have any questions or would like to discuss further, please contact Matthew Williams, the Academy’s senior health policy analyst, at williams@actuary.org.

Sincerely,

Derek Skoog, MAAA, FSA
Chairperson, Health Solvency Subcommittee, Health Underwriting Risk Factors Analysis Work Group
American Academy of Actuaries

Cc: Crystal Brown, Senior Health RBC Specialist & Education Lead, Financial Regulatory Affairs, NAIC

Draft: 8/23/23

Life Risk-Based Capital (E) Working Group
Seattle, Washington
August 13, 2023

The Life Risk-Based Capital (E) Working Group of the Capital Adequacy (E) Task met Aug. 13, 2023. The following Working Group members participated: Philip Barlow, Chair (DC); Sanjeev Chaudhuri (AL); Thomas Reedy (CA); Qing He (CT); Mike Yanacheak (IA); Vincent Tsang (IL); Fred Andersen (MN); William Leung (MO); Michael Muldoon and Margaret Garrison (NE); Jennifer Li (NH); Seong-min Eom (NJ); Michael Cebula (NY); Andrew Schallhorn (OK); Iris Huang (TX); and Tomasz Serbinowski (UT).

1. Adopted its June 22, April 14, and Spring National Meeting Minutes

Yanacheak made a motion, seconded by Leung, to adopt the Working Group's June 22 (Attachment Four-A), April 14 (Attachment Four-B), and March 23 (see *NAIC Proceedings – Spring 2023, Capital Adequacy (E) Task Force, Attachment Four*) minutes. The motion passed unanimously.

2. Adopted the 2023 RBC Newsletter

Yanacheak made a motion, seconded by Muldoon, to adopt the 2023 Life Risk-Based Capital (RBC) Newsletter (Attachment Four-C). The motion passed unanimously.

3. Adopted the 2022 Life RBC Statistics

Muldoon made a motion, seconded by Reedy, to adopt the 2022 Life RBC Statistics (Attachment Four-D). The motion passed unanimously.

4. Adopted its Working Agenda

Andersen made a motion, seconded by Yanacheak, to adopt the Working Group's working agenda (see *NAIC Proceedings – Summer 2023, Capital Adequacy (E) Task Force, Attachment Seven*). The motion passed unanimously.

5. Discussed Repurchase Agreements

Brian Bayerle (American Council of Life Insurers—ACLI) and Martin Mair (ACLI) presented a proposal on the repurchase agreement charge. Mair walked through the proposal and talked through some of the enhancements and additional changes necessary. Barlow asked whether it is possible that repos presumably open the possibility of 364 days of nonconforming repos and one day of conforming repos at the end of the year since they are a series of short-term transactions. He asked whether it is a program or a series of unrelated transactions. Mair said it is a program that must be set up with appropriate financial disclosures ahead of time. He said a transaction cannot be rolled over from a nonconforming program to a conforming program. Muldoon asked whether the risk would be the same for state-sponsored funds, asset managers, and money market funds. He also asked about the asset manager risk. Mair said all of them would typically be very highly rated. He said asset managers have extra cash, which is a good, collateralized way for them to lend out their cash in a low-risk way. The Working Group agreed to expose the ACLI's proposal for a 45-day public comment period.

6. Discussed C-2 Mortality Risk

Barlow said the C-2 mortality risk will be discussed on a call in September to provide clarity on the proposal for year-end 2023.

Tip Tipton (Thrivent), said interested parties are proposing some modifications to the annual statement blanks for 2024, which would subsequently feed the RBC formula and they are working with Dave Fleming (NAIC) and NAIC support staff for the Blanks (E) Working Group on this. Fleming said the Statutory Accounting Principles (E) Working Group received comments, and there have been some decisions on possible changes to the placement of the data in the annual statement. He said what will be in place for 2023 is not contingent upon the note.

7. Discussed Other Matters

Barlow said one of the items that the Life Risk-Based Capital (E) Working Group plans to look at is the covariance. He said the American Academy of Actuaries (Academy) is working on something related to the covariance that it will present to the Working Group when it is ready.

Having no further business, the Life Risk-Based Capital (E) Working Group adjourned.

SharePoint/NAIC Support Staff Hub/Committees/E CMTE/CADTF/2023-2-Summer/Life RBC 08-13-23 Minutes.docx

Draft: 8/7/23

Life Risk-Based Capital (E) Working Group
Virtual Meeting
June 22, 2023

The Life Risk-Based Capital (E) Working Group of the Capital Adequacy (E) Task Force met June 22, 2023. The following Working Group members participated: Philip Barlow, Chair (DC); Thomas Reedy (CA); Wanchin Chou (CT); Hannah Howard (FL); Mike Yanacheak (IA); Vincent Tsang (IL); Fred Andersen and Ben Slutsker (MN); William Leung (MO); Seong-min Eom (NJ); Bill Carmello and Roberto Paradis (NY); Andrew Schallhorn (OK); Rachel Hemphill (TX); and Tomasz Serbinowski (UT).

1. Adopted the Generator of Economic Scenarios (E/A) Subgroup Charges

Barlow said a new joint subgroup of the Working Group and the Life Actuarial (A) Task Force has been formed, and the charges need to be adopted by both groups.

Hemphill made a motion, seconded by Yanacheak, to adopt the charges of the Generator of Economic Scenarios (E/A) Subgroup (see *NAIC Proceedings – Summer 2023, Financial Condition (E) Committee, Attachment One-B*). The motion passed unanimously.

2. Discussed Proposal 2023-08-L

Barlow said one comment letter was received on proposal 2023-08-L (Custody Control Accounts) (Attachment Four-A1). Paradis said this is not a credit for reinsurance issue but whether the security interest is sufficient to mitigate the counterparty risk and results in the risk-based capital (RBC) charge. He said the proposal leaves control over the supporting assets with the reinsurer, and it does not seem to mitigate the counterparty credit exposure for the cedant. Andrew Holland (Sidley Austin LLP) said the intention is that a security interest is affected either through the reinsurance agreement or a separate security agreement. Barlow asked if Holland and Paradis would be willing to discuss this further to come to a consistent understanding so the Working Group can move forward with the proposal. Both agreed.

3. Discussed the Working Agenda

Slutsker suggested adding all payout annuities to the scope of the work on longevity. Barlow asked Slutsker to work with NAIC staff on changing the wording.

Having no further business, the Life Risk-Based Capital (E) Working Group adjourned.

SharePoint/NAIC Support Staff Hub/Committees/E CMTE/CADTF/2023-2-Summer/Life RBC 6-22-23 Minutes.docx

**Capital Adequacy (E) Task Force
RBC Proposal Form**

- | | | |
|---|--|---|
| <input type="checkbox"/> Capital Adequacy (E) Task Force | <input type="checkbox"/> Health RBC (E) Working Group | <input checked="" type="checkbox"/> Life RBC (E) Working Group |
| <input type="checkbox"/> Catastrophe Risk (E) Subgroup | <input type="checkbox"/> P/C RBC (E) Working Group | <input type="checkbox"/> Longevity Risk (A/E) Subgroup |
| <input type="checkbox"/> Variable Annuities Capital. & Reserve (E/A) Subgroup | <input type="checkbox"/> Economic Scenarios (E/A) Subgroup | <input type="checkbox"/> RBC Investment Risk & Evaluation (E) Working Group |

<p align="right">DATE: <u>4/11/23</u></p> <p>CONTACT PERSON: <u>Andrew Holland</u></p> <p>TELEPHONE: <u>212-839-5882</u></p> <p>EMAIL ADDRESS: <u>aholland@sidley.com</u></p> <p>ON BEHALF OF: <u>J.P. Morgan Securities LLC</u></p> <p>NAME: <u>Philip Prince</u></p> <p>TITLE: <u>Managing Director</u></p> <p>AFFILIATION: <u>Interested Party</u></p> <p>ADDRESS: <u>383 Madison Ave., 7th Floor</u> <u>New York, NY 10017</u></p>	<p align="center">FOR NAIC USE ONLY</p> <p>Agenda Item # <u>2023-08-L</u> Year <u>2023</u></p> <p align="center">DISPOSITION</p> <p>ADOPTED:</p> <p><input type="checkbox"/> TASK FORCE (TF) _____</p> <p><input type="checkbox"/> WORKING GROUP (WG) _____</p> <p><input type="checkbox"/> SUBGROUP (SG) _____</p> <p>EXPOSED:</p> <p><input type="checkbox"/> TASK FORCE (TF) _____</p> <p><input type="checkbox"/> WORKING GROUP (WG) _____</p> <p><input type="checkbox"/> SUBGROUP (SG) _____</p> <p>REJECTED:</p> <p><input type="checkbox"/> TF <input type="checkbox"/> WG <input type="checkbox"/> SG _____</p> <p>OTHER:</p> <p><input type="checkbox"/> DEFERRED TO _____</p> <p><input type="checkbox"/> REFERRED TO OTHER NAIC GROUP _____</p> <p><input type="checkbox"/> (SPECIFY) _____</p>
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IDENTIFICATION OF SOURCE AND FORM(S)/INSTRUCTIONS TO BE CHANGED

- | | | |
|--|---|---|
| <input type="checkbox"/> Health RBC Blanks | <input type="checkbox"/> Property/Casualty RBC Blanks | <input type="checkbox"/> Life and Fraternal RBC Blanks |
| <input type="checkbox"/> Health RBC Instructions | <input type="checkbox"/> Property/Casualty RBC Instructions | <input checked="" type="checkbox"/> Life and Fraternal RBC Instructions |
| <input type="checkbox"/> Health RBC Formula | <input type="checkbox"/> Property/Casualty RBC Formula | <input type="checkbox"/> Life and Fraternal RBC Formula |
| <input type="checkbox"/> OTHER _____ | | |

DESCRIPTION/REASON OR JUSTIFICATION OF CHANGE(S)

See attached.

Additional Staff Comments:

** This section must be completed on all forms.

Revised 2-2023

RBC Proposal Form – Custody Control Accounts

Background

- Life reinsurance transactions with Reinsurers which are licensed, accredited or approved as reciprocal jurisdiction reinsurers in a Cedant’s state of domicile generally do not require a collateral mechanism to provide credit for reinsurance (CFR).
- In many life reinsurance transactions, however, the parties nonetheless negotiate and agree to collateral arrangements for commercial reasons.
 - Such collateral arrangements are common in a variety of life reinsurance transactions, including block acquisitions, embedded value and reserve financings, and pension risk transfers.
- The Life RBC Manual instructions currently allow a Cedant to avoid an overstatement of RBC charges that would otherwise be applied for credit exposure to reinsurance counterparties if such collateral is held by the Cedant as funds withheld or a “comfort” reinsurance trust is established by the Reinsurer.
- Other collateral mechanisms can provide the same level of security to Cedants with lower costs and greater flexibility.
 - The Finance industry widely supports and leverages custodial control accounts (“Custody Control Accounts”) where segregated collateralization under third-party control is required (e.g., pledges of assets to Federal Home Loan Banks, posting of initial margin and variation margin on derivatives transactions).
- A Custody Control Account can similarly hold assets pledged by a Reinsurer for the benefit of a Cedant in connection with a reinsurance transaction.
- A Custody Control Account can provide the same protections to the Cedant as would be provided by a trust arrangement. However, a Custody Control Account operates at a reduced cost due to increased scale and automation.
- This proposal would amend the Life RBC formula to similarly avoid overstatement of credit risk on a reinsurance transaction when collateral is held by the Cedant in a Custody Control Account.
 - No changes to the Credit for Reinsurance Model Law or Credit for Reinsurance Model Regulation are being proposed.

Proposed Changes to Life RBC Instructions

From Risk-Based Capital Forecasting & Instructions – Life and Fraternal, 2019

REINSURANCE

LR016 (p. 53 of the 2019 Edition)

There is a risk associated with recoverability of amounts from reinsurers. The risk is deemed comparable to that represented by bonds between risk classes 1 and 2 and is assigned a pre-tax factor of 0.78 percent. To avoid an overstatement of risk-based capital, the formula gives a 0.78 percent pre-tax credit for reinsurance with non-authorized and certified companies, for reinsurance among affiliated companies, for reinsurance with funds withheld or reinsurance with authorized reinsurers that is supported by equivalent trusted **or custodied** collateral ~~that meets the requirements of the types~~ stipulated in **paragraph 18 of** Appendix A-785 (Credit for Reinsurance), where there have been regular bona fide withdrawals from such trusted **or custodied** collateral to pay claims or recover payments of claims during the calendar year covered by the RBC report, and for reinsurance involving policy loans. Withdrawals from trusted **or custodied** collateral that are less than the amounts due the ceding company shall be deemed to not be bona fide withdrawals. **For purposes of these instructions, “custodied collateral” shall mean assets held pursuant to a custodial arrangement with a qualified U.S. financial institution (as defined in Appendix A-785 (Credit for Reinsurance)) pursuant to which the underlying assets are segregated from other assets of the reinsurer and are subject to the exclusive control of, and available to, the ceding company in the event of the reinsurer’s failure to pay under, and otherwise pursuant to the terms of, the subject reinsurance agreement.**

Additional Resource Materials

- Presentation dated October 2022 containing Summary of Contractual Terms for Custody Control Arrangement and Schematic Diagram
- Form of Custody Control Agreement Wording
- Comparison Chart – CFR Trust, Comfort Reinsurance Trust and Custody Control Account

Draft: 8/7/23

Life Risk-Based Capital (E) Working Group
Virtual Meeting
April 14, 2023

The Life Risk-Based Capital (E) Working Group of the Capital Adequacy (E) Task Force met April 14, 2023. The following Working Group members participated: Philip Barlow, Chair (DC); Thomas Reedy (CA); Wanchin Chou (CT); Mike Yanacheak and Carrie Mears (IA); Fred Andersen and Ben Slutsker (MN); William Leung (MO); Seong-min Eom (NJ); Bill Carmello (NY); Andrew Schallhorn (OK); Rachel Hemphill (TX); and Tomasz Serbinowski (UT).

1. Adopted Proposal 2023-05-L

Barlow said the dual presentation is no longer needed, and one comment letter was submitted in support of proposal 2023-05-L (Remove Dual Trend Test). Brian Bayerle (American Council of Life Insurers—ACLI) confirmed that the ACLI supports the proposal.

Chou made a motion, seconded by Andersen, to adopt proposal 2023-05-L (*see NAIC Proceedings – Summer 2023, Capital Adequacy (E) Task Force, Attachment Two-D*). The motion passed unanimously.

2. Adopted Proposal 2023-06-L

Barlow said one comment letter (Attachment Four-B1) was received. Bayerle said the two items the ACLI noted are a minor edit and a request for clarification on some of the language. The ACLI requests that the American Academy of Actuaries (Academy) provide that clarification in writing or on a future call. Dave Fleming (NAIC) said the first item the ACLI noted has already been addressed. He said while the Academy provided two alternatives for the Working Group to consider, one, noted as update two, that included the introduction of a new financial statement note to facilitate the population of the schedule, is not contingent upon the note being in place, and it could be adopted with a simple line description change to company records, along with a guidance document from the Working Group.

Barlow asked Bayerle if he had any questions or concerns. Bayerle said the ACLI is comfortable with the note if it is adopted, but the path that Fleming suggests in terms of clarifying the sources makes sense. Connie Jasper Woodroof (CJW Associates) said she submitted a comment letter to both the Statutory Accounting Principles (E) Working Group and the Blanks (E) Working Group, but she should have included the Life Risk-Based Capital (E) Working Group. She said she does not have a problem with having a note to pull information for risk-based capital (RBC), but she believes the proposed note goes above and beyond the proposed purpose of the note. Additionally, she said the proposed note includes information that is already available in the annual statement, and one of the things the Blanks (E) Working Group has been charged with is reducing redundant reporting. She said she had submitted an alternative to the proposed note that would address those pieces needed for RBC that cannot be pulled from the annual statement. To be clear, Barlow said it sounds like the proposed note might change, but that will not affect what the Working Group needs to decide. Fleming agreed and said if the note changes or is not in place, the dynamic is the same and requires only a simple line description change to company records, along with a guidance document from the Working Group.

Andersen made a motion, seconded by Reedy, to adopt proposal 2023-06-L (C-2 Mortality Structure and Instruction Changes) (*see NAIC Proceedings – Summer 2023, Capital Adequacy (E) Task Force, Attachment Two-E*). Slutsker said his understanding of the new language in the Academy's proposal is that the RBC treatment and

categorization could differ depending upon reinsurance, and he suggested that this be part of discussions about the proposed note. The motion passed unanimously.

3. Adopted Proposal 2023-07-L

Barlow said no comments were received on proposal 2023-07-L (CM6 & CM7 Mortgage Structure Change).

Andersen made a motion, seconded by Leung, to adopt proposal 2023-07-L (*see NAIC Proceedings – Summer 2023, Capital Adequacy (E) Task Force, Attachment Two-F*). The motion passed unanimously.

4. Exposed Proposal 2023-08-L for Comment

The Working Group agreed to expose proposal 2023-08-L (Comfort Trusts) for a 45-day public comment period.

Having no further business, the Life Risk-Based Capital (E) Working Group adjourned.

SharePoint/NAIC Support Staff Hub/Committees/E CMTE/CADTF/2023-2-Summer/Life 4-14-23 Minutes.docx

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March 1, 2023

Phillip Barlow

Chair, NAIC Life Risk-Based Capital (E) Working Group (LRBC)

Re: Academy Proposal for Life C-2 Structural and Instruction Updates and a New Financial Statement Note

Dear Mr. Barlow:

The American Council of Life Insurers (ACLI) appreciates the opportunity to comment on the American Academy of Actuaries' (Academy) Proposal for Life C-2 Structural and Instruction Updates and a New Financial Statement Note which was made available for public comment on January 26, 2023.

ACLI has no opposition to this proposal and is supportive of its adoption during a future LRBC call. With that said, there was one issue we seek clarification on in addition to one minor change we feel should be made help mitigate any potential uncertainty brought about by this APF:

1. What was the reasoning behind the change "in excess of the mortality cost expected under the moderately adverse scenario"?
2. Should the word "term" be removed from the group life reference (highlighted portion below)? This would make it consistent with our understanding of how the size band tiers have been done historically and avoid confusion with the Group & Credit Term Life bucket.

*The NAR size bands apply to the total amounts for individual & industrial life and **group term & credit life**. The size bands are allocated proportionately to the NAR for each of the factor categories. Size band 1 is for NAR amounts up to \$500 million. Size band 2 is for NAR amounts greater than \$500 million and up to \$25 billion. Size band 3 is for NAR amounts greater than \$25 billion.*

American Council of Life Insurers | 101 Constitution Ave, NW, Suite 700 | Washington, DC 20001-2133

The American Council of Life Insurers (ACLI) is the leading trade association driving public policy and advocacy on behalf of the life insurance industry. 90 million American families rely on the life insurance industry for financial protection and retirement security. ACLI's member companies are dedicated to protecting consumers' financial wellbeing through life insurance, annuities, retirement plans, long-term care insurance, disability income insurance, reinsurance, and dental, vision and other supplemental benefits. ACLI's 280 member companies represent 94 percent of industry assets in the United States.

acli.com

Thank you once again and we are looking forward to further discussion.

 *B. Banerji* *Colin Masterson*

cc: Dave Fleming



Newsletter Items for Adoption for 2023 for Life and Fraternal RBC:

Date: July 2023

Volume: 29

Page 1: Intro Section:

What RBC Pages Should Be Submitted?

For year-end 2023 life and fraternal risk-based capital (RBC), submit hard copies of pages LR001 through LR049 to any state that requests a hard copy in addition to the electronic filing. Starting with year-end 2007 RBC, a hard copy was not required to be submitted to the NAIC. However, a portable document format (PDF) file representing the hard copy filing is part of the electronic filing.

If any actuarial certifications are required per the RBC instructions, those should be included as part of the hard copy filing. Starting with year-end 2008 RBC, the actuarial certifications were also part of the electronic RBC filing as PDF files, similar to the financial annual statement actuarial opinion.

Other pages, such as the mortgage and real estate worksheets, do not need to be submitted. However, they still need to be retained by the company as documentation.

Page 1+: Items Adopted for 2023:

Removal of Dual Trend Test

The Capital Adequacy (E) Task Force adopted proposal 2023-05-L to remove the dual presentation of the trend test during its April 28 meeting. This proposal eliminates the presentation of the test at the former 2.5 threshold while member jurisdictions transitioned to the current 3.0 threshold. That transition is now complete, so the dual presentation is not needed.

Washington, DC 444 North Capitol Street NW, Suite 700, Washington, DC 20001-1509 p | 202 471 3990 f | 816 460 7493

Kansas City 1100 Walnut Street NW, Suite 1500, Kansas City, MO 64106-2197 p | 816 842 3600 f | 816 783 8175

New York One New York Plaza, Suite 4210, New York, NY 20004 p | 212 398 9000 f | 212 382 4207

www.naic.org

CM6 and CM7 Mortgages

The Capital Adequacy (E) Task Force adopted proposal 2023-07-L during its April 28 meeting. This proposal aligns the CM6 and CM7 factors for non-performing commercial and farm mortgages with the factors for Schedule A and Schedule BA investments in real estate as those factors were adjusted in 2021. It also adopts the same formula for calculating RBC amounts for non-performing and performing residential, commercial and farm mortgages.

Structure and Instruction Changes to Update the Treatment of C-2 Mortality Risk

The Capital Adequacy (E) Task Force adopted update 2 in proposal 2023-06-L during its April 28 meeting. This proposal makes structural changes and instructional changes for LR025, Life Insurance. The proposal assigns the same factors to group permanent life as individual permanent life for categories stating with and without pricing flexibility. The proposal also included a new financial statement note to develop the net amounts at risk in the categories needed for the Life C-2 schedule to create a direct link to a financial statement source. The new note was deferred for yearend 2023 which will necessitate the line references to the new note to be company records for 2023 and will be supplemented by guidance from the Life Risk-Based Capital (E) Working Group.

Residual Tranches

The Capital Adequacy (E) Task Force adopted proposals 2023-03-IRE and 2023-04-IRE during its April 28 meeting. These proposals added a line to isolate residual tranches reported on Schedule BA and the asset valuation reserve for a specific base factor and to add lines for residual tranches to the sensitivity testing exhibits, respectively. During its June 30 meeting, the Capital Adequacy (E) Task Force adopted proposals 2023-09-IRE and 2023-10-IRE. The first proposal applies a base factor of .30 for yearend 2023 and a base factor for yearend 2024 of .45 which is subject to adjustment based on additional information. The second proposal applies a .15 factor for sensitivity testing for yearend 2023 to be adjusted for yearend 2024.

Modification to the Affiliated Investment Structure and Instructions

The Capital Adequacy (E) Task Force adopted proposal 2022-09-CA during its March 23, 2023 meeting, to revise the instructions and structure of the Affiliated Investment pages to provide consistent treatment of affiliated investments between the Health, Life and Property and Casualty Risk-Based Capital formulas.

Underwriting Risk Factors - Investment Income Adjustment

The Capital Adequacy (E) Task Force adopted proposal 2022-16-CA during its June 30, 2023 meeting. This proposal updated the comprehensive medical, Medicare supplement and dental and vision factors to include a 5% investment yield adjustment. The revised factors are:

	Comprehensive Medical	Medicare Supplement	Dental & Vision
\$0-\$3 Million	0.1434	0.0980	0.1148
\$3-\$25 Million	0.1434	0.0603	0.0711
Over \$25 Million	0.0838	0.0603	0.0711

Stop Loss Premiums

The Capital Adequacy (E) Task Force adopted proposal 2023-01-CA during its June 30 meeting. This proposal clarifies the instructions for stop loss premiums in the Underwriting Risk - Experience Fluctuation Risk, Other Underwriting Risk and Stop Loss Interrogatories.

Last Page: RBC Forecasting & Warning:**RBC Forecasting and Instructions**

The Life and Fraternal RBC forecasting spreadsheet calculates RBC using the same formula presented in the 2023 Life and Fraternal Risk-Based Capital Forecasting & Instructions for Companies, and it is available to download from the NAIC Account Manager. The 2023 Life and Fraternal Risk-Based Capital Forecasting & Instructions for Companies publication is available for purchase in electronic format through the NAIC Publications Department. This publication is available on or about November 1 each year. The User Guide is no longer included in the Forecasting & Instructions.

Warning: The RBC Forecasting Spreadsheet CANNOT be used to meet the year-end RBC electronic filing requirement. RBC filing software from an annual statement software vendor should be used to create the electronic filing. If the forecasting worksheet is sent instead of an electronic filing, it will not be accepted, and the RBC will not have been filed.

Last Page: 2023 National Association of Insurance Commissioners:

2023 NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

Life Risk-Based Capital Newsletter Volume 29. Published annually or whenever needed by the NAIC for insurance regulators, professionals and consumers.

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AGGREGATED LIFE RBC AND ANNUAL STATEMENT DATA

2022 Data as of 7/16/2023

	Year-End 2022	Year-End 2021	Year-End 2020	Year-End 2019	Year-End 2018	Year-End 2017	Year-End 2016	Year-End 2015	Year-End 2014	Year-End 2013
# of Companies Filled RBC	742	750	760	772	703	704	718	725	727	750
# of Companies Filled Annual Statement	885	766	774	786	722	729	739	750	763	770
% of RBC Companies	98%	96%	98%	98%	97%	97%	97%	97%	95%	97%
Company Action Level - Trend Test at 300%	6	8	5	7	6	6	3	2	6	6
Company Action Level - Trend Test at 250%	1	1	1	3	4	4	2	2	4	3
Company Action Level	2	3	2	4	2	3	4	6	5	5
Regulatory Action Level	0	0	0	0	2	4	1	1	0	1
Authorized Control Level	3	1	1	3	0	0	3	4	2	4
Administrative Control Level	1	1	1	3	3	3	3	4	2	4
Total	12	18	12	18	18	20	14	15	18	20
	1.62%	2.13%	1.58%	2.33%	2.56%	2.84%	1.95%	2.07%	2.48%	2.67%
# of Companies with RBC Ratio > 10.000%	45	55	52	50	47	56	57	53	61	67
# of Companies with RBC Ratio > 10.00 & < 10.000%	298	292	306	312	275	311	338	338	333	337
# of Companies with RBC Ratio > 5.00 & < 10.000%	313	315	317	332	311	275	274	270	270	274
# of Companies with RBC Ratio > 5.00 & < 3.000%	69	73	73	73	73	73	73	73	73	73
# of Companies with RBC Ratio > 2.50 & < 3.000%	9	9	9	9	9	9	9	9	9	9
# of Companies with RBC Ratio > 2.00 & < 2.500%	4	4	4	4	4	4	4	4	4	4
# of Companies with RBC Ratio > 2.00 & < 0%	5	2	2	6	8	0	0	0	0	6
# of Companies with RBC Ratio > 0%	0	0	0	0	0	0	0	0	0	1
Total	742	750	760	772	703	704	718	725	727	750
Total Adjusted Capital	696,188,240,900	710,746,904,192	635,213,337,716	606,801,270,691	540,392,904,821	526,559,144,783	508,747,679,202	495,365,058,593	486,612,656,608	472,894,118,204
Authorized Control Level RBC	81,640,007,079	80,264,014,541	74,177,610,650	70,095,026,244	64,286,923,366	56,351,687,796	53,371,992,970	51,286,679,826	49,962,064,876	49,205,729,081
Aggregate RBC %	853%	886%	866%	866%	841%	934%	953%	966%	974%	961%
Median RBC %	931%	965%	972%	964%	945%	1024%	1040%	1080%	1066%	1053%
Total C-0 Asset Risk - Affiliates	33,786,709,697	32,392,696,095	27,689,014,696	25,329,913,376	23,859,057,914	21,480,359,294	19,861,695,520	19,307,636,448	18,663,109,500	19,995,590,081
Total C-1 to Asset Risk - Common Stock	54,900,737,718	55,182,989,079	46,636,935,886	42,580,467,817	38,644,436,197	20,944,388,495	26,849,848,001	25,800,853,730	26,039,253,312	23,483,239,549
Total C-1 to Asset Risk - All Other	64,146,694,016	62,725,669,661	60,109,396,053	55,635,245,596	50,712,357,846	43,666,249,070	42,469,721,515	40,179,612,473	38,560,998,099	37,913,777,972
Total C-2 Insurance Risk	31,195,104,008	37,296,986,693	29,241,196,977	29,733,905,846	28,068,687,917	25,145,118,818	24,540,625,511	24,094,786,786	23,232,226,881	22,969,536,371
Total C-3a Interest Rate Risk	17,190,092,747	16,066,024,280	16,792,371,276	15,883,594,969	15,669,296,624	16,323,727,158	15,229,088,812	14,970,305,244	14,530,897,343	13,910,184,618
Total C-3b Health Credit Risk	18,337,840	111,552,562	104,729,771	92,196,729	88,414,638	77,374,674	36,706,313	2,309,153	2,081,557	5,892,497
Total C-3c Market Risk	3,529,226,438	4,295,739,257	6,181,583,664	5,209,040,590	4,036,702,207	2,288,518,186	2,208,998,989	1,906,066,557	2,224,840,425	2,665,668,425
Total C-4a Business Risk	10,224,912,322	9,240,542,060	8,816,493,013	8,678,807,088	8,042,996,988	7,739,505,134	7,747,940,544	7,357,039,841	6,998,502,423	6,623,950,654
Total C-4b Business Risk, Admin. Expenses	583,359,049	620,366,794	680,983,943	652,941,471	679,693,954	584,193,165	649,189,658	677,624,067	647,290,652	684,425,441
	216,575,164,835	217,822,798,311	195,231,515,099	183,794,400,372	167,845,633,395	147,289,332,894	139,813,816,113	134,297,224,299	130,888,960,192	127,777,285,288
Total C-0 Asset Risk - Affiliates	15.67%	14.82%	14.17%	13.78%	14.21%	14.59%	14.31%	14.38%	14.26%	15.11%
Total C-1 to Asset Risk - Common Stock	25.47%	25.33%	23.38%	23.17%	21.83%	20.33%	19.10%	19.21%	19.89%	18.36%
Total C-1 to Asset Risk - All Other	29.76%	28.80%	30.79%	30.27%	30.21%	29.66%	30.46%	29.92%	29.46%	29.67%
Total C-2 Insurance Risk	14.47%	7.97%	17.12%	16.18%	16.73%	17.07%	17.59%	17.73%	17.75%	17.96%
Total C-3a Interest Rate Risk	7.97%	7.36%	8.60%	8.64%	9.35%	11.08%	10.92%	11.15%	11.10%	10.89%
Total C-3b Health Credit Risk	0.01%	0.05%	0.05%	0.05%	0.05%	0.05%	0.03%	0.00%	0.00%	0.00%
Total C-3c Market Risk	1.64%	1.97%	3.17%	2.83%	2.41%	1.55%	1.42%	1.42%	1.70%	2.09%
Total C-4a Business Risk	4.74%	4.28%	4.52%	4.72%	4.79%	5.26%	5.55%	5.48%	5.35%	5.36%
Total C-4b Business Risk, Admin. Expenses	0.27%	0.28%	0.35%	0.36%	0.40%	0.40%	0.47%	0.50%	0.49%	0.54%
	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Total Assets	8,439,367,712,664	8,832,312,765,460	8,297,856,845,231	7,657,670,761,108	6,932,444,757,225	7,116,411,430,040	6,721,817,618,789	6,430,733,066,141	6,358,609,540,768	6,091,050,647,565
Total Invested Assets	5,312,077,013,619	5,159,452,752,770	4,907,504,359,175	4,582,885,123,381	4,209,696,503,202	4,155,136,070,920	3,976,564,473,802	3,787,990,147,128	3,712,771,801,125	3,585,197,915,336
Reserves (Liabilities Line 1 + 2)	3,580,757,824,976	3,488,243,938,821	3,394,241,406,583	3,285,116,770,876	3,075,849,385,426	3,012,277,013,592	2,923,377,679,259	2,790,917,216,424	2,714,010,331,232	2,596,164,893,854
Surplus (Liabilities Line 3)	589,231,822,136	589,394,009,357	543,174,466,456	524,516,844,871	475,856,631,597	466,945,183,027	452,449,163,948	439,866,508,114	426,214,329,287	410,481,152,085
Premiums Earned (Page 4 Line 1)	714,406,215,905	649,749,402,737	635,913,317,202	691,912,622,389	603,752,144,878	597,830,528,981	601,695,999,830	640,574,026,890	647,588,767,380	580,739,513,985
Claims Incurred (Page 4 Lines 10 Through 13)	327,099,260,850	345,503,167,520	319,751,913,923	308,244,032,091	290,149,583,149	280,435,511,539	270,356,842,990	262,562,416,681	249,920,619,580	285,507,549,061

Source: NAIC Financial Data Repository
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Draft: 8/3/23

Property and Casualty Risk-Based Capital (E) Working Group
Virtual Meeting
July 27, 2023

The Property and Casualty Risk-Based Capital (E) Working Group of the Capital Adequacy (E) Task Force met July 27, 2023. The following Working Group members participated: Tom Botsko, Chair (OH); Wanchin Chou, Vice Chair, Jack Broccoli, and Amy Waldhauer (CT); Rolf Kaumann and Mitchell Bronson (CO); Jane Nelson (FL); Judy Mottar (IL); Sandra Darby (ME); Anna Krylova (NM); HauMichael Ying (NY); Will Davis (SC); Miriam Fisk (TX); and Darcy Paskey and Jody Ullman (WI). Also participating were: Elizabeth Perri (AS); Giovanni Muzzarelli, Mitra Sanandajifar, and Rebecca Armon (CA); Travis Grassel (IA); Julie Lederer and Danielle Smith (MO); Lindsay Crawford (NE); Jesse Kolodin (NJ).

1. Adopted its June 16 and April 24 Minutes

Botsko said the Working Group met June 16 and April 24. During these meetings, the Working Group took the following action: 1) adopted its Spring National Meeting minutes; 2) adopted proposal 2023-02-P, which provided a routine annual update to the Line 1 premium and reserve industry underwriting factors in the property/casualty (P/C) risk-based capital (RBC) formula; and 3) adopted proposal 2023-02-P-MOD, which updated the H/F, WC, and CMP reserve factors due to an incorrect calculation.

Chou made a motion, seconded by Darby, to adopt the Working Group's June 16 (Attachment Five-A) and April 24 (Attachment Five-B) minutes. The motion passed unanimously.

2. Adopted the Report of the Catastrophe Risk (E) Subgroup

Chou said the Subgroup met July 18. During this meeting, the Subgroup took the following action: 1) adopted its Spring National Meeting minutes; 2) discussed its working agenda; 3) received an update from its Catastrophe Model Technical Review Ad Hoc Group; 4) discussed the wildfire peril impact analysis; 5) heard a presentation from Verisk on a severe convective storms model update and technical review; and 6) discussed the flood insurance market.

Chou made a motion, seconded by Davis, to adopt the report of the Catastrophe Risk (E) Subgroup (Attachment Five-C). The motion passed unanimously.

3. Adopted the 2023 P/C RBC Newsletter

Botsko said the 2023 P/C RBC newsletter reflects the adopted proposals for year-end 2023. He said as mentioned last year, the purpose of the adoption is to consider the content of the newsletter, and the format will later be revised. He said when the formatting of the newsletter is complete, it will be posted to the Working Group's web page.

Chou made a motion, seconded by Darby, to adopt the 2023 P/C RBC newsletter (Attachment Five-D). The motion passed unanimously.

4. Discussed 2022 RBC Statistics

Botsko said the 2022 P/C RBC statistics were run on June 29. He said there were 2,522 P/C RBC filings loaded onto the NAIC database, up from 2,511 in 2021. He stated that there were 54 companies that triggered an action level in 2022: 1) 27 were in company action level; 2) seven were in regulatory action level; 3) three were in an authorized control level (ACL); and 4) 17 were in a mandatory control level. Also, there were 19 companies that triggered the trend test. However, the aggregate RBC percentage decreased from 617% in 2021 to 586% in 2022 due to the decrease of both ACL and total adjusted capital (TAC) amounts. Botsko also stated that the interested parties suggested that adding the operational risk component will provide a complete picture of the RBC formula. Without hearing any objections, the Working Group agreed to include the operational risk amount in the 2023 RBC statistics.

5. Discussed its Working Agenda

Botsko summarized the changes of the Working Group's 2023 working agenda, which included the following substantial changes: 1) update the Sept. 26 comment from conduct a review on different convective storm models to conduct a review on severe convective storm models, and add an additional comment of "the SG is finishing reviewing the following SCS vendor models: RMS, Verisk, KCC and Corelogic" in the comment section in item P1; 2) remove item #P5 as the proposal 2022-07-P has been adopted at the 2022 Fall National Meeting; and 3) add a new Item P8 for adding pet insurance line in the RBC formula due to the adoption of the Annual Statement Blanks proposal 2023-01BWG.

6. Discussed the Possibility of Reviewing and Analyzing the P/C RBC Charges That Have Not Been Reviewed Since Developed

Botsko said the Risk Evaluation Ad Hoc Group has met a few times since established. During the last meeting, the Ad Hoc Group decided to create three subgroups to potentially streamline the process of making progress on specific topics: 1) Asset Concentration Ad Hoc Subgroup; 2) RBC Purposes and Guidelines Ad Hoc Subgroup; and 3) Geographic Concentration Ad Hoc Subgroup. He encouraged all the interested parties to contact NAIC staff if anyone is interested in joining the ad hoc subgroups. Also, Botsko anticipated that the ad hoc subgroups will start meeting regularly after the Summer National Meeting.

7. Heard Updates on Current P/C RBC Projects from the Academy

Ron Wilkins (American Academy of Actuaries—Academy) said the purpose of the presentation (Attachment Five-E) is to provide: 1) the background of the report that will be released in the coming days; 2) a summary of the results; and 3) adjustment for catastrophe risk. He stated that the report is currently undergoing final public policy review by the Academy; it should be formally sent to the Working Group in a few days. Botsko said the Working Group is planning to expose the report for a 60-day comment period upon receiving it from the Academy.

Having no further business, the Property and Casualty Risk-Based Capital (E) Working Group adjourned.

SharePoint/NAIC Support Staff Hub/Member Meetings/Summer 2023 National Meeting/Task Forces/CapAdequacy/PCRBC WG/07-27propertyrbcwg.docx

Draft: 6/20/23

Property and Casualty Risk-Based Capital (E) Working Group
E-Vote
June 16, 2023

The Property and Casualty Risk-Based Capital (E) Working Group of the Capital Adequacy (E) Task Force conducted an e-vote that concluded June 16, 2023. The following Working Group members participated: Tom Botsko, Chair (OH); Wanchin Chou, Vice Chair (CT); Rolf Kaumann (CO); Sandra Darby (ME); Anna Krylova (NM); Will Davis (SC); and Miriam Fisk (TX).

1. Adopted Proposal 2023-02-P-MOD

The Working Group and the Subgroup conducted an e-vote to consider adoption of proposal 2023-02-P-MOD. The purpose of this modification is to update the H/F, WC, and CMP reserve factors due to an incorrect calculation.

Darby made a motion, seconded by Kaumann, to adopt proposal 2023-02-P-MOD (*see NAIC Proceedings – Summer 2023, Capital Adequacy (E) Task Force, Attachment One-A*). The motion passed unanimously.

Having no further business, the Property and Casualty Risk-Based Capital (E) Working Group adjourned.

SharePoint/NAIC Support Staff Hub/ Member Meetings/E Cmte/CADTF/2023-2-Summer/PCRBWCG/PC Email Vote 061623

Draft: 4/26/23

Property and Casualty Risk-Based Capital (E) Working Group
Virtual Meeting
April 24, 2023

The Property and Casualty Risk-Based Capital (E) Working Group of the Capital Adequacy (E) Task Force met April 24, 2023. The following Working Group members participated: Tom Botsko, Chair (OH); Wanchin Chou, Vice Chair, Jack Broccoli, and Qing He (CT); Virginia Christy and Nicole Crockett (FL); Judy Mottar (IL); Sandra Darby (ME); Anna Krylova (NM); HauMichael Ying (NY); Will Davis (SC); Miriam Fisk and Monica Avila (TX); and Adrian Jaramillo and Michael Erdman (WI). Also participating were: Jeff Cordell and Leo Liu (AR); Kevin Clark (IA); Julie Lederer (MO); Lindsay Crawford (NE); Doug Hartz (OR); Trey Hancock (TN); and Steve Drutz (WA).

1. Adopted its Spring National Meeting Minutes

Botsko said the Working Group met March 22.

Chou made a motion, seconded by Darby, to adopt the Working Group's March 23 minutes (*see NAIC Proceedings – Spring 2023, Capital Adequacy (E) Task Force, Attachment Five*). The motion passed unanimously.

2. Adopted Proposal 2023-02-P

Botsko said proposal 2023-02-P (Underwriting Risk Line 1 Factors) provided a routine annual update to the Line 1 premium and reserve industry underwriting factors in the property/casualty (P/C) risk-based capital (RBC) formula. He also stated that the Working Group did not receive any comments during the exposure period.

Darby made a motion, seconded by Krylova, to adopt proposal 2023-02-P (*see NAIC Proceedings – Summer 2023, Capital Adequacy (E) Task Force, Attachment Two-A*). The motion passed unanimously.

3. Forwarded the Referral Regarding the Deferral of Adoption of Blanks Proposal 2023-01BWG

Botsko said the Blanks (E) Working Group exposed proposal 2023-01BWG (Attachment Five-B1) on March 7. The purpose of this proposal is to remove pet insurance from the Inland Marine line within the existing P/C Annual Statement Blank for the Underwriting and Investment Exhibits, Exhibit of Premiums and Losses (State Page), and Insurance Expense Exhibit and add new Schedule P Parts 1 through 4 specifically to pet insurance. Botsko said the Working Group reviewed the proposal and suggested sending a referral (Attachment Five-B2) to the Blanks (E) Working Group to delay this proposal for at least one year to allow state insurance regulators time to collect more industry information through other means. He also commented that cyber is also a significantly growing line of business, and it is using the supplemental data option. He indicated that while pet insurance seems to have grown significantly in the past few years, there are only a few carriers that write this line of business, and it is not clear if this supports adding an additional line of business without sufficient data support. Tip Tipton (Thrivent) said the Blanks (E) Working Group interested parties group supports a delayed implementation of at least one year as indicated in the attached memo. He stated that the interested parties group raised concerns about how the new line of business would address RBC and Market Conduct Annual Statement (MCAS) items.

After reviewing the referral, the Working Group agreed to forward the referral regarding the deferral of adoption of Blanks proposal 2021-01BWG to the Blanks (E) Working Group.

4. Discussed Annual Statement Blanks Proposal 2022-15BWG

Botsko said the Blanks (E) Working Group adopted proposal 2022-15BWG (Attachment Five-B3) during its March 7 meeting, which removes the current 5% of premium filing exemption (FE) on the Schedule H, Part 5 for P/C annual statement filing. He stated that the Working Group had a discussion at the Spring National Meeting on whether the same 5% rule should be removed from the P/C RBC formula to be consistent with the change in the annual statement. Connie Jasper Woodroof (CJW Associates) commented that both items are not related at all. It is just a coincidence that 5% is mentioned in both circumstances. She also stated that it would lose some valuable information in the P/C RBC health section by removing the 5% accident and health (A&H) threshold. The Working Group agreed with Woodroof's comment; no adjustment will be made to the P/C RBC formula.

5. Heard Updates on Current P/C RBC Projects from the Academy

Botsko said the Property and Casualty Risk-Based Capital Committee of the American Academy of Actuaries (Academy) provided a presentation at the Spring National Meeting on the following: 1) an overview of the methodology used to determine premium and reserve risk factors; and 2) the adjustment for investment income to the Working Group. Also, he said the Academy will need the NAIC's assistance to perform different impact analyses before sharing the report with the Working Group. He said the Academy anticipates that the report will be delivered in June 2023. Then, the Academy will focus on additional analysis related to premium and reserve risk.

6. Discussed the Possibility of Reviewing and Analyzing the P/C RBC Charges That Have Not Been Reviewed Since Developed

Botsko said the Capital Adequacy (E) Task Force established the Risk Evaluation Ad Hoc Group at the Spring National Meeting to: 1) re-evaluate some of the missing risks to determine if it should now include them in the RBC calculation or whether it appropriately handles those risks utilizing other regulatory methods; and 2) review those factors and instructions that have never been reviewed since development to determine if modifications should be made. He stated that NAIC staff received more than 80 industry requests to be involved in the ad hoc group. He commented that being a member of the group will require active participation in the group discussions, and status updates will be provided in every Task Force meeting. He asked all the interested parties to contact Eva Yeung (NAIC) if they do not plan on participating in the group discussion. Lastly, he said the ad hoc group plans to schedule the first meeting in May.

Having no further business, the Property and Casualty Risk-Based Capital (E) Working Group adjourned.

SharePoint/NAIC Support Staff Hub/Member Meetings/Summer 2022 National Meeting/Task Forces/CapAdequacy/PCRBC WG/04-26propertyrbcwg.docx

NAIC BLANKS (E) WORKING GROUP

Blanks Agenda Item Submission Form

<p style="text-align: right;">DATE: <u>11/4/2022</u></p> <p>CONTACT PERSON: <u>Debbie Doggett (MO DCI) & Gavin Friedman (American Pet Ins Co; ZPIC Ins Co)</u></p> <p>TELEPHONE: <u>Debbie (573) 526-2944 / Gavin (310) 254-5256</u></p> <p>EMAIL ADDRESS: <u>debbie.doggett@insurance.mo.gov / gavin.friedman@trupanion.com</u></p> <p>ON BEHALF OF: <u>Joint submission by (i) the MO Dept of Commerce and Insurance and (ii) American Pet Ins Co and ZPIC Ins Co</u></p> <p>NAME: <u>Debbie Doggett</u></p> <p>TITLE: <u>Chief Financial Analyst</u></p> <p>AFFILIATION: <u>Missouri DCI</u></p> <p>ADDRESS: <u>301 W Hight St. #530, Jefferson City, MO 65101</u></p>	<p style="text-align: center;">FOR NAIC USE ONLY</p> <p>Agenda Item # <u>2023-01BWG</u></p> <p>Year <u>2024</u></p> <p>Changes to Existing Reporting [X]</p> <p>New Reporting Requirement []</p> <hr/> <p style="text-align: center;">REVIEWED FOR ACCOUNTING PRACTICES AND PROCEDURES IMPACT</p> <p>No Impact [X]</p> <p>Modifies Required Disclosure []</p> <p>Is there data being requested in this proposal which is available elsewhere in the Annual/Quarterly Statement? [No]</p> <p><i>***If Yes, complete question below***</i></p> <hr/> <p style="text-align: center;">DISPOSITION</p> <p>[] Rejected For Public Comment</p> <p>[] Referred To Another NAIC Group</p> <p>[] Received For Public Comment</p> <p>[] Adopted Date _____</p> <p>[] Rejected Date _____</p> <p>[] Deferred Date _____</p> <p>[] Other (Specify) _____</p>
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BLANK(S) TO WHICH PROPOSAL APPLIES

- | | | |
|--|---|---|
| <input checked="" type="checkbox"/> ANNUAL STATEMENT | <input checked="" type="checkbox"/> INSTRUCTIONS | <input checked="" type="checkbox"/> CROSSCHECKS |
| <input checked="" type="checkbox"/> QUARTERLY STATEMENT | <input checked="" type="checkbox"/> BLANK | |
| <input type="checkbox"/> Life, Accident & Health/Fraternal | <input type="checkbox"/> Separate Accounts | <input type="checkbox"/> Title |
| <input checked="" type="checkbox"/> Property/Casualty | <input type="checkbox"/> Protected Cell | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Health | <input type="checkbox"/> Health (Life Supplement) | |

Anticipated Effective Date: January 1, 2024

IDENTIFICATION OF ITEM(S) TO CHANGE

Remove Pet Insurance from Inland Marine line of business and add a new line of business to Appendix – P/C Lines of Business. Add Pet Insurance line within the existing P/C Blank for the Underwriting and Investment Exhibits, Exhibit of Premiums and Losses (State Page), and Insurance Expense Exhibit. Add new Schedule P Parts 1 through 4 specific to Pet Insurance.

REASON, JUSTIFICATION FOR AND/OR BENEFIT OF CHANGE**

See Page 2 for detailed reason and justification for change.

*****IF THE DATA IS AVAILABLE ELSEWHERE IN THE ANNUAL/QUARTERLY STATEMENT, PLEASE NOTE WHY IT IS REQUIRED FOR THIS PROPOSAL*****

NAIC STAFF COMMENTS

Comment on Effective Reporting Date: _____

Other Comments:

** This section must be completed on all forms.

Revised 11/17/2022

REASON, JUSTIFICATION FOR AND/OR BENEFIT OF CHANGE

Pet insurance is reported today as an Inland Marine product. Separating Pet Insurance from Inland Marine for financial reporting purposes within the existing Blank is warranted for a number of reasons, including:

- There is no public or regulator visibility into the vast majority of the pet insurance industry's financial reporting. Other than for a monoline insurer that writes only pet insurance, the rest of the industry's pet insurance business financial reporting is included in Inland Marine, along with anything else in that broadly-defined line that the respective insurer has written. In short, regulators do not have clear visibility into even the most basic information about pet insurers and the pet insurance market, such as who is underwriting pet coverage, the volume being sold, losses, and who is selling it.
- The pet insurance industry has grown rapidly, and this high growth rate continues. The industry's self-reported data shows growth in annual gross written premium from \$836.5 M in 2016 to \$2.59 B in 2021, including more than 30% annual growth from 2020 to 2021. This growth rate makes the absence of visibility into each participating company's financial information more an acute challenge with each passing year.
- Relying on regulator data calls to gather basic information such as premium written and loss information is time-consuming for all involved, and prone to inconsistencies and errors.
- The NAIC's D Committee is proceeding with MCAS for pet insurance. It would be inapposite and have potential for inconsistent data, to require MCAS reporting while not requiring dedicated pet insurance financial reporting. In addition, separate financial reporting will be a useful complement to MCAS reporting, both to supplement the MCAS information and to validate it.
- Dedicated financial reporting of pet insurance will be helpful to state regulators' assessment of the appropriate amount of surplus insurers writing this business should hold. It is anticipated that once sufficient history is obtained, a separate RBC factor for pet insurance can be established.

ANNUAL STATEMENT INSTRUCTIONS – PROPERTY/CASUALTY

APPENDIX

PROPERTY AND CASUALTY LINES OF BUSINESS

These definitions should be applied when reporting all applicable amounts for the following schedules: Underwriting and Investment Exhibit Parts 1, 1A, 1B, 2, and 2A; Exhibit of Premiums and Losses (Statutory Page 14); and the Insurance Expense Exhibit. Policy fees, service charges or membership charges are to be included with the line of business or in Other Income, as determined by *SSAP No. 53—Property and Casualty Contracts – Premiums*.



Line 9.1 – Inland Marine

Coverage for property that may be in transit, held by a bailee, at a fixed location, a movable good that is often at different locations (e.g., off-road construction equipment) or scheduled property (e.g., Homeowners Personal Property Floater), including items such as live animals, property with antique or collector’s value, etc. This line also includes instrumentalities of transportation and communication, such as bridges, tunnels, piers, wharves, docks, pipelines, power and phone lines, and radio and television towers.

Animal Mortality

Coverage that provides a death benefit to the owner of a policy in the event of the death of the insured livestock.

EDP Policies

Coverage to protect against losses arising out of damage to or destruction of electronic data processing equipment and its software.

Communication Equipment (Cellular Telephones)

Provides insured subscribers of Communications Equipment Service Provider replacement coverage for loss of and damage, theft or mechanical breakdown to communications equipment. Communications equipment means wireless telephones and pagers, and any other devices incorporating wireless phone and pager capabilities, including but not limited to personal digital assistants (PDA) and wireless aircards.

Line 9.2 – Pet Insurance Plans

Veterinary care plan insurance policy providing care for a pet animal (e.g., dog or cat) of the insured owner in the event of its illness or accident.

SCHEDULE P

SCHEDULE P – PART 1

Part 1 – Summary is the total of the Schedule P lines. For the property lines, it is necessary to supplement the data in the individual sections of Schedule P in order to complete the Part 1 – Summary for all lines for all years. Non-proportional assumed reinsurance – Property, Liability and Financial Lines can be summed together as reported.

↓
===== **Detail Eliminated to Conserve Space** =====
↑

Non-proportional assumed reinsurance –Property Reinsurance

Includes all the following lines: Fire, Allied Lines, Ocean Marine, Inland Marine, Pet Insurance Plans, Earthquake, Group Accident and Health, Credit Accident and Health, Other Accident and Health, Auto Physical Damage, Boiler and Machinery, Burglary and Theft and International (of the foregoing).

↓
===== **Detail Eliminated to Conserve Space** =====
↑

SCHEDULE P – PARTS 1A THROUGH 1U

Reporting entities should complete Schedule P in thousands only but must report all claim counts in whole numbers.

↓
===== **Detail Eliminated to Conserve Space** =====
↑

ANNUAL STATEMENT BLANKS – PROPERTY/CASUALTY

UNDERWRITING AND INVESTMENT EXHIBIT
 PART 1 – PREMIUMS EARNED

Line of Business	1 Net Premiums Written per Column 6, Part 1B	2 Unearned Premiums Dec. 31 Prior Year- per Col. 3, Last Year's Part 1	3 Unearned Premiums Dec. 31 Current Year- per Col. 5 Part 1A	4 Premiums Earned During Year (Cols. 1 + 2 - 3)
1. Fire.....				
2.1 Allied lines.....				
2.2 Multiple peril crop.....				
2.3 Federal flood.....				
2.4 Private crop.....				
2.5 Private flood.....				
3. Farmowners multiple peril.....				
4. Homeowners multiple peril.....				
5.1 Commercial multiple peril (non-liability portion).....				
5.2 Commercial multiple peril (liability portion).....				
6. Mortgage guaranty.....				
8. Ocean marine.....				
9.1 Inland marine.....				
9.2. Pet Insurance Plans.....				
10. Financial guaranty.....				
11.1 Medical professional liability—occurrence.....				
11.2 Medical professional liability—claims-made.....				
12. Earthquake.....				
13.1 Comprehensive (hospital and medical) individual.....				
13.2 Comprehensive (hospital and medical) group				
14. Credit accident and health (group and individual).....				
15.1 Vision only.....				
15.2 Dental only.....				
15.3 Disability income.....				
15.4 Medicare supplement.....				
15.5 Medicaid Title XIX.....				
15.6 Medicare Title XVIII.....				
15.7 Long-term care.....				
15.8 Federal employees health benefits plan.....				
15.9 Other health.....				
16. Workers' compensation.....				
17.1 Other liability—occurrence.....				
17.2 Other liability—claims-made.....				
17.3 Excess workers' compensation.....				
18.1 Products liability—occurrence.....				
18.2 Products liability—claims-made.....				
19.1 Private passenger auto no-fault (personal injury protection).....				
19.2 Other private passenger auto liability.....				
19.3 Commercial auto no-fault (personal injury protection).....				
19.4 Other commercial auto liability.....				
21.1 Private passenger auto physical damage.....				
21.2 Commercial auto physical damage.....				
22. Aircraft (all perils).....				
23. Fidelity.....				
24. Surety.....				
26. Burglary and theft.....				
27. Boiler and machinery.....				
28. Credit.....				
29. International.....				
30. Warranty.....				
31. Reinsurance-nonproportional assumed property.....				
32. Reinsurance-nonproportional assumed liability.....				
33. Reinsurance-nonproportional assumed financial lines.....				
34. Aggregate write-ins for other lines of business.....				
35. TOTALS				
DETAILS OF WRITE-INS				
3401.				
3402.				
3403.				
3498. Sum. of remaining write-ins for Line 34 from overflow page.....				
3499. Totals (Lines 3401 through 3403 plus 3498) (Line 34 above)				

UNDERWRITING AND INVESTMENT EXHIBIT
PART 1A – RECAPITULATION OF ALL PREMIUMS

Line of Business	1 Amount Unearned (Running One Year or Less from Date of Policy) (a)	2 Amount Unearned (Running More Than One Year from Date of Policy) (a)	3 Earned but Unbilled Premium	4 Reserve for Rate Credits and Retrospective Adjustments Based on Experience	5 Total Reserve for Unearned Premiums Cols. 1+2+3+4
1. Fire					
2.1 Allied lines					
2.2 Multiple peril crop					
2.3 Federal flood					
2.4 Private crop					
2.5 Private flood					
3. Farmowners multiple peril					
4. Homeowners multiple peril					
5.1 Commercial multiple peril (non-liability portion)					
5.2 Commercial multiple peril (liability portion)					
6. Mortgage guaranty					
8. Ocean marine					
9.1 Inland marine					
9.2 Pet Insurance Plans					
10. Financial guaranty					
11.1 Medical professional liability—occurrence					
11.2 Medical professional liability—claims-made					
12. Earthquake					
13.1 Comprehensive (hospital and medical) individual					
13.2 Comprehensive (hospital and medical) group					
14. Credit accident and health					
15.1 Vision only					
15.2 Dental only					
15.3 Disability income					
15.4 Medicare supplement					
15.5 Medicaid title XIX					
15.6 Medicare title XVIII					
15.7 Long-term care					
15.8 Federal employees health benefits plan					
15.9 Other health					
16. Workers' compensation					
17.1 Other liability—occurrence					
17.2 Other liability—claims-made					
17.3 Excess workers' compensation					
18.1 Products liability—occurrence					
18.2 Products liability—claims-made					
19.1 Private passenger auto no-fault (personal injury protection)					
19.2 Other private passenger auto liability					
19.3 Commercial auto no-fault (personal injury protection)					
19.4 Other commercial auto liability					
21.1 Private passenger auto physical damage					
21.2 Commercial auto physical damage					
22. Aircraft (all perils)					
23. Fidelity					
24. Surety					
26. Burglary and theft					
27. Boiler and machinery					
28. Credit					
29. International					
30. Warranty					
31. Reinsurance-nonproportional assumed property					
32. Reinsurance-nonproportional assumed liability					
33. Reinsurance-nonproportional assumed financial lines					
34. Aggregate write-ins for other lines of business					
35. TOTALS					
36. Accrued retrospective premiums based on experience					
37. Earned but unbilled premiums					
38. Balance (Sum of Lines 35 through 37)					
DETAILS OF WRITE-INS					
3401.					
3402.					
3403.					
3498. Sum. of remaining write-ins for Line 34 from overflow page					
3499. Totals (Lines 3401 through 3403 plus 3498) (Line 34 above)					

(a) State here basis of computation used in each case

UNDERWRITING AND INVESTMENT EXHIBIT
PART 1B – PREMIUMS WRITTEN

Line of Business	1 Direct Business (a)	Reinsurance Assumed		Reinsurance Ceded		6 Net Premiums Written Cols. 1+2+3- 4-5
		2 From Affiliates	3 From Non- Affiliates	4 To Affiliates	5 To Non- Affiliates	
1. Fire						
2.1 Allied lines						
2.2 Multiple peril crop.....						
2.3 Federal flood						
2.4 Private crop						
2.5 Private flood						
3. Farmowners multiple peril.....						
4. Homeowners multiple peril.....						
5.1 Commercial multiple peril (non-liability portion).....						
5.2 Commercial multiple peril (liability portion) ...						
6. Mortgage guaranty						
8. Ocean marine						
9.1 Inland marine						
9.2 Pet Insurance Plans						
10. Financial guaranty.....						
11.1 Medical professional liability—occurrence.....						
11.2 Medical professional liability—claims-made ...						
12. Earthquake.....						
13.1 Comprehensive (hospital and medical) individual.....						
13.2 Comprehensive (hospital and medical) group ...						
14. Credit accident and health (group and individual).....						
15.1 Vision only.....						
15.2 Dental only.....						
15.3 Disability income						
15.4 Medicare supplement						
15.5 Medicaid Title XIX.....						
15.6 Medicare Title XVIII						
15.7 Long-term care						
15.8 Federal employees health benefits plan						
15.9 Other Health						
16. Workers' compensation						
17.1 Other liability—occurrence.....						
17.2 Other liability—claims-made.....						
17.3 Excess workers' compensation						
18.1 Products liability—occurrence.....						
18.2 Products liability—claims-made						
19.1 Private passenger auto no-fault (personal injury protection).....						
19.2 Other private passenger auto liability						
19.3 Commercial auto no-fault (personal injury protection)						
19.4 Other commercial auto liability						
21.1 Private passenger auto physical damage.....						
21.2 Commercial auto physical damage						
22. Aircraft (all perils).....						
23. Fidelity						
24. Surety						
26. Burglary and theft						
27. Boiler and machinery						
28. Credit						
29. International						
30. Warranty.....						
31. Reinsurance-nonproportional assumed property	XXX					
32. Reinsurance-nonproportional assumed liability.....	XXX					
33. Reinsurance-nonproportional assumed financial lines	XXX					
34. Aggregate write-ins for other lines of business .						
35. TOTALS						
DETAILS OF WRITE-INS						
3401.						
3402.						
3403.						
3498.Sum. of remaining write-ins for Line 34 from overflow page.....						
3499.Totals (Lines 3401 through 3403 plus 3498) (Line 34 above)						

(a) Does the company's direct premiums written include premiums recorded on an installment basis? Yes [] No []
 If yes: 1. The amount of such installment premiums \$.....
 2. Amount at which such installment premiums would have been reported had they been recorded on an annualized basis \$.....

UNDERWRITING AND INVESTMENT EXHIBIT
PART 2 – LOSSES PAID AND INCURRED

Line of Business	Losses Paid Less Salvage			5 Net Losses Unpaid Current Year (Part 2A, Col. 8)	6 Net Losses Unpaid Prior Year	7 Losses Incurred Current Year (Cols 4 + 5-6)	8 Percentage of Losses Incurred to Premiums Earned (Col. 4, Part 1)
	1 Direct Business	2 Reinsurance Assumed	3 Reinsurance Recovered				
1. Fire.....							
2.1 Allied lines.....							
2.2 Multiple-peril crop.....							
2.3 Federal flood.....							
2.4 Private crop.....							
2.5 Private flood.....							
3. Homeowners multiple peril.....							
4. Homeowners multiple peril.....							
5. Commercial multiple peril (non-liability portion).....							
5.1 Commercial multiple peril (liability portion).....							
5.2 Commercial multiple peril (liability portion).....							
6. Mortgage guaranty.....							
8. Ocean marine.....							
9.1 Inland marine.....							
9.2 Pet Insurance Plans.....							
10. Financial guaranty.....							
11.1 Medical professional liability—occurrence.....							
11.2 Medical professional liability—claims-made.....							
12. Earthquake.....							
13.1 Comprehensive (hospital and medical) individual.....							
13.2 Comprehensive (hospital and medical) group.....							
14. Credit accident and health (group and individual).....							
15.1 Vision only.....							
15.2 Dental only.....							
15.3 Disability income.....							
15.4 Medicare supplement.....							
15.5 Medicare Title XIX.....							
15.6 Medicare Title XVIII.....							
15.7 Long-term care.....							
15.8 Federal employees health benefits plan.....							
15.9 Other health.....							
16. Workers' compensation.....							
17.1 Other liability—occurrence.....							
17.2 Other liability—claims-made.....							
17.3 Excess workers' compensation.....							
18.1 Products liability—occurrence.....							
18.2 Products liability—claims-made.....							
19.1 Private passenger auto no-fault (personal injury protection).....							
19.2 Other private passenger auto liability.....							
19.3 Commercial auto no-fault (personal injury protection).....							
19.4 Other commercial auto liability.....							
2.1.1 Private passenger auto physical damage.....							
2.1.2 Commercial auto physical damage.....							
22. Aircraft (all perils).....							
23. Fidelity.....							
24. Surety.....							
26. Burglary and theft.....							
28. Boiler and machinery.....							
29. Credit.....							
30. International.....							
31. Warranty—non-proportional assumed property.....							
32. Reinsurance-non-proportional assumed liability.....							
33. Reinsurance-non-proportional assumed financial lines.....							
34. Aggregate write-ins for other lines of business.....							
35. TOTALS.....							
DETAILS OF WRITE-INS							
3401.....							
3402.....							
3403. Sum of remaining write-ins for Line 34 from overflow page.....							
3499. Totals (Lines 3401 through 3403 + 3498) (Line 34 above).....							

**UNDERWRITING AND INVESTMENT EXHIBIT
PART 2A – UNPAID LOSSES AND LOSS ADJUSTMENT EXPENSES**

Line of Business	Incurred But Not Reported					9 Net Unpaid Loss Adjustment Expenses		
	1 Direct	2 Reinsurance Assumed	3 Deduct Reinsurance Recoverable	4 Net Losses Excl. Incurred But Not Reported (Cols. 1-2-3)	5 Direct		6 Reinsurance Assumed	7 Reinsurance Ceded	8 Net Losses Unpaid (Cols. 4 + 5 + 6 + 7)
1. Fire.....								
2.1 Allied lines.....								
2.2 Multiple peril crop.....								
2.3 Federal flood.....								
2.4 Private crop.....								
2.5 Private flood.....								
3. Homeowners multiple peril.....								
4. Homeowners multiple peril (non-liability portion).....								
5.1 Commercial multiple peril (non-liability portion).....								
5.2 Commercial multiple peril (liability portion).....								
6. Mortgage guaranty.....								
8. Ocean marine.....								
9.1 Inland marine.....								
9.2 Pet insurance plans.....								
10. Financial guaranty.....								
11.1 Medical professional liability—claims-made.....								
11.2 Medical professional liability—occurrence.....								
12. Earthquake.....								
13.1 Comprehensive (hospital and medical) individual.....								
13.2 Comprehensive (hospital and medical) group.....								
14. Credit accident and health (group and individual).....								
15.1 Vision only.....								
15.2 Dental only.....								
15.3 Disability income.....								
15.4 Medicare supplement.....								
15.5 Medicare Title XIX.....								
15.6 Medicare Title XVIII.....								
15.7 Long-term care.....								
15.8 Federal employees health benefits plan.....								
15.9 Other health.....								
16. Workers' compensation.....								
17.1 Other liability—occurrence.....								
17.2 Other liability—claims-made.....								
17.3 Excess workers' compensation.....								
18.1 Products liability—occurrence.....								
18.2 Products liability—claims-made.....								
19.1 Private passenger auto no-fault (personal injury protection).....								
19.2 Other private passenger auto liability.....								
19.3 Commercial auto no-fault (personal injury protection).....								
19.4 Other commercial auto liability.....								
21.1 Private passenger auto physical damage.....								
21.2 Commercial auto physical damage.....								
22. Aircraft (all perils).....								
23. Fidelity.....								
24. Surety.....								
26. Burglary and theft.....								
27. Boiler and machinery.....								
28. Credit.....								
29. Commercial.....								
30. International.....								
31. Guaranty.....								
32. Reinsurance-nonproportional assumed property liability.....								
33. Reinsurance-nonproportional assumed liability.....								
34. Reinsurance-nonproportional assumed financial lines.....								
35. Aggregate write-ins for other lines of business.....								
TOTALS.....								
3401. DETAILS OF WRITE-INS.....								
3402. XXX								
3403. XXX								
3404. XXX								
3498. Sum. of remaining write-ins for Line 34 from overflow page.....								
3499. Totals (Lines 3401 through 3403 + 3498) (Line 34 above).....								

(a) Including \$.....for present value of life indemnity claims reported in Lines 13 and 15.

EXHIBIT OF PREMIUMS AND LOSSES (Statutory Page 14)

Line of Business	BUSINESS IN THE STATE OF _____ DURING THE YEAR _____										NAIC Company Code _____	
	1 Direct Premiums Written	2 Direct Premiums Earned	3 Dividends or Credits to Policyholders on Direct Business	4 Direct Unearned Reserves	5 Direct Losses Paid (including salvage)	6 Direct Losses Incurred	7 Direct Losses Unpaid	8 Direct Defense and Cost Expense Paid	9 Direct Defense and Cost Expense Incurred	10 Direct Defense and Cost Expense Unpaid	11 Commissions and Expense	12 Taxes, Licenses and Fees
1. Fire.....
2.1 Allied Lines.....
2.2 Multiple Peril Crop.....
2.3 Federal Flood.....
2.4 Private Flood.....
2.5 Private Flood.....
3. Farmowners Multiple Peril.....
4. Homeowners Multiple Peril.....
5.1 Commercial Multiple Peril (Non-Liability).....
5.2 Commercial Multiple Peril (Liability Portion).....
6. Mortgage Guaranty.....
8. Ocean Marine.....
9.1 Inland Marine.....
9.2 Pet Insurance Plans.....
10. Medical Professional Liability—Occurrence.....
11.1 Medical Professional Liability—Claims-Made.....
12. Earthquake.....
13.1 Comprehensive (hospital and medical) and (b).....
13.2 Comprehensive (hospital and medical) and (b).....
14. Credit A&H Group and Individual.....
15.1 Vision Only (b).....
15.2 Dental Only (b).....
15.3 Disability Income (b).....
15.4 Health Care (b).....
15.5 Medicare Part XVIII (b).....
15.6 Medicare Title XVIII (b).....
15.7 Long-Term Care (b).....
15.8 Federal Employees Health Benefits Plan (b).....
15.9 Other Health (b).....
16. Life.....
17.1 Other Liability—Occurrence.....
17.2 Other Liability—Claims-Made.....
17.3 Excess Workers' Compensation.....
18.1 Products Liability—Occurrence.....
18.2 Products Liability—Claims-Made.....
19.1 Private Passenger Auto No-Fault (Personal Injury Protection).....
19.2 Other Private Passenger Auto Liability.....
19.3 Commercial Auto No-Fault (Personal Injury Protection).....
19.4 Commercial Auto Liability.....
21.1 Private Passenger Auto Physical Damage.....
21.2 Commercial Auto Physical Damage.....
22. Aircraft (all perils).....
23. Fidelity.....
24. Forgery.....
26. Burglary and Theft.....
27. Boiler and Machinery.....
28. Credit.....
29. International.....
30. Surety.....
31. Reins nonproportional assumed process.....
32. Reins nonproportional assumed liability.....
33. Reins nonproportional assumed financial lines.....
34. Aggregate Write-Ins for Other Lines of Business.....
35. TOTAL (b)
DETAILS OF WRITE-INS												
3492.....
3493.....
3498 Sum of remaining write-ins for Line 34 from overflow page.....
3499 TOTAL (Lines 3401 through 3493 plus 3498) (Line 34 above)

(a) Finance and service charges not included in Lines 1 to 35 S..... and number of persons insured under indemnity only products.....
 (b) For health business on indicated lines report: Number of persons insured under PPO managed care products..... and number of persons insured under indemnity only products.....

INSURANCE EXPENSE EXHIBIT
PART II – ALLOCATION TO LINES OF BUSINESS NET OF REINSURANCE
PREMIUMS, LOSSES, EXPENSES, RESERVES AND PROFITS AND PERCENTAGES TO PREMIUMS EARNED FOR BUSINESS NET OF REINSURANCE
(\$'000 OMITTED)

	Premiums Written (Pg. 8, Pt. 1B, Col. 6)		Premiums Earned (Pg. 6, Pt. 1, Col. 4)		Dividends to Policyholders (Pg. 4, Line 17)		Incurred Loss (Pg. 9, Pt. 2, Col. 7)		Loss Adjustment Expense			Unpaid Losses (Pg. 10, Pt. 2A, Col. 8)			Loss Adjustment Expense			Unearned Premium Reserves (Pg. 7, Pt. 1A, Col. 5)		Agents' Balances			
	1 Amount	2 %	3 Amount	4 %	5 Amount	6 %	7 Amount	8 %	9 Amount	10 %	11 Amount	12 %	13 Amount	14 %	15 Amount	16 %	17 Amount	18 %	19 Amount	20 %	21 Amount	22 %	
1. Fire	XXX			100.0																			
2.1 Allied Lines	XXX			100.0																			
2.2 Multiple Peril Crp	XXX			100.0																			
2.3 Private Crop	XXX			100.0																			
2.4 Private Flood	XXX			100.0																			
2.5 Private Flood	XXX			100.0																			
3. Farmowners Multiple Peril	XXX			100.0																			
4. Homeowners Multiple Peril	XXX			100.0																			
5. Comm Multi Peril (Lab)	XXX			100.0																			
5.2 Comm Multi Peril (Lab)	XXX			100.0																			
6. Mortgage Guaranty	XXX			100.0																			
8. Ocean Marine	XXX			100.0																			
9. Inland Marine	XXX			100.0																			
10. Pet Insurance Plans	XXX			100.0																			
10.2 Pet Insurance Plans	XXX			100.0																			
11.1 Med Prof Lib—Occurrence	XXX			100.0																			
11.2 Med Prof Lib—Claims-Made	XXX			100.0																			
12. Earthquakes	XXX			100.0																			
13.1 Comprehensive Individual	XXX			100.0																			
13.2 Comprehensive Group	XXX			100.0																			
14. Credit A&H	XXX			100.0																			
15.1 Vision Only	XXX			100.0																			
15.2 Dental Only	XXX			100.0																			
15.3 Disability Income	XXX			100.0																			
15.4 Life	XXX			100.0																			
15.5 Medical Title XIX	XXX			100.0																			
15.6 Medicare Title XVIII	XXX			100.0																			
15.7 Long-Term Care	XXX			100.0																			
15.8 FEHBP	XXX			100.0																			
15.9 Other Health	XXX			100.0																			
16.1 Other Health	XXX			100.0																			
17.1 Other Liability—Occurrence	XXX			100.0																			
17.2 Other Liability—Claims-Made	XXX			100.0																			
17.3 Excess Workers' Compensation	XXX			100.0																			
18.1 Products Lib—Occurrence	XXX			100.0																			
18.2 Products Lib—Claims-Made	XXX			100.0																			
19.1 Private Passenger Auto No-Fault	XXX			100.0																			
19.2 Other Priv Passenger Auto Lib	XXX			100.0																			
19.3 Commercial Auto No-Fault	XXX			100.0																			
19.4 Other Commercial Auto Liability	XXX			100.0																			
20.1 Private Passenger Auto No-Fault	XXX			100.0																			
21.2 Commercial Auto No-Fault	XXX			100.0																			
22. Aircraft (all perils)	XXX			100.0																			
23. Fidelity	XXX			100.0																			
24. Surety	XXX			100.0																			
26. Burglary and Theft	XXX			100.0																			
27. Marine and Machinery	XXX			100.0																			
28. Credit	XXX			100.0																			
29. International	XXX			100.0																			
30. Warranty	XXX			100.0																			
31. Reins-Nonproportional Assumed Property	XXX			100.0																			
32. Reins-Nonproportional Assumed Property	XXX			100.0																			
33. Reins-Nonproportional Assumed Fire Lines	XXX			100.0																			
34. A&P White-Ins for Other Lines of Bus.	XXX			100.0																			
35. TOTAL (Lines 1 through 34)	XXX			100.0																			
DETAILS OF WRITINGS																							
3401.	XXX			100.0																			
3402.	XXX			100.0																			
3403.	XXX			100.0																			
3408. Summary of remaining writings for Line																							
3499. TOTAL (Lines 3401 through 3403 plus	XXX			100.0																			
3498 (Line 34 above)																							

INSURANCE EXPENSE EXHIBIT
PART II—ALLOCATION TO LINES OF BUSINESS NET OF REINSURANCE (Continued)
PREMIUMS, LOSSES, EXPENSES, RESERVES AND PROFITS AND PERCENTAGES TO PREMIUMS EARNED FOR BUSINESS NET OF REINSURANCE
(\$'000 OMITTED)

	Other Underwriting Expenses										Pre-Tax Profit or Loss Excluding All Investment Gain	Investment Gain on Funds Attributable to Insurance Transactions	Profit or Loss Excluding Investment Gain Attributable to Capital and Surplus	Investment Gain Attributable to Capital and Surplus	Total Profit or Loss			
	Commission and Brokerage Expenses Incurred (IEE Pt. 1, Line 2.8, Col. 2)	Taxes, Licenses & Fees Incurred (IEE Pt. 1, Line 20.5, Col. 4)	Other Acquisitions, Field Supervision, and Collection Expenses Incurred (IEE Pt. 1, Line 25, Col. 3)	General Expenses Incurred (IEE Pt. 1, Line 25, Col. 3)	Other Income Less Other Expenses (Pg. 4, Line 15 minus Line 5)	31	32	33	34	35						36	37	38	39	40	41	42
1. Fire	Amount	%	Amount	%	Amount	%	Amount	%	Amount	%	Amount	%	Amount	%	Amount	%	Amount	%
2.1 Allied Lines
2.2 Multiple Peril Cop
2.3 Auto
2.4 Private Flood
2.5 Private Flood
3. Farmowners Multiple Peril
4. Homeowners Multiple Peril
5.1 Comm Multi Peril (Non-Lab)
5.2 Comm Multi Peril (Lab)
6. Mortgage Guaranty
8. Ocean Marine
9.1 Inland Marine
9.2 Pet Insurance Plans
10.1 Med Prof Lab—Occurrence
11.1 Med Prof Lab—Occurrence
11.2 Med Prof Lab—Claims-Made
12. Earthquake
13.1 Comprehensive Individual
13.2 Comprehensive Group
14. Vision
15.1 Vision Only
15.2 Dental Only
15.3 Disability Income
15.4 Medicare Supplement
15.5 Medicare Supplement
15.6 Medicare Title XVIII
15.7 Long Term Care
15.8 FEHBP
15.9 Other Health
16.1 Other Compensation
17.1 Other Liability—Occurrence
17.2 Other Liability—Claims-Made
17.3 Excess Workers' Compensation
18.1 Products Lib—Occurrence
18.2 Products Lib—Claims-Made
19.1 Other Priv Passenger Auto Lib
19.2 Commercial Auto No-Fault
19.3 Commercial Auto Lib
19.4 Other Commercial Auto Lib
21.1 Priv Passenger Auto Phys Damage
21.2 Commercial Auto Phys Damage
22. Aircraft (all risks)
23. Fidelity
24. Surety
26. Burglary and Theft
27. Boiler and Machinery
28. International
29. International
30. Warranty
31. Reins-Nonproportional Assumed Property
32. Reins-Nonproportional Assumed Liab
33. Agr Write-ins for Other Lines of Bus
34. Agr Write-ins for Other Lines of Bus
35. TOTAL (Lines 1 through 34)
DEFINITIONS OF WRITE-INS
3401.
3402.
3403.
3404. Summary of remaining write-ins for Line 34 from overflow page
3498. TOTAL (Lines 3401 through 3403 plus 3498) (Line 34 above)
3499. TOTAL (Lines 3401 through 3403 plus 3498) (Line 34 above)

NOTE: THE ALLOCATION OF INVESTMENT INCOME FROM CAPITAL AND SURPLUS BY LINE OF BUSINESS MAY NOT ACCURATELY REFLECT THE PROFITABILITY OF A PARTICULAR LINE FOR USE IN THE RATE MAKING PROCESS.

INSURANCE EXPENSE EXHIBIT
PART III – ALLOCATION TO LINES OF DIRECT BUSINESS WRITTEN
PREMIUMS, LOSSES, EXPENSES, RESERVES AND PROFITS AND PERCENTAGES TO PREMIUMS EARNED FOR DIRECT BUSINESS WRITTEN
(\$800 OMITTED)

	Premiums Written (Pg. 8, Pt. 1B, Col. 1)		Premiums Earned (Sch. T, Line 59, Col. 3)		Dividends to Policyholders		Incurred Loss (Sch. T, Line 59, Col. 6)		Loss Adjustment Expense Defense and Cost Containment Expenses Incurred			Loss Adjustment Expense Adjusting and Other Expenses Incurred			Unpaid Losses (Sch. T, Line 59, Col. 7)			Loss Adjustment Expense Defense and Cost Containment Expenses Unpaid			Unpaid Premium Reserves			Agents' Balances					
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	
	Amount	%	Amount	%	Amount	%	Amount	%	Amount	%	Amount	%	Amount	%	Amount	%	Amount	%	Amount	%	Amount	%	Amount	%	Amount	%	Amount	%	
1. Fire.....	XXX		100.0																										
2.1 Allied Lines.....	XXX		100.0																										
2.2 Multiple Peril Crop.....	XXX		100.0																										
2.3 Federal Flood.....	XXX		100.0																										
2.4 Private Flood.....	XXX		100.0																										
2.5 Private Fire.....	XXX		100.0																										
2.6 Farmowners Multiple Peril.....	XXX		100.0																										
3. Homeowners Multiple Peril.....	XXX		100.0																										
4.1 Comm Mutl Peril (Non-Liab).....	XXX		100.0																										
4.2 Comm Mutl Peril (Liab).....	XXX		100.0																										
5. Ocean Marine.....	XXX		100.0																										
6. Inland Marine.....	XXX		100.0																										
7. Pet Insurance Plans.....	XXX		100.0																										
8. Financial Guaranty.....	XXX		100.0																										
9. Life Insurance.....	XXX		100.0																										
10. Motor Vehicle Liability.....	XXX		100.0																										
11.2 Excess Workers' Compensation.....	XXX		100.0																										
12. Earthquake.....	XXX		100.0																										
13.1 Comprehensive Individual.....	XXX		100.0																										
13.2 Comprehensive Group.....	XXX		100.0																										
14. Credit & Surety.....	XXX		100.0																										
15.1 Denial Only.....	XXX		100.0																										
15.2 Disability Income.....	XXX		100.0																										
15.3 Medicare Supplement.....	XXX		100.0																										
15.4 Medicaid Title XX.....	XXX		100.0																										
15.5 Medicare Title XVIII.....	XXX		100.0																										
15.6 Long Term Care.....	XXX		100.0																										
15.7 FEHBP.....	XXX		100.0																										
15.8 Other Health.....	XXX		100.0																										
16. Workers' Compensation.....	XXX		100.0																										
17.1 Excess Workers' Compensation.....	XXX		100.0																										
17.2 Other Liability - Claims Made.....	XXX		100.0																										
17.3 Excess Workers' Compensation.....	XXX		100.0																										
18.1 Products Liab - Occurrence.....	XXX		100.0																										
18.2 Products Liab - Claims Made.....	XXX		100.0																										
19.1 Priv Passenger Auto No-Fault.....	XXX		100.0																										
19.2 Commercial Auto No-Fault.....	XXX		100.0																										
19.3 Commercial Auto No-Fault.....	XXX		100.0																										
19.4 Other Commercial Auto Liability.....	XXX		100.0																										
21.1 Priv Passenger Auto Phys Damage.....	XXX		100.0																										
21.2 Commercial Auto Phys Damage.....	XXX		100.0																										
22.1 Commercial Auto Phys Damage.....	XXX		100.0																										
23. Fidelity.....	XXX		100.0																										
24. Surety.....	XXX		100.0																										
26. Burglary and Theft.....	XXX		100.0																										
27. Boiler and Machinery.....	XXX		100.0																										
28. Credit.....	XXX		100.0																										
29. Financial.....	XXX		100.0																										
30. Warranty.....	XXX		100.0																										
31. Reins-Nonproportional Assumed Property.....	XXX		100.0																										
32. Reins-Nonproportional Assumed Liab.....	XXX		100.0																										
33. Reins-Nonproportional Assumed Ftn Lines.....	XXX		100.0																										
34. TOTAL (Lines 1 through 34).....	XXX		100.0																										
DEFINES OF WRITE-INS																													
3401.	XXX		100.0																										
3402.	XXX		100.0																										
3403.	XXX		100.0																										
3408. Summary of remaining write-ins for Line	XXX		100.0																										
3498.	XXX		100.0																										
3499. TOTAL (Lines 3401 through 3403) plus	XXX		100.0																										
3498.	XXX		100.0																										

INSURANCE EXPENSE EXHIBIT
PART III – ALLOCATION TO LINES OF DIRECT BUSINESS WRITTEN (Continued)
PREMIUMS, LOSSES, EXPENSES, RESERVES AND PERCENTAGES TO PREMIUMS EARNED FOR DIRECT BUSINESS WRITTEN
(\$'000 OMITTED)

	Other Underwriting Expenses										Pre-Tax Profit or Loss Excluding All Investment	
	Commission and Brokerage Expenses Incurred		Taxes, Licenses & Fees Incurred		Other Acquisitions, Field Supervision, and Collection Expenses Incurred		General Expenses Incurred		Other Income Less Other Expenses		Pre-Tax Profit or Loss Excluding All Investment	
	23 Amount	24 %	25 Amount	26 %	27 Amount	28 %	29 Amount	30 %	31 Amount	32 %	33 Amount	34 %
1. Fire.....												
2.1 Allied Lines.....												
2.2 Multiple Peril Crop.....												
2.3 Multiple Peril Non-Crop.....												
2.4 Flood.....												
2.5 Private Flood.....												
2.6 Multiple Peril Non-Crop.....												
3. Farmowners Multiple Peril.....												
4. Homeowners Multiple Peril.....												
5.1 Comm Multi Peril (Non-Liab).....												
5.2 Comm Multi Peril (Liab).....												
6. Mortgage Guaranty.....												
7. Multiple Peril Non-Crop.....												
8. Ocean Marine.....												
9.1 Inland Marine.....												
9.2 Pet Insurance Plans.....												
10. Multiple Peril Non-Crop.....												
11. Multiple Peril Non-Crop.....												
11.1 Multiple Peril Non-Crop.....												
11.2 Multiple Peril Non-Crop.....												
12. Earthquake.....												
13.1 Comprehensive Individual.....												
13.2 Comprehensive Group.....												
14.1 Comprehensive Individual.....												
14.2 Comprehensive Group.....												
15.1 Vision Only.....												
15.2 Dental Only.....												
15.3 Disability Income.....												
15.4 Medicare Supplement.....												
15.5 Medicare Supplement.....												
15.6 Medicare Supplement.....												
15.7 Long-Term Care.....												
15.8 FEHBP.....												
15.9 Other Health.....												
16. Workers' Compensation.....												
17.1 Workers' Compensation.....												
17.2 Other Liability—Claims Made.....												
17.3 Excess Workers' Compensation.....												
18.1 Products Liab—Occurrence.....												
18.2 Products Liab—Claims Made.....												
18.3 Products Liab—Occurrence.....												
19.1 Other Prio Passenger Auto Liab.....												
19.2 Other Prio Passenger Auto Liab.....												
19.3 Commercial Auto Non-Fault.....												
19.4. Other Commercial Auto Liability.....												
21.1 Prio Passenger Auto Phys Damage.....												
21.2 Commercial Auto Phys Damage.....												
22. Commercial Auto Phys Damage.....												
23. Fidelity.....												
24. Surety.....												
25. Surety.....												
26. Burglary and Theft.....												
27. Boiler and Machinery.....												
28. Boiler and Machinery.....												
29. International.....												
30. Warranty.....												
31. Reins-Nonproportional Assumed Property.....												
32. Reins-Nonproportional Assumed Liab.....												
33. Reins-Nonproportional Assumed Liab.....												
34. Assur Write-ups for Other Lines of Bus.....												
35. TOTAL (Lines 1 through 34)												
DETAILS OF WRITE-UPS												
3401.....												
3402.....												
3403.....												
3408.....												
3499.....												

Summary of remaining write-ups for Line 34 from overflow page 3499. TOTAL (Lines 3401 through 3405 plus 3499) (Line 34 above)

SCHEDULE P – PART 1U – PET INSURANCE PLANS
(\$000 OMITTED)

Years in Which Premiums Were Earned and Losses Were Incurred	Premiums Earned			Loss and Loss Expense Payments						12 Number of Claims Reported Direct and Assumed		
	1 Direct and Assumed	2 Ceded	3 Net (Cols. 1 – 2)	Loss Payments		Defense and Cost Containment Payments		Adjusting and Other Payments			10 Salvage and Subrogation Received	11 Total Net Paid (Cols. 4 - 5 + 6 - 7 + 8 - 9)
				4 Direct and Assumed	5 Ceded	6 Direct and Assumed	7 Ceded	8 Direct and Assumed	9 Ceded			
1. Prior	XXX	XXX	XXX	.....	.....	.....	.....	.....	.....	.....	.....	XXX
2. 2023 .....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	XXX
3. 2024 .....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	XXX
4. Totals	XXX	XXX	XXX									XXX

	Losses Unpaid				Defense and Cost Containment Unpaid				Adjusting and Other Unpaid		23 Salvage and Subrogation Anticipated	24 Total Net Losses and Expenses Unpaid	25 Number of Claims Outstanding Direct and Assumed
	Case Basis		Bulk + IBNR		Case Basis		Bulk + IBNR		21 Direct and Assumed	22 Ceded			
	13 Direct and Assumed	14 Ceded	15 Direct and Assumed	16 Ceded	17 Direct and Assumed	18 Ceded	19 Direct and Assumed	20 Ceded					
1.
2.
3.
4.

	Total Losses and Loss Expenses Incurred			Loss and Loss Expense Percentage (Incurred/Premiums Earned)			Nontabular Discount		34 Inter-Company Pooling Participation Percentage	Net Balance Sheet Reserves After Discount	
	26 Direct and Assumed	27 Ceded	28 Net	29 Direct and Assumed	30 Ceded	31 Net	32 Loss	33 Loss Expense		35 Losses Unpaid	36 Loss Expenses Unpaid
1.	XXX	XXX	XXX	XXX	XXX	XXX	.....	.....	XXX	.....	.....
2. ....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
3. ....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
4.	XXX	XXX	XXX	XXX	XXX	XXX			XXX		



Detail Eliminated to Conserve Space


SCHEDULE P – PART 2U – PET INSURANCE PLANS

Years in Which Losses Were Incurred	INCURRED NET LOSSES AND DEFENSE AND COST CONTAINMENT EXPENSES REPORTED AT YEAR-END (\$000 OMITTED)										DEVELOPMENT	
	1 2015	2 2016	3 2017	4 2018	5 2019	6 2020	7 2021	8 2022	9 2023	10 2024	11 One Year	12 Two Year
1. Prior	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	.....	.....
2. 2023	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	.....	XXX
3. 2024	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	.....	XXX
4. Totals												

SCHEDULE P – PART 3U – PET INSURANCE PLANS

Years in Which Losses Were Incurred	CUMULATIVE PAID NET LOSSES AND DEFENSE AND COST CONTAINMENT EXPENSES REPORTED AT YEAR-END (\$000 OMITTED)										11 Number of Claims Closed With Loss Payment	12 Number of Claims Closed Without Loss Payment
	1 2015	2 2016	3 2017	4 2018	5 2019	6 2020	7 2021	8 2022	9 2023	10 2024		
1. Prior.....	XXX	XXX	XXX	XXX	XXX	XXX	XXX	000	.....	.....	XXX	XXX
2. 2023.....	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	.....	.....	XXX	XXX
3. 2024.....	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	.....	XXX	XXX


Detail Eliminated to Conserve Space

SCHEDULE P – PART 4U – PET INSURANCE PLANS

Years in Which Losses Were Incurred	BULK AND IBNR RESERVES ON NET LOSSES AND DEFENSE AND COST CONTAINMENT EXPENSES REPORTED AT YEAR-END (\$000 OMITTED)									
	1 2015	2 2016	3 2017	4 2018	5 2019	6 2020	7 2021	8 2022	9 2023	10 2024
1. Prior.....	XXX	XXX	XXX	XXX	XXX	XXX	XXX	.....	.....	.....
2. 2023.....	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	.....	.....
3. 2024.....	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	.....

W:\QA\BlanksProposals\2023-01BWG.docx



MEMORANDUM

TO: Pat Gosselin (NH), Chair of the Blanks (E) Working Group

FROM: Tom Botsko (OH), Chair of the Property and Casualty Risk-Based Capital (E) Working Group

DATE: April 24, 2023

RE: Request for Deferral of Adoption of Blanks Proposal 2023-01BWG

Thank you for the opportunity to provide feedback on the blanks proposal 2023-01BWG.

We suggest that this proposal be delayed for at least one year. This will allow us to collect industry information through other means. Collecting industry data through the Supplemental Data option is one alternative. This information is also provided on March 1 with the annual statement submittal, and it provides industry information for analysis.

Please keep in mind that cyber is also a significantly growing line of business and has not been added to the annual statement but is currently using the Supplemental Data option.

Another option would be to use an Interrogatory for this data. This data will be available on March 1, along with the other annual statement information. The data provided under the Interrogatory is accessible through the annual statement databases.

While pet insurance seems to have grown significantly in the past few years, no data has been shared to evaluate this specific line of business. The data will provide valuable insight and potential support for separating this product.

In addition, it appears there are only a few carriers that write this line of business. At this time, it is not clear if this supports adding an additional line of business, which may be costly to the industry.

If industry data is available, it would be helpful to share this information to better understand the significance of this line and determine if the data supports the separation of this line of business.

One additional recommendation is removing the word "insurance" from the added line. No other lines of business include the word "insurance" in their description.

Thank you for the opportunity to provide input to this exposure. We are happy to discuss this with you and the Working Group at your convenience.

Washington, DC 444 North Capitol Street NW, Suite 700, Washington, DC 20001-1509

p | 202 471 3990

Kansas City 1100 Walnut Street, Suite 1500, Kansas City, MO 64106-2197

p | 816 842 3600

New York One New York Plaza, Suite 4210, New York, NY 10004

p | 212 398 9000

www.naic.org

If you have any questions regarding this request, please contact Eva K. Yeung at eyeung@naic.org.

cc: Mary K. Caswell, Kris DeFrain, Eva K. Yeung

NAIC BLANKS (E) WORKING GROUP

Blanks Agenda Item Submission Form

<p style="text-align: right;">DATE: <u>08/19/2022</u></p> <p>CONTACT PERSON: _____</p> <p>TELEPHONE: _____</p> <p>EMAIL ADDRESS: _____</p> <p>ON BEHALF OF: _____</p> <p>NAME: <u>Debbie Doggett</u></p> <p>TITLE: _____</p> <p>AFFILIATION: <u>Missouri Department of Insurance</u></p> <p>ADDRESS: <u>301 W High St #630</u> <u>Jefferson City, MO 65101</u></p>	<p style="text-align: center;">FOR NAIC USE ONLY</p> <p>Agenda Item # <u>2022-15BWG</u></p> <p>Year <u>2023</u></p> <p>Changes to Existing Reporting <input checked="" type="checkbox"/> [X]</p> <p>New Reporting Requirement <input type="checkbox"/> []</p> <hr/> <p style="text-align: center;">REVIEWED FOR ACCOUNTING PRACTICES AND PROCEDURES IMPACT</p> <p>No Impact <input checked="" type="checkbox"/> [X]</p> <p>Modifies Required Disclosure <input type="checkbox"/> []</p> <hr/> <p style="text-align: center;">DISPOSITION</p> <p><input type="checkbox"/> [] Rejected For Public Comment</p> <p><input type="checkbox"/> [] Referred To Another NAIC Group</p> <p><input checked="" type="checkbox"/> [X] Received For Public Comment</p> <p><input type="checkbox"/> [] Adopted Date _____</p> <p><input type="checkbox"/> [] Rejected Date _____</p> <p><input type="checkbox"/> [] Deferred Date _____</p> <p><input type="checkbox"/> [] Other (Specify) _____</p>
--	--

BLANK(S) TO WHICH PROPOSAL APPLIES

- | | | |
|---|--|---|
| <input checked="" type="checkbox"/> [X] ANNUAL STATEMENT | <input checked="" type="checkbox"/> [X] INSTRUCTIONS | <input checked="" type="checkbox"/> [X] CROSSCHECKS |
| <input type="checkbox"/> [] QUARTERLY STATEMENT | <input type="checkbox"/> [] BLANK | |
| <input checked="" type="checkbox"/> [X] Life, Accident & Health/Fraternal | <input type="checkbox"/> [] Separate Accounts | <input type="checkbox"/> [] Title |
| <input checked="" type="checkbox"/> [X] Property/Casualty | <input type="checkbox"/> [] Protected Cell | <input type="checkbox"/> [] Other _____ |
| <input type="checkbox"/> [] Health | <input type="checkbox"/> [] Health (Life Supplement) | |

Anticipated Effective Date: Annual 2023

IDENTIFICATION OF ITEM(S) TO CHANGE

Revise the language of the Schedule H, Part 5 to remove the 5% of premiums filing exemption (FE).

REASON, JUSTIFICATION FOR AND/OR BENEFIT OF CHANGE**

The purpose of the proposal is to remove the 5% of premium filing exemption on the Schedule H, Part 5. Before Schedule H was updated for Annual 2022 to bring uniformity in the accident and health lines of business, the Property/Casualty instructions for Schedule H, Part 5 had the less than 5% filing exemption and the Life/Fraternal instructions did not have the 5% filing exemption. The removal of the 5% exemption would require both Property/Casualty and Life/Fraternal filers to file the Schedule H, Part 5.

NAIC STAFF COMMENTS

Comment on Effective Reporting Date: _____

Other Comments:

** This section must be completed on all forms.

Revised 7/18/2018

ANNUAL STATEMENT INSTRUCTIONS – LIFE\FRATERNAL AND PROPERTY

SCHEDULE H

ACCIDENT AND HEALTH EXHIBIT

↓
↑ ===== **Detail Eliminated to Conserve Space** ===== ↓
↑

PART 5 – HEALTH CLAIMS

A. DIRECT

Line 1 – Incurred Claims

Should agree with Line 3 plus Line 4 minus Line 2.

↓
↑ ===== **Detail Eliminated to Conserve Space** ===== ↓
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Draft: 8/10/23

Catastrophe Risk (E) Subgroup
Virtual Meeting
July 18, 2023

The Catastrophe Risk (E) Subgroup of the Property and Casualty Risk-Based Capital (E) Working Group of the Capital Adequacy (E) Task Force met July 18, 2023. The following Subgroup members participated: Wanchin Chou, Chair, Jack Broccoli, and Amy Waldhauer (CT); Jane Nelson, Vice Chair (FL); Rolf Kaumann and Mitchell Bronson (CO); Kevin Clark (IA); Judy Mottar (IL); Sandra Darby (ME); Anna Krylova (NM); HauMichael Ying (NY); Tom Botsko (OH); and Miriam Fisk, Rebecca Armon, and Monica Avila (TX). Also participating were: Elizabeth Perri (AS); Mitra Sanandajifar, Lynne Wehmueller, and Giovanni Muzzarelli (CA); Julie Lederer and Danielle Smith (MO); Jesse Kolodin (NJ); Liz Ammerman and Elizabeth Kelleher Dwyer (RI); and Darcy Paskey and Jody Ullman (WI).

1. Adopted its Spring National Meeting Minutes

Darby made a motion, seconded by Botsko, to adopt the Subgroup's March 22 minutes (*see NAIC Proceedings – Spring 2023, Capital Adequacy (E) Task Force, Attachment Five-A*). The motion passed unanimously.

2. Discussed its Working Agenda

Chou summarized the changes to the Subgroup's 2023 working agenda, which included the following changes in item P1: 1) update the Sept. 26 comment from conducting the review on different convective storm models to conduct a review on severe convective storm models; and 2) add an additional comment of "the SG is finishing reviewing the following SCS vendor models: RMS, Verisk, KCC and CoreLogic" in the comment section. He said the working agenda will be forwarded to the Property and Casualty Risk-Based Capital (E) Working Group for consideration.

3. Received an Update from its Catastrophe Model Technical Review Ad Hoc Group

Chou said the Catastrophe Model Technical Review Ad Hoc Group had three separate meetings with three different modelers—Karen Clarke & Company (KCC), Risk Management Solutions (RMS), and Verisk—to discuss the technical questions after the Spring National Meeting. He also said the Ad Hoc Group will schedule one for CoreLogic shortly after the Summer National Meeting. Jason Butke (Travelers) said the Ad Hoc Group submitted a list of technical questions to the three modeling companies, which covered hazard, vulnerability, and financial model components. He also stated that the modeling companies have been engaged in discussions and helpful in understanding the models. Chou said the goal of this reviewing process is to gain a better understanding of each vendor model to determine whether each model's results are in a reasonable range.

4. Discussed Wildfire Peril Impact Analysis

Chou said as discussed at the Spring National Meeting, the Subgroup members are required to sign nondisclosure agreements (NDAs) with the vendor modeling companies to ease the catastrophe modelers' concerns regarding their proprietary information while evaluating the impacts and determining the appropriate risk-based capital (RBC) catastrophe risk charge for wildfire peril. He stated that five state members have submitted responses so far. He encouraged the rest of the state members to submit their responses to NAIC staff by the end of July so the Subgroup can start the discussion soon.

5. Heard a Presentation from Verisk on a Severe Convective Storms Model Update and Technical Review

Julia Borman (Verisk) said this presentation (Attachment Five-C1) provides a more in-depth technical presentation to the Subgroup, which includes the following items: 1) an introduction to Verisk extreme event solutions and catastrophe modeling; and 2) approaching severe conductive storm risk with the Verisk severe thunderstorm model for the U.S. Chou said he appreciates that Verisk presented twice to the Subgroup to provide a better understanding on its model. He encouraged all the interested parties to review the materials and provide feedback to the Subgroup during its next meeting.

6. Discussed the Flood Insurance Market

Shana Oppenheim (NAIC) provided a brief update on the National Flood Insurance Program (NFIP) (Attachment Five-C2), which includes the following topics: 1) a brief overview of the NFIP review; 2) inaccurate flood maps causing disparity in NFIP payments; and 3) what is floating around the U.S. Congress (Congress).

Nancy Watkins (Milliman) provided a presentation on the U.S. private flood market (Attachment Five-C3), which includes the following items: 1) the market is underserved; 2) a shift in the market; and 3) private flood market dynamics.

Chou expressed appreciation to the presenters for speaking to the Subgroup. He said he believes the presentation will provide some ideas to the Subgroup to determine the possibility of adding Flood into the catastrophe risk component.

Having no further business, the Catastrophe Risk (E) Subgroup adjourned.

SharePoint/NAIC Support Staff Hub/Member Meetings/Summer 2023 National Meeting/Task Forces/CapAdequacy/Cat Risk SG/07-18propertycatsg.docx



The Verisk Severe Thunderstorm Model for the United States

Dr. Julia Borman

July 18, 2023

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Introduction to Verisk Extreme Event Solutions and Catastrophe Modeling

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A Brief History

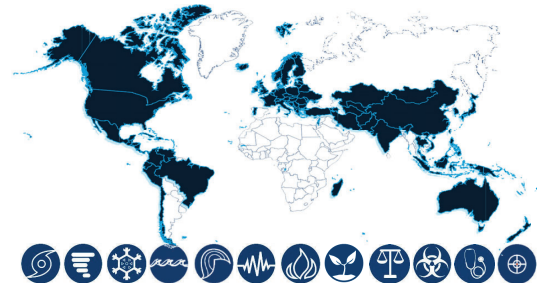
- Founded the catastrophe modeling industry in 1987
- Scientific leader of risk modeling software and consulting services
- Locations in Boston, Halifax, London, Munich, Beijing, Tokyo, Singapore, and Hyderabad
- Grown to serve more than 400 clients in a wide range of industries, including insurance, reinsurance, finance, corporate, and government

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Formerly known as AIR Worldwide

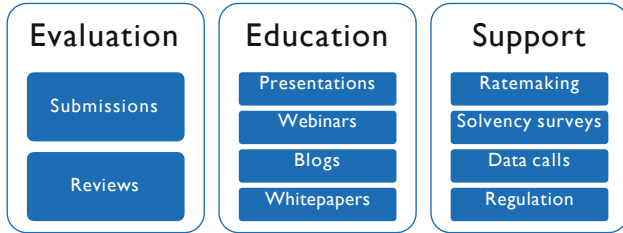
Extreme Event Models in 110+ Countries



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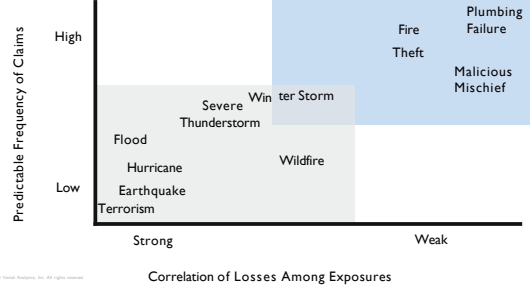


Regulatory Client Services Team



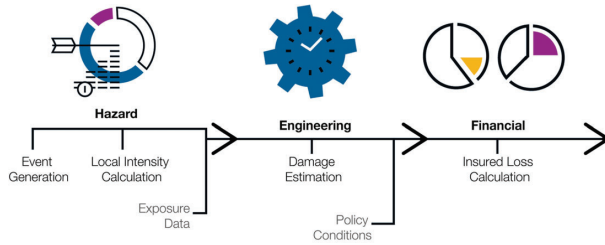
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Traditional Methods of Estimating Loss Ineffective for Catastrophe Risk Management



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Extreme Event Modeling Framework



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Touchstone Software – Inputs, Models, Outputs



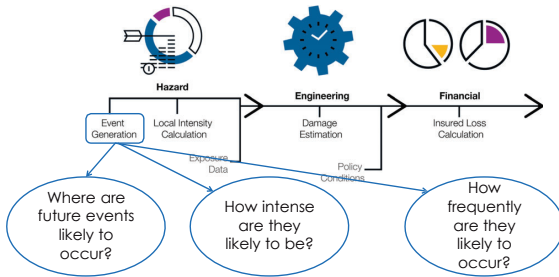
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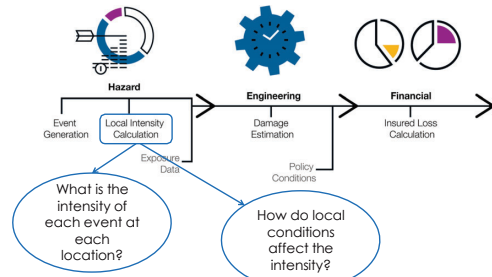
- Modeled Perils:
 - Straight-line wind
 - Hail
 - Tornado
- Model Domain:
 - Contiguous United States
- Model Resolution:
 - 90-meter



Hazard Module: Event Generation



Hazard Module: Intensity Calculation



Data is a Key Component of the Model

Observation Data Sets

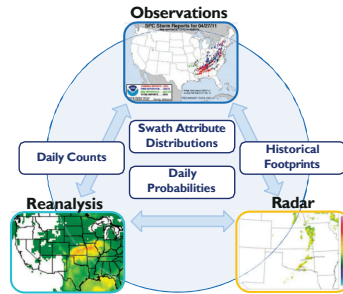
- Storm Prediction Center (SPC) – 40 years
- Community Collaborative Rain, Hail and Snow Network (CoCoRaHS) – 21 years
- Severe Hazards Analysis and Verification Experiment (SHAVE) – 10 years
- Insurance Institute for Business and Home Safety (IBHS)

Reanalysis Data Sets

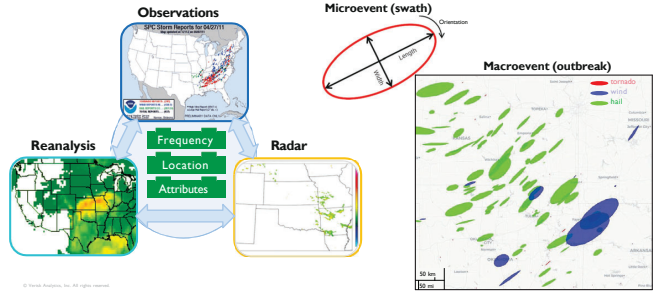
- Climate Forecast System Reanalysis (CFSR) – 40 years

Radar Data Sets

- 20 years of continuous data
- Verisk's Respond® data

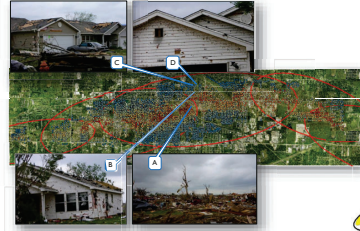


Complementary Data Sources Inform All Hazard Components

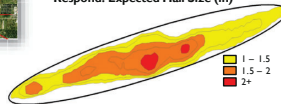


Realistic Hazard Models Are Necessary to Study Impacts of Vulnerability and Mitigation

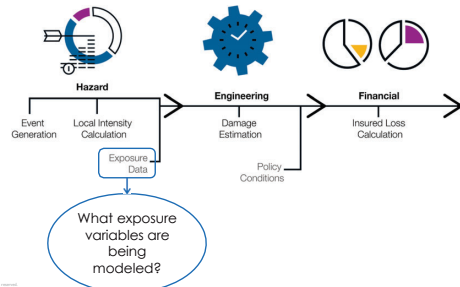
Tornado Damage Analyzed by TTU and Verisk



Respond: Expected Hail Size (in)

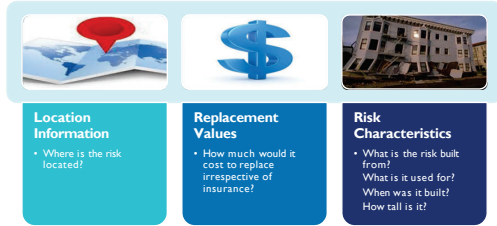


Hazard Module: Exposure Data Input



How does the User Define their Exposure Data?

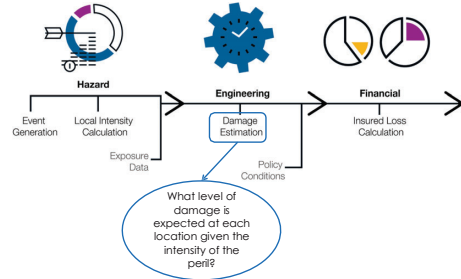
Primary Features: Construction, Occupancy, Height, Year Built, Gross Area



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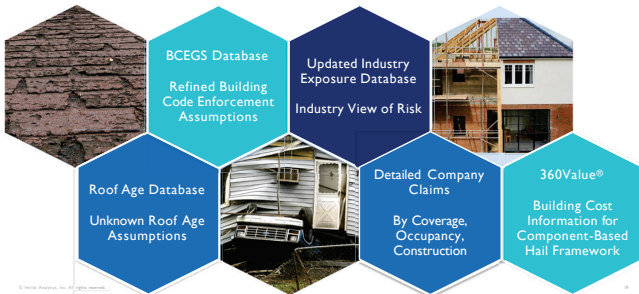
Engineering Module: Damage Estimation



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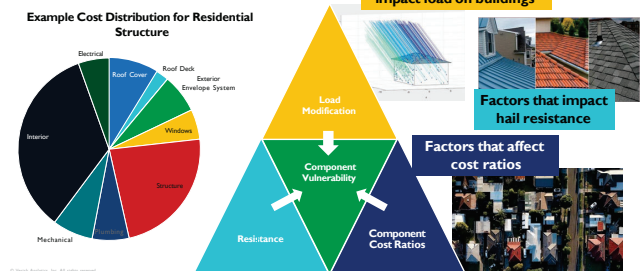
Engineering-Based Data Set Summary



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Necessary to Appropriately Consider Vulnerability of Individual Components



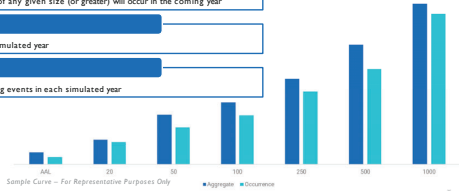
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Key Model Outputs for Risk Assessment



- Average Annual Loss (AAL)**
 - The loss that can be expected to occur per year, on average, over a period of many years
- Exceedance Probability (EP)**
 - The likelihood that a loss of any given size (or greater) will occur in the coming year
- Occurrence Loss**
 - The largest loss in each simulated year
- Aggregate Loss**
 - The sum of all loss-causing events in each simulated year



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Thank you!
RegulatorySupport@aii-worldwide.com

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National Flood Insurance Program Update

**NAIC Property and Casualty Risk-Based Capital (E) Working Group
Catastrophe Risk (E) Subgroup**


Shana Oppenheim, Sr. Financial Services
Policy and Legislative Advisor

August 23, 2023

NAIC NATIONAL ASSOCIATION OF
INSURANCE COMMISSIONERS


NAIC GOVERNMENT AFFAIRS

NFIP Review




25 short-term reauthorizations since 2017


Last five-year renewal expired



FEMA Risk Rating 2.0



Deadline September 30, 2023




Conflict between:


- Shoring up NFIP finances
- Ensuring rates better match risk
- Avoiding premium spikes that threaten the housing market


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NAIC GOVERNMENT AFFAIRS

On the Ground: Inaccurate Flood Maps Causing Disparity in NFIP Payments?

 Florida and Kentucky Hurricanes 2022

 Average NFIP payment to **Florida** households from September 2022 Hurricane Ian - **\$91,000**

 Average NFIP payment to **Kentucky's** July 2022 storm - **\$49,000**

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What's Floating Around Congress?

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Bipartisan & Bicameral National Flood Insurance Program Reauthorization (NFIP-RE) Act of 2023

- Reauthorize NFIP for five-years and impose changes:
- Cap annual premium increase at 7% (down from 18%)
- Provide funding for mitigation
- Freeze interest payments on NFIP debt
- Offer means-tested vouchers to boost flood insurance affordability for low- and middle-income homeowners and renters
- Create oversight measures targeting "write-your-own" insurance companies that handle NFIP policies and revamp the claims process

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8/23/2023 5

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Other Bills (1 of 2)

- Senate:**
- National Flood Insurance Program Consultant Accountability Act of 2023 (S. 1039)
 - Risk Rating 2.0 Transparency Act (S. 602)
 - Flood Insurance Affordability Act (S. 601)
 - Repeatedly Flooded Communities Preparation Act (S. 1417)
 - Homeowner Flood Insurance Transparency and Protection Act (S. 721)

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8/23/2023 6

NAIC GOVERNMENT AFFAIRS

Other Bills (2 of 2)

- House:**
- National Flood Insurance Program Affordability Act (H.R. 1540)
 - FAIRNESS in Flood Insurance Act of 2023 (H.R. 634)
 - National Flood Insurance Program Extension Act of 2023 (H.R. 1392)
 - Amend the NFIP to Allow for Consideration of Flood Insurance for the Purposes of Applying Continuous Coverage Requirement (H.R. 900)
 - Require Use of Replacement Cost Value in Determining Premium Rates for Flood Insurance Coverage Under the NFIP (H.R. 1309)
 - Community Mapping Act (H.R. 1308)

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Reading the Tea Leaves

House Financial Services *might* vote in July on a National Flood Insurance Program extension that would decouple the NFIP from its recent cycle of being attached to government funding legislation

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Questions

Shana Oppenheim
soppenheim@naic.org



U.S. private flood market

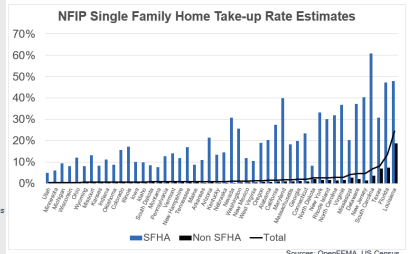
NAIC Property and Casualty Risk-Based Capital (E) Working Group Catastrophe Risk (E) Subgroup

July 18, 2023

Nancy Watkins, FCAS, MAAA
Principal & Consulting Actuary, Milliman

The U.S. flood insurance market is underserved

- Estimated 4% of SFHs have flood insurance in 2022 (Note 1)
- NFIP: \$3.5B total premium on 4.7M total policies as of March 2023 (Note 2)
- Private insurers reported \$1.29B in total Private Flood DWP in 2022 vs. \$1.03B in 2021 and \$715M in 2020 (Note 3)
- Potential U.S. residential flood insurance market between \$41B and \$52B of DWP (Note 4)
- 2022 HO DWP was \$132B (Note 3)

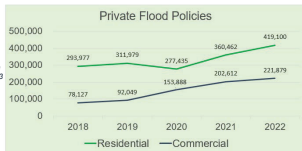


Milliman

A shift in the market



Sources:
NFIP: includes all policies (residential + non-residential)
From OpenFEMA through 2020 and <https://infocentre.floodsmart.gov/reports/flood-insurance-data>
All evaluations at end of year (12/31/00) except 2023 at 3/31/23
Private Flood: NAIC Annual Statement data via SNL



Milliman

Private flood market dynamics

- Reinsurance
- Florida developments
- Hurricane Ian
- Cat model approvals
- Citizens mandatory purchase
- Impact of rising flood risk on mortgage and real estate markets
- Strengthening flood risk disclosures



Milliman





Newsletter Items for Adoption for 2023 for Property and Casualty RBC:

Date: July 2023

Volume: 27.1

Page 1: Intro Section:

What Risk-Based Capital Pages Should Be Submitted?

For year-end 2023 property/casualty (P/C) risk-based capital (RBC), hard copies of pages PR001–PR035, as well as pages PR038 and PR039, should be submitted to any state that requests a hard copy. Beginning with year-end 2011 RBC, a hard copy was not required to be submitted to the NAIC, but a portable document format (PDF) file representing the hard copy filing is part of the electronic filing with the NAIC.

Page 1+: Items Adopted for 2023:

Underwriting Risk

Underwriting and Investment Exhibit – Premiums Written (PR035)

The Capital Adequacy (E) Task Force adopted proposal 2022-07-P to modify the lines of business categories in PR035 during its Dec. 14, 2022, meeting. The purpose of this proposal is to provide consistency in the granularity of the Property and Casualty Underwriting Investment Exhibit pages.

New Industry Average Risk Factors – Annual Update

Washington, DC 444 North Capitol Street NW, Suite 700, Washington, DC 20001-1509 p | 202 471 3990 f | 816 460 7493

Kansas City 1100 Walnut Street NW, Suite 1500, Kansas City, MO 64106-2197 p | 816 842 3600 f | 816 783 8175

New York One New York Plaza, Suite 4210, New York, NY 20004 p | 212 398 9000 f | 212 382 4207

www.naic.org

During its April 25 meeting, the Capital Adequacy (E) Task Force adopted the annual update of industry average development factors. However, the Property and Casualty Risk-Based Capital (E) Working Group noticed the incorrect calculation of the reserve factors of H/F, WC, and CMP lines of business after the Task Force's adoption. The Working Group re-exposed the following updated factors for seven days. No comments were received during the exposure period. The Task Force re-adopted the modified proposal during its June 30 meeting.

PR017 Underwriting Risk - Reserves				PR018 Underwriting Risk - Net Written Premiums			
Line (1), Industry Development Factors				Line (1), Industry Average Loss and Expense Ratios			
Col.	Line of Business	2023 Factor	2022 Factor	Col.	Line of Business	2021 Factor	2022 Factor
(1)	H/F	0.999	1.001	(1)*	H/F	0.679	0.665
(2)	PPA	1.047	1.022	(2)	PPA	0.791	0.793
(3)	CA	1.106	1.082	(3)	CA	0.777	0.761
(4)	WC	0.873	0.906	(4)	WC	0.651	0.664
(5)	CMP	1.026	1.037	(5)*	CMP	0.671	0.661
(6)	MPL Occurrence	0.906	0.887	(6)	MPL Occurrence	0.767	0.750
(7)	MPL Claims Made	0.984	0.983	(7)	MPL Claims Made	0.815	0.829
(8)	SL	0.994	0.990	(8)*	SL	0.578	0.585
(9)	OL	0.969	0.995	(9)	OL	0.641	0.637
(10)	Fidelity/Surety	0.852	0.842	(10)	Fidelity/Surety	0.363	0.366
(11)	Special Property	0.983	0.993	(11)*	Special Property	0.550	0.547
(12)	Auto Physical Damage	1.016	1.011	(12)	Auto Physical Damage	0.727	0.718
(13)	Other (Credit A&H)	0.946	0.955	(13)	Other (Credit A&H)	0.702	0.698
(14)	Financial/Mortgage Guaranty	0.674	0.694	(14)	Financial/Mortgage Guaranty	0.209	0.203
(15)	INTL	2.414	3.041	(15)*	INTL	1.136	1.166
(16)	REIN. P&F Lines	0.924	0.917	(16)*	REIN. P&F Lines	0.578	0.566
(17)	REIN. Liability	1.024	1.008	(17)*	REIN. Liability	0.743	0.725
(18)	PL	0.874	0.867	(18)	PL	0.597	0.601
(19)	Warranty	0.995	0.998	(19)	Warranty	0.652	0.665

* Cat Lines

Catastrophe Risk

Modification to the Instructions of Obtaining Permission to Use the Own Model

As a result of the adoption of proposal 2022-08-CR by the Capital Adequacy (E) Task Force during its Dec. 14, 2022, meeting, the revised instructions to: 1) capture the spirit of the own model permission review; and 2) clarify the requirements expected from the company who submits its own model for permission are included in the PR027 instructions.

Affiliated Investments

Modification to the Affiliated Investment Structure and Instructions

The Capital Adequacy (E) Task Force adopted proposal 2022-09-CA during its March 23 meeting to revise the instructions and structure of the Affiliated Investment pages (pages PR003-PR005) to provide consistent treatment of affiliated investments between the Health, Life, and Property/Casualty (P/C) RBC formulas. The Capital Adequacy (E) Task Force adopted proposal 2022-09-CA (MOD) during its June 30 call. The modified proposal clarified the examples provided for the Indirectly Owned Alien Insurance Affiliates/Subsidiaries section within the instructions and added a footnote for the “% Owned” column within the blank.

Accident and Health Business

Health Premiums (PR019) and Health Underwriting Risk (PR020) References

As a result of the adoption of proposal 2022-13-CA by the Capital Adequacy (E) Task Force during its March 23 meeting, the Health Premiums (PR19) and the Health Underwriting Risk (PR020) references in the instructions and structure will be updated to provide consistent categories used in the Annual Statement, Schedule H, Part 1.

Underwriting Risk Factors

The Capital Adequacy (E) Task Force adopted proposal 2022-16-CA during its June 30 meeting. This proposal updated the comprehensive medical, Medicare supplement, and dental and vision factors to include a 5% investment yield adjustment. The revised factors are:

	Comprehensive Medical	Medicare Supplement	Dental & Vision
\$0-\$3 Million	0.1434	0.0980	0.1148
\$3-\$25 Million	0.1434	0.0603	0.0711
Over \$25 Million	0.0838	0.0603	0.0711

Stop Loss Premiums

The Capital Adequacy (E) Task Force adopted proposal 2023-01-CA to clarify the instructions to provide clarity on reporting stop loss premiums in the RBC formula during its June 30 meeting.

Last Page: RBC Forecasting & Warning:

Risk-Based Capital Forecasting and Instructions

The P/C RBC forecasting spreadsheet calculates RBC using the same formula presented in the 2023 NAIC *Property & Casualty Risk-Based Capital Report Including Overview & Instructions for Companies*. The entire RBC publication, including the forecasting spreadsheet, can be downloaded from the [NAIC Account Manager](#) through the NAIC Publications Department. The User Guide is no longer included in the RBC publications.

WARNING: The RBC forecasting spreadsheet CANNOT be used to meet the year-end RBC electronic filing requirement. RBC filing software from an annual financial statement software vendor should be used to create the electronic filing. If the forecasting worksheet is sent instead of an electronic filing, it will not be accepted, and the RBC will not have been filed.

Last Page: 2023 National Association of Insurance Commissioners:

2023 NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

Property and Casualty Risk-Based Capital Newsletter Volume 27.1. Published annually or whenever needed by the NAIC for state insurance regulators, professionals, and consumers.

Direct correspondence to: Eva Yeung, RBC Newsletters, NAIC, 1100 Walnut Street, Suite 1500, Kansas City, MO 64106-2197. Phone: 816-783-8407. Email: eyeung@naic.org.

Address corrections requested. Please mail the old address label with the correction to: NAIC Publications Department, 1100 Walnut St., Suite 1500, Kansas City, MO 64106-2197. Phone: 816-783-8300. Email: prodserv@naic.org.

NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

Property and Casualty Risk-Based Capital Committee—Release of Recent Report

Ronald Wilkins, MAAA, FCAS
Vice Chairperson
Property and Casualty Risk-Based Capital Committee

Discussion of Report on Investment Income Adjustment Factors and Catastrophe-Adjusted Risk Factors

July 27, 2023

Topics Covered Today

- Background
- Summary of Results
- Adjustment for Catastrophe Risk



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Status of Final Report

- In the coming days, the American Academy of Actuaries will publish on its website a final report to this working group.
- The report is currently undergoing public policy review by the Academy.

Please refer to the final report for explanations of the methodology and implications of the analysis which produced the results presented here.

Key Topics Covered in Report

1. Summary of Results
 - And impacts to industry ACL
2. Interest Rates
 - Use of recent and historical U.S. Treasury rates
3. Payment Patterns
 - 40-year runoff payment pattern
 - Risk development horizon/40-year truncated payment pattern
4. Present Value Method
 - Discount historical datapoints by then-prevailing U.S. Treasury interest rates, which have declined across the experience period
5. Safety Level Calculations
 - These calculations are included to support potential future discussions and should not be used as the basis for increasing the safety margin
6. Adjustment for Catastrophe Risk Captured in Rcat



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Indicated Changes in Risk Charges by Line

(1)	Premium Risk			Reserve Risk		
	(2)	(3)	(4)	(5)	(6)	(7)
	Risk Charge	Risk Chg	Change in	Risk Charge	Risk Charge	In Risk
LOB	Current	Indicated	Current	Indicated	Chg	
AHD	0.152	0.185	3.0%	0.138	0.156	20.0%
BPPA	0.175	0.177	0.1%	0.094	0.129	37.2%
C-GA	0.185	0.201	9.1%	0.167	0.239	59.7%
D-ACC	0.138	0.126	-8.8%	0.116	0.082	-29.9%
E-CMP	0.148	0.160	8.7%	0.309	0.351	13.1%
F-EMPL-D	0.534	0.383	-28.0%	0.156	0.094	-39.1%
F-EMPL-C	0.189	0.244	28.4%	0.127	0.050	-60.5%
G-S	0.166	0.164	-1.1%	0.161	0.238	48.3%
H-DL	0.130	0.135	3.5%	0.304	0.293	-3.9%
I-PF	0.120	0.082	-31.5%	0.204	0.213	4.9%
J-APP	0.044	0.050	13.0%	0.127	0.112	-12.0%
K-F&Sur	0.272	0.105	-61.2%	0.289	0.440	52.4%
L-Other	0.142	0.143	1.2%	0.180	0.147	-18.2%
M-Int	0.516	0.504	-2.4%	0.188	0.352	85.8%
N-Re-Prop	0.312	0.162	-48.3%	0.275	0.204	-25.7%
O-Re-Liab	0.319	0.227	-28.7%	0.388	0.266	-31.3%
P-S	0.307	0.286	-6.9%	0.513	1.013	96.0%
S-F&MG	0.714	1.134	159.5%	0.092	0.050	-45.8%
T-Wrtry	0.030	0.215	617.5%	0.289	0.302	4.0%
Total/Avrg	0.135	0.133	-1.7%	0.261	0.262	0.3%

Indicated Changes in ACL by Type of Company

(1)	(2)	(3)	(4)	(5)	(6)
Row	Type of Company	ACL Value with 2019 Risk Charges (\$Billions)	Reserve Risk Charge	Premium Risk Charge	ACL
1	Commercial	64.9	4.8%	-4.5%	2.1%
2	Med Prof Liab	2.4	-52.2%	4.8%	-14.3%
3	NOC	0.9	21.3%	-17.6%	1.4%
4	Personal	84.3	12.4%	4.2%	1.6%
5	Reinsurance	8.2	-18.6%	-23.5%	-2.2%
6	Workers Comp	10.1	-9.7%	-2.9%	-4.8%
7	Total	170.6	3.4%	-0.8%	1.0%

Distribution of Number of Companies by Indicated Change in ACL Values

(1)	(2)	(3)
% Changes in ACL RBC	# companies	% companies
Less Than -50%	9	0%
-50% to -25%	96	5%
-25% to -15%	117	6%
-15% to -5%	194	11%
-5% to 5%	951	52%
5% to 15%	298	16%
15% to 25%	95	5%
25% to 50%	71	4%
Over 50%	6	0%
Total	1,837	100%

Key Topics Covered in Report

- Summary of Results
 - And impacts to industry ACL
- Interest Rates
 - Use of recent and historical U.S. Treasury rates
- Payment Patterns
 - 40-year runoff payment pattern
 - Risk development horizon/40-year truncated payment pattern
- Present Value Method
 - Discount historical datapoints by then-prevailing U.S. Treasury interest rates, which have declined across the experience period
- Safety Level Calculations
 - These calculations are included to support potential future discussions and should not be used as the basis for increasing the safety margin
- Adjustment for Catastrophe Risk Captured in Rcat

Premium Risk—Catastrophe Adjustments

(1) LOB	(2) Current Cat Adjustment	(3) Data		(4)	(5)	(6) Selected Cat Adjustment	(7) (3)+exp-100% 87.5th Total Risk Charge	(8) (6)/(7) Cat Adj As % of Risk Charge
		87.5th Total LR	87.5th Non Cat LR	(3)-(4) Indicated Cat Adjustment	(3)-(4) Indicated Cat Adjustment			
A-HO	2.8%	91.5%	88.9%	2.6%	2.6%	20.4%	12.7%	
E-CMP	1.8%	83.3%	81.7%	1.6%	1.6%	18.9%	8.6%	
G-SL	1.6%	96.0%	91.7%	4.3%	4.3%	29.8%	14.4%	
I-SP	1.6%	82.8%	79.4%	3.4%	3.4%	12.9%	26.3%	
J-APD	0.0%	84.8%	84.2%	0.6%	0.6%	8.0%	7.5%	
M-Intl	0.0%	192.1%	159.3%	32.8%	15.0%	136.0%	11.0%	
N-Re-Prop	6.9%	122.1%	96.2%	25.9%	25.9%	48.8%	53.0%	
O-Re-Liab	0.0%	100.5%	100.2%	0.4%	0.4%	27.2%	1.3%	
R-PL	0.0%	100.8%	100.6%	0.3%	0.0%	33.8%	0.0%	

Contact

- Rob Fischer—fischer@actuary.org

Draft: 8/22/23

Risk-Based Capital (RBC) Investment Risk and Evaluation (E) Working Group
Seattle, Washington
August 13, 2023

The RBC Investment Risk and Evaluation (E) Working Group of the Capital Adequacy (E) Task Force met Aug. 13, 2023. The following Working Group members participated: Philip Barlow, Chair (DC); Thomas Reedy (CA); Qing He (CT); Carolyn Morgan (FL); Carrie Mears and Kevin Clark (IA); Vincent Tsang (IL); Roy Eft (IN); Fred Andersen (MN); Debbie Doggett (MO); Lindsay Crawford (NE); Bob Kasinow (NY); Dale Bruggeman and Tom Botsko (OH); Jamie Walker (TX); David Smith and Greg Chew (VA); Steve Drutz (WA); and Amy Malm (WI). Also participating was: Mike Yanacheak (IA).

1. Adopted its June 14, May 17, April 20, and Spring National Meeting Minutes

Botsko made a motion, seconded by Drutz, to adopt the Working Group's June 14 (Attachment Six-A), May 17 (Attachment Six-B), April 20 (Attachment Six-C), and March 22 (*see NAIC Proceedings – Spring 2023, Capital Adequacy (E) Task Force, Attachment Six*) minutes. The motion passed unanimously.

2. Received Updates from the Valuation of Securities (E) Task Force and Statutory Accounting Principles (E) Working Group

Mears said the Valuation of Securities (E) Task Force was going to review progress on the work of a definition of a designation, and she talked about how the concept of how a designation works within the insurance regulatory process. In addition, it was going to discuss a proposal for the Securities Valuation Office (SVO) to have some discretion of individual ratings that come from credit rating providers (CRPs) and the ability to challenge those via a due process that has been laid out. The Task Force will also discuss the comment letters received and the next steps from there.

Bruggeman said the Statutory Accounting Principles (E) Working Group adopted the principle-based bond definition that would become effective Jan. 1, 2025. It also updated *Statement of Statutory Accounting Principles (SSAP) No. 26R—Bonds, SSAP No. 43R—Loan-Backed and Structured Securities*, and some of the references in other SSAPs for issuer credit obligations and asset-backed securities (ABS). The project included updating Schedule D1 for those that meet the bond definition, which was almost completed by the Blanks (E) Working Group. Along with exposing the project issue paper, the Statutory Accounting Principles (E) Working Group also exposed an update to *SSAP No. 21R—Other Admitted Assets* for debt-related securities that do not meet the definition. The exposure also included a new concept for the measurement method of residual tranches, in which they would initially be reported at cost, with all cashflows received reducing the reported value until the value reaches zero. Any additional cash flows received once the value is reduced to zero would be reported as income. The Statutory Accounting Principles (E) Working Group is going to sponsor the Blanks (E) Working Group's proposal to revise Schedule BA for ABS and debt-related securities that do not meet the definition. The Statutory Accounting Principles (E) Working Group plans to have separate reporting lines based on why it did not meet the definition under three categories. Part of the Schedule D1 break-up setup will make it easier for the RBC schedules to pull collateralized loan obligation (CLO) information directly from blanks.

3. Heard a Presentation from the Academy

Steve Smith (American Academy of Actuaries—Academy) presented principles for structured securities risk-based capital (RBC) (Attachment Six-D). There are two main sections of the presentation. The first section, which is on

asset modeling, covers how granular C-1 should be in terms of asset classes. Smith walked through the C-1 modeling flow chart. Mears asked how state insurance regulators should assess the information available in the designation if the rating itself is informative enough. Smith said it is interconnected with the second section of the presentation. It depends on what C-1 is specifically measuring. Barlow said he is not clear on whether ratings for corporate bonds mean the same thing for CLOs. Smith said the Academy does not believe a given rating in terms of the tail risk on a corporate bond means the same thing for a CLO. Yanacheak asked whether it is right to say a risk measure of the same percentile could have different meanings between two completely different asset types. Smith said he agrees with him on this.

For the second section of the presentation, Smith started off with defining terminologies, one of which being definitions of RBC arbitrage. According to Smith, there is a narrow-scope and a broad definition for RBC arbitrage. Smith then talked about seven candidate principles that would govern structured securities for RBC. He explained what these candidate principles are and how they work. Barlow made a comment on the first principle. He said it is worthwhile for the Working Group to consider how easy it is to adjust the RBC when considering the extent of precision with a particular component. Mears asked a question on the fifth principle. She asked whether there is a need to have a separate set of factors for CLOs compared to other ABS due to the active management incorporated into the CLO rating. Smith said it depends on the situation. In a filing-exempt (FE) world, no additional work would be needed for CLOs to satisfy this candidate principle. However, an awareness of this principle should be kept in modeling assets for CLOs individually. Clark asked a question on the last candidate principle. He asked whether the Academy asked state insurance regulators to provide feedback on whether the conditional tail expectation (CTE) would be a better measure or an endorsement of the CTE (90) versus CTE (96). Smith said that feedback is requested regarding whether the Working Group supports using different risk measures for different assets.

The Academy asked the Working Group to provide its feedback on these principles, based on which the Academy would work to produce a general framework around the principles.

4. Discussed its Next Steps

Barlow said the next step for the Working Group would be to have a follow-up call to get questions and comments from the state insurance regulators and interested parties on the principles presented. Then, the questions and comments will be exposed for a public comment period.

Having no further business, the RBC Investment Risk and Evaluation (E) Working Group adjourned.

SharePoint/NAIC Support Staff Hub/Committees/E CMTE/CADTF/2023-2-Summer/RBC Investment Risk 08-13-23 Minutes.docx

Draft: 8/9/23

Risk-Based Capital (RBC) Investment Risk and Evaluation (E) Working Group
Virtual Meeting
June 14, 2023

The RBC Investment Risk and Evaluation (E) Working Group of the Capital Adequacy (E) Task Force met June 14, 2023. The following Working Group members participated: Philip Barlow, Chair (DC); Thomas Reedy (CA); Wanchin Chou (CT); Ray Spudeck (FL); Carrie Mears and Kevin Clark (IA); Vincent Tsang (IL); Roy Eft (IN); Fred Andersen (MN); Debbie Doggett (MO); Lindsay Crawford (NE); Bob Kasinow and Bill Carmello (NY); Dale Bruggeman and Tom Botsko (OH); Rachel Hemphill and Jamie Walker (TX); Doug Stolte (VA); Steve Drutz and Tim Hays (WA); and Amy Malm (WI).

1. Discussed Comment Letters Received on Residual Factor and Sensitivity Test Factor

Clark presented the comment letter submitted by Iowa and Connecticut (Attachment Six-A1). He said there have been comments that there is more information supporting a 45% charge than a 30% charge. He said that, presumably, the support being referred to is the example of a broadly syndicated loan (BSL) collateralized loan obligation (CLO), which shows a two-thirds reduction in capital pre- and post-securitization. While it may be true that this serves as a data point supporting an increase in the charge for BSL CLOs, he said there is no evidence supporting this singular example being representative of all asset-backed securities (ABS) residuals. Clark said that based on the information available, it is believed that the population of ABS that are not BSL CLOs makes up a significant portion of the residual tranche population. It is not believed that they constitute outliers or merely 10% of the population. Clark said it is not believed that there is sufficient analysis to support an increase in RBC charge at this time. Iowa and Connecticut still believe that such an increase lacks sufficient supporting analysis. Therefore, unless the alternative proposal, which is to delay the implementation, includes a process or mechanism to consider further information that may be available prior to implementing an increase, they continue to not support an automatic increase.

Walker presented the comment that Texas submitted (Attachment Six-A2). She said she looked for a solution that would address the direction of the Financial Condition (E) Committee regarding an interim charge, something that acknowledges that the factor established for traditional equity investments did not anticipate residual tranche investments, which have a different risk profile, allows time for companies to address any investment changes needed in their asset mix and provides for the most efficient use of regulatory tools. She said changing the charge for year-end 2023 would be too disruptive to companies and may even result in companies divesting assets at suppressed prices because of the timing. She said they are trying to avoid that outcome in the deterioration of company surplus. However, leaving the charge at 30% until a final solution for all tranches is developed would not address the concerns raised by segments of the industry and some regulators. Therefore, she said a compromise is to align the residual tranche base charge with the current charge of 30% for 2023 and propose a 15% sensitivity rate for 2023 to get more information and understanding about the potential concentration on these types of investments for companies. Additionally, Walker proposed that the 2024 base charge be raised to 45% to get more certainty for future years. She said it would allow time for all parties to adjust and plan as if that charge will be in place. She said any action taken today needs to be qualified such that if the Working Group receives or develops information that indicates that a 45% charge is not appropriate for the segment of structured securities residual tranche investments, the Working Group commit to act on that information and set the appropriate charge as soon as practical.

Jeff Johnson (Global Atlantic Financial Group—Global Atlantic) presented Global Atlantic's comment letter (Attachment Six-A3). He said Global Atlantic supports the proposal made by Iowa and Connecticut for reasons

presented in their comment letter from May 12. Global Atlantic stands by the principles described in its letter, which are fundamental to developing charges and reflect equal capital for equal risk. Johnson said Global Financial's June 9 comment letter is focused on explaining why the proposed 45% percent factor should not apply to all residual tranches, and two examples are included to illustrate this point.

John Golden (Athene) presented Athene's comment letter (Attachment Six-A4). He said Athene's main concern is regarding the need for an overarching, consistent, reliable system, ensuring fairness across all asset classes. It recommends that the Working Group and the NAIC take a holistic approach, meaning they take a step back and review this workstream in the context of the broader NAIC framework for consistency. He said Athene is supportive of any further efforts to study any asset class, including residuals, in this context.

2. Adopted the Residual Tranche Base Factor and Sensitivity Test Factor

Andersen said that while Minnesota prefers a 45% charge for the residual tranche being implemented for year-end 2023, he said the Texas alternative could be considered a strong and practical approach. He made a motion to adopt the Texas proposal, which contains the 30% charge and an additional 15% sensitivity test for year-end 2023, which is to be replaced by the 45% charge applied beginning year 2024 with a consideration of positive or negative adjustments based on the additional information as mentioned by Walker and her oral and written comments. This motion was seconded by Walker.

Clark suggested that NAIC staff summarize the sensitivity data when it becomes available, which could be provided to the Financial Analysis (E) Working Group on an informational basis for their possible use. Bruggeman said he is pleased with the Texas commentary, and Ohio would support the motion as it stands now. Stolte expressed concern that they are out of step with other financial service regulators regarding the capital charge for this asset class.

A roll call vote was taken, and the motion passed unanimously.

Having no further business, the RBC Investment Risk and Evaluation (E) Working Group adjourned.

SharePoint/NAIC Support Staff Hub/Committees/E Committee/CADTF/2023-2-Summer/RBCIREWG/RBC Investment Risk 06-14-23
Minutes.docx

June 9, 2023

Mr. Philip Barlow, Chair
Risk-Based Capital Investment Risk and Evaluation Working Group
c/o Dave Fleming
1100 Walnut Street, Suite 1500
Kansas City, MO 64106-2107

Re: Residual Tranche Exposures

Dear Mr. Barlow:

The Connecticut Insurance Department (“CID”) and Iowa Insurance Division (“IID”) are jointly submitting this letter to supplement those comments discussed in our previous letters dated May 12, 2023. Both letters are attached as appendices for ease of reference and should be read together with this letter in order to understand the basis for our position. As a brief summary of the points made in our previous letters:

- Absent a material and pressing solvency concern requiring immediate action, changes in RBC factors should be supported by fulsome, data-driven analysis.
- Changes that lack such analysis may not be warranted and therefore risk unforeseen and unintended consequences.
- The reported level of insurer investment in residual tranches does not reflect a material and pressing solvency concern, either in the aggregate, or for individual insurers.
- The basis for the proposed factor is based on a singular example of a subset of the asset-backed security (“ABS”) population, though it is intended to apply broadly to the entire population. No analysis has been performed to assess whether this subset is representative of other types of ABS.
- There is an alternative option (“Alternative Interim Proposal”) that would fully address the noted concerns without the risk of unintended consequences, as described again at the end of this letter.

In addition to expressing our joint support for the Alternative Interim Proposal, we would also provide the following comments in regards to remarks made on the May 17, 2023 Working Group call:

- In response to concerns raised by several Working Group members around the lack of analytical support for a change in factor, a comment was made that “we have better support for the 45% than the 30%”. Presumably, the support being referred to is the example of a broadly-syndicated CLO (“BSL CLO”) which shows a 2/3 reduction in capital pre- and post- securitization.
- We would like to reiterate, to the extent that this example serves as adequate support for an increase in factor, **it only provides support for BSL CLOs**. No analysis has been done to determine whether it is reasonable to extrapolate this singular observation to all types of ABS, which the 45% factor is proposed to apply to.
- Likewise, the sole comment letter received in support of the 45% factor continued to focus on the same example showing the reduction in RBC for BSL CLOs pre- and post-securitization, noting non-CLO holdings as “outliers”.

- Another comment made was that RBC is always blunt and imperfect and that it should generally be assumed that factors are off by at least 10%.
- Based on the information we have, we believe that the population of ABS that are not BSL CLOs makes up a significant portion of the residual tranche population. We do not believe they constitute outliers or merely 10% of the population.

Alternative Interim Step

In order to address the regulatory concerns raised around residual tranches, without the risk of unintended consequences of a temporary increase in RBC charge, the CID and IID support the following alternative:

- Set the previously-adopted sensitivity disclosure factor for residual tranches to 15%. This added to the existing 30% charge will allow regulators the ability to easily observe companies' RBC position using a 45% factor.
- Request NAIC staff to generate a summary report that includes the RBC ratio pre- and post-sensitivity test, by company. This report can be provided to both the RBC IRE Working Group and Financial Analysis Working Group ("FAWG") for review in regulator-only session.
- Upon review of this report, FAWG can identify any individual companies that have higher concentration in residual tranches, and through coordination with the domiciliary state, request additional information from the insurer.
- This information could include, though is not limited to: 1) detail around the structure and underlying collateral, 2) summary of the insurer's risk management processes and how it determines its risk appetite for its asset allocation to residual tranches, and 3) detail around how the company models its residual tranches and the projected impact to the company's solvency in stress scenarios.
- Additionally, if upon review, the RBC IRE Working Group determines that the growth in holdings significantly alters the urgency of action, whether by organic growth or refinement to reporting guidance, it can revisit an interim step to increase the charge. The structure to accommodate such an increase has already been adopted.
- It is also possible that, at the time revisiting an interim charge may be warranted, work on the longer-term project will have provided better clarity around: 1) what the charge should be and 2) whether an increased charge should apply to all ABS residual tranches.
- To the extent that regulators desire more timely reporting of this data, semi-annual or quarterly supplemental filings could be requested to be confidentially submitted to FAWG for any companies where more frequent monitoring is desired.

The CID and IID believe the process described here would adequately address the regulatory concerns around investments in residual tranches while the longer-term, data-driven, analytical process plays out. It would avoid any potential for unforeseen and unintended consequences of adopting a change without the usual amount of supporting analysis.

Thank you for your consideration,

Wanchin W. Chou
Chief Insurance Actuary and Asst. Deputy Commissioner
Connecticut Insurance Department



Kevin Clark
Chief Accounting Specialist
Iowa Insurance Division

Carrie Mears
Chief Investment Specialist
Iowa Insurance Division



Cc: Andrew N. Mais, Insurance Commissioner, Connecticut Insurance Department
Doug Ommen, Insurance Commissioner, Iowa Insurance Division

Appendix

- 1) Letter dated May 12, 2023 – Connecticut Insurance Department
- 2) Letter dated May 12, 2023 – Iowa Insurance Division

May 12, 2023

Mr. Philip Barlow, Chair
RBC Investment Risk & Evaluation (E) Working Group
National Association of Insurance Commissioners
1100 Walnut Street, Suite 1500
Kansas City, MO 64106-2197

RE: Structured securities – Proposed 45% interim RBC factor for residual tranches

Dear Mr. Barlow,

I understand the concerns as a regulator that some companies are investing more in the residual tranches and the RBC factor has not reflected the risk charge properly yet for the residual tranches. However, on behalf of CID I would like to propose a delay in implementing the proposed 45% interim RBC factor for residual tranches for the following reasons:

1. Most of us actuaries agree that a more detailed analysis is needed to meet our professional standards in communication per ASOP 41.
2. We have not completed the cost and benefit analysis for the proposed 45% interim RBC factor for residual tranches to clearly define the impacts to some companies, and the benefits in regulation to avoid any unexpected capital risk if incurred.
3. With many uncertainties in the current high inflation high interest rate environment and with a small probability of potential recession in the market in 2023, we should avoid any potential disruptions to the market.
4. We have discussed with companies; some of them in favor of the 45% interim proposal but some against. Although they have different views, they mostly agreed that they could deliver a better study to support their arguments within a year.

CID appreciates your attention to the issues raised in this letter and looks forward to discussing with you further.

Best Regards,

Wanchin W. Chou, FCAS, MAAA, CPCU, CSPA, CCRMP
Chief Insurance Actuary and Asst. Deputy Commissioner
State of Connecticut Insurance Department
Office Phone: 860-297-3943
Cell: 860-488-4408

Cc: Commissioner Mais,
Deputy Commissioner Kosky,



STATE OF IOWA

KIM REYNOLDS
GOVERNORDOUG OMMEN
COMMISSIONER OF INSURANCEADAM GREGG
LT. GOVERNOR

May 12, 2023

Mr. Philip Barlow, Chair
Risk-Based Capital Investment Risk and Evaluation Working Group
c/o Dave Fleming
1100 Walnut Street, Suite 1500
Kansas City, MO 64106-2107

Re: Residual Tranche Exposures

Dear Mr. Barlow:

The Iowa Insurance Division appreciates the opportunity to comment on the two items related to residual tranches in securitizations which are currently exposed for comment. The majority of our comments relate to the proposal for an interim increase in the risk-based capital (“RBC”) factor that applies for residual tranches from 30% to 45%, followed by an alternative interim proposal utilizing the sensitivity disclosures adopted during the April 20 meeting.

Background

Upon establishment of the Risk-Based Capital Investment Risk and Evaluation (“RBC IRE”) Working Group, the Financial Condition (E) Committee charged the working group with two initial mandates. The first was to proceed with Phase II of the bond factor project to develop new factors tailored specifically to structured securities / asset backed securities (“ABS”). The second was to review the factor for residual tranches in ABS structures specifically.

For the avoidance of doubt, **the Iowa Insurance Division continues to support both of these projects in the strongest of terms.** Without question, ABS now make up a significant portion of life insurers’ investment portfolios. The bond factors that are currently applied for ABS were derived from historical corporate bond data. Due to the nature by which cash flows are distributed through the capital stack of a structured asset, it would be reasonably expected that loss experience, particularly during tail stress scenarios, would be different between equivalently rated corporate bonds and ABS. This was acknowledged at the time the bond factors were reassessed as a necessary Phase II of the bond factor project. Through data-driven modeling, these differences can be quantified and tailored factors can be developed. The Working Group has kicked off efforts for such a project, leveraging assistance from the American Academy of Actuaries.

While the current bond factors are likely not sufficiently well fit-to-purpose, they are at least risk-sensitive based on the assigned NAIC Designation. The same cannot be said for the residual tranche of securitized assets. The factor that currently applies is a flat default charge of 30%, which was developed to apply to equity investments. This factor is neither risk-sensitive, nor was it developed based on any data that could reasonably be expected to correlate to the risks of residual tranches. As a result, it is likely that the current

factor for residual tranches is a particularly poor fit. Similar to the debt tranches, it is possible to develop more tailored factors through data-driven modeling, which is incorporated into the working plan of the project mentioned above.

Because of the particularly poor fit of the current capital framework as it applies to residual tranches, the Working Group has been considering an interim step to increase the RBC factor temporarily, while the longer-term analytical project plays out. This step is based on the strong intuition that the charge that applies should be higher based on review of two types of ABS: Collateralized Fund Obligations (“CFOs”) and Broadly-Syndicated Collateralized Loan Obligations (“BSL CLOs”). In these examples, a clear reduction in RBC is observable pre- and post-securitization.

Several unknowns have existed throughout Working Group discussions. These include 1) what factor should apply based on the risk of the investment, 2) whether the observations from the two ABS examples referenced above are representative of all ABS, and 3) whether insurers hold material amounts of residual tranches. With the exception of #3, the answers to these questions remain unknown.

Beginning with the filing of the 2022 Annual statement, residual tranches became separately reported for the first time. Upon NAIC staff’s review of the reported data as summarized in the public materials, Life insurers hold approximately \$4.7B of residual tranches as of 12/31/22, in aggregate. This makes up approximately 0.06% of the \$8.5T+ of life industry assets. Larger concentrations in individual insurers exist, with no single insurer investing greater than 3% of their total assets in residual tranches. From an RBC perspective, some high-level analysis of insurers with the largest holdings indicates no individual insurer would have an RBC ratio reduction of greater than 8% (e.g. 400% CAL RBC to 368% CAL RBC) using a 45% factor. Two insurers would have their RBC impacted by 4-8%, while four others would be impacted 1-3%. All others were under 1%.

The proposal to apply an interim charge applies to residual tranches of all types of ABS and is currently exposed using a 45% factor.

45% Interim Factor

The Iowa Insurance Division does not support an interim increase in the RBC charge at this time for the following reasons:

- It is our view that changes in capital requirements should be developed and supported through data-driven, analytical processes. This allows all stakeholders an opportunity to provide input into the methodology and assumptions used in developing capital requirements, and provides a process for surfacing the direct and indirect consequences of proposed changes.
- As this process is often long, it has the drawback of being slow to respond to pressing regulatory concerns. For this reason, rare circumstances may require temporary action without the usual amount of analytical support. While we believe that certain circumstances may warrant a temporary approach, we also believe such an approach should be limited to situations that present a material and pressing solvency concern. Absent these infrequent, urgent situations, we believe that changes in capital requirements should follow the usual analytical process.
- Based on our review of the current data as referenced above, we do not believe the level of investment in residual tranches constitutes a material and pressing solvency concern, currently or in the near-term future, in the aggregate or for individual insurers. No individual company would have

its RBC ratio in relation to Company Action Level meaningfully impacted by increasing the charge to 45%.

- Taking a temporary step in situations where there is no material and pressing solvency concern risks unforeseen consequences which have the potential to negatively impact financial markets, insurers, and policyholders.
- The proposal to apply an interim charge applies to residual tranches of all types of ABS. The view that a higher charge is warranted is primarily informed by a review of CFOs and BSL CLOs where a clear reduction in RBC is observable pre- and post-securitization. However, it remains unknown whether the same applies to all types of ABS, and many of the reported residual tranches appear to fall into this “other” category
- Various types of ABS have varying thicknesses or sizes of the residual tranche. A fixed charge will result in a higher RBC requirement for thicker tranches. Larger, thicker tranches are by definition less leveraged than smaller, thinner ones. While more analysis would be needed to understand the impact of this dynamic on the various types of ABS, it is possible that the RBC reduction observed for BSL CLOs would not be observed to the same extent in other types of ABS. If this is the case, increasing the factor to 45% for any such investments may be not be warranted.
- We believe alternative regulatory tools exist that would be effective in mitigating the risks that are of concern, without the potential for unintended consequences, as detailed in the next section.

Alternative Interim Step

As an alternative interim step to increasing the RBC charge for residual tranches at this time, we would propose the following:

- Set the sensitivity factor for residual tranches to 15%. This added to the existing 30% charge will allow regulators the ability to easily observe companies’ RBC position using a 45% factor.
- Request NAIC staff to generate a summary report that includes the RBC ratio pre- and post-sensitivity test.
- This report can be provided to both the RBC IRE Working Group and Financial Analysis Working Group (“FAWG”) for review in regulator-only session.
- Upon review of this report, FAWG can identify any individual companies that have higher concentration in residual tranches, and through coordination with the domiciliary state, request additional information from the insurer.
- This information could include, though is not limited to: 1) detail around the structure and underlying collateral, 2) summary of the insurer’s risk management processes and how it determines its risk appetite for its asset allocation to residual tranches, and 3) detail around how the company models its residual tranches and the projected impact to the company’s solvency in stress scenarios.
- Additionally, if upon review, the RBC IRE Working Group determines that the growth in holdings significantly alters the urgency of action, whether by organic growth or refinement to reporting guidance, it can revisit an interim step to increase the charge. The structure to accommodate such an increase has already been adopted.
- It is also possible that, at the time revisiting an interim charge may be warranted, work on the longer-term project will have provided better clarity around the remaining unknowns mentioned earlier in

this letter: 1) what the charge should be and 2) whether an increased charge should apply to all ABS residual tranches.

- To the extent that regulators desire more timely reporting of this data, semi-annual or quarterly supplemental filings could be requested to be confidentially submitted to FAWG for any companies where more frequent monitoring is desired.

Iowa believes the process described here would adequately address the regulatory concerns around investments in residual tranches while the longer-term, data-driven, analytical process plays out. It would avoid any potential for unforeseen and unintended consequences of adopting a change without the usual amount of supporting analysis.

Closing

The ongoing work to address the capital treatment of ABS is among the most important initiatives currently in process at the NAIC. Iowa offers its full support of these ongoing efforts, including the potential outcome of higher RBC factors for certain assets, when supported by deliberative, data-driven analysis.

Thank you for your consideration,

Kevin Clark, Chief Accounting Specialist, Iowa Insurance Division

Carrie Mears, Chief Investment Specialist, Iowa Insurance Division

Cc: Doug Ommen, Insurance Commissioner, Iowa Insurance Division



PO Box 12030 | Austin, TX 78711 | 800-578-4677 | tdi.texas.gov

June 9, 2023

Mr. Phillip Barlow, Chair
Risk-Based Capital Investment Risk and Evaluation Working Group
c/o Dave Fleming
1100 Walnut Street
Kansas City, MO 64106-2107

RE: Residual tranche base and sensitivity test factors

Dear Mr. Barlow,

The Texas Department of Insurance appreciates the opportunity to comment on the residual tranche factors currently exposed by the working group. Texas would like to offer a way forward regarding the residual tranche factors that we feel accomplishes the following:

- Addresses the direction from the Financial Condition (E) Committee to develop an RBC factor for residual tranches;
- Acknowledges that the factor established for traditional equity investments did not anticipate residual tranche investments, which have a different risk profile;
- Allows time for companies to address any investment changes needed in their asset mix; and
- Provides for the most efficient use of regulatory tools.

TDI supports a compromise that would set the residual tranche base factor at 30% and a sensitivity test factor at 15% for the 2023 risk-based capital formula. Then, in 2024 the base factor would move to 45% and the sensitivity test factor would drop to 0%.

This approach would give companies time to evaluate or divest assets in a manner that preserves surplus to meet future obligations. It would also provide additional information to the regulators in 2023 regarding the potential impact of each company's residual tranche holdings with the additional capital being required in 2024 so that there is a seamless consideration of this risk within the risk-focused solvency surveillance framework adopted for the U.S. state-based system of insurance regulation. This approach would also reduce any financial market disruption because the base rate is modified with more than a year's notice.

Phillip Barlow
June 9, 2023
Page 2

Most importantly, this approach will conclude the consideration of the interim solution for residual tranches so that the work on the charges for all tranches can start.

Thank you for consideration of our comments.

Sincerely,

A handwritten signature in black ink that reads "Jamie Walker". The signature is written in a cursive, flowing style.

Jamie Walker
Deputy Commissioner



June 9, 2023

Mr. Philip Barlow, Chair
Risk-Based Capital Investment Risk and Evaluation (E) Working Group (RBCIRE)
National Association of Insurance Commissioners
1100 Walnut Street, Suite 1500
Kansas City, MO 64106-2197

Re: Global Atlantic Response to 2023-09-IRE Residual Factor

Dear Mr. Barlow:

Global Atlantic¹ appreciates another opportunity to comment on [2023-09-IRE Residual Factor \(“Interim Solution”\)](#), which proposes to set the Risk Based Capital (“RBC”) charge at 45% for all residual tranches on an interim basis.

We stand by the principles from our prior letter, but the purpose of this letter is to explain why the proposed 45% factor is not appropriate for many residual tranches. The Interim Solution with the proposed increase in capital charges for residual tranches was originally designed to address the perceived regulatory capital “arbitrage” associated with Broadly Syndicated Collateralized Loan Obligations (“BSL CLOs”). The concern expressed with insurance company ownership of BSL CLO residuals is that the weighted average capital charge of the underlying collateral is much higher than the blended capital charge of the rated notes. Thus, a higher charge on the residual tranche was proposed to close the gap between the capital charge on the underlying assets and the notes.

To date, the proponents for adoption of the Interim Solution have sought to conflate concerns around the perceived “capital arbitrage” in BSL CLOs with residuals related to other asset classes without any credible justification or analysis. These other asset classes include those that are a meaningful portion of insurance company assets, potentially more so than BSL CLOs, and for which there is no evidence of “arbitrage.”

We urge the RBCIRE to consider adoption of the Iowa proposal that would apply a sensitivity test to residual tranches, and targeted regulatory company review for 2023. This would allow regulators the time to determine, based on appropriate data and analysis, which asset classes should be in scope for an adjustment to capital charges, and what those new capital charges should be.

¹ Global Atlantic Financial Group is a leading insurance company meeting the retirement and life insurance needs of individuals and institutions. With a strong financial foundation and risk and investment management expertise, the company delivers tailored solutions to create more secure financial futures. The company’s performance has been driven by its culture and core values focused on integrity, teamwork, and the importance of building long-term client relationships. Global Atlantic is a majority-owned subsidiary of KKR, a leading global investment firm. Through its relationship, the company leverages KKR’s investment capabilities, scale, and access to capital markets to enhance the value it offers clients. KKR’s parent company is KKR & Co. Inc. (NYSE: KKR).

Data and analysis were provided to the RBCIRE in an attempt to demonstrate that a 45% capital charge on all residuals is appropriate. We believe that analysis is flawed. However, even if this analysis were free of criticism, conflating BSL CLOs with the high-quality assets that we highlighted in our prior letter (e.g., student loans to prime consumers and financing for core US commercial and industrial infrastructure, such as railcar leases) is inappropriate.

To demonstrate that point, we have provided two examples of transactions completed in the securitization market where we attempted to provide a capital charge on the underlying assets of (1) a securitization of railcar leases² and (2) a securitization of student loans³. In contrast to BSL collateral of a CLO, neither of these assets have a native capital charge. Yet, we have attempted to lay out a simplistic framework to demonstrate that assets outside of BSL CLOs do not present the same “arbitrage” concern that has been used to justify the 45% charge.

In the first example, we show that an insurer would hold more capital under a securitization of railcar leases than holding underlying railcar leases directly, based on the imputed ratings of the lessee.

Example 1: Securitization of railcar leases

Underlying Lessee Rating				Securitization Structure			
Lessee Rating (S&P)	Railcars	% of Total	c1	30% Residual Charge			
AAA	223	5.0%	0.2%	Class Rating	Rating	Balance	c1
AA-	1,099	24.5%	0.5%	Class A	A	302,560,000	0.8%
A+	124	2.8%	0.7%	Class B	BBB	20,720,000	1.5%
A	250	5.6%	1.0%	Class C	NR	89,382,752	30.0%
BBB+	538	12.0%	1.3%	Blended C1			7.17%
BBB	861	19.2%	1.5%				
BBB-	257	5.7%	2.2%				
BB	74	1.7%	6.0%				
B	100	2.2%	9.5%				
B-	10	0.2%	12.4%				
C+	100	2.2%	30.0%				
Not Rated	479	10.7%	30.0%				
Off Lease	246	5.5%	30.0%				
Blended C1			6.70%				

On the left of the chart, we show what the capital charge would be if each railcar in a sample securitization were capitalized based on the rating of the lessee. Note that the RBC framework does not permit an investor to use a lessee’s rating for capital purposes and, as noted previously, railcars have no native capital charge (which is what makes securitization necessary). Of course, a lessee’s rating is not the same as a rating on the underlying asset, but the ratings of relevant lessees do provide a measure for the level of risk inherent in a securitization of leased assets.

On the right of the chart, we show the resulting capital charges associated with a securitization of rail car leases, including the residual tranche. Both the ratings on the left and the ratings on the right were assigned by S&P. Note that the capital charge for the securitization structure (including the residual tranche) is already higher than the implied rating of the “underliers,” in this case developed using the rating of each lessee (obligor). This example does not appear to present an “arbitrage” opportunity for insurance company investors. However, it seems to be inappropriately subject to the Interim Solution.

² Sources: GBX Leasing 2022-1, LLC Series 2022-1 KBRA New Issue Report, February 9, 2022; Intex; GBX Leasing 2022-1, LLC Final Offering Circular, February 1, 2022

³ Sources: SMB Private Education Loan Trust 2023-A DBRS Morningstar Presale Report, March 2, 2023; Intex; SMB Private Education Loan Trust 2023-A Offering Memorandum, March 8, 2023

The second example to demonstrate this point is the private student loan market. While again there is no native capital charge for this asset, the closest proxy in the existing RBC framework for student loans issued to, or guaranteed by, prime (750+ FICO) borrowers could be the 0.68% charge for residential mortgage loans⁴. The below bullets attempt to calibrate the residential mortgage charge to student loans based on historical performance of worst performing crisis vintage collateral.

Example 2: Securitization of student loans

Asset Charge Proxy	Securitization Structure																															
<ul style="list-style-type: none"> - Peak cumulative defaults of prime student loan collateral reached 18.5% for the 2008 vintage which is slightly higher than peak prime mortgage defaults of 14.5% for the 2007⁵ vintage - Comparing mortgage loans and student loans, one must acknowledge that mortgage loans are secured by real estate and will have lower loss once a default occurs than a student loan - Cumulative loss for 2007 prime vintage mortgage loans was 7.9%⁵ - Assuming that there was no recovery on all defaulted student loans that would mean student loan losses were 18.5% - 2.3x higher than the losses of the worst performing mortgage vintage - Based on the above a proxy capital charge for student loans would be 1.59% which is 2.3x the mortgage loan charge of 0.68% 	<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr style="background-color: #1a3a7a; color: white;"> <th style="text-align: center;">Rating</th> <th style="text-align: center;">Tranche Size</th> <th style="text-align: center;">Residual at 30%</th> <th style="text-align: center;">Residual at 45%</th> </tr> </thead> <tbody> <tr style="border-top: 1px dashed black;"> <td style="text-align: center;">AAA</td> <td style="text-align: center;">82%</td> <td style="text-align: center;">0.16%</td> <td style="text-align: center;">0.16%</td> </tr> <tr style="border-top: 1px dashed black;"> <td style="text-align: center;">AA</td> <td style="text-align: center;">7%</td> <td style="text-align: center;">0.42%</td> <td style="text-align: center;">0.42%</td> </tr> <tr style="border-top: 1px dashed black;"> <td style="text-align: center;">Residual</td> <td style="text-align: center;">11%</td> <td style="text-align: center;">30.00%</td> <td style="text-align: center;">45.00%</td> </tr> <tr style="border-top: 1px dashed black;"> <td colspan="2">Blended c1 Charge</td> <td style="text-align: center;">3.46%</td> <td style="text-align: center;">5.11%</td> </tr> <tr style="border-top: 1px dashed black;"> <td colspan="2">Residential Mortgage Charge</td> <td style="text-align: center;">0.68%</td> <td style="text-align: center;">0.68%</td> </tr> <tr style="border-top: 1px dashed black;"> <td colspan="2">Multiple of Mortgage</td> <td style="text-align: center;">5.1x</td> <td style="text-align: center;">7.5x</td> </tr> </tbody> </table>				Rating	Tranche Size	Residual at 30%	Residual at 45%	AAA	82%	0.16%	0.16%	AA	7%	0.42%	0.42%	Residual	11%	30.00%	45.00%	Blended c1 Charge		3.46%	5.11%	Residential Mortgage Charge		0.68%	0.68%	Multiple of Mortgage		5.1x	7.5x
Rating	Tranche Size	Residual at 30%	Residual at 45%																													
AAA	82%	0.16%	0.16%																													
AA	7%	0.42%	0.42%																													
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Blended c1 Charge		3.46%	5.11%																													
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Multiple of Mortgage		5.1x	7.5x																													

The table on the right again demonstrates that the securitization charge is higher than the underlying asset charge assuming the residual capital charge stays at 30%. Adopting the Interim Solution would exacerbate this impact even further. Given the comparable peak cumulative defaults between student loans and mortgage loans, it is difficult to support the premise that capital “arbitrage” exists and represents a material risk that requires the Interim Solution.

We recognize that residual tranches are complex and would require detailed modeling and analysis to arrive at a new capital framework. This is exactly why we believe rushing to impose an arbitrary capital charge derived without the benefit of any credible data, analysis, or field testing is inappropriate and will result in unintended consequences.

We reiterate our strong support of the Iowa proposal which would allow the NAIC to spend the appropriate time defining these assets and evaluating their risks. The sooner that proposal is adopted,

⁴ Under the RBC framework, a 0.68% charge applies to all residential mortgage loans, regardless of credit quality of the borrower.

⁵ Bank of America Securities, Sectors-Historical loss rates, March 2023

the sooner regulators partnering with industry can begin gathering the necessary data and performing the required analysis to ensure appropriate capital charges and “equal capital for equal risk”.

Thank you very much for your consideration and we look forward to participating on the NAIC’s June 14th RBCIRE call and working on this important issue going forward.

Sincerely,

A handwritten signature in cursive script that reads "Lauren Scott".

Lauren Scott

Global Atlantic Financial Group

SVP and Head of Regulatory & Government Affairs



June 9, 2023

Mr. Philip Barlow
Chair, RBC Investment Risk & Evaluation (E) Working Group
National Association of Insurance Commissioners
1100 Walnut Street, Suite 1500
Kansas City, MO 64106-2197

Via email: dfleming@naic.org

RE: IRE Residual Factor (the "Proposal")

Dear Mr. Barlow:

We write again to reiterate concerns regarding the Proposal and the need for an overarching system that leads to comprehensive and consistent capital calibration across all asset classes and investments.

We believe the NAIC should use the same careful and considered approach it has historically taken as it considers residuals for asset backed securities and the several parallel NAIC workstreams concerning structured securities. We are concerned that the NAIC has rapidly begun to make systemic changes to many aspects of the regulatory capital model without comprehensive empirical analyses to ensure statistical consistency across asset classes.

Consumers are facing a retirement income crisis with fewer available options. Honorably, the NAIC has been addressing this issue as a top priority. Inconsistent and punitive capital frameworks will necessarily impede insurers' offering of products that address this crisis, and may ultimately result in market disruptions similar to those that resulted from the European Union's adoption of Solvency II in 2016. To date, the NAIC has refrained from adopting similar measures to avoid these negative impacts.

We recommend that the Working Group and the NAIC more broadly step back and conduct a fair, data-driven, holistic review of the capital framework, including with respect to designations and capital charges, for all asset classes before making decisions that could influence competition and harm consumers, insurers, and investors.

Sincerely

A handwritten signature in black ink, appearing to read "D. Niemann", written over a light blue horizontal line.

Doug Niemann
Executive Vice President and Chief Risk Officer

Draft: 8/9/23

Risk-Based Capital (RBC) Investment Risk and Evaluation (E) Working Group
Virtual Meeting
May 17, 2023

The RBC Investment Risk and Evaluation (E) Working Group of the Capital Adequacy (E) Task Force met May 17, 2023. The following Working Group members participated: Philip Barlow, Chair (DC); Thomas Reedy (CA); Wanchin Chou (CT); Ray Spudeck (FL); Carrie Mears and Kevin Clark (IA); Vincent Tsang (IL); Roy Eft (IN); Fred Andersen (MN); William Leung and Debbie Doggett (MO); Lindsay Crawford (NE); Bill Carmello (NY); Dale Bruggeman and Tom Botsko (OH); Rachel Hemphill (TX); Greg Chew and David Smith (VA); Steve Drutz and Tim Hays (WA); and Amy Malm (WI).

1. Discussed 2022 Data Reported for Residual Tranches

Julie Gann (NAIC) presented an NAIC staff review of the information reported for residuals by life companies on Schedule BA for year-end 2022 (Attachment Six-B1). This review included the size of residuals held, residuals involving related parties, residuals as a percentage of surplus and invested assets, and the impact of a 45% risk-based capital (RBC) factor.

Barlow said when a new type of asset is added to an insurer's portfolio, they decide where they think it goes in the annual statement, and, based on that reporting and rating, if it has one, it gets an RBC factor. At some point, regulators recognize the new asset and may move it someplace else in the annual statement, which will generate a new RBC charge. None of that involves any analysis of the appropriate RBC charge. While it is true that neither 30% nor 45% factors for residuals have had a full RBC review, there is a difference in the factor that was generated solely by where the asset landed in the annual statement and the review that has been done of residual tranches, which has included: 1) understanding how the structured assets and residual tranches work; 2) seeing how structuring assets could cause a loss of two-thirds of the RBC charge without a change to the underlying risk; 3) the capital charge that bank regulators use, which is effectively 100%; and 4) the data just presented that shows, among other things, the growth of residual tranches and that no insurers would fall into an action level as a result. Barlow said that the analysis has led him to conclude that the 30% charge is not sufficient. He also said the Working Group also does not have the option of deferring this decision because a factor has to be adopted for the new bucket of residual tranches created.

2. Discussed Comment Letters on the Residual Factor and Sensitivity Test

The Working Group discussed the comment letters received on the residual tranche factor and the sensitivity test (Attachments Six-B2).

Tsang said that if it takes a long time to come up with a more thorough analysis for collateralized loan obligation (CLO) residual tranches, an interim solution is needed. Barlow said that what is being addressed are residual tranches generally rather than CLO residual tranches. Carmello said New York supports 45% and asked whether there is another NAIC group that looks at whether a given asset should be admitted because he questions whether this is appropriate for an insurance company.

Eft said he agreed that something needs to be done to address the disparity in the factor currently charged and the 45% that is being proposed. However, he supports the sensitivity factor as an interim solution rather than changing the RBC factor for these residual tranches because there are so many variations in the residual tranches.

Andersen said there is some variation within an asset class, which happens to all asset classes. He said data shows holdings of these assets have increased by a multiple of 10 over the past three years. His concern is that the sensitivity test alone is not going to change the trajectory at all. He said having liabilities supported by an under-capital-charged asset class does not seem to be the way to go.

Barlow said there is an exposure for 45%, and a call for the middle of June will be scheduled to get additional feedback before a final decision is to be made on a factor to be set. He said any new comments will be taken through June 9.

Having no further business, the RBC Investment Risk and Evaluation (E) Working Group adjourned.

SharePoint/NAIC Support Staff Hub/Committees/E Committee/CADTF/2023-2-Summer/RBCIREWG/RBC Investment Risk 05-17-23
Minutes.docx



MEMORANDUM

TO: Members of the RBC Investment Risk and Evaluation (E) Working Group
 FROM: NAIC Staff
 DATE: May 10, 2023
 RE: Residual Data – Life Companies

This memo has been developed to provide information on the reporting of residuals by life companies on Schedule BA for year-end 2022. Summaries of information are provided for the following aspects:

- Residual Acquisition Dates
- Residual Investments Involving Related Parties
- Size of Residuals Held by Reporting Entity
- Residuals as a Percentage of Surplus and Invested Assets
- Impact of 45% Residual Factor

Note: Investments identified as misreported as residuals have been removed from the data.

Residual Acquisition Dates

A vast majority in terms of count (67%) and BACV (80%) reported were acquired in the last three years.

Year Acquired	Count	Reported BACV	Percentage of Total BACV
2022	247	1,783,005,489	38%
2021	191	1,246,440,600	27%
2020	75	682,486,811	15%
2019	36	171,991,877	3.7%
2018	49	146,490,438	3.2%
2017	29	56,481,661	1.2%
2016	32	128,910,951	2.8%
2015	4	1,827,971	0.04%
2014	84	420,424,276	9.0%
2013	2	708,750	0.02%
2002 -2012	5	0	
No Date	11	10,675,518	0.23%
Total	762	4,649,444,342	

Notes:

- Amount shown is book adjusted carrying value (BACV) as of year-end 2022.
- The count includes all reported investments, including those with zero BACV.
- 76 of the 2014 residuals identified the same vendor.
- For the securities without a reported acquisition date, all had a zero BACV except 1.

Residual Investments Involving Related Parties:

As shown below, 56% of residuals involve related parties in some form. Most of these are from securitizations (or similar structures) with a small percentage of the underlying collateral in direct credit exposure. The full description is as follows:

3. *Securitization or other similar investment vehicles, such as mutual funds, limited partnerships, and limited liability companies involving a relationship with a related party as sponsor, originator, manager, servicer, or other similar influential role and for which less than 50% (including 0%) of the underlying collateral represents investments in direct credit exposure to related parties.*

This description generally means that a related party was involved in originating the investments. This could be another company within the group or other affiliate that serves as an asset manager.

As detailed in SSAP No. 25, paragraph 1, related party transactions can be subject to abuse because reporting entities may be induced to enter transactions that may not reflect economic realities or may not be fair or reasonable to the reporting entity or its policyholders.

In addition to these concerns, specifically for investments that may be formed and held completely within a single group or by related parties, there may be no market validation on the investment in terms of price, fair value, fees, or overall structure. *(It is uncertain the extent these investments are 100% owned by related parties or have non-related party investors.)*

Related Party Code		Count	Reported BACV	Percentage of Total BACV
1	Direct credit exposure.	43	306,533,214	6.6%
2	Securitization with related party with 50% or more of the underlying collateral in direct credit exposure.	1	5,039,607	0.1%
3	Securitization with related party with less than 50% of the underlying collateral in direct credit exposure.	236	2,280,012,224	49%
4	Securitization where structure reflects an in-substance related party transaction, but does not involve a related party as sponsor, originator, manager, servicer, etc.	0		
5	Investment is identified as related party, but the role is a different arrangement from the prior options.	1	13,960,500	0.3%
6	Investment does not involve a related party.	478	2,035,403,345	44%
No Entry		3	8,495,452	0.2%
Total		762	4,649,444,342	

Size of Residual Investments Held by Each Reporting Entity:

The individual BACV for each reported residual investment also varies significantly. As detailed below, over 50% of reported residuals reflect less than \$2M BACV and over 80% are reported at less than \$10M.

122 investments were reported with a BACV greater than \$10M, and 9 investments were reported with a BACV of \$50M or greater.

BACV	Count	Running Total	Percentage of Total
0	60	60	7.87%
0 - \$500,000	161	221	29.00%
\$500K - \$1M	76	297	38.98%
\$1M - \$2M	115	412	54.07%
\$2M - \$3	61	473	62.07%
\$3M - \$5M	65	538	70.60%
\$5M - \$7M	48	586	76.90%
\$7M - \$10M	54	640	83.99%
\$10M - \$20M	51	691	90.68%
\$20M - \$30M	38	729	95.67%
\$30M - \$50M	24	753	98.82%
\$50M - \$70M	3	756	99.21%
\$70M - \$100M	4	760	99.74%
> \$100M	2	762	100%
Total	762		

Residuals as a Percentage of Surplus and Total Invested Assets

The amount of residuals held as a percentage of surplus varies significant by company:

Count	% of Surplus	Count	% of Invested Assets
1	Over 50%	7	1-3%
2	20-30%	4	0.5%-1%
7	10-20%	67	< 0.5%
2	5-10%		
32	1-5%		
34	< 1%		
78 Companies		78 Companies	

For the 12 companies with residuals over 5% of surplus, \$1.36 billion was noted to have underlying collateral of fixed income and \$1.69 billion was noted with 'other' underlying collateral.

Impact of 45% RBC Factor

Although company specific information cannot be shared publicly, estimated individual company calculations of RBC, after removing the impacts of the 30% factor on the risk component totals going into the covariance adjustment and replacing them with the results of a 45% factor, was noted to have the following impact to RBC results:

Number of Companies	Percentage Change*
3	4.0% - 8.0%
5	1.0% - 3.0%
8	0.50% - 1.0%
6	0.20% - 0.50%
6	0.10% - 0.20%
6	Less than 0.10%

** These numbers have been calculated by determining the difference between current and estimated RBC and then calculating the percentage of the change. For example, if a company had an 860% RBC and the application of the 45% factor within the estimation decreased RBC to 859%, this would represent a change of 1, and a 0.12% percentage change in the calculated RBC ratio.*

This exercise was completed for 34 of the reporting entities with residuals. The companies represent those with the largest amounts of residuals and those whose residual balances are a greater percentage of surplus and/or total invested assets. The analysis also made certain simplifying assumptions such as excluding any change to the impact of concentration or reinsurance included in the actual RBC result.

Although significant discussion has occurred regarding the impact of the factor increase, this information illustrates that the underlying concern of the factor increase is likely not the actual impact to RBC for most companies.

May 12, 2023

Mr. Philip Barlow, Chair
RBC Investment Risk & Evaluation (E) Working Group
National Association of Insurance Commissioners
1100 Walnut Street, Suite 1500
Kansas City, MO 64106-2197

RE: Structured securities – Proposed 45% interim RBC factor for residual tranches

Dear Mr. Barlow,

I understand the concerns as a regulator that some companies are investing more in the residual tranches and the RBC factor has not reflected the risk charge properly yet for the residual tranches. However, on behalf of CID I would like to propose a delay in implementing the proposed 45% interim RBC factor for residual tranches for the following reasons:

1. Most of us actuaries agree that a more detailed analysis is needed to meet our professional standards in communication per ASOP 41.
2. We have not completed the cost and benefit analysis for the proposed 45% interim RBC factor for residual tranches to clearly define the impacts to some companies, and the benefits in regulation to avoid any unexpected capital risk if incurred.
3. With many uncertainties in the current high inflation high interest rate environment and with a small probability of potential recession in the market in 2023, we should avoid any potential disruptions to the market.
4. We have discussed with companies; some of them in favor of the 45% interim proposal but some against. Although they have different views, they mostly agreed that they could deliver a better study to support their arguments within a year.

CID appreciates your attention to the issues raised in this letter and looks forward to discussing with you further.

Best Regards,

Wanchin W. Chou, FCAS, MAAA, CPCU, CSPA, CCRMP
Chief Insurance Actuary and Asst. Deputy Commissioner
State of Connecticut Insurance Department
Office Phone: 860-297-3943
Cell: 860-488-4408

Cc: Commissioner Mais,
Deputy Commissioner Kosky,



STATE OF IOWA

KIM REYNOLDS
GOVERNORDOUG OMMEN
COMMISSIONER OF INSURANCEADAM GREGG
LT. GOVERNOR

May 12, 2023

Mr. Philip Barlow, Chair
Risk-Based Capital Investment Risk and Evaluation Working Group
c/o Dave Fleming
1100 Walnut Street, Suite 1500
Kansas City, MO 64106-2107

Re: Residual Tranche Exposures

Dear Mr. Barlow:

The Iowa Insurance Division appreciates the opportunity to comment on the two items related to residual tranches in securitizations which are currently exposed for comment. The majority of our comments relate to the proposal for an interim increase in the risk-based capital (“RBC”) factor that applies for residual tranches from 30% to 45%, followed by an alternative interim proposal utilizing the sensitivity disclosures adopted during the April 20 meeting.

Background

Upon establishment of the Risk-Based Capital Investment Risk and Evaluation (“RBC IRE”) Working Group, the Financial Condition (E) Committee charged the working group with two initial mandates. The first was to proceed with Phase II of the bond factor project to develop new factors tailored specifically to structured securities / asset backed securities (“ABS”). The second was to review the factor for residual tranches in ABS structures specifically.

For the avoidance of doubt, **the Iowa Insurance Division continues to support both of these projects in the strongest of terms.** Without question, ABS now make up a significant portion of life insurers’ investment portfolios. The bond factors that are currently applied for ABS were derived from historical corporate bond data. Due to the nature by which cash flows are distributed through the capital stack of a structured asset, it would be reasonably expected that loss experience, particularly during tail stress scenarios, would be different between equivalently rated corporate bonds and ABS. This was acknowledged at the time the bond factors were reassessed as a necessary Phase II of the bond factor project. Through data-driven modeling, these differences can be quantified and tailored factors can be developed. The Working Group has kicked off efforts for such a project, leveraging assistance from the American Academy of Actuaries.

While the current bond factors are likely not sufficiently well fit-to-purpose, they are at least risk-sensitive based on the assigned NAIC Designation. The same cannot be said for the residual tranche of securitized assets. The factor that currently applies is a flat default charge of 30%, which was developed to apply to equity investments. This factor is neither risk-sensitive, nor was it developed based on any data that could reasonably be expected to correlate to the risks of residual tranches. As a result, it is likely that the current

factor for residual tranches is a particularly poor fit. Similar to the debt tranches, it is possible to develop more tailored factors through data-driven modeling, which is incorporated into the working plan of the project mentioned above.

Because of the particularly poor fit of the current capital framework as it applies to residual tranches, the Working Group has been considering an interim step to increase the RBC factor temporarily, while the longer-term analytical project plays out. This step is based on the strong intuition that the charge that applies should be higher based on review of two types of ABS: Collateralized Fund Obligations (“CFOs”) and Broadly-Syndicated Collateralized Loan Obligations (“BSL CLOs”). In these examples, a clear reduction in RBC is observable pre- and post-securitization.

Several unknowns have existed throughout Working Group discussions. These include 1) what factor should apply based on the risk of the investment, 2) whether the observations from the two ABS examples referenced above are representative of all ABS, and 3) whether insurers hold material amounts of residual tranches. With the exception of #3, the answers to these questions remain unknown.

Beginning with the filing of the 2022 Annual statement, residual tranches became separately reported for the first time. Upon NAIC staff’s review of the reported data as summarized in the public materials, Life insurers hold approximately \$4.7B of residual tranches as of 12/31/22, in aggregate. This makes up approximately 0.06% of the \$8.5T+ of life industry assets. Larger concentrations in individual insurers exist, with no single insurer investing greater than 3% of their total assets in residual tranches. From an RBC perspective, some high-level analysis of insurers with the largest holdings indicates no individual insurer would have an RBC ratio reduction of greater than 8% (e.g. 400% CAL RBC to 368% CAL RBC) using a 45% factor. Two insurers would have their RBC impacted by 4-8%, while four others would be impacted 1-3%. All others were under 1%.

The proposal to apply an interim charge applies to residual tranches of all types of ABS and is currently exposed using a 45% factor.

45% Interim Factor

The Iowa Insurance Division does not support an interim increase in the RBC charge at this time for the following reasons:

- It is our view that changes in capital requirements should be developed and supported through data-driven, analytical processes. This allows all stakeholders an opportunity to provide input into the methodology and assumptions used in developing capital requirements, and provides a process for surfacing the direct and indirect consequences of proposed changes.
- As this process is often long, it has the drawback of being slow to respond to pressing regulatory concerns. For this reason, rare circumstances may require temporary action without the usual amount of analytical support. While we believe that certain circumstances may warrant a temporary approach, we also believe such an approach should be limited to situations that present a material and pressing solvency concern. Absent these infrequent, urgent situations, we believe that changes in capital requirements should follow the usual analytical process.
- Based on our review of the current data as referenced above, we do not believe the level of investment in residual tranches constitutes a material and pressing solvency concern, currently or in the near-term future, in the aggregate or for individual insurers. No individual company would have

its RBC ratio in relation to Company Action Level meaningfully impacted by increasing the charge to 45%.

- Taking a temporary step in situations where there is no material and pressing solvency concern risks unforeseen consequences which have the potential to negatively impact financial markets, insurers, and policyholders.
- The proposal to apply an interim charge applies to residual tranches of all types of ABS. The view that a higher charge is warranted is primarily informed by a review of CFOs and BSL CLOs where a clear reduction in RBC is observable pre- and post-securitization. However, it remains unknown whether the same applies to all types of ABS, and many of the reported residual tranches appear to fall into this “other” category
- Various types of ABS have varying thicknesses or sizes of the residual tranche. A fixed charge will result in a higher RBC requirement for thicker tranches. Larger, thicker tranches are by definition less leveraged than smaller, thinner ones. While more analysis would be needed to understand the impact of this dynamic on the various types of ABS, it is possible that the RBC reduction observed for BSL CLOs would not be observed to the same extent in other types of ABS. If this is the case, increasing the factor to 45% for any such investments may be not be warranted.
- We believe alternative regulatory tools exist that would be effective in mitigating the risks that are of concern, without the potential for unintended consequences, as detailed in the next section.

Alternative Interim Step

As an alternative interim step to increasing the RBC charge for residual tranches at this time, we would propose the following:

- Set the sensitivity factor for residual tranches to 15%. This added to the existing 30% charge will allow regulators the ability to easily observe companies’ RBC position using a 45% factor.
- Request NAIC staff to generate a summary report that includes the RBC ratio pre- and post-sensitivity test.
- This report can be provided to both the RBC IRE Working Group and Financial Analysis Working Group (“FAWG”) for review in regulator-only session.
- Upon review of this report, FAWG can identify any individual companies that have higher concentration in residual tranches, and through coordination with the domiciliary state, request additional information from the insurer.
- This information could include, though is not limited to: 1) detail around the structure and underlying collateral, 2) summary of the insurer’s risk management processes and how it determines its risk appetite for its asset allocation to residual tranches, and 3) detail around how the company models its residual tranches and the projected impact to the company’s solvency in stress scenarios.
- Additionally, if upon review, the RBC IRE Working Group determines that the growth in holdings significantly alters the urgency of action, whether by organic growth or refinement to reporting guidance, it can revisit an interim step to increase the charge. The structure to accommodate such an increase has already been adopted.
- It is also possible that, at the time revisiting an interim charge may be warranted, work on the longer-term project will have provided better clarity around the remaining unknowns mentioned earlier in

this letter: 1) what the charge should be and 2) whether an increased charge should apply to all ABS residual tranches.

- To the extent that regulators desire more timely reporting of this data, semi-annual or quarterly supplemental filings could be requested to be confidentially submitted to FAWG for any companies where more frequent monitoring is desired.

Iowa believes the process described here would adequately address the regulatory concerns around investments in residual tranches while the longer-term, data-driven, analytical process plays out. It would avoid any potential for unforeseen and unintended consequences of adopting a change without the usual amount of supporting analysis.

Closing

The ongoing work to address the capital treatment of ABS is among the most important initiatives currently in process at the NAIC. Iowa offers its full support of these ongoing efforts, including the potential outcome of higher RBC factors for certain assets, when supported by deliberative, data-driven analysis.

Thank you for your consideration,

Kevin Clark, Chief Accounting Specialist, Iowa Insurance Division

Carrie Mears, Chief Investment Specialist, Iowa Insurance Division

Cc: Doug Ommen, Insurance Commissioner, Iowa Insurance Division



May 8, 2023

Philip Barlow
Chair, Risk-Based Capital Investment Risk and Evaluation (E) Working Group (RBCIRE WG)
National Association of Insurance Commissioners (NAIC)

Re: Exposure 2023-09-IRE—Interim Residual Tranche C1 Factor

Dear Chair Barlow,

On behalf of the American Academy of Actuaries¹ C1 Work Group (C1WG), thank you for the opportunity to comment on the interim residual tranche C1 factor of 45% that was exposed at the April 20 meeting of RBCIRE WG.

We are continuing our work toward a rigorous approach for setting collateralized loan obligation (CLO) C1 factors, including for CLO residual tranches.

As outlined in our [December CLO report](#) to the RBCIRE WG, the 30% C1 factor that currently applies to residual tranches is based on an analysis of the S&P 500, which is unrelated to residual tranches of structured securities. The same is true for the exposed 45% C1 factor proposal.² This is the case not only for CLOs, but for effectively all residual tranches.

We understand that regulators have a concern regarding residual tranche C1 and have exposed a new residual factor to be applied on an interim basis.

We agree with interested parties² that equities and residual tranches have materially different risk profiles. For this reason, we believe equities and residual tranches should not automatically share the same C1 factor.

Any factor that is adopted on an interim basis will be the product of regulator judgment, which we respect is at the discretion of regulators. We encourage a directed effort to substitute appropriate analytical basis for regulator discretion to establish statistically justified capital requirements for structured securities.

We look forward to supporting regulators in the broader objective of developing an appropriate basis for structured security C1 factors.

¹ The American Academy of Actuaries is a 19,500-member professional association whose mission is to serve the public and the U.S. actuarial profession. For more than 50 years, the Academy has assisted public policymakers on all levels by providing leadership, objective expertise, and actuarial advice on risk and financial security issues. The Academy also sets qualification, practice, and professionalism standards for actuaries in the United States.

² A 45% factor was first introduced in a Feb. 3 interested party letter by a coalition of life insurers. An April 12 letter by the same group of interested parties elaborated further on their support for a factor equal to at least 45%. The Feb. 3 letter justifies the level of 45% by applying a 1.5-beta adjustment to the current equity factor of 30%. The April 12 letter supplements this with historical loss data on the collateral of structured securities compared against typical sizes for residual tranches.

Sincerely,

Stephen Smith
Chairperson, C1 Work Group
American Academy of Actuaries



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Mariana Gomez-Vock
Senior Vice President, Policy Development
marianagomez-vock@acli.com

May 12, 2023

Mr. Phil Barlow, Chair
Life RBC Investment Risk and Evaluation (E) Working Group
National Association of Insurance Commissioners
1100 Walnut Street, Suite 1500
Kansas City, MO 64106-2197

Via email: dfleming@naic.org

Re: 2023-09 IRE Residual Factor Exposure

Dear Mr. Barlow:

Thank you for the opportunity to provide these initial comments on the proposed residual factor (the “factor”) that was exposed on April 20, 2023.

ACLI continues to support regulators’ efforts to assess the potential need for determining capital charges associated with securitized investments that better reflect the actual risk of the various tranches. ACLI appreciates the Working Group’s recent adoption of a structure for a single interim factor approach, rather than a three-bucket approach.

While we understand some regulators’ desire to develop an interim solution with some level of expediency, we do have concerns that 45% was recommended without the typical level of rigor provided when making RBC changes.

ACLI members have a variety of views on the proposed factor of 45%. Some ACLI members suggest that the factor chosen should not be more conservative than complete non-admittance of the asset for the average industry participant, and likely less so, given the risk premium already contained in policy reserves. For example, using 2021 aggregated life RBC data, ACLI calculated that on average, due to covariance, approximately 57% of a C1cs factor ends up impacting the RBC requirement. Thus, a 45% factor would result in an ultimate after-tax RBC charge of 20.26%. This seems to suggest that for a company with a CAL RBC of 486%, a 45% factor is the rough

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The American Council of Life Insurers (ACLI) is the leading trade association driving public policy and advocacy on behalf of the life insurance industry. 90 million American families rely on the life insurance industry for financial protection and retirement security. ACLI’s member companies are dedicated to protecting consumers’ financial wellbeing through life insurance, annuities, retirement plans, long-term care insurance, disability income insurance, reinsurance, and dental, vision and other supplemental benefits. ACLI’s 280 member companies represent 94 percent of industry assets in the United States.

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equivalent of non-admittance. Of course, the impact for any individual company will vary from this average. ACLI is not privy to the data necessary to determine other metrics, such as a distribution of the impact.

While RBC is often described as a “blunt instrument”, ACLI believes that thoughtful analysis of proposed factors ultimately benefits the strength of the RBC framework - and we look forward to reviewing the Working Group’s impact assessment of the 45% factor as described in the Capital Adequacy Task Force procedures.¹

Thank you for the opportunity to share these views with you. Please feel free to contact us if you have any questions or concerns about our comments.

Sincerely,



Steve Clayburn



Mariana Gomez-Vock

cc: Brian Bayerle, ACLI

¹ The Capital Adequacy Task Force procedures for proposed amendments to RBC blanks and instructions requires an impact analysis for any factor change. See Procedures of the Financial Condition (E) Committee Capital Adequacy Task Force in Connection with Proposed Amendments to Risk Based Capital Blanks and Instructions, available at https://content.naic.org/sites/default/files/inline-files/committees_e_capad_related_rbc_procedures.pdf (last retrieved on May 3, 2023).



Steve Clayburn, FSA, MAAA
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May 12, 2023

Mr. Philip Barlow, Chair
RBC Investment Risk & Evaluation (E) Working Group
National Association of Insurance Commissioners
1100 Walnut Street, Suite 1500
Kansas City, MO 64106-2197

Via email: dfleming@naic.org

Re: 2023-10-IRE Sensitivity Test Factor

Dear Mr. Barlow:

The American Council of Life Insurers (“ACLI”) appreciates the opportunity to provide comments on the NAIC’s exposure of the sensitivity test factor. ACLI continues to think that sensitivity testing for residual tranches could be an important tool for regulators. The importance varies depending on the decision for the interim solution for residual tranches.

Originally, ACLI suggested a 10% factor as it will provide regulators with a 10% increase as well as a 10% reduction for an insurer’s sensitivity testing with the current 30% residual tranche factor. (We note that the factor on the RBC sensitivity testing is additive, e.g., a 30% residual tranche factor would have the .1 (10%) “added” for sensitivity testing.)

Knowing that there is current exposure and discussion to potentially change the interim factor for residual tranches, if the residual tranche factor is increased, ACLI does not see the need for a sensitivity factor at this time; however, the exhibit could include a factor in the future as the work on asset-backed securities continues and this sensitivity testing can be used for future calculations and future impact assessments for the permanent solution (i.e., the results of decisions made once modeling is complete). If regulators decide to continue with the current year-end 2022 factor, we suggest the 10% factor, such that sensitivity testing could occur.

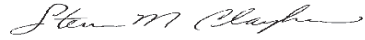
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The American Council of Life Insurers (ACLI) is the leading trade association driving public policy and advocacy on behalf of the life insurance industry. 90 million American families rely on the life insurance industry for financial protection and retirement security. ACLI’s member companies are dedicated to protecting consumers’ financial wellbeing through life insurance, annuities, retirement plans, long-term care insurance, disability income insurance, reinsurance, and dental, vision and other supplemental benefits. ACLI’s 280 member companies represent 94 percent of industry assets in the United States.

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Thank you for the opportunity to outline the ACLI's thoughts the sensitivity testing.

Sincerely,



Steve Clayburn

cc: Mariana Gomez-Vock, ACLI
Brian Bayerle, ACLI

May 12, 2023

Mr. Philip Barlow, Chair
RBC Investment Risk & Evaluation (E) Working Group
National Association of Insurance Commissioners
1100 Walnut Street, Suite 1500
Kansas City, MO 64106-2197

Via email: dfleming@naic.org

RE: Structured securities – Proposed 45% interim RBC factor for residual tranches

Dear Mr. Barlow,

On behalf of the undersigned life insurance companies (“the companies”), we are writing to express our continued support for an interim RBC factor for the residual tranches of structured securities. The process for consideration of interim RBC charges has been transparent, thorough, and provided adequate time for interested parties to review and respond to these issues over the last year.¹ Accordingly, we strongly feel that the RBC Investment Risk & Evaluation (E) Working Group (“RBC IRE”) should adopt the proposed single, interim RBC factor of 45% without delay.

Adoption of a higher interim RBC factor for securitized residuals represents an important first step in reducing capital arbitrage—as identified and discussed in the May 25, 2022 IAO Issue Paper (the “IAO Issue Paper”) on the “Risk Assessment of Structured Securities – CLOs”—between securitized tranches of structured securities and the underlying collateral. To that end, based on the results of the last several years of SVO-led CLO stress testing, the IAO Issue Paper suggested the adoption of new NAIC Designation Categories (i.e., 6.A, 6.B and 6.C) with recommended RBC factors of 30%, 75% and 100% respectively, to address tail risk in structured finance tranches and any unintended arbitrage opportunities. The August 20, 2022 referral from the Valuation of Securities Task Force (“VoSTF”) to the Capital Adequacy Task Force (“CATF”) and RBC IRE endorsed these recommendations as an appropriate interim step while the SVO began modeling CLOs to help determine potential loss risk under stressed scenarios.

In our previous letters to the Working Group on February 3, 2023 and April 12, 2023 (attached), the companies provided support for a single 45% interim RBC charge for the residual tranches of structured securities as a data driven compromise in lieu of the SVO’s proposal, which we believe achieves the same goals of better addressing underlying risk and appropriately narrowing the capital arbitrage gap. The companies’ February 3 letter also noted that sensitivity testing can provide regulators with valuable information, but sensitivity testing alone will not provide data on what appropriate RBC factors should be nor will it meet the regulators’ goals of reducing RBC arbitrage while

¹ The Securities Valuation Office (SVO) recommendation surrounding three suggested interim RBC charges for the NAIC 6 designation (30%, 75%, and 100%) was initially included in the IAO “Issue Paper on the Risk Assessment of Structured Securities – CLOs,” which was released on May 25, 2022 and exposed as part of the VoSTF’s June 9, 2022 meeting activities. The RBC IRE exposed the SVO interim RBC proposal on December 14, 2022, the proposed single interim RBC charge framework on March 23, 2023, and the companies’ suggested 45% interim RBC charge on April 20, 2023. The companies’ suggested 45% interim RBC charge was initially proposed in the February 27, 2023 Working Group materials.

more refined charges are developed. As such, immediate adoption of the interim 45% RBC factor is warranted regardless of whether regulators decide to employ sensitivity testing.

The companies further note that without a measurable increase in the RBC factor for residual tranches there is mathematically no logical way to narrow the capital arbitrage gap. That is, in order to have the RBC of the assets supporting a CLO (“Collateral RBC”) be comparable to the RBC of the combined CLO bonds (“Blended RBC”), mathematically we need to have a greater than 30% RBC assigned to the residual tranche of the CLO in order to reasonably match the risk of each CLO tranche and its RBC. If the RBC factor for residual tranches were to remain at the current 30% level, then in order to eliminate the opportunities for capital arbitrage the BB, BBB and A-rated tranches would also need to receive a 30% RBC factor (NAIC 6 designation) and the AA-rated tranche would need a 16.9% factor (NAIC 5A designation):

Current CLO RBC Arbitrage				Solving Arbitrage without Interim Factor			
Tranche	% of CLO	Designation	RBC	Tranche	% of CLO	Designation	RBC
AAA	63%	1A	0.158%	AAA	63%	1A	0.158%
AA	12%	1C	0.419%	AA	12%	5A	16.942%
A	6%	1F	0.816%	A	6%	6	30%
BBB	6%	2B	1.523%	BBB	6%	6	30%
BB	5%	3B	4.537%	BB	5%	6	30%
Residual	8%	6	30%	Residual	8%	6	30%
Blended RBC [A]			2.917%	Blended RBC [A]			9.633%
Collateral RBC [B]			9.535%	Collateral RBC [B]			9.535%
Arbitrage [B-A]			6.618%	Arbitrage [B-A]			-0.098%

Sources, Barclays, MIM.

As demonstrated above, attempting to solve the capital arbitrage issue without changing the RBC factor for the residual tranche is not logical: the tranches are sequentially subordinated and RBC factors should be proportional to the varying degrees of risk. In the table above the RBC factor for multiple tranches senior to the residual tranche would need to share the same flat 30% level instead of a declining level of RBC as would be expected given their declining levels of risk. The only logical, mathematically feasible way to reduce the capital arbitrage problem is to significantly increase the RBC factor for the residual tranche. Furthermore, this change aligns with an RBC framework that was derived in a **data-driven fashion** by the NAIC in developing of factors for corporate credits – which serve as the collateral and sole source of repayment in CLOs.

The interim factor solution addresses a present and *growing* risk. In this current environment of economic uncertainty, it is critical for regulators to enact an interim RBC factor that better protects insurers (and by extension policyholders) from potential losses associated with the riskiest tranches of structured securities as soon as possible. As discussed in our February 17, 2023 letter to VoSTF, we note that, in particular, U.S. life insurer CLO investments have grown 20% per year over the last decade, whereas General Account assets have only grown 5% per year. We expect to see additional growth in CLOs as a percentage of general account assets this year. The companies also believe the application of an interim factor will provide regulators with additional information for facilitating the long-term

solution to address the remaining tranches (which will remain at the C-1 bond factor levels in the interim) and provide more granular capital considerations for the residual and mezzanine tranches.

The companies agree with regulators that the process of determining an interim RBC charge should be both transparent and data driven. To that end, we provided analysis to support an interim RBC charge of at least 45% for the residual tranches in our April 12, 2023 letter to the Working Group. In that letter, we noted that when historical collateral losses are compared to typical residual tranche thickness, it demonstrates a likely potential residual tranche loss in excess of 45% in stress events. In 2020, some CLO residuals saw losses exceeding 60%, far greater than the losses experienced by public equities. We would also note the SVO is currently running the first “proof of concept” tests of the CLO modeling methodology with six different types of actual CLOs based on the stress levels it uses for its own stress tests. We would encourage the Working Group to review the results of those findings to help its final decisions on the appropriate level of the interim RBC charge.

Additionally, ACLI’s May 12 letter identifies CATF procedures for proposed amendments to RBC blanks and instructions as requiring an impact analysis for any factor change. We believe that our data can help to inform that impact analysis; further, it is the companies’ understanding that such analysis does not need to be completed before approval of any factor and therefore does not present a hurdle to continued expedient action on this issue.

The companies are aware of concerns that an interim 45% RBC factor may be inappropriate for the residual tranches of some structured securities due to differing underlying risks and/or thicknesses. We believe concerns about any such outliers are best addressed through increased transparency as we work toward a permanent solution. For this to be a data driven process, those who believe there are “low-risk” residual tranches should identify the securities in question and provide clear justification for different treatment.

Some parties have also raised concerns that a 45% RBC charge held at 300%+ redundancy will result in a capital holding of over 100% or an incentive to non-admit the asset. However, this is an overly simplistic conclusion, as RBC charges are pre-diversification with other risks (C-2 through C-3) and it also ignores other negative effects of non-admitting an asset.² More importantly, regulatory capital requirements are intended to identify weakly capitalized companies, not to incentivize investment choices under “normal” circumstances.

Finally, the current 30% RBC factor does not meet regulators’ commitment to a transparent and data driven interim charge. The existing RBC treatment of the residual tranche is based arbitrarily on public equity experience. However, public equities and the residual tranche of structured securities have materially different risk profiles. We have not seen **any** data that justifies maintaining a 30% RBC factor for the residual tranche.

The companies strongly believe the proposed single interim RBC factor of 45% should be adopted as exposed. As discussed in our April 12 letter, such a charge is consistent with the existing high-beta equity RBC charge and a directionally appropriate outcome demonstrated by the data.

² Regulators should consider if it is appropriate to assume diversification benefit with credit for a residual tranche when its underlying collateral is comprised of credit assets.

Respectfully Submitted,

Equitable

MetLife

New York Life

Northwestern Mutual

Pacific Life

Prudential Financial, Inc.

Western & Southern

Mr. Philip Barlow
Risk-Based Capital Investment Risk and Evaluation (E) Working Group
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RE: Exposure 2023-09-IRE Residual Factor

Dear Mr. Barlow:

Thank you for the opportunity to comment on the April 20, 2023, proposal by the Risk-Based Capital Investment Risk and Evaluation (E) Working Group (the "Working Group") to establish an interim 45% Risk-Based Capital ("RBC") charge for "residual tranches or interests" of all asset-backed securities (the "RBC Proposal").

Overview

We have listed below several concerns in this letter followed by a detailed discussion of each concern and concluding remarks.

1. There is no evidence of an urgent need for the NAIC to depart from its required diligent, fact-based, and thoughtful process that it uses to establish C1 risk-based factors. Overall RBC levels among life insurers have been very robust and relatively stable in recent years. In the one specific type of asset-backed security (ABS) that the NAIC has been closely examining for years, namely collateralized loan obligations (CLOs), the NAIC has consistently concluded that there is no material risk to the life insurance industry at large.
2. The proposed level of the charge has been chosen arbitrarily based on scant, misleading, and superficial analysis that contradicts recent studies by the NAIC, the American Academy of Actuaries ("AAA"), academics and market analysts.
3. The proposal reflects a lack of understanding of the inherent risk-mitigation structure of ABS investments and instead focuses on one aspect of them without any analysis of its potential impact on the industry as a whole.
4. ABS risk must be comprehensively studied as CLOs have been able to outperform and experience lower losses than comparable corporate bonds with the same risk rating.
5. Regulators must undertake their own neutral study of risks associated with ABS residuals before unintentionally creating artificial barriers and unintentionally choosing sides in a competitive battle.
6. Regulators have significant supervisory tools today to address concerns regarding specific ABS investments without adopting a punitive RBC charge and causing significant disruption to the larger ABS market.
7. The proposed 45% RBC charge is not within the Financial Condition (E) Committee's charge to the Working Group.

8. The charge would likely be more than “Interim” and would bias the longer-term analysis that should properly be completed before establishing the appropriate charge for ABS.

Before the NAIC imposes the highest capital charge on any asset in its entire history, we urge the NAIC to follow its typical thorough and rigorous analytical process.

As a standard setting body, the NAIC should be cautious about advancing a proposal supported by one segment of the industry in an April 12, 2023, letter that may cause competitive distortions not reflective of risk. The RBC Proposal may tilt competition in favor of insurers that have direct equity exposure versus ABS residuals exposure and does not reflect a thoughtful analysis of whether ABS residuals are safer or not than direct equity exposure.

Finally, as an alternative to an interim charge, we urge the NAIC to form a working group and retain neutral experts to study the structural and risk mitigation features of ABS and report back to the Working Group. We commit to efficiently and effectively working with the NAIC to analyze the various types of ABS, their loss experience, and risk mitigation features to determine appropriate capital charges.

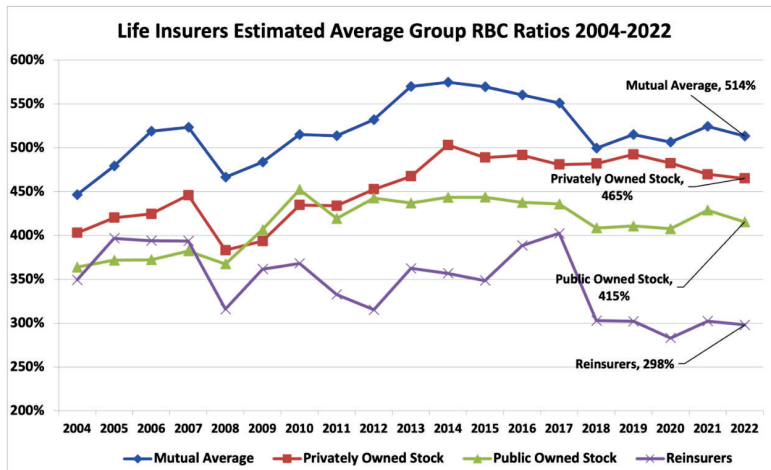
Detailed Discussion

- 1. There is no evidence of a need for urgent action as RBC levels are robust and all analysis to date indicates no material risks to the life insurance industry.**

A recent analysis of YE2022 life insurer’s regulatory filings found the industry to be very well capitalized, with the average RBC level for mutual insurance companies at 514%, PE-owned insurers at 465%, publicly owned insurers at 415%, and reinsurers at 298%.¹

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¹ Colin Devine, “U.S. Life Insurer RBC Trends Confirm Industry Capital Levels Remain Strong,” the Alliance for Lifetime Income's Retirement Income Institute, April 16, 2023, <https://www.linkedin.com/pulse/us-life-insurer-rbc-trends-suggest-industry-capital-levels-devine/>



This annual study confirmed that life insurance RBC levels have remained relatively stable over the last few years. Also, a recent Fitch analysis found that the insurance sector has only “modest exposure” to the recent bank failures and that its “liability profiles support stability.”²

Further, ABS do not present a material risk to life insurers. Indeed, the RBC Proposal is completely contrary to data and risk analysis by the NAIC which is made available to regulators through the NAIC. Over the past five years, regulators have received the following studies by or through the NAIC with specific findings regarding the limited risk in ABS investments.

- The NAIC has been stress testing CLOs since 2019 and has repeatedly found that they do **not** pose a material risk. In the most recent January 5, 2023, NAIC Capital Markets Bureau Special Report, it was determined that, “Based on the NAIC’s stress test results, U.S. insurer investments in CLOs remain an insignificant risk.”³

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² Fitch, U.S. Insurers’ Direct Exposures to Bank Failures Modest; Liability Profiles Support Stability, March 15, 2023 <https://www.fitchratings.com/research/insurance/us-insurers-direct-exposures-to-bank-failures-modest-liability-profiles-support-stability-15-03-2023>

³ NAIC Capital Markets Special Report, Collateralized Loan Obligation – Stress Testing U.S. Insurers’ Year-End 2021 Exposure, January 5, 2023. See also, Collateralized Loan Obligation (CLO) – Stress Testing U.S. Insurers’ Year-End 2020 Exposure, October 7, 2021; Collateralized Loan Obligations – Stress Testing U.S. Insurers’ Year-End 2019 Exposure, June 18, 2020; and Collateralized Loan Obligations – Stress Testing U.S. Insurers’ Year-End 2018 Exposure, December 6, 2019

- A December 2022 American Academy of Actuaries (“AAA”) C1 Working Group presentation to the NAIC said that CLOs do not present a material risk to the industry: “In the C1WG’s view, CLOs do not present a material risk to the aggregate solvency of the life insurance industry currently.”⁴
- In 2019, the NAIC’s Capital Markets Bureau published reports on Consumer ABS⁵ and Auto ABS⁶, which again did not identify any urgent need for regulatory action.

The AAA presentation to the Working Group in December 2022 indicated that a limited number of life insurance companies held CLO interests, and even fewer held CLO residuals. The study recommended the AAA’s C-1 Working Group should review CLO and ABS interests further, especially since ABS instruments are being identified in more detail starting in the 2022 Annual Financial Statement Blanks. We see no reason the NAIC should not wait for the results of the AAA’s additional analytical work and instead accelerate for adoption the single largest capital charge in the history of the RBC system based on anecdotal background.

2. The proposed charge level of 45% was established arbitrarily and without analytical support

The RBC Proposal’s 45% factor appears to have been developed through a short, less than two-page letter from a limited number of insurers rather than the objective study, modeling and analysis that is the usual and customary practice for the Working Group and other Capital Adequacy (E) Task Force (“CATF”) working groups. Prior to exposing the RBC Proposals, the NAIC and the Working Group were not presented with any data, studies, or other evidence that demonstrated that 45% percent is the appropriate charge on ABS residual investments.

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⁴ American Academy of Actuaries, Presentation to the Risk-Based Capital Investment Risk and Evaluation Working Group (RBCIRE WG) on Collateralized Loan Obligations (CLOs), December 14, 2022.
https://www.actuary.org/sites/default/files/2022-12/C1_Presentation_CLOs.pdf

⁵ NAIC Capital Markets Bureau, Consumer ABS Primer, April 2, 2019

⁶ NAIC Capital Markets Bureau, Auto ABS, December 20, 2019

A much more thorough analysis of CLOs and their equity performance was conducted by Larry Cordell, an economist at the Federal Reserve Bank of Philadelphia, Professor Michael Roberts of the Wharton School at the University of Pennsylvania, and Michael Schwert.⁷ That study compared the risk-adjusted performance of CLO equity to the S&P 500 from 1997 to 2016 and found that CLO equity outperformed common stock.⁸ Importantly, one of the key findings of this study was the relative stability of CLO equity during two periods of significant market instability, including the 2008 financial crisis, which led the

Panel B: Public Market Equivalent versus S&P 500

Vintage	Mean	StDev	p10	p25	p50	p75	p90	Obs.
1997-2002	1.50	0.69	0.74	0.88	1.40	1.84	2.37	19
2003	0.91	0.31	0.61	0.75	0.85	1.06	1.28	25
2004	1.11	0.38	0.61	0.90	1.03	1.26	1.58	49
2005	1.48	0.45	1.04	1.22	1.47	1.77	2.04	79
2006	1.76	0.55	1.21	1.44	1.76	2.04	2.27	151
2007	2.03	0.60	1.32	1.79	2.06	2.35	2.69	148
2008	1.11	0.55	0.34	0.70	1.15	1.53	1.75	27
2009-2010	0.75	0.28	0.36	0.57	0.79	1.00	1.02	12
2011	0.95	0.24	0.72	0.79	1.00	1.11	1.25	27
2012	0.83	0.16	0.65	0.75	0.82	0.93	1.03	93
2013	0.84	0.22	0.62	0.74	0.83	0.96	1.13	63
2014	0.81	0.18	0.59	0.67	0.82	0.94	1.00	74
2015	0.81	0.21	0.48	0.66	0.86	0.94	1.10	26
2016	0.79	0.19	0.47	0.71	0.84	0.92	0.99	13
CLO 1.0	1.64***	0.64	0.83	1.20	1.66	2.05	2.37	500
CLO 2.0	0.83***	0.20	0.59	0.72	0.84	0.96	1.07	308
Full Sample	1.33***	0.65	0.66	0.84	1.15	1.81	2.18	808

authors to note that CLOs' "equity performance highlights the resilience of CLOs to market volatility."⁹

Exhibit 2 shows the average level of CLO equity performance compared to the S&P 500 for each year during that period of time. The chart includes CLO equity results over the entire sample period and separately for each

year both on an aggregate basis and on a percentile basis--including the 90th, 75th, 50th, 25th, and 10th percentiles. In that chart, any performance greater than 1.0 means that CLO equity outperformed the S&P index. The overall score was 1.33, which the authors describe as meaning "that CLO equity earned higher returns than an index of public equities."¹⁰

Of note, the authors also found that CLO equity particularly outperformed during the two periods of economic stress during the sample period and noted that the "temporal variation in equity performance highlights the resilience of CLOs to market volatility due to their closed-end structure, long-term funding,

Source: CLO data from Intex Solutions and S&P

⁷ CORDELL, L., ROBERTS, M.R. and SCHWERT, M, CLO Performance, Journal of Finance, 2023. <https://doi.org/10.1111/jofi.13224>

⁸ *Id.* at 2. "Our central finding is that CLO equity tranches provide statistically and economically significant abnormal returns, or "alpha," against a variety of public benchmarks" during the sample period of 1997 to 2016.

⁹ *Id.* at 20.

¹⁰ *Id.* at 20.

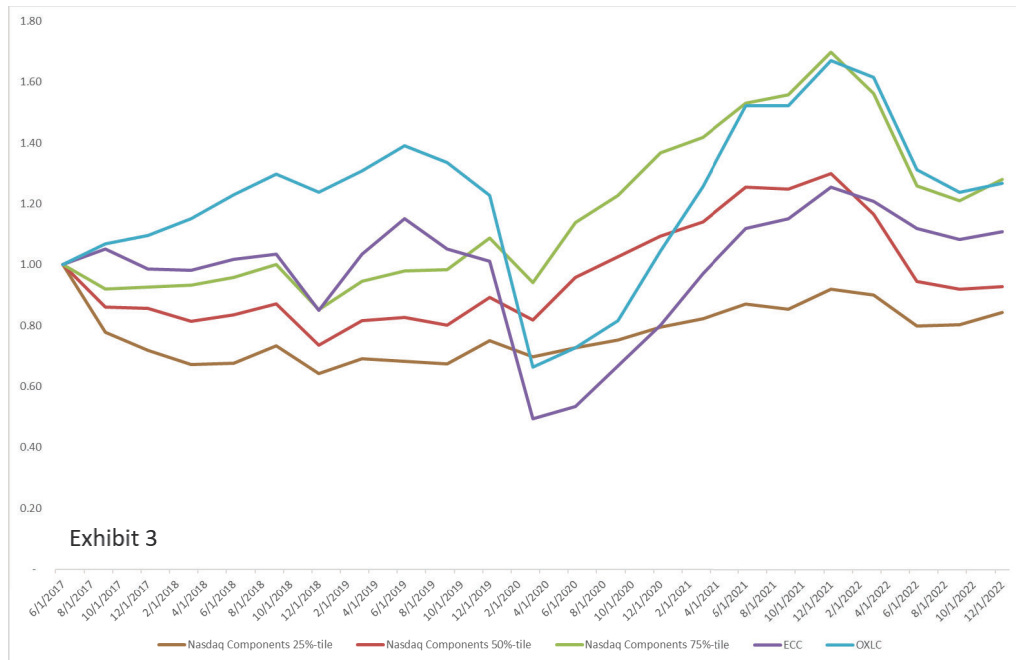
and embedded options to reinvest principal proceeds.”¹¹ This analysis directly addresses the question of whether CLO equity is more or less risky than common stock, whereas the April 12 letter only has data on total CLO losses without any precise information about actual CLO equity performance. An article about CLOs issued by Western Asset found similar results for both the 2008 and 2020 economic downturns, finding that, based on median CLO equity cash flow returns, “CLOs that were originated before the last two recessions produced better returns for shareholders than in other years.”¹²

(This section intentionally left blank)

¹¹ *Id.* at 1.

¹² Jeff Helsing, Can CLO Equity Outperform if the Economy Tips into Recession?, September 26, 2022, [Can CLO Equity Outperform If the Economy Tips Into Recession? | Western Asset](#) (See Appendix for a full copy of this article.)

The additional analysis of CLO equity in Exhibit 3 below looks at data from 2016 to 2023 to corroborate the Journal of Finance study’s conclusion about the overall outperformance of CLO equity compared to the 50th-tile of Nasdaq stock.



Source: Bloomberg

The chart in Exhibit 3 provides a better perspective on the two CLO equity ETFs, (ECC and OXLC), than the April 12 letter as it only provides data from the year 2020, which is very unique given that was the year of the government-mandated shutdowns due to COVID-19. This longer time frame provides a better sense of how CLO equity outperforms the 25th and 50th %-tile of the NASDAQ index components as of YE 2016 and tracks the performance of such stocks from YE 2016 to YE 2022, showing that CLO equity is less volatile than single-name stocks.

Note that the ECC and OXLC performance here is shown net of fees. Actual performance of the underlying CLOs would have been even higher.

Use of anecdotal evidence supplied by a segment of the industry, rather than credible data, study, or evaluation to support the RBC Proposal is contrary to the foundational principles established by regulators regarding RBC charges. The *NAIC Life & Fraternal RBC Instructions* (the “Instructions”) state that:

“the [Capital Adequacy Task Force (CATF)] and its RBC working groups are charged with evaluating refinements to the existing NAIC RBC formula. . . .The CADTF will consider different methods of determining whether a particular risk should be added as a new risk to be studied and selected for a change to the applicable RBC formula, but due consideration will be given to the materiality of the

risk to the industry, as well as the very specific purpose of the RBC formula to develop regulatory threshold capital levels.¹³

3. The proposed 45% charge does not take into account the risk mitigation features of ABS or the variety of ABS collateral types

ABS investments were originally designed with risk mitigation features in mind without any consideration of insurance capital charges. Because of their risk mitigation features and structural protections, insurers have invested in various types of ABS for decades without material issue. As noted above, the NAIC has been monitoring and studying the insurance industry's exposure to ABS investments for several years, and particularly closely since 2019. Not once in all these many years did the NAIC find a material risk to the insurance industry related to ABS residual tranches.

Two recent publications—Guggenheim's most recent annual report on the ABCs of ABS¹⁴ and the Western Asset Management article on CLO equity¹⁵—identify the following risk mitigation and structural features of ABS:

1. Over-collateralization
2. Bankruptcy remoteness
3. Diversification of underlying borrowers/payers
4. Amortization ahead of expected maturity
5. Duration matching between the investment assets and financing liabilities
6. Covenants not based on the market price
7. Active management, which in some cases can include buying in or out of the underlying, or in other cases where the investment manager can reinvest or refinance depending on market conditions and individual component performance.

The Western Asset article notes that CLO equity originated prior to the 2008 financial crisis and the 2020 Covid recession outperformed both credit and stocks, which it attributes to several of the structural features of CLOs.¹⁶ Given these findings, we think the NAIC needs to closely study these structural features of ABS before imposing an interim charge.

We also think the NAIC should consider the types of underlying collateral for the primary types of ABS, such as auto and student loans, before imposing such a high interim charge. For instance, in the NAIC's capital charges for bonds, the portfolio adjustment factor recognizes that diversification of a bond portfolio can reduce risk. In a similar manner, some ABS have thousands of underlying loans. In addition, over-collateralization, duration matching, and especially active management can significantly reduce risk for the entire security at issue and should be fully analyzed before determining an

¹³ NAIC Life & Fraternal RBC Instructions at iii, ¶¶16-17.

¹⁴ Guggenheim, The ABC's of Asset-Backed Securities (ABS), April 3, 2023, [The ABCs of Asset-Backed Securities \(ABS\) | Guggenheim Investments](#)

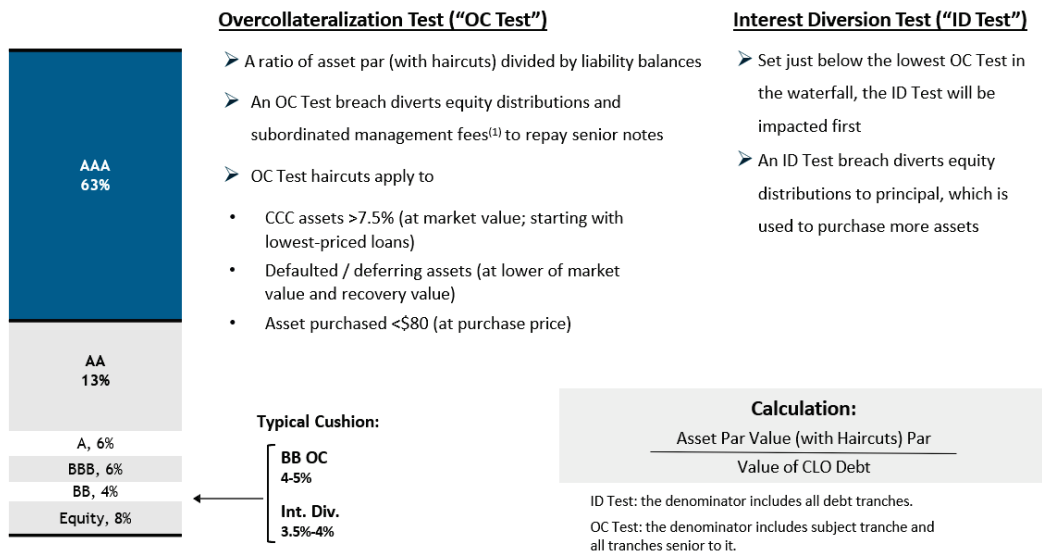
¹⁵ Jeff Helsing, Can CLO Equity Outperform if the Economy Tips into Recession?, September 26, 2022, [Can CLO Equity Outperform If the Economy Tips Into Recession? | Western Asset](#)

¹⁶ *Id*

appropriate charge. Taken as a whole, these ABS features if sufficient analysis concludes higher charges are appropriate for residual tranches, it may also conclude that lower charges are appropriate for higher tranches given they have a much better track record of fewer losses than stand-alone bonds.

As illustrated in the exhibit below, ABS are specifically designed to include risk mitigation features such as over-collateralization, excess spread protection, and refinancing optionality. These features combine to create a risk profile significantly different from any one of the individual components—including the residual tranche. Isolating the residual tranche ignores the inherent economics of this ABS structure as a whole.

CLO Structure / Structural Protection



4. ABS risk must be comprehensively studied as CLOs have been able to outperform and experience lower losses than comparable corporate bonds with the same risk rating.

As demonstrated in the chart below, the improved performance covers all rating categories.

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CLO OVERVIEW - STRUCTURE AND RISK PROFILE

- CLO tranches benefit from (i) overcollateralization, (ii) excess spread protection and (iii) refinancing optionality, which again, differentiates CLO structures from holding individual loans
- CLO fixed income tranches have experienced fewer losses historically than corporate bonds of comparable ratings, an asset class for which the SVO accepts NRSRO ratings
- Over the long term, CLO debt has experienced lower losses than corporate bonds while the residual equity has delivered consistent cash on cash returns and return on capital, even during the GFC

Historical CLO Losses vs Corporate Credit		
Rating / Tranche	Historical Corp Credit Losses ⁽¹⁾	Historical CLO Losses ⁽²⁾
AAA	0.00%	0.00%
AA	0.03%	0.00%
A	0.04%	0.01%
BBB	0.11%	0.09%
BB	0.42%	0.35%

Sources: S&P Global Default, Transition, and Recovery: 2020 Annual Global Leveraged Loan CLO Default and Rating Transition Study. Moody's Investor Service
 (1) S&P Default and Rating Transition Study. Corp credit losses assume average default rate from 1998 to 2020, and 35% recovery rate based on historical market performance
 (2) Moody's US CLO impairment rates since 1998 through 2020

Developing appropriate structured security RBC factors must be carefully developed to avoid unintended consequences. The debt and the residual risk analysis must be studied comprehensively and together. The appropriate solution is for the NAIC to take the requisite time to understand the types of ABS, their relevant risk mitigation features, and the overall resulting risk before deciding what charge to impose on all tranches, including the residual tranches—this would better reflect the actual economic risks and historical loss experience, and avoid creating market and competitive distortions.

5. Regulators must undertake their own neutral study of risks associated with ABS residuals before unintentionally creating artificial barriers and unintentionally choosing sides in a competitive battle.

Members of our coalition have talked with several regulators regarding the performance and risk history of ABS residuals. In many of these conversations, we have heard that concerns regarding arbitrage in ABS structures are primarily based on concerns from certain market participants unrelated to quantifiable investment risks. We believe that this observation may be correct.

Over the past decade, insurance company ownership and investments have witnessed new market entrants who bring new business models and competition to the market. In its September 27, 2022, Special Report, AM Best states “PE insurers tend to offer more attractive rates on their products than other insurers, in the belief that through their investment expertise, they can earn a higher yield on investments and still make an adequate spread. This competitive pricing puts more pressure on

traditional insurer that lack the same scale and find growing the business more difficult because of their more conservative crediting rates.”¹⁷ These new entrants are required to operate their businesses in the same regulatory environment (*e.g. AG 53 regarding Higher Yielding Assets in Asset Adequacy Testing*) as existing businesses. Everyone is operating under the same rules in a changing business environment and innovation that benefits consumers should be supported by NAIC rulemaking.

In a recent comment letter, one group of companies has suggested that the NAIC disregard well-accepted and tested historical data to support a 50% increase in the capital charge based on a misleading analysis. The letter makes the incongruous suggestion that CLO data from the Great Financial Crisis of 2008 is insufficient to support stress testing of data. Data from the Great Financial Crisis is widely accepted to represent an atypical and extreme stress scenario for the industry, and the studies cited above provide concrete evidence of the resilience of ABS equity even during periods of financial stress.

The NAIC must avoid unintended consequences and undertake its own neutral study of risks associated with ABS residuals. For instance, direct investments in bank loans are explicitly authorized in SSAP 26R and thus qualify for a C1 bond charge. However, in most cases the underlying collateral for CLOs are bank loans. Should the NAIC move forward with a 45% charge on CLO residuals, the effect would be a higher charge based on the form rather than the substance and would ignore the ABS structural mechanisms that make them safer than direct ownership. Additionally, a 45% charge would effectively be worse than making ABS residuals a non-admitted asset.

6. Regulators have significant supervisory tools today to address concerns regarding specific ABS investments without adopting a punitive RBC charge and causing significant disruption to the larger ABS market.

State Insurance regulators have significant authority to address any concerns they may have regarding a company’s solvency, as well as any individual investments that may be of concern to them. They utilize a variety of solvency testing and analysis tools to monitor insurer solvency and can demand a company take corrective action to address any anomaly or concern associated with the company’s financial condition. Sensitivity testing can be used to review equity tranche holdings and take supervisory action if needed, without punitively and arbitrarily assessing increase charges on all ABS and all insurers, which is unjustified.

Per NAIC accreditation standards, domiciliary regulators can call a targeted examination of an insurance company at any time, as can foreign state regulators working through the Financial Analysis (E) Working Group (“FAWG”).¹⁸ If regulators have concerns regarding the solvency of any insurance company holding

¹⁷ “Best’s Special Report, Private Equity Continues to Make Inroads in the Life/Annuity Segment,” AM Best, September 27, 2022

¹⁸ See NAIC Model Law 380, “On Examinations,” <https://content.naic.org/sites/default/files/MO390.pdf> and Model Law 385, “Model Regulation to Define Standards and Commissioner’s Authority for Companies Deemed to be in Hazardous Financial Condition,” <https://content.naic.org/sites/default/files/MO385.pdf>

ABS residuals or the ratings on individual investments held by insurers, regulators can demand additional information regarding the investment.

Considering the significant regulatory authority and the historic risk analysis on ABS investments described above, the suggested basis for the proposed RBC charge as being necessary to limit “arbitrage” occurring with ABS instruments is specious. During the debate leading up to the RBC Proposal, concerns regarding “arbitrage” were raised by NAIC staff in the Securities Valuation Office (“SVO”) which is not responsible for addressing capital charges. Even as regulators responded to these concerns raised by the SVO, no specific examples have been provided to the industry or the NAIC or exposed publicly to demonstrate how existing regulatory tools are insufficient to address these arbitrage concerns. Even if isolated examples regarding “arbitrage” do exist, a punitive and excessive RBC charge is a blunt instrument to address the concern. Instead, state insurance regulators should apply their existing and substantial regulatory authority to address and correct isolated examples of questionable or inappropriately classified assets.

7. The proposed 45% is not within the Financial Condition (E) Committee’s charge to the Working Group

In prior meetings, the RBC Proposal has been labeled as being directed by the Financial Condition (E) Committee (the “E Committee”). The RBC Proposal, however, does not align with the standing E Committee instructions. The E Committee established the Working Group with the authority to establish a proposed RBC charge with suggested assistance from an outside advisor. The specific proposal of adopting an increased factor for the residual tranches has been developed within the Working Group, whose charge to the Working Group was more general. The 2023 RBCIRE Working Agenda, disclosed as part of the Fall 2022 meeting materials for the RBCIRE lists item 12 as

“Evaluate the appropriate RBC treatment of Asset-Backed Securities (ABS), including Collateralized Loan Obligations (CLO), collateralized fund obligations (CFOs), or other similar securities carrying similar types of tail risk (Complex Assets)”

as a request from E Committee, SAPWG, and VOSTF added 1/12/2022. The comment states

“Per the request of E committee comments were solicited asking if these types of assets should be considered a part of the RBC framework.”

A change in the factor was never suggested or adopted formally by the E Committee.¹⁹ At no time did the E Committee approve of the Working Group developing a proposed RBC charge based on anecdotal evidence rather than on professionally developed data or a professional study. There was no direction from the E Committee exposed to public comment to impose an interim charge

¹⁹ Minutes of Financial (E) Committee Meeting, April 5, 2022, https://content.naic.org/sites/default/files/national_meeting/Financial%20Condition%20%28E%29%20Committee%20Agenda%204-5-22_2.pdf

8. The charge would likely be more than “Interim” and would bias the longer-term analysis that should properly be completed before establishing the appropriate charge for ABS.

The Working Group has suggested that the RBC Proposals would be implemented on an interim basis. However, the RBC Proposal makes no reference to whether the Proposed Charge is being recommended on an interim or permanent basis. In Working Group discussions, the “interim” nature of the charge seems to be the justification for adopting the Proposed Charge without any supporting data. The RBC Proposal does not include a workplan or reference how or when the proposed 45% charge would be studied, modeled, or evaluated in the future to finalize the recommendation. Based on historical precedent, this so-called “interim” charge could last years or decades. For example, the NAIC established a 15% and 23% charge, respectively, on real estate equity charges for wholly owned and joint venture equity charges. Only after over a decade of industry discourse, roughly from 2012 to 2021, did the NAIC update those charges.

Concluding Remarks

Market participants operate under the understanding that the regulatory environment will reflect true risk and historical experience. Imposing a 45% charge on ABS residuals with no evidence of significant investment or solvency risk runs counter to the integrity of the RBC system and fair competition. We respectfully request that regulators withdraw the RBC Proposal until a thorough analysis by a respected third party can be conducted to better inform sound regulatory decision-making and avoid significant unintended consequences and competitive distortions. In the meantime, we encourage regulators to use the robust tools at their disposal to address any concerns with specific insurance company investments.

We appreciate the opportunity to provide these comments. We stand ready to engage with regulators and neutral experts in continued study and evaluation of ABS residuals, and we request that the Working Group table the RBC Proposals pending the completion of a thorough study and evaluation.

Kind Regards,

Everlake Life Insurance Company	Clear Spring Life and Annuity Company
Delaware Life Insurance Company	Security Benefit Life Insurance Company

cc: Superintendent Elizabeth Dwyer, Chair, Financial Condition (E) Committee
Dave Fleming, NAIC Staff for the RBCIREWG, DFleming@naic.org.

Appendix



Can CLO Equity Outperform If the Economy Tips Into Recession?

September 26, 2022

By Jeff Helsing

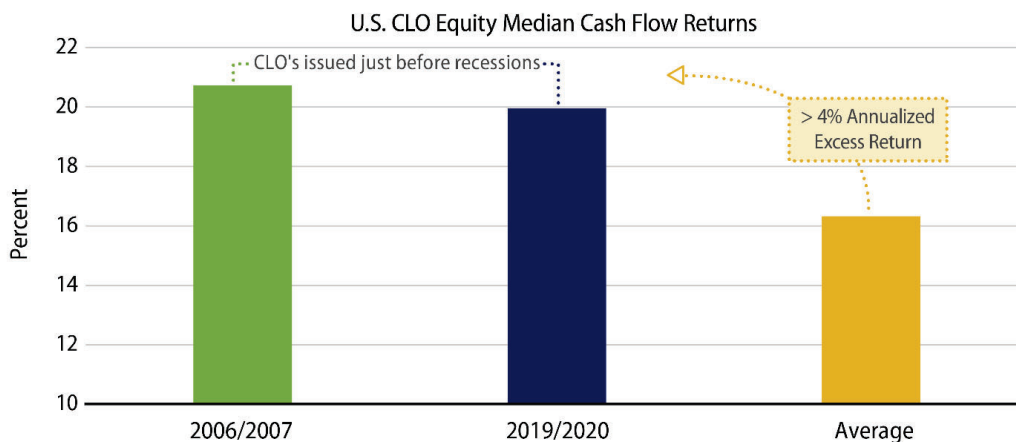
Our base case is not for a US recession in 2022, but the risks of a mild recession are increasing as higher borrowing costs and tighter credit conditions will likely weigh on investment and consumption.

If the recession is mild, where unemployment doesn't rise substantially and defaults don't pick up materially, then credit spreads may not rise to levels seen in previous recessions as in 2009 or 2020. If the recession is worse, then equity multiples will likely decline further and defaults will likely rise above historical averages—both will negatively impact the returns in equity and credit markets.

With yields around 9% in below-investment-grade-credit markets, credit is looking attractive compared to equity in a slower-growth or mild-recession scenario. However, the equity of collateralized loan obligations (CLOs) may perform even better than both of those sectors if market pricing resembles those of a recession similar to the last two.

What may be counterintuitive when reviewing business cycles and the impact they have on market returns is that the equity of an actively managed CLO—which invests in bank loans—may outperform both credit and stocks should the US tip into recession. With history providing some guidance, it's worth noting that CLOs that were originated before the last two recessions produced better returns for shareholders than in other years.

Exhibit 1: CLOs—Pre Global Financial Crisis and 2020 Covid Recession Vintages Outperformed



Source: JPMorgan. Cash flow returns are annualized for the median actively managed CLO equity invested in syndicated bank loans. “Average” represents 2002 through 2021. As of 30 Jun 22. Select the image to expand the view.

Heads I Win, Tails You Lose

Why would the equity of a CLO perform better if we head into a recession? For background, a CLO issues debt and equity securities, then the proceeds are invested in a diversified portfolio of syndicated bank loans. The bank loans provide income to pay interest and other expenses, then the remainder is distributed to equity holders. [CLOs feature structural advantages](#) that other investment vehicles don’t. They include two main sources of optionality for a CLO manager that typically enhance returns for the CLO equity holder: the option to refinance in bull markets and to reinvest in bear markets. This is akin to flipping a coin to guess the business cycle, but where both investment outcomes are positive.

When bank loan prices are falling (i.e., credit spreads are widening)—as they did during the global financial crisis and Covid-induced lockdown—a conservatively positioned CLO manager will reinvest their portfolio into higher-yielding securities. Reinvesting as spreads widen is why some CLO managers structure their portfolios conservatively at origination, as they will have several years to wait for an opportunity to swap into higher-yielding securities. On the other hand, when bank loan prices are rising (i.e., credit spreads are tightening), a CLO manager can often reduce their borrowing costs by refinancing their debt securities.

Capitalizing on the option to reinvest in bearish markets or refinance in bullish markets are two ways to increase the returns to CLO equity holders. The median manager that issued CLOs in 2006/2007 as well as in 2019/2020 locked in financing before volatility rose, then swapped into higher-yielding securities as prices declined in the respective recessions—subsequently increasing the returns to equity holders.

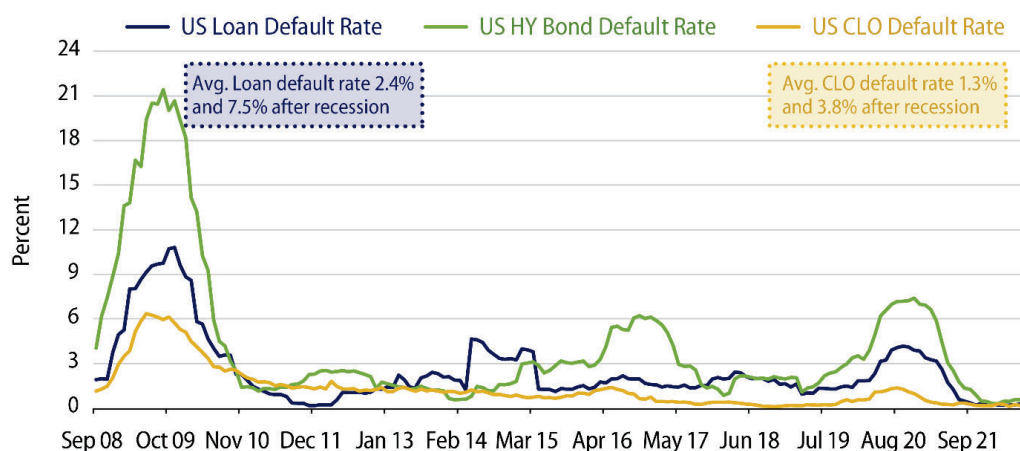
What Reduces CLO Equity Returns?

There are several other advantages to investing in CLOs that have historically supported attractive equity returns relative to other asset classes. These include covenants that aim to reduce default risk and, importantly, the covenants aren’t based on market prices.

One of the most relevant risks to CLO equity returns are defaults in the underlying bank loans. As the bank loan cash flow (i.e., the CLO’s assets) are reduced when defaults happen, there is typically less available cash to distribute to equity holders, so avoiding defaults through active selection and credit research is the goal for managers.

Also, it is worth noting that covenants in CLOs typically limit the concentration in CCC and lower-rated issues. The lower-rated and riskier company limits are typically capped at 7.5% of a CLO’s holdings. For comparison, CCCs and lower-rated issues exceeded 15% in broad loan indices in 2009 (according to the Morningstar LSTA US Leveraged Loan Index). The covenants that limit CCC and lower-rated issues’ risk may help explain why defaults in CLOs were about 50% lower than defaults in the overall bank loan market for the last two recessions.

Exhibit 2: CLO Defaults Historically Are About Half as Frequent as in the Bank Loan Market



Source: BAML, Intex, LCD. As 31 Aug 22. Select the image to expand the view.

Benefits of the CLO Structure

"The investor's chief problem—and even his worst enemy—is likely to be himself." ~Benjamin Graham

While CLO equity may outperform other asset classes, the outsized returns accrued to investors that commit to holding the securities until the CLO matures or is called may be even greater than the historical average if the market tilts into recession.

As mentioned earlier, there are several benefits to the CLO structure that have historically led to outperformance versus other asset classes. The three main structural factors that support CLO equity outperformance are: optionality to reinvest or refinance in bear and bull markets, robust match between investment assets and financing liabilities, and covenants that aren't based on market prices.

Based on the analysis of Cordell, Roberts and Schwert in 2021, the option to reinvest alone may explain about a third of CLO equity's historical outperformance versus other sectors, especially for vintages before recessions. The next two structural advantages are also meaningful to CLO equity returns as they reduce the behavior risk of both the investor and the manager. In other words, these advantages help reduce the risk of the investor or manager becoming their own enemy. For example, liability financing is essentially to the term of the investment so the CLO doesn't subject itself to the possibility of the lender changing terms when volatility rises. Also, as the capital is committed for the life of the investment, and covenants in the CLO aren't based on market prices, the CLO manager can then focus on investment fundamentals rather than being influenced or coerced into selling assets in the portfolio due to market-price fluctuations.

All of these factors may help explain why CLO equity has historically performed better than other sectors, and even more so following the last two recessions.



May 12, 2023

Mr. Philip Barlow, Chair
Risk-Based Capital Investment Risk and Evaluation (E) Working Group
National Association of Insurance Commissioners
1100 Walnut Street, Suite 1500
Kansas City, MO 64106-2197

Re: Global Atlantic Response to 2023-09-IRE Residual Factor

Dear Mr. Barlow:

Global Atlantic¹ appreciates the opportunity to comment on [2023-09-IRE Residual Factor \(“Interim Solution”\)](#) which proposes to set the Risk Based Capital (“RBC”) charge at 45% for all residual tranches on an interim basis. Our comments reflect the following three principles:

- I. The RBC factors for all assets should be based on a rigorous, data-driven analysis that incorporates both historical performances, where applicable, and the relevant substantive structural features of any investment.
- II. The RBC framework should be derived using consistent criteria across assets and risk profiles - a concept we refer to as “equal capital for equal risk.”
- III. The process employed to reach important decisions, such as the Interim Solution, should follow the traditional, transparent, and deliberative process that has been a hallmark of insurance regulation under the NAIC.

We would like to highlight that the principles above do not appear to have been followed regarding the evaluation of the Interim Solution for Residual Tranches. In conclusion, we offer an alternative to the current proposal.

I. Rigorous Work, Grounded in Data and Analytics, Not Undertaken:

The timeline to implement new RBC charges effective for all residual tranches for year-end 2023 did not allow for the quantitative rigor normally deployed prior to making changes to

¹ Global Atlantic Financial Group is a leading insurance company meeting the retirement and life insurance needs of individuals and institutions. With a strong financial foundation and risk and investment management expertise, the company delivers tailored solutions to create more secure financial futures. The company's performance has been driven by its culture and core values focused on integrity, teamwork, and the importance of building long-term client relationships. Global Atlantic is a majority-owned subsidiary of KKR, a leading global investment firm. Through its relationship, the company leverages KKR's investment capabilities, scale, and access to capital markets to enhance the value it offers clients. KKR's parent company is KKR & Co. Inc. (NYSE: KKR).

RBC. The precedential nature of setting capital charges without any analysis and data should be of concern to both the industry and regulators alike.

This approach deviates sharply from previous changes to RBC factors, such as the C-1 corporate bond factors, C-1 factor for Real Estate, C-2 Longevity factor, and C-3 factor for interest rate risk, all of which involved field testing and were supported by strong data and analytics. We are not aware of any analysis, field testing or data used to develop the “45%” factor proposed in the Interim Solution. It would be the 1) highest capital charge applied to any eligible asset; 2) would apply to a wide range of assets given the lack of clarity provided as to the intended scope of the Interim Solution, and; 3) does not appear to be linked either to an analysis of historical losses in respect of the relevant assets or to the specific risk-mitigating features that may apply to certain of the potentially in-scope investments.

The most comparable capital charge currently available is the capital charge applicable to public equities. While it was developed using a seemingly sensible approach for evaluating historical data with respect to the asset class, industry participants have also raised the possibility that given the data backing this analysis is largely out of date, it could be revisited for all equity-type investments. *See Exhibit 1* for more detail. The more recent development of updated C-1 bond factors also followed a data-gathering exercise and an analysis of the impact on insurance companies. This approach lent transparency, credibility, and predictability to the process.

As a result of the decision to forego any of the usual analysis associated with potential capital charge changes, the impact on the industry is very unclear. In 2023, for the first time, regulators received enhanced transparency related to investments in residual tranches. Insurance companies were required to report these tranches in a separate category of Schedule BA as of December 31, 2022. Unfortunately, it appears that industry participants applied these instructions with a wide range of interpretations. The total amount of residual tranches disclosed was ~\$5bn. This is less than 1.5% of the assets on Schedule BA and 0.10% of the assets on life insurance company balance sheets. Some carriers chose to disclose any tranche that could be considered a “first loss” tranche across asset classes. Some, it appears, interpreted the guidance much more narrowly, and scoped far fewer assets into the disclosure. If, indeed, only those assets disclosed in early 2023 are those that concern regulators, one would conclude that these assets do not present a pressing solvency issue for the industry.

This discrepancy in disclosure is just one of the many issues that a rigorous, data-driven field-testing approach would resolve. The stated practice of the Capital Adequacy Task Force is that “an impact analysis will be required for any factor change”. To date, to our knowledge, no studies or analysis have been performed.

II. “Equal Capital for Equal Risk” Not Upheld:

The goal of “equal capital for equal risk” is fundamental to regulating the solvency of insurance companies and protecting policy holders against risk of loss in stress scenarios. Consequently, the capital required for a given investment, or other activity, should be proportional to the risk posed by that activity.

Given the broad scope and lack of specificity as to what constitutes a “residual tranche,” this goal is unlikely to be achieved even among investments that could plausibly be considered “residual tranches.” It is even less likely to be achieved across the other categories of Schedule BA assets.

“Residual tranches” could be backed by cashflows from a wide variety of investments in everything from broadly syndicated non-investment grade rated loans to seemingly non-controversial investments in student loans, prime consumer loans, and investments backed by aircraft, railcars, infrastructure, and other “hard assets.”

Also, investments that would generally be perceived as posing far greater risk of loss, including venture capital funds, private equity funds, and hedge funds, would all now receive a lower capital charge than these “residuals.” Note that even CLO “residuals” are, by definition, structurally senior to the equity-type investments referenced in this paragraph. See *Exhibit 2* for an illustration. In the private equity example, the loans held in the CLOs are often to the very same companies as are held in the private equity fund, creating the paradoxical outcome that the first dollar of loss will appear, by necessity, in the investment receiving the lower capital charge.

If the appropriate field testing and data analysis is undertaken, the return profile of the investment would need to be considered. Given the features of structured products transactions as well as the ability to underwrite the pool of assets, residual tranches can provide cashflow day one de-risking an investment in its earliest years. *Exhibit 3* illustrates that CLO equity/residuals provide return on investment much earlier than other Schedule BA investments that are subject to a 30% charge. In fact, CLO residuals, on average, have returned 50% of their initial investments in ~3 years while, historically, other equity-like BA investments have taken ~4-6 years to return the same 50%.

At the very least, applying a 45% factor only to a portion of the assets on Schedule BA simply favors certain types of investments – and thus certain insurance companies for reasons not based on differences in the relative risk of the assets in question. This has implications for competition, asset selection, and risk management, with the potential for unintended consequences.

III. Transparent Process Not Followed:

The process to impose an interim capital charge has been a departure from the normal methodical NAIC process. A recent public call of the RBC IRE Working Group was held on April 20 and a discussion of the capital charge for residual tranches was not on the agenda. Nevertheless, this group voted to expose the 45% factor for a short 21-day comment period.

There could be significant unintended consequences arising from a capital charge factor that has not been well vetted. The increased charge might deter insurance companies from holding certain lower-risk residuals associated with stable fixed income assets, and instead steering them toward other investments with equity-like properties that could pose greater risk. This is one implication of failing to adhere to “equal capital for equal risk.”

Another implication may be a push to invest in similar risk, but under different structures. Consider that certain assets that have been presented to the NAIC as representative of residual performance, such as the CLO ETF cited, as underperforming relative to the S&P during a 1-year period of the COVID lockdown, would still require only a 30% charge as it is structured as an equity investment not as a direct investment in residual tranches.

We are also concerned that assets that have exhibited very strong performance over many cycles, including student loans, prime consumer loans, and investments backed by aircraft, railcars, infrastructure, and other “hard assets,” will become more difficult for insurance companies to hold, even though they do not pose the risk of “RBC arbitrage.” The investment structures associated with these assets are not intended to reduce capital requirements. The underlying individual assets are too small and too numerous to be rated individually, and there is no “prescribed RBC treatment for the assets (as there may be for commercial mortgage or residential mortgage loans). Instead, the aggregation of many underlying student loans, for example, into a large pool that can be rated pursuant to a securitization is the conventional way for an insurance company to participate in a valuable asset class.

Because no field testing has been done, it is also not clear what effect these changes will have on the industry. They may be applied inconsistently across jurisdictions, and even across companies within jurisdictions.

Proposed Alternative Interim Solution:

We recognize and understand that the types of investments that insurance companies make evolve over time, as an inevitable consequence of participating in dynamic financial markets. In serving our policyholders, it is incumbent upon us to identify and capitalize investments in a manner that enables us to offer security to our customers. We support the mission of regulators to ensure a stable industry that can reliably fulfill its promises through cycles.

We continue to recommend sensitivity testing as a first step in providing regulators with more clarity into the residual tranches that companies hold and those assets’ performance in stress situations. We do not believe the ownership of residual tranches poses an imminent solvency threat to the industry, and we are not aware of any information that suggests otherwise.

We support the development of a clear definition of a “residual tranche” such that a complete population can be analyzed. Once a population is defined, the appropriate framework and modeling can be identified. This should include both a historical analysis of realized losses and consideration of any structural features present in particular investments that may influence risk. The industry-wide impact of any proposed change should be evaluated, along with the risk of unintended consequences.

We believe it is critical for any proposal to be developed in a manner that supports the principle of “equal capital for equal risk.” Only once the analysis above has been completed will it be possible to determine whether the proposed capital charges are commensurate with the risk of the in-scope investments.

Conducting an appropriately transparent and deliberative process is critical. However, we acknowledge that some regulators desire to move quickly before sufficient analysis is completed. While we would argue that the low prevalence of residual tranches across the industry permits an appropriately rigorous and data-driven analysis, we expect that with clear goals, the benefit of experience gained from the recent C-1 bond project, and a group of incentivized participants, the process for developing a robust proposal can be expedited.

Thank you for the opportunity to comment on 2023-09-IRE Residual Factor and we look forward to working with you to study residual tranche risk and provide data which promotes a thoughtful development of appropriate capital charges. For all the reasons stated in this letter, we respectfully request that the current charge of 30% remains in effect until further analysis is completed.

Sincerely,

A handwritten signature in cursive script that reads "Lauren Scott".

Lauren Scott
Global Atlantic Financial Group
SVP and Head of Regulatory & Government Affairs

Exhibits

Exhibit 1 – S&P Historical Performance

S&P Historical Performance

Criteria	1960 - 1991	1991-Present
Maximum	-46.78%	-54.70%
95 th Percentile	-24.65%	-36.06%
90 th Percentile	-21.05%	-24.39%

Exhibit 2 – Corporate Capital Structure Relative to CLO Capital Structure

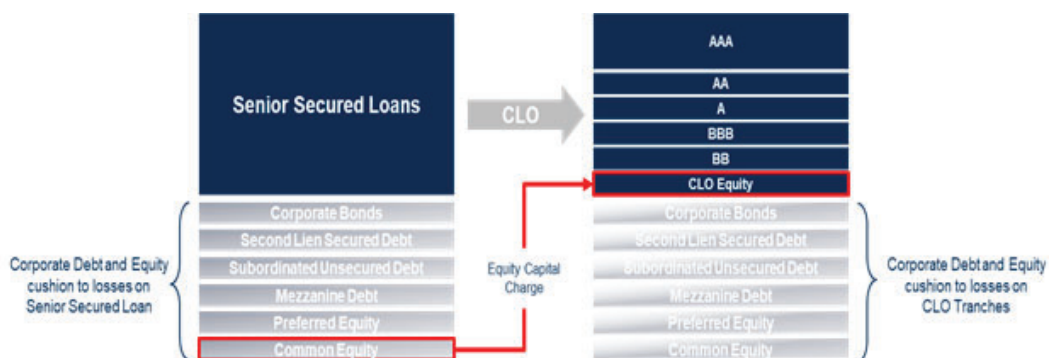
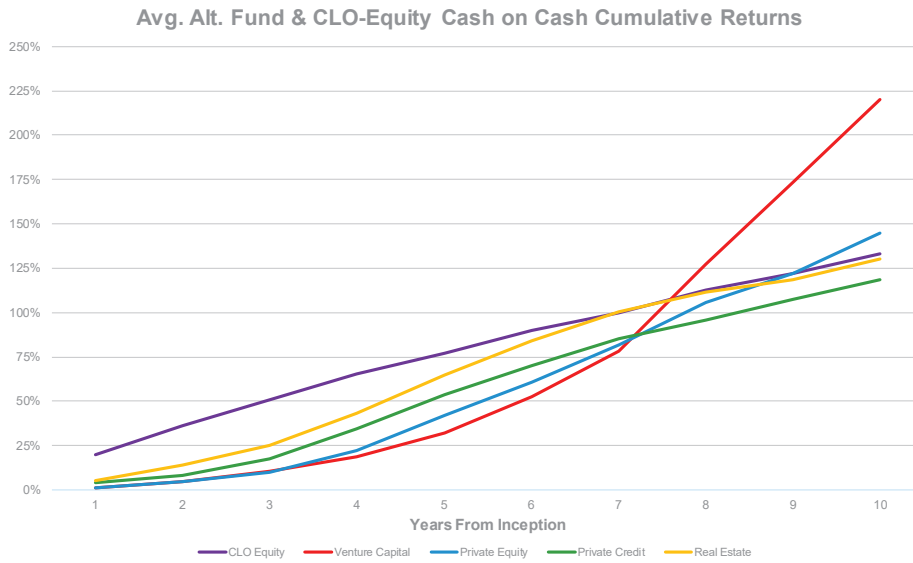


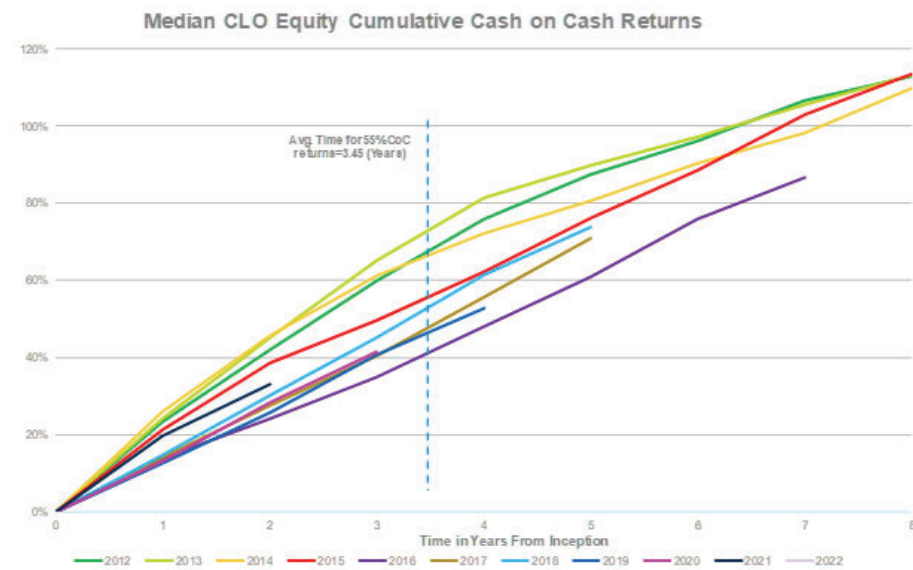
Exhibit 3 – Cashflow Profile of Residual Tranches

Comparison of CLO Equity to Various Alternatives 2012-2018 Vintage



Source: BofA Research, CLO Equity Research, March 2023

Source: Cambridge Associates, Manager_Private_Equity_Benchmark_Book_2022, September 2022; Cambridge Associates, Manager_Rea_Estate_Benchmark_Book_2022, September 2022; Cambridge Associates, Manager_Venture_Capital_Benchmark_Book_2022, September 2022; Cambridge Associates, Manager_Private_Credit_Benchmark_Book_2022, September 2022;



Source: Bank of America Research, CLO Equity Research, March 2023



May 12, 2023

Mr. Philip Barlow
Chair, RBC Investment Risk & Evaluation (E) Working Group
National Association of Insurance Commissioners
1100 Walnut Street, Suite 1500
Kansas City, MO 64106-2197

Via email: dfleming@naic.org

RE: Working Group Exposure – IRE Residual Interim Factor

Dear Mr. Barlow:

The RBC Investment Risk & Evaluation (E) Working Group has exposed a proposed interim 0.45 base RBC factor in the life RBC formula for residual tranches of CLOs and other ABS. The proposal did not include a quantitative analysis.

As you know, this process is undertaken at a time when retirement needs in our country are tremendous, while retirees are experiencing declining guaranteed income choices. With these structural demographics, our industry should be rapidly expanding and attracting capital from other parts of the financial system. However, over the past decade, U.S. life and annuity insurers have returned capital equal to 89% of today's market capitalization through share buybacks and dividends, a trend directly contrary to consumer needs. Fundamentally, this trend is due to the complex and often inconsistent frameworks that govern insurers, effectively constituting prohibitive obstacles for many investors. Capital framework inconsistencies are a key underpinning to equity capital frustrations. While RBC has performed well in ensuring life companies' solvency since the 1990s, an acknowledgement of its limitations is a first step in improving outcomes for policyholders. Under that principle, we write to express our concern with the process and express no opinion on the ultimate level of the factor. We are not active residual investors.

As we and others have written in the past, the data demonstrates that investment grade structured securities present safer credit risk than investment grade corporate bonds.¹ After more than two decades of data—decades that included major economic disruptions including the dotcom bubble, the financial crisis, and COVID—that conclusion is robust. It is no mark against the reliability of this data that it does not stretch back as long as the data concerning corporate bonds. Nonetheless, on the basis of stated concerns regarding arbitrage in residual tranches, we are observing a rapid structural shift in a significant but incomplete portion of the regulatory framework for insurer investments through concurrent changes to NAIC designations, RBC capital factors, regulatory processes and the role and oversight of NRSROs.

¹ E.g., Athene "[Understanding Structured Credit: Perspectives for Insurance Capital Requirement](#)", December 2, 2022; Professor Robert Jarrow and Donald R. van Deventer, "[A Bottom-up, Reduced Form Credit Risk Model Approach for the Determination of Collateralized Loan Obligation Capital](#)", January 2023.

We believe these processes, including any on an expedited basis, should be data-driven and result in asset capital factors that align with risk across all asset classes in a comprehensive ‘equal capital for equal risk’ framework. The fact that RBC is a “blunt instrument” does not mitigate the management incentives created by the RBC model, which of course involves broad regulatory intervention rights upon control-level triggers. Our comments below identify our concerns with the increasingly inconsistent regulatory framework, as well as third party information that influenced the proposed factor.

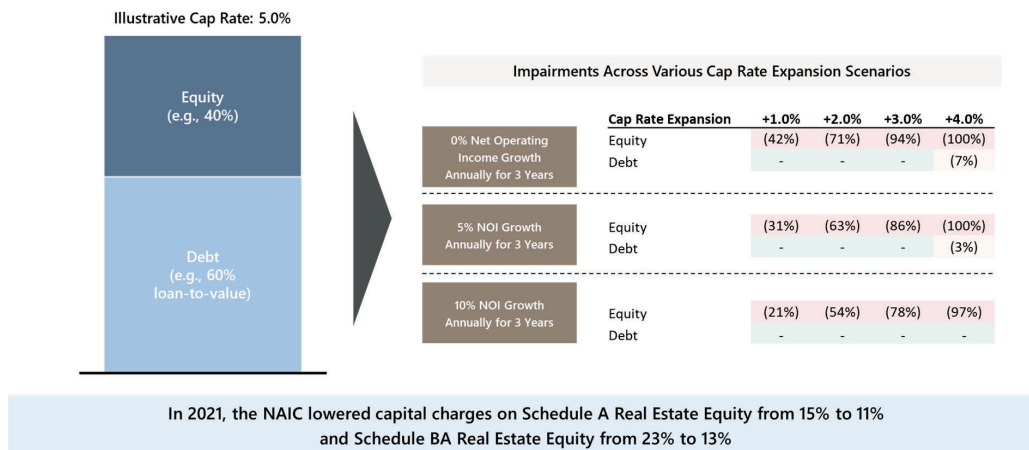
Equal Capital for Equal Risk

We highlight two examples below that illustrate our concerns across asset classes.

Real Estate Equity

As you probably are aware, heightened risks have developed in commercial real estate markets. We believe that equity investments in certain subsectors of commercial real estate represent significant capital risks to insurers. Real estate valuations are often measured through ‘capitalization rates’ (or “cap rates”), which represent a net operating income-to-value ratio for a given property.² As illustrated below, in the current market, where cap rates are rising and there is little or negative net operating income growth, a significant quantum of commercial real estate equity holdings may be impaired when debt on these properties matures.

There Has Been a Massive Change in the Real Estate Markets



In light of these metrics, it is difficult to discern why, in 2021 the NAIC lowered capital factors on Schedule A Real Estate Equity from 15% to 11% and Schedule BA Real Estate Equity from 23% to 13%. We are unaware of any consistent, data-driven approach that would lower capital

² Cap rate is a measure of yield earned on a commercial real estate property (calculated by dividing NOI by property value). See [Athene Perspectives on Real Estate: Cap Rates, Explained | JPMorgan Chase](#).

requirements for real estate equity in 2021, and raise capital requirements for residual tranches of CLOs today.

Moreover, the charges for commercial real estate are inherently procyclical, reaching a minimum at the market peak. The capital requirements for commercial real estate vary based on prescribed metrics, including debt service coverage ratio (“DSCR”).³ The DSCR is measured using three-year trailing income on the properties, resulting in capital requirements that are lowest at the peak of the market. This feature is, in general, avoided by other rulemaking bodies in the United States and globally.⁴

Corporate Equity






Since the time of the initial “no-arbitrage” dialogue in 2022, some have considered why the principle has not been applied to corporate securities. Like structured credit, corporations issue different tranches of securities to investors with different risk tolerances – senior secured debt, senior unsecured debt, junior debt, preferreds, and equity. The insurance capital framework for corporate bonds uses ratings to determine the appropriate capital charges for the debt and preferred tranches, and then assigns a flat “equity” charge for all corporate equity. But, similar to the different types of collateral pools for structured credit (with auto loans, airplane leases, and consumer loans as collateral), there are many different types of companies with different underlying risk profiles (for example, car manufacturers and technology companies with negative free cashflow).

The chart below illustrates how the equity risk in five different companies held by U.S. insurers can differ materially despite carrying the same capital charge. A true application of the “no-arbitrage” principle would also apply differentiated equity capital charges on corporate securities based on the underlying business model, financial profile, and risks of the corporations that issued those securities. This principle should also be examined and applied across every class of equity and debt within the RBC framework.

³ DSCR measures the amount of income generated in excess of interest payment obligations.

⁴ See for example, [Federal Reserve Board votes to affirm the Countercyclical Capital Buffer \(CCyB\)](#), or [The capital buffers in Basel III - Executive Summary](#).

A Comparison of Similarly Rated Companies⁵

					
Market Cap (\$bn)	\$457.7	\$260.1	\$327.8	\$47.2	\$7.4
Price Change Since 52 Wk High	(7)%	(11)%	(5)%	(14)%	(85)%
Ratings (S&P/Moody's/Fitch)	AAA/Aaa/NA	A+/A1/A	AA-/Aa2/NA	BBB-/Baa3/BBB-	NR
2021 EBITDA (\$bn)	\$32.6	\$12.8	\$33.4	\$6.4	(\$0.3)
Net Debt / EBITDA	0.6x	2.7x	0.9x	3.0x	NM
Implied LTV ¹	7%	15%	10%	32%	21%
Commentary	Better credit rating than the U.S. government	Strong post-pandemic recovery, with revenue up 4% from pre-pandemic levels	S&P downgraded in 2021. Idiosyncratic exposure to climate change and oil prices	Downgraded to high yield in 2020	Affirm is down ~85% from its 52-week high and has negative EBITDA

We highlight these examples to illustrate our concerns with consistency across asset classes. We are not advocating for increasing or decreasing capital requirements, only that the NAIC and stakeholders should take the time to develop overarching principles that are designed to achieve appropriate, data-driven charges and “equal capital for equal risk”. Without such a comprehensive framework, distortions will endure, and there will continue to be industry risk-taking incentives divorced from true economic risk.

Third Party Data

We also write regarding certain data that has been cited in support of the interim factor from one group of companies (“Equitable Letter”, dated April 12, 2023).

A 25 Year Time Period Is More Conservative

The Equitable Letter suggested that securitization markets have a history that is “less robust than the 40-year history used to develop the corporate bond factors.” Using a 25-year estimation period to determine capital charges may actually be more conservative than using longer periods given that substantial market disruptions (e.g., dot com downturn, the great financial crisis, COVID and the recent banking crisis). In the spirit of equal capital for equal risk, we utilized the C-1 framework to analyze the 95% two-year capital factor on the S&P 500 over different windows ranging from 20 to 70 years. Perhaps not surprisingly, the highest implied capital factor resulted when the most recent 25-year window was used rather than a longer 40- or 70-year window.

Changes in the Financial Markets Since 2008

The Equitable Letter included structured credit issued before and after the financial crisis. As discussed in our whitepaper on structured credit (available [here](#)), terms in the structured credit market have changed materially since the financial crisis. The letter does not account for these

⁵ Market Data as of May 19th, 2022. ‘Implied LTV’ represents an illustrative concept for comparison to securitization calculated as Debt / (Debt plus Market Capitalization). Source: company filings, Bloomberg.

changes, and included losses for a securitization market that is non-existent today (Pre-GFC Non-Agency RMBS). Diagram 1 set forth in the Appendix, using CMBS as an example, illustrates that structured products issued post-crisis (2.0) experienced significantly lower cumulative losses from structural protections⁶ than pre-crisis (1.0).

Residual Tranches Earn Income, Which Can Offset Losses

The letter’s graph “Historical Collateral Losses vs. Residual Tranche Size” fails to acknowledge a fundamental aspect of the investment proposition of residual tranches by overlooking income in the form of excess spread. The income or excess spread received operates to shield losses and is highly relevant to an accurate presentation of the concept in that graph.

If Calibrated Within the C-1 Framework, the Analysis Would Imply a Different Factor Than 45%

The Equitable Letter points to Oxford Lane Capital Corp. (OXLC) and Eagle Point Credit Company (ECC) as proxies for the underlying residuals and the 60% price loss over the first few months of 2020 as evidence of the need for a higher capital charge. However, this is divorced from the C-1 Framework, capturing risks not intended to be covered by C-1 – in particular, liquidity. In addition, the chart uses a maximum loss over a 1-year calculation window, rather than the 95% worst 2-year return that was used to calibrate the 30% equity factor, and excludes other items (e.g., income offsets) that are contemplated within the framework.⁷

In the interest of highlighting the materiality of different features within the C-1 framework, we performed a simple exercise of comparing the 60% loss with the 95% 2-year loss and then considered the impact of dividend income resulting in a 35% factor, which would need to be further adjusted for other aspects of the C-1 framework, such as taxes.⁸ The results of this analysis appear in the Appendix, Diagram 2. We are not proposing such a factor; rather we are highlighting the need for a thoughtful process when estimating the charges.

* * * * *

⁶ See Athene “[Understanding Structured Credit: Perspectives for Insurance Capital Requirement](#)”, p. 17.

⁷ These companies are incrementally leveraged with preferred shares, and shareholders bear significant fees. Therefore, performance of the common stock is not equal to the performance of underlying residuals. It would be expected that the stock would perform adversely relative to the underlying residuals given the presence of these additional factors in declining conditions.

⁸ These numbers represent the weighted average across ECC and OXLC with the ECC time series starting on 10/9/2014 and OXLC on 1/202011.

As noted, we express no view on the proposed 0.45 interim factor other than our significant concerns with the process and the absence of a comprehensive framework. We believe any review, even an expedited one, should be data-driven and result in asset capital factors that align to an 'equal capital for equal risk' framework across asset classes. We appreciate the opportunity to comment.

Sincerely

A handwritten signature in black ink, appearing to read "D. Niemann", is positioned above a horizontal line.

Doug Niemann
Executive Vice President and Chief Risk Officer

Appendix

Diagram 1

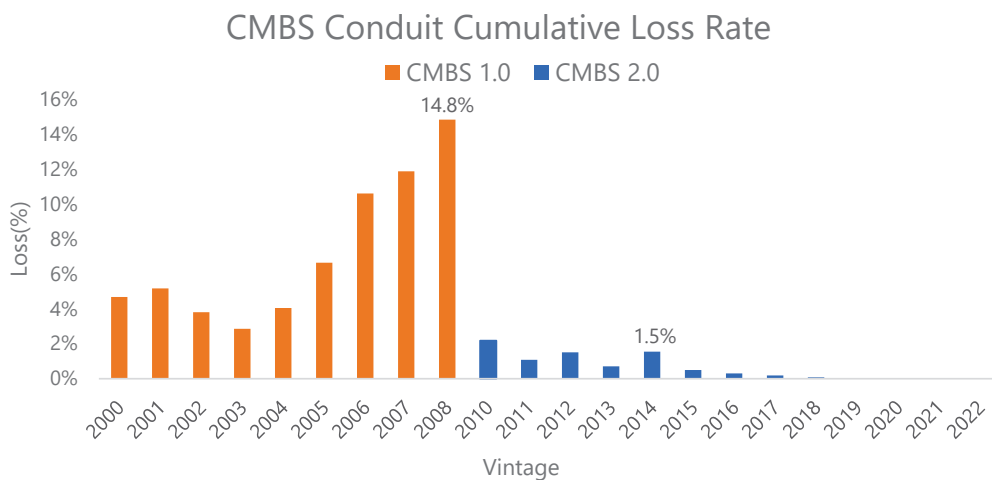
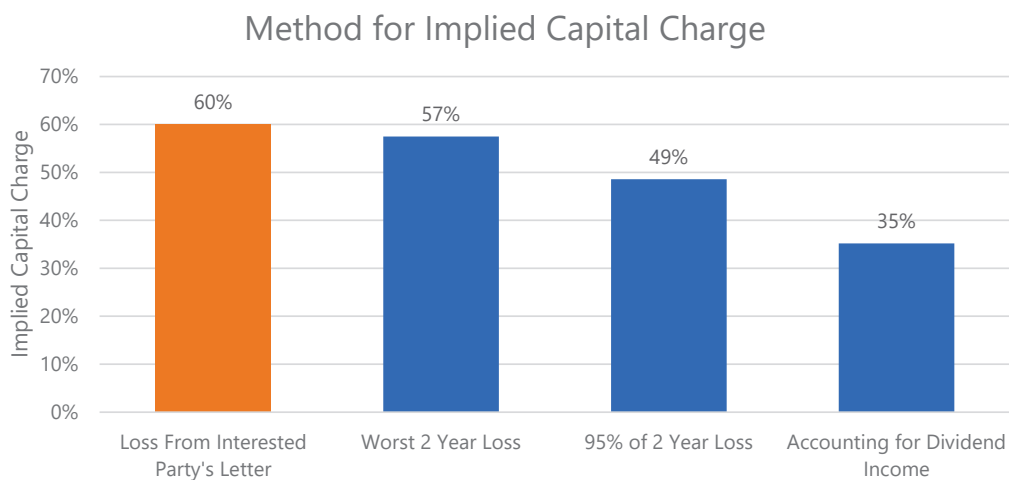


Diagram 2



May 12, 2023

Mr. Phillip Barlow
Risk-Based Capital Investment Risk and Evaluation Working Group
National Association of Insurance Commissioners
1100 Walnut Street, Suite 1500
Kansas City, MO 64106-2197

RE: Exposure 2023-09-IRE Residual Factor

Dear Mr. Barlow:

Thank you for the opportunity to comment on the April 20, 2023, proposal by the Risk-Based Capital Investment Risk and Evaluation (E) Working Group (the "Working Group") to establish an interim 45% Risk-Based Capital ("RBC") charge for "residual tranches or interests" of all asset-backed securities. We very much appreciate the hard work that the members of the Working Group, NAIC staff and others have dedicated to studying this issue. However, we believe that implementing the proposed interim charge for 2023 would amount to a "rush to judgment" given that there is still much work and analysis that needs to be done to meet the NAIC's high standards of scrutiny that characterizes its prior work on issues like this one.

For the reasons described below we respectfully submit that the performance data for CLOs does not support a higher risk charge.

- The performance of CLOs demonstrates that they **do not** present the same investment risk as the underlying investments comprising CLOs.
 - CLO performance since 1999 demonstrates that they have had lower default rates than other loans or high yield investments, including during the financial crisis of 2008-2009.
 - CLOs' historically low default rates compare favorably overall to corporate debt.
 - The break-even underlying default rate for CLO equity is equivalent to BB corporate rating.
 - CLO equity investments have held up well in adverse stress scenarios; median equity IRRs for redeemed deals issued 2005-2007 were higher than 20% and for 2020 deals, higher than 40%.
- CLO performance data does not support higher capital charges, including on the equity tranche of CLOs. Yet, the proposed 45% interim charge would cause insurers to carry a disproportionate amount of capital (i.e., a 50% increase) relative to the risk of these investments.

For the foregoing reasons, we urge the Working Group to reject the proposed 45% interim charge. There is no data supporting that specific charge. On the other hand, the performance data for CLOs indicate that the current risk charge is appropriate. We would be happy to provide you and the Working Group with the data referenced in our letter. Given the volume of comments we expect you to receive, we wanted this letter to be as concise as possible.

Sincerely,

Nassau Financial Group



May 12, 2023

Dear Chair Barlow, Mr. Fleming, and members of Risked-Based Capital Investment Risk and Evaluation (E) Working Group (the “Working Group”):

We appreciate the opportunity to comment on the proposed interim Risk-Based Capital (“RBC”) solution for residual interests [exposed by the Working Group in April 2023](#).^{1 2} We believe a more thorough process is needed before adopting the proposed 45% RBC for CLO equity,³ even on an interim basis. Additionally, robust analysis is desirable to provide a sound basis to revise the RBC treatment broadly for other asset classes.

We recommend allowing the NAIC CLO Ad Hoc working group to complete its detailed analysis and modeling process for CLOs prior to implementing an interim change to CLO equity RBC. A comprehensive analysis would provide a sound basis. We support the analytical work undertaken by the NAIC. In fact, PineBridge has been actively participating in the modeling efforts led by the NAIC CLO Ad Hoc working group. We expect CLO equity loss rates to be driven by a variety of factors such as collateral composition, leverage, and manager profile. We believe active collateral management, portfolio diversification, and structural protections have all contributed to the strong track record of CLOs as stated in our [July 15, 2022 response letter to the NAIC](#).⁴

Given that the analytical work to date has been largely focused on CLOs, we are concerned that assigning the CLO equity risk charge (to be determined), or the proposed interim RBC of 45%, to the residual interests of other types of structured assets is unsupported. CLOs are not necessarily comparable to other securitizations. As seen in other comment letters and prior modeling work for other securitized products (e.g., CMBS and RMBS), there are significant differences in deal structure and performance across structured assets. CMBS, RMBS, and sub-prime autos experienced more severe losses during times of extreme stress such as the 2008 global financial crisis as compared to CLOs.⁵ A logical sequencing for determining appropriate RBC treatment for other asset classes is to continue the NAIC’s analytical efforts on CLOs (including the modeling work led by the NAIC CLO Ad Hoc working group). After the CLO results have been thoroughly analyzed, we would recommend applying a consistent framework regarding cashflow analysis and stress testing to determine an appropriate solution for other structured asset classes.

We support having a sound basis for any RBC revision and do not believe that it is prudent to increase RBC for residual interests broadly due to the NAIC’s concern around capital arbitrage, which was cited as one of the primary reasons for the proposed RBC increase. While it is possible certain residual interests could warrant RBC factors greater than 45% due to capital arbitrage or other reasons, not all structures create capital arbitrage. In [our February 2023 comment letter](#) to the Valuation of Securities Task Force (“VOSTF”),⁶ we shared a framework to help fret out adverse cases. Below is an example of a structure held by various insurers demonstrating that some structures are not aimed at achieving RBC arbitrage, and in fact, they may have higher RBC than that for the underlying assets, i.e., the sum can be greater than the parts.

¹ [2023-09-IRE residual factor.pdf \(naic.org\)](#).

² [Materials - Risk-Based Capital Investment Risk and Evaluation \(E\) Working Group \(naic.org\)](#), April 20, 2023.

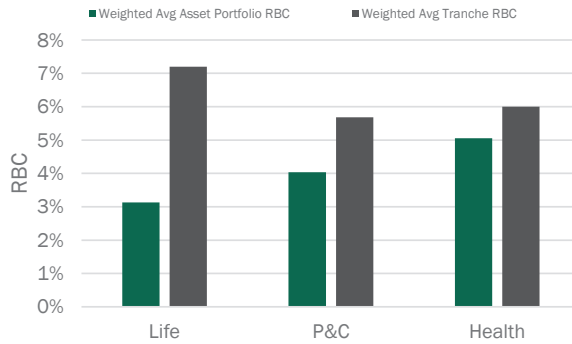
³ For purposes of this letter, we only refer to broadly syndicated loan (“BSL”) CLOs.

⁴ [Agenda - VOSTF \(naic.org\)](#), 2022 Summer National Meeting, Valuation Of Securities (E) Task Force, August 11, 2022.

⁵ [Agenda - VOSTF \(naic.org\)](#), 2022 Summer National Meeting, Valuation Of Securities (E) Task Force, August 11, 2022.

⁶ Materials for 2023 NAIC Spring National Meeting, Valuation of Securities (E) Task Force Thursday, March 23, 2023.

PineBridge Investments
65 E 55th St, New York, NY 10022



In conclusion, we strongly recommend allowing the working groups to collaborate with industry and properly model CLO residuals first, and then apply a consistent modeling framework to other structured assets, before implementing any changes to residual interest RBC broadly.

Sincerely yours,
PineBridge Insurance Solutions and Strategies, CLO team, Leveraged Finance team



May 12, 2023

VIA ELECTRONIC SUBMISSION

Mr. Philip Barlow, Chair
Risk-Based Capital Investment Risk and Evaluation (E) Working Group
National Association of Insurance Commissioners
1100 Walnut Street, Suite 1500
Kansas City, MO 64106-2197

**Re: Comments regarding Risk-Based Capital Investment Risk and Evaluation (E)
Working Group 2023-09-IRE Residual Factor Proposal**

Dear Mr. Barlow,

The American Investment Council (“AIC”)¹ welcomes the opportunity to comment on the National Association of Insurance Commissioners (“NAIC”) Risk-Based Capital Investment Risk and Evaluation (E) Working Group (“RBCIRE WG” or “Working Group”) exposure of *RBC Proposal Form 2023-09-IRE Residual Factor* regarding the proposed 45% risk-based capital (“RBC”) factor for Residual Tranches or Interests reported on Schedule BA of the Annual Statement for life insurance companies and fraternal benefit societies.

The AIC appreciates the NAIC’s objective of promoting insurer solvency and policyholder protection by ensuring that the various tranches of asset-backed securities (“ABS”) are assigned appropriate RBC capital charges. We also understand that certain external stakeholders are advocating for state insurance regulators to take action on perceived issues regarding insurer ABS investments, which, as you know, have historically performed quite well.

¹ The American Investment Council, based in Washington, D.C., is an advocacy, communications, and research organization established to advance access to capital, job creation, retirement security, innovation, and economic growth by promoting responsible long-term investment. In this effort, the AIC develops, analyzes, and distributes information about private equity and private credit industries and their contributions to the US and global economy. Established in 2007 and formerly known as the Private Equity Growth Capital Council, the AIC’s members include the world’s leading private equity and private credit firms which have experience with the investment needs of insurance companies. As such, our members are committed to growing and strengthening the companies in which, or on whose behalf, they invest, to helping secure the retirement of millions of pension holders and to helping ensure the protection of insurance policyholders by investing insurance company general accounts in appropriate, risk-adjusted investment strategies. For further information about the AIC and its members, please visit our website at <http://www.investmentcouncil.org>.

AMERICAN INVESTMENT COUNCIL

For example, collateralized loan obligations (“CLOs”) have historically performed – and continue to perform – better than equivalently rated corporate debt instruments. Along with the performance of CLOs, it is significant to note that studies conclude that CLO default rates are substantially lower than default rates for corporates with equivalent ratings. In fact, studies indicate that the number of cumulative losses that would have had to occur with respect to the loans underlying CLOs for CLOs to have suffered significant defaults during the 2008-2012 financial crisis is significantly higher than what actually occurred during such time (assuming a reasonable recovery rate).² These consistent returns, including the performance of ABS residuals, have been important in supporting insurers’ core mission of meeting policyholder obligations.

For those reasons, we support a thoughtful, methodological approach to assessing residual tranche capital charges (and ABS considerations more broadly), characteristics which, as a standard setting organization, have long been hallmarks of the NAIC and its consensus-driven process. Furthermore, while we can see the utility of the proposed sensitivity analysis as an additional regulatory tool, we do not believe changing capital charges prior to completion of data driven analysis will improve policyholder protection, but rather will unduly increase costs for both insurers and policyholders.

Life insurers also face risks when they are discouraged from accessing appropriate investments that support policyholder obligations. The consequence of this is typically to increase costs for policyholders, reduce availability of products, and/or place downward pressure on insurance company capital. Consequently, we strongly recommend against taking hasty action that could constrain insurer liquidity, or otherwise disrupt the capital markets, during an uncertain economic environment.

To date, the NAIC has not conducted a rigorous, data-focused assessment of what might constitute a proper residual tranche capital charge.³ The lack of a supporting quantitative analysis was observed by the American Academy of Actuaries (“Academy”) during the RBCIRE WG’s December 2022 meeting, which, in the same context, stated that it had “zero confidence” in the accuracy of the RBCIRE WG’s December 2022 capital charge proposal. The issue of what constitutes a “residual tranche or interest” also seems to be unresolved.⁴

The Working Group appears to be considering an untested capital charge on an ill-defined asset class. What we do know at this stage is that the “interim” RBC solution for residual tranches is expected to last in perpetuity for any asset class for which a dedicated modeling methodology is not developed (a process that, for CLOs, is proving to be more complex than may have been initially anticipated). We also know that, to the extent that ABS investment risk has been assessed more broadly, the NAIC has routinely concluded that insurer aggregate ABS

² See e.g., Moody’s *Impairment and Loss Rates of Global CLOs* (June 2021) at pp. 14-19 (Appendix I: List of CLO material impairments worldwide).

³ Subsequent to the December 14, 2022 RBCIRE WG meeting, the Working Group agreed to reduce the number of RBC factors for ABS residual tranches from three to one – again, seemingly without quantitative analysis or support.

⁴ See e.g., RBCIRE WG February 27, 2023 *Meeting Minutes* at page 4 (page 3 of Attachment A), available at: https://content.naic.org/sites/default/files/national_meeting/RBCIREWG_2023SpringNM_Materials.pdf.

AMERICAN INVESTMENT COUNCIL

exposure is small and does not currently present a solvency risk to the industry.⁵ State regulators have tools available to them to address concerns about individual company investments. These facts alone support a more methodological approach to the “interim solution” work stream.

Importantly, the RBCIRE WG recently gained access to new ABS investment data that was included for the first time in insurers’ 2022 year-end reports. That data should facilitate a proper analysis of, or otherwise serve as a starting point for, a number of the considerations referenced above, including how to appropriately define a “residual tranche or interest” for purposes of Schedule BA. Careful analysis of that data is also essential for the consideration of other issues, such as: the impact that a single RBC capital charge could have on insurer RBC; whether such a charge might disproportionately or unintentionally impact certain investments or asset classes; and, at the most fundamental level, whether the baseline assumptions underpinning the Financial Condition (E) Committee’s mandate to the RBCIRE WG to develop an “interim solution” continues to be fit for purpose.

In light of the foregoing considerations, we encourage the RBCIRE WG to leave the RBC factor at 30%, while undertaking a more quantitative and methodological approach to any potential “interim” solution with the benefit of stakeholder engagement. We welcome the opportunity to serve as a resource to the RBCIRE WG as it considers both “interim” and “long-term” regulatory frameworks for ABS and would be pleased to present or otherwise provide insight into our members’ perspective on these issues.

Thank you for the opportunity to comment. We look forward to continuing to work with you on these important issues.

Sincerely,

/s/ Rebekah Goshorn Jurata
General Counsel
American Investment Council

cc: Mr. Dave Fleming
Senior Life Risk-Based Capital Analyst
National Association of Insurance Commissioners (via email)

⁵ See e.g., NAIC Capital Markets, Special Report, *Collateralized Loan Obligation Stress Testing U.S. Insurers’ Year End 2021 Exposure*, January 5, 2023, available at: <https://content.naic.org/sites/default/files/capital-markets-special-reports-clo-stressed-analysis-ye2021.pdf> (regarding collateralized loan obligations); NAIC Capital Markets, Special Report, *U.S. Insurers’ Exposure to Consumer Asset-Backed Securities as of Year-End 2018*, August 7, 2019, available at: <https://content.naic.org/sites/default/files/capital-markets-special-report-consumer-asset-backed-securities.pdf>. Here, too, the Academy has reached a similar conclusion in the context of CLOs.

Draft: 8/9/23

Risk-Based Capital (RBC) Investment Risk and Evaluation (E) Working Group
Virtual Meeting
April 20, 2023

The RBC Investment Risk and Evaluation (E) Working Group of the Capital Adequacy (E) Task Force met April 20, 2023. The following Working Group members participated: Philip Barlow, Chair (DC); Thomas Reedy (CA); Wanchin Chou (CT); Ray Spudeck (FL); Kevin Clark (IA); Roy Eft (IN); Fred Andersen (MN); Debbie Doggett (MO); Lindsay Crawford (NE); Bob Kasinow and Bill Carmello (NY); Dale Bruggeman and Tom Botsko (OH); Rachel Hemphill (TX); Steve Drutz and Tim Hays (WA); and Amy Malm (WI).

1. Discussed Comment Letters Received on Residual Tranches

Connie Jasper Woodroof (CJW Associates) said her only comment was that the proposal was strictly for the life risk-based capital (RBC) formula, but property and health companies could also have residual tranches, and those would only be subject to a 20% charge for the RBC. She said this may need to be addressed in the other formulas. Barlow said they did not intend to ignore the health and property/casualty (P/C) formulas, but the issue is most pronounced for life companies, and the current proposal is only for the life formula. He believes the initial referral received from the Financial Condition (E) Committee indicated a focus on life first.

Christopher Halldorson (Prudential Financial—Prudential) said there is currently no theoretical foundation for the current capital treatment of residual tranches, and the 30% capital charge was developed based on Standard & Poor's 500 index (S&P 500) experience between 1960 and 1991. He said there were not any residual collateralized loan obligation (CLO) tranches included in that analysis. He said there has been some analysis since that indicates 30% seems quite low, given the volatility of the underlying collateral of these types of transactions.

Kim Welsh (Athene) said Athene is not opposed to the proposal to employ one factor instead of three, but it continues to have concerns about the interim solution. She said Athene believes everything should be viewed through the principle of equal capital for equal risk, and structured products need to be reviewed holistically with respect to the risk in other asset classes.

Hemphill said she appreciated the comments from and dialogue with all the interested parties on both sides, which really helped her understand the issues. She said she understands there is a lot of sensitivity on this topic, and it is important to have an inclusive and transparent delivery process so that decisions that best represent the relevant facts will be made.

2. Adopted the Residual Tranche Structure Change

Barlow said the proposal is revised from the recommendation from the Valuation of Securities (E) Task Force, which included three buckets for residuals and only one bucket for the interim proposal. He said this is for all residual tranches that are reported in the annual statement and are not limited to CLOs or any other particular type of structure.

Chou made a motion, seconded by Botsko, to adopt the residual tranche structure change. The motion passed unanimously.

3. Adopted the Sensitivity Test

Steve Clayburn (American Council of Life Insurers—ACLI) said the proposal adds a line to incorporate the residual tranches into the sensitivity test. Barlow said the Working Group was not able to expose this structural change for the sensitivity test by the normal timeline but asked for and did not get any comments from vendors on their ability to handle this.

Clark made a motion, seconded by Crawford, to adopt the sensitivity test structure change. The motion passed.

4. Exposed a Residual Tranche Factor for Comment

Andersen made a motion, seconded by Stolte, to expose a 45% interim RBC charge for the residual tranches. The motion passed unanimously.

Having no further business, the RBC Investment Risk and Evaluation (E) Working Group adjourned.

SharePoint/NAIC Support Staff Hub/E Committee/CADTF/2023-2-Summer/RBCIREWG/RBC Investment Risk 04-20-23 Minutes.docx

Principles for Structured Securities RBC

Presentation to NAIC's RBCIRE
 August 13, 2023
 Steve Smith, MAAA, FSA, CFA
 Academy C-1 Subcommittee, Chairperson

Executive Summary— C-1 Asset Modeling

- The American Academy of Actuaries proposes a flowchart to determine whether (a) an asset class needs to be modeled and (b) whether securities within an asset class need to be modeled individually to determine C-1 factors.
- Preference is given toward simpler solutions—if an existing factor can be used, it should be used. Individual security modeling for C-1 determination is a last resort.



Executive Summary— Principles-Based Approach for Structured Securities

- If the result of the flowchart is that an asset class requires modeling, the Academy would support a principles-based approach to the derivation of C-1 factors
- A principles-based approach to RBC for structured securities will allow regulators flexibility in adapting to new structures as they emerge in the marketplace
- This presentation proposes several candidate-principles
 - The Academy supports each of these candidate-principles, but we believe reasonable and informed people may disagree and are seeking guidance from regulators
 - We request that regulators identify which candidate-principles accurately reflect their views—these can then be incorporated into a principles-based approach to structured securities RBC

Discussion Topics

- I. C-1 Modeling Flowchart
- II. Structured Securities C-1 Principles
- III. Appendices
 - a) Appendix A—RBC Arbitrage
 - b) Appendix B—Definitions of Terms



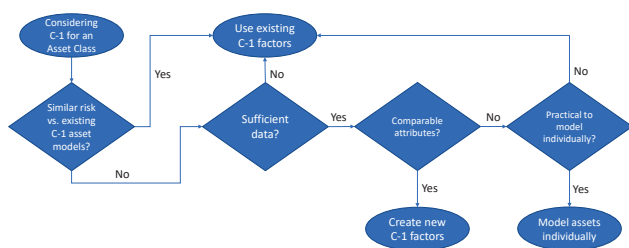
C-1 Modeling Flowchart

Threshold Questions

- For an asset class to be considered using this flowchart, it should first be verified as having all of the following attributes:
 - Materiality or likely materiality in the future across the industry. Allocations from a small handful of companies would not justify changes to the RBC formula.
 - The risk that would be modeled needs to be incorporated in C-1. For example, illiquidity alone would not be a sufficient justification because C-1 does not measure illiquidity risk.
 - The expected benefits of a more precise calculation should outweigh the expected costs of building and using a new model. Costs include both time and energy spent to build the model as well as the negative effect of added complexity within the RBC formula.
- The burden to verify these attributes falls on the party asking for a more exact determination of RBC



C-1 Modeling Flowchart



Decision: similar risk vs. existing C-1 asset models



- Answer "yes" if the relative risk differences between risk categories (usually ratings or designations for fixed income) is similar to that of an existing set of C-1 factors.
- For example, municipal bonds and bank loans would each likely have an answer of "yes," because relative increase in risk as ratings decrease is similar to that of corporate bonds.
- CLOs and some other structured securities would likely have an answer of "no," because tail risk increases more quickly as the rating decreases compared to corporate bonds.



Decision: sufficient data



- Answer “yes” if data exist to enable risk modeling, and in particular tail risk modeling.
- For example, CLOs would likely have an answer of “yes,” because their bank loan collateral has ample historical loss data and the waterfall structure is well documented.
- Some esoteric ABS, especially residual tranches, may have an answer of “no” if insufficient data are available.

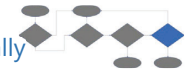
Decision: comparable attributes



- Answer “yes” if most individual assets within this asset class have an easily identifiable attribute that can be used to sort the assets into risk buckets.
- For example, CLOs would likely have an answer of “yes,” because most CLOs are rated by CRPs and those ratings can reasonably sort each individual CLO security into a risk bucket.
- Asset classes that are typically not rated by CRPs may have an answer of “no” here, but don’t automatically. For example, commercial mortgage loans are also a likely “yes” because DSCR and LTV substitute for CRP ratings as comparable attributes.

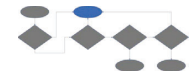
Initialism guide: CLO = collateralized loan obligation, CRP = credit rating provider, DSCR = debt service coverage ratio, LTV = loan-to-value

Decision: practical to model individually



- Answer “yes” if individual assets within the asset class have several attributes that differentiate individual assets and can be used for risk modeling or if existing modeling software can be used.
- For example, CLOs would likely have an answer of “yes” because off-the-shelf software exists that can model individual CLOs (however, CLOs may never have arrived at this decision point if they were deemed to have comparable attributes).
- If modeling cannot reasonably be done in a timely and cost-effective manner for RBC filing, then the answer here must be “no.”
- Some esoteric ABS may have an answer of “no” if the relevant risk is so specific to each deal that a common modeling framework does not apply across a reasonably large share of securities.

Outcome: use existing C-1 factors



- This outcome can either mean to use existing C-1 factors directly, without adjustment, or it can mean to make slight adjustments to existing C-1 factors.
- For example, municipal bonds and bank loans currently use corporate bond C-1 factors without adjustment.
- Schedule BA real estate currently uses Schedule A real estate C-1 factors but with an upward adjustment resulting in a proportionately higher C-1 factor for BA real estate.

Outcome: create new C-1 factors



- This outcome means that a new set of C-1 factors should be developed for this asset class.
- For example, CLOs may retain the 20 possible designations that they are currently mapped into. But instead of those 20 designations corresponding to the 20 corporate bond C-1 factors, CLOs may instead have their own set of 20 C-1 factors.
- Instead of just a slight adjustment to existing C-1 factors, this outcome requires fundamental modeling work to derive new factors.

Outcome: model asset individually



- This outcome means that each asset within this asset class needs to be modeled individually in order to generate a C-1 factor.
- In practice, this is currently how non-agency RMBS and CMBS are treated. The modeling work is done by the Structured Securities Group to determine the NAIC designation, after which point corporate bond factors are used. This is functionally similar to modeling each RMBS and CMBS security individually to determine its C-1 factor.
- Because of the significant operational complexity involved, this outcome is a last resort.

Structured Securities C-1 Principles

Glossary of Terms

- **ABS**: bonds falling within the emerging definition of ABS in SSAP 26, most recently exposed November 16, 2022
- **Vertical Slice**: an investment in all tranches of an ABS in equal proportion to the total outstanding
- **RBC-transformative ABS**¹: ABS where a vertical slice draws a lower aggregate C-1 requirement, considering only base factors (before portfolio adjustment and covariance adjustment), than its underlying collateral would draw if held directly by a life insurer
- **RBC Arbitrage (narrower)**: Holding a vertical slice of an RBC-transformative ABS
- **RBC Arbitrage (broad)**: Holding any part of an RBC-transformative ABS

¹ Conversely, one could then define RBC-neutral ABS as ABS where a vertical slice draws aggregate C1 equal to that which would be drawn by its underlying collateral

Candidate-Principle #1.
 The RBC Formula Is a Blunt Filtering Tool

- **The purpose of RBC is to help regulators identify weakly capitalized insurers, therefore small inaccuracies in RBC formulaic requirements will seldom justify a change to the RBC formula**
 - A structure that is close to RBC-neutral may not require a change in C-1 requirements.
 - Small allocations to RBC-transformative ABS may not require a change in C-1 requirements.
 - Small allocations to RBC-transformative ABS at the industry level will not avoid regulatory scrutiny.

Candidate-Principle #2.
 RBC Is Based on Statutory Accounting

- **RBC measures the impact of risk on statutory surplus. Changes in accounting treatment will affect C-1 requirements**
 - All else equal, assets that are marked to market (“MTM”) may have higher C-1 requirements because C-1 on MTM assets incorporates price fluctuations in addition to credit losses.

Candidate-Principle #3.
 C-1 Established for Underlying Collateral

- **RBC arbitrage can only be measured for ABS where the underlying collateral has an established asset-class-specific C-1 requirement**
 - ABS collateral may include unrated debt securities that would be either NAIC-6 or non-admitted if held directly by insurers—NAIC-6 assets draw a 30% pre-tax C-1 factor regardless of risk.
 - This unrated collateral, often non-corporate, typically does not have an established asset-class-specific framework for assigning C-1 (e.g., auto loans or credit card receivables).
 - ABS including such collateral is very often RBC-transformative because it converts NAIC-6 or non-admitted assets into rated paper.
 - Because the underlying collateral does not have an established asset-class-specific C-1 requirement, forcing C-1 on the ABS to be RBC-neutral would likely result in a C-1 requirement that is more conservative than C-1 for comparable risk in other asset classes.

Candidate-Principle #4.
 Intentions Don’t Matter For C-1 Requirements

- **The motivation behind creating an ABS structure should have no bearing on its C-1 requirements.** Even a structure designed with the explicit intent of reducing C-1 requirements should be treated like any other ABS. C-1 requirements represent a quantitative assessment of risk.
 - For many structures, it may be impractical or even impossible to objectively determine the intention of the design.
 - Even structures not designed to reduce C-1 may nevertheless lead to insufficient C-1 requirements.

Candidate-Principle #5. C-1 Requirements Reflect Likely Future Trading Activity

- **C-1 requirements on ABS should treat the collateral as a dynamic pool of assets, incorporating future trading activity that is likely to occur based on historical data or mandated by the structure's legal documents.**
 - If C-1 requirements on ABS acknowledge the evolving nature of the collateral pool, the total C-1 of the structure may not equal the C-1 of a snapshot of the collateral pool at any one point in time.
 - Specific to CLOs, management of the collateral is a known factor impacting risk that can be modeled with reference to historical data.
 - While the Academy supports this candidate-principle, we acknowledge that the current C-1 framework generally does not incorporate likely future changes to a portfolio, except indirectly in cases where Credit Rating Providers have assigned a rating that incorporates assumptions about portfolio management.
 - The RBCIRE WG have expressed concerns with incorporating active management in C-1 requirements for CLOs.
 - This candidate-principle does not imply incorporating credit selection on the part of the ABS manager. In other words, this candidate-principle is separate from the concept of active management as commonly understood.

Candidate-Principle #6. C-1 Requirement for Each Tranche Is Independent

- **RBC is based on the holdings of an insurer; assets not owned by an insurer should not impact its RBC**
 - This principle would imply RBC arbitrage depends on which tranche is held, even if an insurer holds a tranche issued by an RBC-transformative ABS.
 - This principle would imply that RBC arbitrage exists only in the tranches whose C-1 requirement is inadequate relative to the measured risk.
 - This principle would avoid tainting an entire structure with the label of RBC arbitrage in cases where C-1 is already sufficient for the particular tranche held by an insurer.
 - One practical drawback to this principle is it requires measuring risk at each tranche. The broad definition is simpler; showing that a structure is RBC-transformative is sufficient to identify RBC arbitrage per the broad definition. However, a C-1 requirement is still needed for each tranche held by an insurer, so the apparent simplicity under the broad definition is illusory.

Candidate-Principle #7. Different Risk Measures

- Each C-1 factor is based on the asset class's risk profile. However, the risk profile for at least some ABS is quite different from the risk profile for bonds. Therefore, **C-1 requirements for ABS** should be calibrated to **different risk measures** where appropriate.
 - In our December 2022 report to RBCIRE WG, the Academy recommended adopting a different risk measure for CLOs—Conditional Tail Expectation (“CTE”)—because CTE may better capture tail risk inherent in CLOs.
 - While different risk measures are appropriate, each asset's C-1 factor aims for a similar magnitude: For example, because most bonds use a 96th percentile, a CTE-96 for CLOs would be overly conservative. CTE-90 would be more consistent with the 96th percentile.
 - It is impossible to simultaneously reject this candidate-principle and require that all ABS structures are RBC-neutral, because in this case the collateral and the ABS would have C-1 requirements set to different statistical safety levels.

Summary of Candidate-Principles

1. The purpose of RBC is to help regulators identify weakly capitalized insurers, therefore small inaccuracies in RBC requirements may not justify a change to the RBC formula.
2. RBC measures the impact of risk on statutory surplus. Changes in accounting treatment will affect C-1 requirements.
3. RBC arbitrage can only be measured for ABS where the underlying collateral has an established asset-class-specific C-1 requirement.
4. The motivation behind creating an ABS structure should have no bearing on its C-1 requirements.
5. C-1 requirements on ABS should treat the collateral as a dynamic pool of assets, incorporating future trading activity that is likely to occur based on historical data or mandated by the structure's legal documents.
6. RBC is based on the holdings of an insurer; assets not owned by an insurer should not impact its RBC.
7. C-1 requirements for ABS should be calibrated to different risk measures where appropriate.

Key Questions for Regulators

- Which candidate-principles do regulators support?
- Are there additional principles not outlined herein that also ought to be incorporated into RBC for ABS?

Appendix A—RBC Arbitrage

Impact of Principles on Definition of RBC Arbitrage

- By discussing broader principles, this presentation seeks to spark conversation on the definition of Risk-Based Capital (RBC) arbitrage in Asset Backed Securities (ABS) and clarify the implications of conflicting RBC arbitrage definitions.
- The NAIC's Investment Analysis Office (IAO) has proposed a constraint in the model used to determine designations, and therefore RBC requirements, for CLOs. This constraint would eliminate RBC arbitrage, as defined by the IAO, that the IAO believes is present in CLOs.
- Competing definitions among interested parties and regulators have been used in some formal and informal discussions, so far without a forum for being discussed directly.
- This presentation attributes differences in RBC arbitrage definitions to underlying principles of RBC. The C1WG is requesting guidance from regulators on which principles should be followed. Once the principles have been identified, RBC arbitrage can be more clearly defined and more effectively mitigated. These principles will also guide a broader effort around improving the C-1 framework for all ABS.

Asset Classes With Greatest Potential for RBC Arbitrage

Established asset-class-specific C-1	CLO Non-Agency RMBS/CMO CMBS CFO	Agency RMBS
No established asset-class-specific C-1	Consumer Finance Asset-based Lending Credit feeder fund	
	Tranched	Pass-Through

- Quantifying RBC arbitrage is most direct when the underlying collateral has an explicit C-1 factor
- Tranched structures are more likely to produce RBC arbitrage than pass-through structures because tranching transforms risk
- RBC arbitrage discussions should focus on tranched structures with established asset-class-specific C-1

Definitions of RBC Arbitrage

- IAO has expressed its view that holding **any tranche** of a securitization whose vertical slice carries a different aggregate C-1 requirement compared to the underlying collateral constitutes RBC arbitrage—we term this the **broad**¹ definition of RBC arbitrage
- An alternative, **narrower**¹ definition of RBC arbitrage includes only instances where an insurer holds a **vertical slice**¹
- Many other possible definitions lie somewhere in between

IAO Usage of the Term “RBC Arbitrage”

- A [letter from IAO to VOSTF](#) dated May 25, 2022, introduces the concept of RBC arbitrage within the context of CLOs: “The aggregate RBC factor for owning all of the CLO tranches should be the same as that required for owning all of the underlying loan collateral. If it is less, it means there is RBC arbitrage.”
- SVO’s Structured Equity & Funds Proposal dated November 28, 2022, also uses the term “RBC arbitrage” with effectively the same meaning but expanding the scope from CLOs to include certain feeder fund structures.

¹ Please see Appendix B—Definitions of Terms for precise definitions of technical terms.

Academy Usage of “RBC Arbitrage”

- In our presentation to RBCIREWG dated December 14, 2022, the Academy disagreed with the concept that the existence of RBC arbitrage, as defined by IAO, necessarily implied an incorrect C-1 requirement
- The Academy believes dialogue among all parties will be improved if we first collectively agree on a definition of RBC arbitrage before discussing its implications for C-1 requirements

Related Regulatory Concerns

- IAO has also pointed out the possibility of RBC-transformative ABS being used to reclassify investments to technically comply with investment limits set forth in state insurance law, for example converting equity to debt for statutory purposes
- RBC-transformative ABS may also be used to reclassify investment returns or losses from an accounting perspective
- While we acknowledge these related potential issues, this presentation focuses only on C-1 implications of RBC-transformative ABS

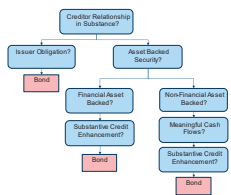
Appendix B—Definitions of Terms

ABS Definition

- RBC arbitrage discussions typically involve structured securities, for example CLOs and rated note feeder fund structures.
- Within this presentation, we refer to all such structured securities as **ABS**, and we intend for the definition of ABS to align with the emerging definition of ABS in **SSAP 26**, [most recently exposed November 16, 2022](#). Under this definition, ABS has a primary purpose of raising debt capital backed by collateral that provides the cash flows to service the debt.

ABS Definition, Continued

Bond Principles Flowchart



- Exposed principles-based definition of ABS is illustrated here
- Image taken from "Assets: Regulatory Updates in Life Insurance" April 4, 2023, [webinar](#) by the American Academy of Actuaries

Vertical Slice Definition

A vertical slice is an investment in all tranches of an ABS in equal proportion to the total outstanding. A vertical slice is economically equivalent to a direct investment in the underlying collateral at any one point in time.

RBC-Transformative ABS Definition

An RBC-transformative ABS is any ABS where a vertical slice draws a lower aggregate C-1 requirement than its underlying collateral would draw if held directly by a life insurer.

Narrowly Defined RBC Arbitrage

- **Holding a vertical slice of an RBC-transformative ABS** constitutes RBC arbitrage under the narrow definition.
- In this case, it is unambiguously true that absent the structure of the ABS a life insurer would be required to hold a higher level of C-1 capital.
- Even under the narrow definition of RBC arbitrage, C-1 requirements for the collateral may be inappropriately high rather than the ABS C-1 requirements being inappropriately low. Also, C-1 for the ABS and its collateral may be calibrated precisely to the prescribed risk measures despite the ABS being RBC-transformative. Regardless, in such cases holding a vertical slice of an RBC-transformative ABS would still constitute RBC arbitrage.

Broadly Defined RBC Arbitrage

- **Holding any part of an RBC-transformative ABS** constitutes RBC arbitrage under the broad definition
- For example, any CLO holdings would constitute RBC arbitrage under this definition, because CLOs are an RBC-transformative ABS (as discussed in the Academy's [December 2022 presentation to RBCIREWG](#))
- IAO letters written to VOSTF during 2022 employ the broad definition of RBC arbitrage

QUESTIONS

Contact:

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barrymoilanen@actuary.org

**CAPITAL ADEQUACY (E) TASK FORCE
WORKING AGENDA ITEMS FOR CALENDAR YEAR 2023**

Priority 1 – High Priority
Priority 2 – Medium Priority
Priority 3 – Low Priority

2023 #	Owner	2023 Priority	Expected Completion Date	Working Agenda Item	Source	Comments	Date Added to Agenda
Ongoing Items – Life RBC							
L1	Life RBC WG	Ongoing	Ongoing	Make technical corrections to Life RBC instructions, blank and /or methods to provide for consistent treatment among asset types and among the various components of the RBC calculations for a single asset type.			
L2	Life RBC WG	1	2023 or later	1. Monitor the impact of the changes to the variable annuities reserve framework and risk-based capital (RBC) calculation and determine if additional revisions need to be made. 2. Develop and recommend appropriate changes including those to improve accuracy and clarity of variable annuity (VA) capital and reserve requirements.	CADTF	Being addressed by the Variable Annuities Capital and Reserve (E/A) Subgroup	
L3	Life RBC WG	1	2023 or later	Provide recommendations for the appropriate treatment of longevity risk transfers by the updated longevity factors and consider expanding the scope to include all payout annuities.	New Jersey	Being addressed by the Longevity (E/A) Subgroup	
L4	Life RBC WG	1	2023 or later	Monitor the economic scenario governance framework, review material economic scenario generator updates, key economic conditions and metrics, support the implementation of an economic scenario generator for use in statutory reserve and capital calculations and develop and maintain acceptance criteria		Being addressed by the Generator of Economic Scenarios (GOES) (E/A) Subgroup	
Carryover Items Currently being Addressed – Life RBC							
L4	Life RBC WG	1	2023 or later	Update the current C-3 Phase I or C-3 Phase II methodology to include indexed annuities with consideration of contingent deferred annuities as well	AAA		
L5	Life RBC WG	1	2023 or later	Review companies at action levels, including previous years, to determine what drivers of the events are and consider whether changes to the RBC statistics are warranted.			
L6	Life RBC WG	1	2023 or later	Work with the Academy on creating guidance for the adopted C-2 mortality treatment for 2023 and next steps.			
2023 #	Owner	2023 Priority	Expected Completion Date	Working Agenda Item	Source	Comments	Date Added to Agenda
Ongoing Items – RBC IR & E							
Carryover Items Currently being Addressed – RBC IR & E							
IR1	RBC IRE	2	2023 or later	Supplementary Investment Risks Interrogatories (SIRI)	Referred from CADTF	The Task Force received the referral on Oct. 27. This referral will be tabled until the bond factors have been adopted and	1/12/2022 11/19/2020

Revised 12/14/2022

IR2	RBC IRE	2	2023 or later	NAIC Designation for Schedule D, Part 2 Section 2 - Common Stocks Equity investments that have an underlying bond characteristic should have a lower RBC charge. Similar to existing guidance for SVO-identified ETFs reported on Schedule D-1, are treated as bonds.	Referral from Blackrock and IL DOI Referred from CADTF Referral from SAPWG 8/13/2018	the TF will conduct a holistic review all investment referrals.	1/12/2022 10/11/2018
IR3	RBC IRE	2	2023 or later	Structured Notes - defined as an investment that is structured to resemble a debt instrument, where the contractual amount of the instrument to be paid at maturity is at risk for other than the failure of the borrower to pay the contractual amount due. Structured notes reflect derivative instruments (i.e. put option or forward contract) that are wrapped by a debt structure.	Referred from CADTF Referral from SAPWG April 16, 2019	10/8/19 - Exposed for a 30-day comment period ending 11/8/2019 3-22-20 - Tabled discussion pending adoption of the bond structure and factors. 1/12/2022 8/4/2019	
IR4	RBC IRE	2	2023 or later	Comprehensive Fund Review for investments reported on Schedule D Pt 2 Sn2	Referred from CADTF Referral from VOSTF 9/21/2018	Discussed during Spring Mtg. NAIC staff to do analysis. 10/8/19 - Exposed for a 30-day comment period ending 11/8/19 3-22-20 - Tabled discussion pending adoption of the bond structure and factors. 1/12/2022 11/16/2018	
New Items – RBC IR & E							
IR5			2023 or later	Evaluate the appropriate RBC treatment of Asset-Backed Securities (ABS), including Collateralized Loan Obligations (CLO), collateralized fund obligations (CFOs), or other similar securities carrying similar types of tail risk (Complex Assets).	Request from E Committee, SAPWG, VOSTF	Per the request of E Committee comments were solicited asking if these types of assets should be considered a part of the RBC framework. 1/12/2022	
IR6			2023 or later	Evaluate the appropriate RBC treatment of Residual Tranches.	Request from E Committee, SAPWG, VOSTF	Per the request of E Committee comments were solicited asking if these types of assets should be considered a part of the RBC framework. 1/12/2022	
IR7			2025 or later	Phase 2 Bond analysis - evaluate and develop an approach to map other ABS to current bond factors following the established principles from Phase I where the collateral has an assigned RBC. This project will likely require an outside consultant and the timeline could exceed 2-3 years.	Request from E Committee	Per the request of E Committee comments were solicited requesting the need for outside review. 1/12/2022	
IR8	RBC IRE		2023 or later	Address the tail risk concerns no captured by reserves for privately structured securities.	Referral from the Macroprudential (E) Working Group	8/11/2022	

Revised 12/14/2022

2023 #	Owner	2023 Priority	Expected Completion Date	Working Agenda Item	Source	Comments	Date Added to Agenda
Ongoing Items – P&C RBC							
P1	Cat Risk SG	1	Year-end 2023 or later	Continue development of RBC formula revisions to include a risk charge based on catastrophe model output: a) Evaluate other catastrophe risks for possible inclusion in the charge - determine whether to recommend developing charges for any additional perils, and which perils or perils those should be.	Referral from the Climate and Resiliency Task Force. March 2021	4/26/21 - The SG exposed the referral for a 30-day period. 6/1/21 - The SG forwarded the response to the Climate and Resiliency Task Force. 2/22/22 - The SG adopted proposal 2021-17-CR (adding the wildfire peril for informational purposes only). The SG continues reviewing other perils for possible inclusion in the Rcat. 8/11/22 – The TF adopted Proposal 2022-04-CR (2013-2021 Wildfire Event Lists) 9/26/22 – The SG formed an ad hoc group to conduct review on severe convective storm models. 7/18/23-The SG is finishing reviewing the following SCS vendor models: RMS, Verisk, KCC, and Corelogic.	4/26/2021
Carryover Items Currently being Addressed – P&C RBC							
P2	P&C RBC WG	1	Year-end 2020 or later	Evaluate a) the current growth risk methodology whether it is adequately reflects both operational risk and underwriting risk; b) the premium and reserve based growth risk factors either as a stand-alone task or in conjunction with the ongoing underwriting risk factor review with consideration of the operational risk component of excessive growth; c) whether the application of the growth factors to NET proxies adequately accounts for growth risk that is ceded to reinsurers that do not trigger growth risk in their own right. Continue working with the Academy to review the methodology and revise the underwriting (Investment Income Adjustment, Loss Concentration, LOB UW risk) charges in the PRBC formula as appropriate.	Refer from Operational Risk Subgroup	1) Sent a referral to the Academy on 6/14/18 conference call.	1/25/2018
P3	P&C RBC WG	1	2023 Summer Meeting or later	Evaluate the Underwriting Risk Line 1 Factors in the P/C formula.			6/10/2019
P4	P&C RBC WG	1	2023 Summer Meeting or later				7/30/2020

Revised 12/14/2022

P7	PCRBBCWG	4	2023 Spring Meeting	Changing the RBC PR035 Line of Business categories to match the Lines of Business categories in the Annual Statement, Underwriting and Investment Exhibit, Part 1B.	-	8/9/22 - The WG exposed proposal 2022-07-P for a 30-day comment period.	7/7/2022
P5	PCRBBCWG	1	Ongoing	Review and analyze the P/C RBC charges that have not been reviewed since developed.			3/23/2023
P6	Cat Risk SG	1	2024 Spring Meeting	Quantify the R5 Ex-cat Factors for wildfire peril (for informational purposes only) Evaluate the possibility of adding PR018A to determine the R5 including the wildfire peril			3/21/2023
P7	Cat Risk SG	2	2025 Spring Meeting	Evaluate the impact of flood peril to the insurance market			3/21/2023
New Items – P&C RBC							
P8	PCRBBCWG	1	2024 Spring Meeting	Adding pet insurance line in the RBC PR017, 018, 035 and RBC Schedule P, parts due to the adoption of the Annual Statement Blanks proposal 2023-01BWG.			7/27/2023
2023 #	Owner	2023 Priority	Expected Completion Date	Working Agenda Item	Source	Comments	Date Added to Agenda
Ongoing Items – Health RBC							
X1	Health RBC WG	Yearly	Yearly	Evaluate the yield of the 6-month U.S. Treasury Bond as of Jan. 1 each year to determine if further modification to the Comprehensive Medical, Medicare Supplement and Dental and Vision underwriting risk factors is required. Any adjustments will be rounded up to the nearest 0.5%.	HRBCWG	Adopted 2022-16-CA (YE-2023)	11/4/2021
X2	Health RBC WG	3	Ongoing	Continue to monitor the Federal Health Care Law or any other development of federal level programs and actions (e.g., state reinsurance programs, association health plans, mandated benefits, and cross-border) for future changes that may have an impact on the Health RBC Formula.	4/13/2010 CATF Call	Adopted 2014-01H Adopted 2014-02H Adopted 2014-05H Adopted 2014-06H Adopted 2014-24H Adopted 2014-25H Adopted 2016-01-H Adopted 2017-09-CA Adopted 2017-10-H The Working Group will continually evaluate any changes to the health formula because of ongoing federal discussions and legislation. Discuss and monitor the development of federal level programs and the potential impact on the HRBC formula.	1/11/2018
Carryover Items Currently being Addressed – Health RBC							

Revised 12/14/2022

X3	Health RBC WG	2	Year-End 2024 RBC or Later	Consider changes for stop-loss insurance or reinsurance.	AAA Report at Dec. 2006 Meeting	(Based on Academy report expected to be received at YE-2016) 2016-17-CA Adopted proposal 2023-01-CA	
X4	Health RBC WG	2	Year-end 2024 RBC or later	Review the individual factors for each health care receivables line within the Credit Risk H3 component of the RBC formula. Work with the American Academy of Actuaries (Academy) to inquire through the NAIC on the reporting of the health care receivables to better understand why these receivables are being reported as such. With the intention to produce recommendations to improve instruction clarity or provide additional guidance.	HRBC WG	Adopted 2016-06-H Rejected 2019-04-H Annual Statement Guidance (Year-End 2020) and Annual Statement Blanks Proposal (Year-End 2021) referred to the Blanks (E) Working Group	
X5	Health RBC WG	1	Year-end 2024 RBC or later	Work with the Academy to perform a comprehensive review of the H2 - Underwriting Risk component of the health RBC formula including the Managed Care Credit review (Item 18 above) Review the Managed Care Credit calculation in the health RBC formula - specifically Category 2a and 2b. Review Managed Care Credit across formulas. As part of the H2 - Underwriting Risk review, determine if other lines of business should include investment income and how investment income would be incorporated into the existing lines if there are changes to the structure.	HRBCWG		4/23/2021 12/3/2018
X6	Health RBC WG	1	Year-end 2024 or later	Review referral letter from the Operational Risk (E) Subgroup on the excessive growth charge and the development of an Ad Hoc group to charge.	HRBCWG	Review if changes are required to the Health RBC Formula	4/7/2019
X7	Health RBC WG	2	Year-End 2024 or later	Consider the impact of COVID-19 and pandemic risk in the health RBC formula.	HRBCWG		7/30/2020
X8	Health RBC WG	3	Year-End 2025 or later	Discuss and determine the re-evaluation of the bond factors for the 20 designations.	Referral from Investment RBC July/2020	Working Group will use two- and five-year time horizon factors in 2020 impact analysis. Proposal 2021-09-H - Adopted 5/25/21 by the WG	9/11/2020
New Items – Health RBC							
2023 #	Owner	2023 Priority	Expected Completion Date	Working Agenda Item	Source	Comments	Date Added to Agenda
Ongoing Items – Task Force							

Revised 12/14/2022

CA1	CADTF	2	2023	Affiliated Investment Subsidiaries Referral Ad Hoc group formed Sept. 2016	Ad Hoc Group	Structural and instructions changes will be exposed by each individual working group for comment in 2022 with an anticipated effective date of 2023. Proposal 2022-09-CA was adopted at the 2022 Summer Meeting. Proposal 2022-09-CA MOD was adopted at the 2023 Spring Meeting.	1/12/2022
Carryover Items Currently being Addressed – Task Force							
CA2			Ongoing	All investment related items referred to the RBC Investment Risk & Evaluation (E) Working Group			
CA3	CADTF	3	Ongoing	Receivable for Securities factor		Consider evaluating the factor every 3 years. (2021, 2024, 2027, etc.) Factors are exposed for comment. Comments due May 28, 2021 for consideration on June 30th. Factors Adopted for 2021.	
New Items –Task Force							
CA4	CADTF	1	2023	Evaluate if changes should be made to RBC formulas to better assess companies in runoff	PCRBWVG	TF shared the referral to the Life and Health RBC WGs at the summer meeting. TF forwarded the responses to the RMSG at the Spring meeting.	8/11/2022
CA5	CADTF	1	2023	Update the Health Premiums and Underwriting Risk Premium References to match the Annual Statement Schedule H, Part 1, and Part 5 references	2021-14-BWVG	TF adopted the proposal 2022-13-CA at the Spring meeting.	11/30/2022
CA6	CADTF	1	2026 or later	Established the Risk Evaluation Ad Hoc Group to: a) Evaluate the RBC factors; b) Potentially develop an evaluating process; c) Prioritize those factors that require reviewing.		7/26/23 – the Risk Evaluation Ad Hoc Group established 3 Ad Hoc Subgroup to focus on different issues: 1) RBC Purposes & Guidelines Ad Hoc Subgroup; 2) Asset Concentration Ad Hoc Subgroup; and 3) Geographic Concentration Ad Hoc Subgroup.	03/23/2023

Revised 12/14/2022

EXAMINATION OVERSIGHT (E) TASK FORCE

Examination Oversight (E) Task Force July 24, 2023, Minutes	9-827
Financial Examiners Handbook (E) Technical Group June 20, 2023, Minutes (Attachment One)	9-830
Information Technology (IT) Examination (E) Working Group April 11, 2023, Minutes (Attachment Two)	9-832

Draft: 7/31/23

Examination Oversight (E) Task Force
Virtual Meeting (*in lieu of meeting at the 2023 Summer National meeting*)
July 24, 2023

The Examination Oversight (E) Task Force met July 24, 2023. The following Task Force members participated: Judith L. French, Chair, represented by Dwight Radel (OH); Karima M. Woods, Vice Chair, represented by N. Kevin Brown (DC); Lori K. Wing-Heier represented by David Phifer (AK); Mark Fowler represented by Blase Abreo (AL); Ricardo Lara represented by Laura Clements (CA); Michael Conway represented by Carol Matthews (CO); Andrew N. Mais represented by Michael Estabrook (CT); Trinidad Navarro represented by Tom Hudson (DE); Michael Yaworsky represented by Jane Nelson (FL); Doug Ommen represented by Daniel Mathis (IA); Dean L. Cameron represented by Eric Fletcher (ID); Amy L. Beard represented by Roy Eft (IN); Vicki Schmidt represented by Levi Nwasoria (KS); Sharon P. Clark represented by Jeff Gaither (KY); James J. Donelon represented by Melissa Gibson (LA); Gary D. Anderson represented by James A. McCarthy (MA); Anita G. Fox represented by Judy Weaver (MI); Grace Arnold represented by Kathleen Orth (MN); Chlora Lindley-Myers represented by Shannon Schmoeger (MO); Mike Chaney represented by Mark Cooley (MS); Jon Godfread represented by Matt Fischer (ND); Eric Dunning represented by Andrea Johnson (NE); D.J. Bettencourt represented by Colin Wilkins (NH); Glen Mulready represented by Eli Snowbarger (OK); Michael Humphreys represented by Diana Sherman (PA); Elizabeth Kelleher Dwyer represented by John Tudino (RI); Michael Wise represented by Gwendolyn McGriff (SC); Larry D. Deiter represented by Johanna Nickelson (SD); Cassie Brown represented by Shawn Frederick (TX); Scott A. White represented by Greg Chew (VA); Mike Kreidler represented by Tarik Subbagh (WA); and Nathan Houdek represented by John Litweiler (WI).

1. Adopted its 2022 Fall National Meeting Minutes

Orth made a motion, seconded by Eft, to adopt the Task Force's Dec. 14, 2022, minutes (*see NAIC Proceedings – Fall 2022, Examination Oversight (E) Task Force*). The motion passed unanimously.

2. Adopted the Reports of its Working Groups and Technical Group

A. Financial Analysis Solvency Tools (E) Working Group

Radel provided the report of the Financial Analysis Solvency Tools (E) Working Group. He stated that the Working Group met June 1 in regulator-to-regulator session, pursuant to paragraph 4 (internal or administrative matters) of the NAIC Policy Statement on Open Meetings, to continue work on its goals. The Working Group also conducted a regulator-only e-vote, pursuant to paragraph 4 (internal or administrative matters) of the NAIC Policy Statement on Open Meetings, that concluded July 12 to adopt revisions to the *Insurer Profile Summary Sharing Best Practices Guide*.

B. Financial Examiners Coordination (E) Working Group

Radel provided the report of the Financial Examiners Coordination (E) Working Group. He stated that the Working Group met April 17 and March 22 in regulator-to-regulator session, pursuant to paragraph 4 (internal or administrative matters) of the NAIC Policy Statement on Open Meetings, to continue work on its goals.

C. Electronic Workpaper (E) Working Group

Radel stated that although the Electronic Workpaper (E) Working Group had not met this year, it wanted to provide a brief update regarding the TeamMate+ transition. Clements provided the update for the Working Group and said that it continues to oversee the transition to TeamMate+. She noted that the transition is progressing at a steady pace and as of July 20, 23 states have signed the rider agreement, 13 states have access to live databases, and 10 states are in the transition process. There are currently 18 states in the Gold Team Cloud environment and four states in the FedRAMP environment. She said the Working Group expects to have enough states online by year-end to facilitate exam coordination.

D. Financial Examiners Handbook (E) Technical Group

Snowbarger provided the report of the Financial Examiners Handbook (E) Technical Group. He stated that the Technical Group met June 20 to expose updates related to Exhibit G – Consideration of Fraud and a memorandum of understanding for a 30-day public comment period. He noted that Exhibit G was updated to further align with the risk-focused examination approach and encouraged regulators to leverage the work performed by others (especially external auditors) in this area. Revisions clarified that if the auditor’s fraud testing is deemed to be reliable, the examination team is not expected to complete the Fraud Risk Factor Checklist part of the exhibit.

Additionally, in response to a Receivership Law (E) Working Group referral, Section 1-3 of the *Financial Condition Examiners Handbook* was updated to include a reference to the memorandum of understanding template. This template can be used to facilitate transitional planning and preparation, communication, and information sharing in a pre-liquidation situation. As no comments were received, the Technical Group will consider adoption of this guidance during its next meeting.

Snowbarger said that the Technical Group also discussed its other 2023 projects, which include proposed revisions to incorporate: 1) consideration of climate-related risks; and 2) takeaways from the May 2023 Examination Peer Review. The Technical Group expects these proposed revisions to be considered for exposure during its next meeting, which is anticipated in late August.

Finally, Snowbarger mentioned that the Technical Group has formed a drafting group to address the referral from the Financial Analysis (E) Working Group related to strategic and operational risks faced by health insurers.

E. Information Technology (IT) Examination (E) Working Group

Ehlers provided the report of the IT Examination (E) Working Group. He stated that the Working Group met April 11 to discuss a referral received from the Cybersecurity (H) Working Group, which requests that the Working Group consider adding and/or revising IT review guidance within the *Financial Condition Examiners Handbook* to better prioritize cybersecurity risks and to consider a variety of sources in developing such guidance. The Working Group formed a drafting group to begin researching different frameworks that could be leveraged in the development of this guidance. He stated that the drafting group also plans to review the current procedures within Exhibit C to determine if there are any areas that can be streamlined to become more effective. Due to the nature of this project, the Working Group anticipates its efforts to carry over into 2024.

Cooley made a motion, seconded by Mathis, to adopt reports of the Financial Analysis Solvency Tools (E) Working Group, the Financial Examiners Coordination (E) Working Group, the Electronic Workpaper (E) Working Group, the Financial Examiners Handbook (E) Technical Group including its June 20 minutes (Attachment One), and the

IT Examination (E) Working Group, including its April 11 minutes (Attachment Two). The motion passed unanimously.

Having no further business, the Examination Oversight (E) Task Force adjourned.

SharePoint/NAIC Support Staff Hub/Member Meetings/E CMTE/EOTF/EOTF Summer NM Minutes Draft.docx

Draft: 7/11/23

Financial Examiners Handbook (E) Technical Group
Virtual Meeting
June 20, 2023

The Financial Examiners Handbook (E) Technical Group of the Examination Oversight (E) Task Force met June 20, 2023. The following Technical Group members participated: Susan Bernard, Chair (CA); John Litweiler, Vice Chair (WI); Blase Abreo (AL); William Arfanis (CT); N. Kevin Brown (DC); Cindy Andersen (IL); Grace Kelly (MN); Shannon Schmoeger (MO); Lindsay Crawford (NE); Colin Wilkins (NH); Nancy Lee Chice (NJ); Eli Snowbarger (OK); Diana Sherman (PA); and Tarik Subbagh (WA).

1. Exposed Handbook Guidance

A. Exhibit G – Consideration of Fraud

Bernard said the first set of revisions to consider for exposure relates to Exhibit G – Consideration of Fraud and related guidance. She noted that Exhibit G is structured in a way that is more conducive to the former exam approach, similar to a financial statement audit, instead of being aligned with the present risk-focused exam approach. Additionally, some state insurance regulators have mentioned that the exhibit, as it stands now, requires very detailed and specific knowledge of various aspects of the company to complete the Fraud Risk Factors checklist portion of the exhibit.

In response, a drafting group was formed to revise Exhibit G and corresponding references. Bernard stated that the proposed revisions emphasize that state insurance regulators are encouraged to leverage the work performed by others, specifically the external auditors, to the fullest extent possible when completing this exhibit. If the certified public accountant (CPA) testing is deemed reliable, the exam team is not expected to complete the Fraud Risk Factor Checklist within the exhibit. However, if the CPA work is deemed insufficient, incomplete, or at the incorrect level—i.e., holding company or legal entity level—the exam team may use the checklist to conduct and document fraud risk factors. Bernard added that related guidance was updated to ensure consistency throughout the *Financial Condition Examiners Handbook* (Handbook).

B. Receivership Law (E) Working Group Referral

Bernard introduced the next set of proposed revisions related to a referral received late last year from the Receivership Law (E) Working Group. She noted that the Working Group adopted a template for a memorandum of understanding that can be utilized to facilitate transitional planning and preparation, communication, and information sharing in a pre-liquidation situation.

Bernard mentioned that proposed revisions add a reference to the memorandum into Sections 1–3 of the Handbook, stating that it is an optional tool available for state insurance regulator use.

As there were no objections, the Technical Group exposed the revisions for a 30-day public comment period ending July 20.

2. Received a Referral from the Financial Analysis (E) Working Group

The Technical Group received a referral from the Financial Analysis (E) Working Group. Litweiler said the referral suggests considering additional guidance that would encourage examiners to review strategic/operational risks

faced by health insurers during an on-site examination. He noted that some examples of these unique risks include failure to maintain an adequate federal Centers for Medicare and Medicaid Services (CMS) star rating, failure to properly identify/code member health status, failure to plan for variation in membership levels, and challenges in provider contracting. He stated that the Technical Group would like to create a drafting group to address this referral, and he directed members to contact NAIC staff to volunteer to be a part of the drafting group. Tom Finnell (America's Health Insurance Plans—AHIP) asked if industry members would be allowed to participate in this drafting group. Elise Klebba (NAIC) clarified that the drafting group is only open to state insurance regulators and contractors at the moment.

3. Received an Update on the Climate and Resiliency (EX) Task Force Referral and Proposed Revisions

Bernard said NAIC staff are in the midst of drafting revisions to multiple areas of the Handbook to further integrate the consideration of climate change risks into the financial examination process. Working revisions include the following sections of the Handbook: Investments, Reinsurance (Assuming and Ceding), Underwriting Repositories, Exhibit A (Planning Procedures), Exhibit B (Planning Questionnaire), Exhibit I (Planning Memo), Exhibit V (Prospective Risks), Exhibit Y (Interview Questions), and Exhibit DD (Critical Risk Categories). Bernard stated that revisions are anticipated to be finalized later this year, at which time they will be brought before the Technical Group to consider for exposure and adoption.

4. Discussed Other Matters

Bernard announced that she would be retiring from the California Department of Insurance (DOI). Her last day at the DOI will be June 30. As such, she announced that Snowbarger would join Litweiler as co-chair of the Technical Group for the remainder of the year.

Having no further business, the Financial Examiners Handbook (E) Technical Group adjourned.

SharePoint/NAIC Support Staff Hub/Member Meetings/E CMTE/EOTF

Draft: 4/17/23

Information Technology (IT) Examination (E) Working Group
Virtual Meeting
April 11, 2023

The IT Examination (E) Working Group of the Examination Oversight (E) Task Force met April 11, 2023. The following Working Group members participated: Jerry Ehlers, Chair (IN); Ber Vang, Vice Chair (CA); Blase Abreo (AL); Mel Anderson (AR); William Arfanis and Michael Shanahan (CT); Ginny Godek (IL); Shane Mead (KS); Dmitriy Valekha (MD); Kim Dobbs and Cynthia Amann (MO); Colton Schulz (ND); Lindsay Crawford (NE); Eileen Fox (NY); Metty Nyangoro (OH); Eli Snowbarger (OK).

1. Discussed a Referral from the Cybersecurity (H) Working Group

Vang led the discussion on a referral received from the Cybersecurity (H) Working Group, which asks the IT Examination (E) Working Group to consider making cybersecurity a higher priority in the examination process. The Cybersecurity (H) Working Group is willing to support the IT Examination (E) Working Group, acknowledging that the project may take longer than a year. Vang presented a few options for addressing the referral, and he requested feedback from the Working Group. Those options were to: 1) enhance the current Exhibit C by interlacing additional cybersecurity procedures into existing procedures; and 2) create a separate document or appendix to Exhibit C to specifically house the cybersecurity-focused procedures.

Mead said Exhibit C already has a plethora of cybersecurity procedures. He asked the Working Group if it is sure carving out a separate cybersecurity appendix is warranted. Ehlers said he agrees that there are cybersecurity procedures in Exhibit C already, but Exhibit C was written several years ago, and bad actors are continuously creating new threats, so another look at the cybersecurity procedures may be beneficial.

Mead acknowledged the importance of a cybersecurity assessment, but he expressed his uncertainty about the approach of creating a separate evaluation document. He suggested that the Working Group could focus on strengthening the current procedures that are already present in Exhibit C instead of creating a new document.

Vang agreed with Mead's point of view, but he explained that the purpose of Exhibit C is to focus on internal controls. He added that creating a new document would help fill the gaps that are present in the current cybersecurity procedures.

Schulz said he had been following the National Institute of Standards and Technology (NIST) Cybersecurity Framework (CSF) 2.0 transition, and he pointed out the importance of governance and vendor management type risks. He also suggested that the Working Group should consider a refresh or a bolt-on approach to incorporate cybersecurity into the existing Exhibit C.

Ehlers shared that some states like New York have implemented cybersecurity models such as its Regulation 500. He stated that Indiana has implemented the NAIC *Insurance Data Security Model Law* (#668) and is beginning to use additional cybersecurity procedure steps on complex companies. However, Ehlers is not sure if a document similar to the New York Regulation 500 would work best as a separate document or included in Exhibit C and the examination report.

Ehlers believes the process of addressing cybersecurity in financial examination reports is an evolutionary process. He suggested starting by identifying what needs to be added to Exhibit C, determining that as a stand-alone item, and then integrating it into Exhibit C in the future.

Godek and Dobbs agree that Exhibit C and the work done by the examiners are substantial, and she emphasized the importance of examiner's ability to rely on the company's data. She expressed that adding cybersecurity to Exhibit C may not be necessary.

Miguel Romero (NAIC) suggested that among the options available for the state insurance regulators, the Working Group should consider redoing the exhibits used to document the IT Review and specifically focus on cybersecurity, as it is the most significant risk in today's world. He believes that the current work program does not facilitate a cohesive examination, and he suggested leveraging new resources outlined in the referral, such as the Center for Internet Security (CIS) controls or the Cybersecurity and Infrastructure Security Agency's (CISA) Cross-Sector Performance Goals, to make the program more efficient. Both the CIS and CISA resources include components that could enable state insurance regulators to more nimbly scale the extent of work performed based on the size of the company being examined.

Fox said she agrees with Romero's point that the current process needs to be reviewed to remove any unnecessary steps. She suggested coordinating with other states and reviewing the IT process to update and combine it with cybersecurity measures. She believes this will help to ensure the reliability of the information technology general controls (ITGC) before beginning Phase 2 and will help IT examiners review cybersecurity developments throughout the course of the examination.

Ehlers reiterated that the intention is not to delay the ITGC review conclusion beyond Phase 2, but it is important to assess the current and future cybersecurity weaknesses and the impact they could have on the company going forward.

Bruce Jenson (NAIC) said he agrees with Fox's suggestion, and he mentioned that it could be difficult to fully assess cybersecurity risks before beginning Phase 2.

Vang asked if the referral anticipates that an assessment of a company's cybersecurity will be expected, in addition to the assessment of IT general controls that is currently performed using Exhibit C.

Jenson suggested that the Working Group first conduct a gap analysis that compares the current Exhibit C procedures against the cybersecurity frameworks referenced in the referral (i.e., CISA, CIS, NIST).

Fox said that conducting an analysis to identify the extent of possible gaps in the current guidance would help the Working Group determine whether it would be appropriate to update Exhibit C or create a standalone document for assessing cybersecurity.

Jacob Steilen (NAIC) proposed forming a drafting group to perform the gap analysis and develop a response to the referral.

Jenson said that it may be appropriate to implement a separate approach for cybersecurity related risks. Currently, the IT review is focused on evaluating a company's IT general controls so that the financial examiner knows the extent to which company data and corresponding reports can be relied upon to support control and detail testing in later phases of the exam. On the other hand, a company's preparedness to manage cybersecurity events and attacks in the future is more of a prospective concern. Although the outcome of assessing the company's cybersecurity protocols and processes is important and relevant to the company's overall solvency, the results of that review would not likely impact the examiner's ability to test and rely on automated controls or system reports

in later phases of the exam. Therefore, it may be appropriate to allow for the conclusion on cybersecurity related risks to be finalized separately from the conclusion regarding IT general controls.

Ehlers asked Fox if she sees any additional information coming out of the New York State Department of Financial Services (NYDFS) reports on compliance with New York Regulation 500 that would not be addressed through Exhibit C procedures.

Fox replied that she has not seen any recommendations related to Regulation 500 cybersecurity events that were not covered by Exhibit C. She stated that she has not seen anything come out of any exams she has dealt with so far that should be added to Exhibit C.

Ehlers asked that Working Group members who may be familiar with the resources referenced in the referral (i.e., CISA, NIST, and CIS), share their experience and/or preference with using these frameworks that could be considered by the drafting group to bolster cybersecurity procedures.

Brian de Vallance (CIS) emphasized the importance of the federal government updating its guidance to allow CIS members to take advantage of the innovations in the world of cyber defense. He also mentioned that the CIS is a nonprofit organization that provides cybersecurity best practices and is willing to assist the Working Group as a free resource.

Having no further business, the IT Examination (E) Working Group adjourned.

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FINANCIAL STABILITY (E) TASK FORCE

Financial Stability (E) Task Force Aug. 13, 2023, Minutes	9-836
Financial Stability (E) Task Force June 20, 2023, Minutes (Attachment One)	9-842
NAIC – Reinsurance Comparison Worksheet (Attachment One-A)	9-847
Plan for the List of 13 Considerations – Private Equity (PE)-Related and Other (Attachment Two)	9-850
Minnesota Department of Commerce Update on <i>Actuarial Guideline LIII—Application of the</i> <i>Updates on Actuarial Guideline LIII—Application of the Valuation Manual for Testing the</i> <i>Adequacy of Life Insurer Reserves (AG 53)</i> (Attachment Two-A).....	9-860

Draft: 8/16/23

Financial Stability (E) Task Force
and the Macroprudential (E) Working Group
Seattle, Washington
August 13, 2023

The Financial Stability (E) Task Force met in Seattle, WA, Aug. 13, 2023, in joint session with the Macroprudential (E) Working Group. The following Task Force members participated: Nathan Houdek, Chair (WI); Judith L. French, Vice Chair (OH); Alan McClain represented by Chris Erwin (AR); Andrew N. Mais represented by William Arfanis (CT); Karima M. Woods represented by Philip Barlow (DC); Michael Yaworsky represented by Virginia Christy (FL); Doug Ommen represented by Carrie Mears (IA); Amy L. Beard represented by Roy Eft (IN); Vicki Schmidt represented by Tish Becker (KS); Gary D. Anderson represented by John Turchi (MA); Kathleen A. Birrane represented by Lynn Beckner (MD); Timothy N. Schott represented by Vanessa Sullivan (ME); Grace Arnold represented by Fred Andersen (MN); Chlora Lindley-Myers represented by John Rehagen (MO); Mike Causey represented by Angela Hatchell (NC); Jon Godfread represented by Matt Fischer (ND); Eric Dunning represented by Lindsay Crawford (NE); Justin Zimmerman represented by David Wolf (NJ); Adrienne A. Harris represented by John Finston (NY); Andrew R. Stolfi represented by Kristen Anderson (OR); Michael Humphreys represented by Diana Sherman (PA); Elizabeth Kelleher Dwyer (RI); Michael Wise represented by Will Davis (SC); Cassie Brown represented by Jamie Walker (TX); and Scott A. White (VA). The following Working Group members participated: Bob Kasinow, Chair (NY); Carrie Mears, Vice Chair (IA); William Arfanis (CT); Philip Barlow (DC); Charles Santana (DE); Virginia Christy (FL); Roy Eft (IN); John Turchi (MA); Lynn Beckner (MD); Vanessa Sullivan (ME); Steve Mayhew (MI); Fred Andersen (MN); John Rehagen (MO); Lindsay Crawford (NE); Jennifer Li (NH); David Wolf (NJ); Kristen Anderson (OR); Diana Sherman (PA); Elizabeth Kelleher Dwyer (RI); Jamie Walker (TX); Dan Bumpus (VA); and Amy Malm (WI).

1. Heard Opening Remarks

Commissioner Houdek said materials for consideration and discussion for this meeting were sent via email Aug. 7, and they are available on the NAIC website in the “Committees” section under the Financial Condition (E) Committee.

2. Adopted the Task Force’s June 20 and Spring National Meeting Minutes

Mears made a motion, seconded by Superintendent Dwyer, to adopt the Task Force’s June 20 (Attachment One) and March 22, 2023 minutes (*see NAIC Proceedings– Spring 2023, Financial Stability (E) Task Force*). The motion passed unanimously.

3. Heard an Update on FSOC Developments

Superintendent Dwyer reported on a few Financial Stability Oversight Council (FSOC) discussions identified publicly that are most directly related to the NAIC’s work:

- On April 21, the FSOC released its new proposed guidance and analytic framework for designating nonbanks that potentially pose financial stability risks, which are the policies and documents that would guide the FSOC should it decide to “designate” a non-bank entity. This could potentially include insurers. After a brief extension, the comment period closed July 27.
- A designation means the FSOC has determined that the particular entity poses a systemic risk to the entire financial system and, therefore, should be subject to enhanced supervision by the Federal Reserve, in addition to any existing functional oversight by another state insurance regulator, which is the authority

that led to the designations of American International Group Inc. (AIG), MetLife, and Prudential Financial after the 2008 financial crisis.

- The designations were eventually removed from all three companies, with MetLife winning a lawsuit that challenged the FSOC’s ability to designate a company without specific findings.
- In the intervening years, the FSOC was encouraged to focus more on an “activities-based” approach to dealing with systemic risk; i.e., focusing on the type of activities that lead to contagion and catastrophe regardless of which entities may be engaged in them.
- While the NAIC prefers the “activities-based” approach to designating individual firms, the designations authority is a function of law, and it remains a potent tool in the FSOC’s toolbox.
- The FSOC has not indicated whether there are particular firms or insurers on its radar. However, recent public work of the FSOC has focused on broad areas of the financial sector, including non-bank lenders, hedge funds, crypto firms, and asset managers.
- In keeping with past precedent, the NAIC did not comment publicly on the FSOC’s internal guidance, given its role as a sitting member of the FSOC. However, the NAIC has long argued that the business of insurance is not inherently systemic, and while insurers can be affiliated with other parts of the financial system that could create risk, state insurance regulation has evolved significantly since the 2008 financial crisis, and the NAIC has spent the last decade further refining and improving what was already an effective system. The NAIC now has far deeper and broader insights into non-insurance entities within a group, better risk management, reporting and liquidity tools, and enhanced disclosure to further limit the potential for systemic risk in the insurance sector.
- While the non-bank designation guidance has gotten most of the attention, the FSOC has continued to make progress on other important projects, like enhancing data sharing among FSOC agencies related to climate risk, banking sector supervision due to recent regional bank failures, hedge fund vulnerabilities, and non-bank mortgage servicing concerns.

4. Received a Working Group Update

Kasinow provided a brief update on the liquidity stress test (LST) project:

- The 2022 LST filings were due June 30, and NAIC staff are continuing to review the filings and will provide summarized results and insights soon.
- Work on the 2023 Liquidity Stress Testing Framework (LST Framework) will begin soon. State insurance regulators will once again consider whether to modify the scope criteria used to identify life insurers and their groups for potential participation in the LST project, as well as consider any modifications to the stress scenarios and other requirements to be included in the 2023 LST Framework.
- Separate account liquidity concerns, other than the guaranteed portion included in the general account, are excluded from the current LST Framework. The LST Study Group is in the process of considering how to address potential separate account asset sales in a stress scenario. The Study Group is working on a data call for lead states to require their participant life insurance groups to provide some context around the dollar amount of specific asset types included in separate accounts, which are not already subject to U.S. Securities and Exchange Commission (SEC) liquidity stress requirements.
- Once the Study Group has access to the results of this data call, state insurance regulators will be in a better position to consider the potential impact of this universe of assets. If deemed significant, state insurance regulators will move on to constructing a methodology for assessing the potential asset sales, which could occur in likely stress scenarios.

Kasinow reported that NAIC staff recently posted a new status update document on the referrals of the Working Group’s list of 13 private equity (PE) and related considerations (Attachment Two), which includes a brief title for

each of the 13 considerations, the initial status when referrals were sent to other groups, the March 22 status update, and the recently added Aug. 13 status update.

Kasinow summarized some key developments of the 13 PE and related considerations:

- For items 1 and 2, addressing concerns around holding company structures, ownership, and control, the Group Solvency Issues (E) Working Group formed a drafting group to develop best practices for regulatory review in this area.
- For items 4 and 10, Andersen’s update on *Actuarial Guideline LIII—Application of the Valuation Manual for Testing the Adequacy of Life Insurer Reserves* (AG 53) (Attachment Two-A) will provide insights into efforts, which involve ensuring that long-term liabilities are appropriately supported and the complex and/or privately structured securities’ risks are appropriately modeled.
- For item 5, which raises questions about operational, governance, and market conduct practices, the Working Group will soon begin considering this item now that the Task Force has completed the Reinsurance Worksheet to address the offshore/complex reinsurance topic in item 13.
- Item 7, which concerns identifying related party-originated investments, has been addressed by the 2022 adoption of additional related party codes for investment reporting and the more recent adoption of revisions in the Statutory Accounting Principles (E) Working Group’s Ref #2022-15. These revisions clarify that any invested asset held by a reporting entity that is issued by an affiliated entity, or which includes the obligations of an affiliated entity, is an affiliated investment.
- The revisions for item 7 also address many of the considerations for item 8, which concerns identifying underlying affiliated/related party investments and/or collateral in structured securities, and item 9, which concerns asset manager affiliates and disclaimers of affiliation. There may be additional work as state insurance regulators gain more insights from reviewing statutory financial statements, including these new disclosures and accounting clarifications.
- For item 11, reliance on rating agencies, the Valuation of Securities (E) Task Force has had a lot of discussion and activity around this consideration, which is expected to continue and possibly expand in scope.
- For item 12 and its considerations around pension risk transfers (PRTs), it is the NAIC’s understanding that the U.S. Department of Labor (DOL) has had many meetings with trade associations and insurers, along with many other groups to work to update the fiduciary requirements under 95-1.

Kasinow also reported that the Working Group will be working on the following items before the Fall National Meeting:

- Updating the Macprudential Risk Assessment (MRA) dashboard, including incorporating additional climate risk metrics.
- The MRA work will also include comparing the NAIC’s framework to the FSOC’s framework to identify any gaps and propose a way forward.
- Continue counterparty identification and an enhancement project.

Andersen reported that in 2022, the NAIC adopted AG 53, with its main purpose being to help ensure claims-paying ability even if complex assets do not perform as expected. He added that it requires disclosure for most life insurers over a size threshold of asset-related information with first submissions due April 2023. He added that the disclosures provide an opportunity for companies to tell their stories regarding their complex assets and associated risks, as well as how their cash-flow testing models address those risks. He said the NAIC has received AG 53 filings from 246 life insurers. He added that the Valuation Analysis (E) Working Group formed an AG 53 Review Group consisting of a team of actuaries, investment experts, and other financial staff to perform reviews. He said the review process has started with company prioritization based on prior knowledge and template

information. He explained that the Review Group meets frequently to identify companies with outlier net yield assumptions and engage with state insurance regulators for companies with outlier assumptions.

Andersen explained that the Valuation Analysis (E) Working Group considered a review of net yield assumptions to be its top priority due to the implications if a company is assuming high investment returns:

- More favorable asset adequacy analysis results.
- With more favorable asset adequacy results, a lower amount of assets could be held for reserves to be considered adequate.
- The concern is if risk is understated and assets underperform, reserves will turn out to be inadequate, and previously released money may have been needed.

Andersen explained the table in his presentation:

- Listed are examples of cash-flow testing results showing adequate reserving amounts, with the only difference being a change in the net yield assumptions. As the net yield assumption increases, the cash-flow testing indicates that a lower reserve amount is adequate.
- From a state insurance regulator's perspective, companies with high net yield assumptions would be vulnerable to not having sufficient reserves if their assets do not perform as expected. Companies assuming aggressively high net yields may be perceived as being dependent on that level of return to be able to pay all future claims.
- This illustrates why the Review Group first focused on net yield assumptions.

Andersen reported some findings related to AG 53 net yield assumptions:

- AG 53 filings for companies that are active and have outlier net yield assumptions have been reviewed, and the Review Group has the following concerns:
 - Reserve adequacy using moderately adverse conditions criteria is not met for companies that rely on high investment returns over a long period of time to be able to pay future claims.
 - Other companies may feel a need to assume unreasonably high yields to compete.
- Separated companies with above 7% and below 7% net returns for a variety of asset classes, but 7% is not meant as a safe harbor, rather just a demonstration of companies with outlying assumptions.
- A vast majority of life insurers assume reasonable returns on their assumptions; i.e., 85% to 95% of companies are in the below 7% category.
- There is a sizable number of companies that assumed net yields above 7% with more widespread assumptions of yields for Schedule BA assets and equities.

Andersen reported some of the upcoming activities of the Review Group:

- Reviewing reinsurance counterparty risk by sending requests for additional information from a targeted set of ceding companies, as relevant:
 - Description and reason for significant reinsurance-related ceded transactions.
 - Process and metrics used to evaluate the counterparty's asset risk and financial health.
- Continuing efforts to help ensure claims-paying ability even if complex assets do not perform as expected.

5. Heard an International Update

Tim Nauheimer (NAIC) reported that the International Association of Insurance Supervisors (IAIS) has completed numerous data calls and analyses as part of the Global Monitoring Exercise (GME), which includes individual insurer monitoring (IIM) and sector-wide monitoring (SWM). He added that the GME is part of the IAIS's holistic

framework for systemic risk identification, which takes a broader approach to financial stability and macroprudential surveillance.

Nauheimer summarized with respect to the GME that the IAIS has done the following:

- Completed the IIM quantitative data analysis of about 60 insurers.
- Completed the quantitative and qualitative SWM data collection, which includes additional data on reinsurance and climate risk.
- Continues to analyze SWM reinsurance data.
- Continues to analyze SWM data to compare to IIM data.
- Published the Global Insurance Market Report (GIMAR) mid-year update in July that provides a summary of the initial outcomes of this year's data collections and highlights key themes identified for the 2023 GME as being:
 - Risks faced by insurers in light of the challenging macroeconomic backdrop, notably interest rate, liquidity, and credit risk.
 - Structural shifts in the life insurance sector, specifically the use of cross-border asset-intensive reinsurance.
 - The increased allocation of capital to alternative assets.
- Will complete the annual GIMAR publication in November, for which the NAIC will continue to monitor and contribute to the development of the report.

Nauheimer stressed that the IIM and SWM data collections help determine the scope for an annual collective discussion by the IAIS on potential systemic risk issues. He added that the IAIS held a global seminar in Seattle in June, where this year's collective discussion of insurers and SWM themes was approved. He said for the IIM collective discussion, the focus will be on firms identified by quantitative scoring, as well as some overarching themes related to financial stability that were identified through expert judgment. He added that the process resulted in the identification of six insurers for this year's collective discussion: two firms were included due to quantitative scoring; three firms were included due to expert judgment; and one firm as a top-up for regional balance. He said identification of the insurers is confidential, and the group-wide supervisors were sent questionnaires, which were due Aug. 11. He said the collective discussion will take place at the Macroprudential (E) Working Group and Executive (EX) Committee meetings at the end of September, in which the group-wide supervisors will provide an overview of the supervision of their insurers.

Nauheimer reported that the IAIS has approved the updated IIM Assessment Methodology after the resolution of comments, but work on the following ancillary indicators to refine systemic monitoring will continue this year: 1) level 3 assets; 2) credit risk; 3) derivatives; and 4) reinsurance. He added that the IAIS Liquidity Workstream will meet at the end of August to analyze data received as part of the GME to continue to develop liquidity metrics, especially regarding an LST.

Nauheimer said the SWM overarching themes this year are:

- Managing increased interest rate, credit, and liquidity risks against a challenging macroeconomic backdrop.
- Cross-border reinsurance.
- Alternative assets.

Nauheimer reported that NAIC staff completed extensive questionnaires on each of the above risk themes that were due Aug. 11 and describe how the NAIC takes these risk themes into account in the U.S. regulatory system, including identification and monitoring tools in place. He added that NAIC staff shared the questionnaires with the Working Group for its input as well.

Nauheimer also reported that some of the additional climate data was proposed by the IAIS Climate Risk Steering Group (CRSG). He added that the IAIS released its first public consultation that covers the addition of new material into the IAIS Insurance Core Principles (ICPs) Introduction, work related to climate risk and governance, and the IAIS's plans to address climate more broadly. He said the CRSG met June 28 to discuss initial observations on the feedback received from the public consultation and initial feedback on the latest draft Application Paper materials on both climate-related market conduct considerations and climate scenario analysis. He added that the Application Paper, which is scheduled to be published for consultation by the end of 2023, contains guidance on scenario analysis in ICP 16 on enterprise risk management and ICP 24 on macroprudential supervision.

Nauheimer said the IAIS Macroprudential Supervision Working Group (MSWG) is conducting a holistic framework review of supervisory standards with a number of subcommittees of the MSWG reviewing SWM themes and future data collection points. He added that the MSWG has been engaged in providing educational sessions on asset-intensive reinsurance/cross-border reinsurance, including hearing many presentations from insurers and supervisors from across the globe that are similar to the ones heard by the Working Group and Task Force over the past year, but if new information is provided at the IAIS, NAIC staff will inform the Working Group and the Task Force.

Having no further business, the Financial Stability (E) Task Force and Macroprudential (E) Working Group adjourned.

SharePoint/NAIC Support Staff Hub/Committees/E Committee/FSTF/2023_2 Summer/Minutes

Draft: 7/10/23

Financial Stability (E) Task Force
and the Macroprudential (E) Working Group
Virtual Meeting
June 20, 2023

The Financial Stability (E) Task Force met June 20, 2023, in joint session with the Macroprudential (E) Working Group. The following Task Force members participated: Marlene Caride, Chair, represented by John Sirovetz (NJ); Nathan Houdek, Vice Chair (WI); Alan McClain represented by Leo Liu (AR); Ricardo Lara represented by Susan Bernard (CA); Andrew N. Mais represented by William Arfanis (CT); Karima M. Woods represented by Philip Barlow (DC); Michael Yaworsky represented by Virginia Christy (FL); Doug Ommen represented by Mike Yanacheak (IA); Amy L. Beard represented by Roy Eft (IN); Vicki Schmidt represented by Tish Becker (KS); Gary D. Anderson represented by Christopher Joyce (MA); Timothy N. Schott represented by Vanessa Sullivan (ME); Grace Arnold represented by Fred Andersen (MN); Chlora Lindley-Myers represented by John Rehagen (MO); Mike Causey represented by Jackie Obusek (NC); Jon Godfread represented by Colton Schulz (ND); Eric Dunning represented by Lindsay Crawford (NE); Adrienne A. Harris represented by Bob Kasinow (NY); Judith L. French represented by Tim Biler (OH); Michael Humphreys represented by Diana Sherman (PA); Elizabeth Kelleher Dwyer (RI); Michael Wise represented by Thomas Baldwin (SC); Cassie Brown represented by Rachel Hemphill (TX); and Scott A. White represented by Dan Bumpus (VA). The following Working Group members participated: Bob Kasinow, Chair (NY); Mike Yanacheak, Vice Chair (IA); Susan Bernard (CA); William Arfanis (CT); Philip Barlow (DC); Tom Hudson (DE); Virginia Christy (FL); Roy Eft (IN); Christopher Joyce (MA); Vanessa Sullivan (ME); Steve Mayhew (MI); Fred Andersen (MN); John Rehagen (MO); John Sirovetz (NJ); Diana Sherman (PA); Elizabeth Kelleher Dwyer (RI); Rachel Hemphill (TX); Dan Bumpus (VA); and Amy Malm (WI). Also participating were: David Phifer (AK); Mark Fowler (AL); David Lee (AZ); Rolf Kaumann (CO); Russell Coy (KY); Pat Gosselin (NH); Leatrice Geckler (NM); Carter Lawrence (TN); Jon Pike (UT); Kevin Gaffney (VT); and Tim Hays (WA).

1. Heard Opening Remarks

Commissioner Houdek said materials for consideration and discussion for this meeting are available on the NAIC website in the Committees section under the Financial Condition (E) Committee. He added that the materials were intentionally released two weeks in advance of the Task Force call to allow participants extra time to review and the option to express any major concerns. He summarized that the purpose of the call is to ensure comments received on the draft Reinsurance Worksheet have been addressed by the Working Group and to consider the draft for adoption, which the Task Force will be considering jointly with the Working Group.

2. Adopted the Reinsurance Worksheet

Kasinow summarized the clarifications of the Reinsurance Worksheet from comment letters received:

- **OPTIONAL TOOL:** This worksheet is designed as an **OPTIONAL** tool to assist lead state/domiciliary regulators when reviewing reinsurance transactions to allow them to obtain the information necessary to understand the economic impacts, typically upon initial review of the proposed transaction but also potentially when the lead state/domiciliary regulator is performing a historical review of the transaction for some specific purpose.
- **NOT AN ONGOING FILING:** This worksheet is **NOT** for use as an ongoing filing with the NAIC and/or the lead/domiciliary state. It is an **EDUCATIONAL** tool for lead state/domiciliary regulators to use on an ad hoc basis as needed.

- **ONLY USED IF NEEDED:** The worksheet is **NOT** designed to be used with **EVERY** reinsurance transaction. It is designed as a consistent tool for lead state/domiciliary regulators to use when reviewing reinsurance transactions for which they need to determine the economic impacts of said reinsurance transactions. If a reinsurance transaction is easily understood without the use of this worksheet, then a worksheet would not be used by the lead state/domiciliary regulator.
- **NOT A FIXED TEMPLATE:** The worksheet is **NOT** a fixed template that **MUST** be used to answer the lead state/domiciliary regulators' information needs. If an insurer has materials used in its own assessment of the reinsurance transaction that answer the information needs of the lead state/domiciliary regulator expressed in the worksheet, then those materials may be accepted by the lead state/domiciliary regulator rather than requiring the insurer to use the worksheet format. Every effort should be made to **avoid duplicate requests** for information.
- **OPEN TO REINSURANCE TYPE:** The worksheet **was designed with life reinsurance transactions** as the initial focus, but there is **no reason to limit this tool to life reinsurance transactions**. If the lead state/domiciliary regulator has a property/casualty (P/C) reinsurance transaction for which they are struggling to understand the economic impact (despite any existing notes, interrogatories, and Schedule F disclosures for already approved transactions), the lead state/domiciliary regulator would be able to use the worksheet to request the needed information, with appropriate edits. Again, this worksheet should not be used if the lead state/domiciliary regulator has a clear understanding of the transaction from data already provided.
 - Similarly, the worksheet was designed with affiliated transactions as the initial focus, but a lead state/domiciliary regulator should use the template for unaffiliated transactions if existing information does not provide a clear understanding of the transaction.
- **NOT REINSURANCE POLICY:** The Working Group is working in coordination with the Reinsurance (E) Task Force. This optional, informational tool is **not intended to affect any of its reinsurance policies or procedures**, such as the qualified/reciprocal jurisdiction evaluation process or the "Bilateral Agreement Between the United States of America and the European Union on Prudential Measures Regarding Insurance and Reinsurance" (EU Covered Agreement).
- **ONLY REFERENCED IN HANDBOOKS:** The worksheet is **not included in the *Financial Analysis Handbook* or the *Financial Condition Examiners Handbook***; although, it may be referenced there as an optional tool. The worksheet will be available on StateNet.
- **CONFIDENTIALITY:** The worksheet would be confidential under a lead/domiciliary state's existing confidentiality laws and regulations in place to allow the lead state/domiciliary regulator to assess such transactions.

Kasinow asked the following interested parties that provided comment letters if there were any remaining concerns: Swiss Re; the American Council of Life Insurers (ACLI); a representative for jointly made comments from the National Association of Mutual Insurance Companies (NAMIC), the Reinsurance Association of America (RAA), and American Property Casualty Insurance Association (APCIA); the Bermuda International Long Term Insurers and Reinsurers (BILTIR); and the Association of Bermuda Insurers and Reinsurers (ABIR).

Steve Clayburn (ACLI) said concerns expressed in the ACLI's comment letter were addressed in a positive direction in the resolution of comments, with confidentiality and avoiding duplication being the most important. He stressed that the Task Force should be working collaboratively with the Reinsurance (E) Task Force on any future enhancements.

Belfi asked if the questions on the transaction being requested by the lead or ancillary state would be the direct writer or ceding regulator or the reinsurance regulator. Kasinow responded that the ceding regulator would initiate questions to understand the economics of the transaction. He added that some states are already using

something similar to the Reinsurance Worksheet as part of their financial analysis and review of transactions, and the intent was only to capture information for states that did not previously have that information.

Tim Nauheimer (NAIC) summarized the resolution of comments received:

- Indiana and Nebraska suggested that a fair amount of terminology should be defined; the other jurisdiction should be named; a summary description of key elements of that jurisdiction's accounting basis should be provided. Nauheimer said the Task Force would incorporate those suggestions.
- Swiss Re said the information requested in the Reinsurance Worksheet, such as cross-border reinsurance transaction details, is already available through existing filings.
- Nauheimer said state insurance regulators' use of the Reinsurance Worksheet is primarily intended for life but may be used for P/C. He added that the Reinsurance Worksheet is intended as needed not as an ongoing disclosure requirement, and it is intended for specific transaction approval. He concluded that state insurance regulators will leverage existing information, but they do not get all the data needed from annual statements.
- Swiss Re said the Working Group expressed concerns emanating from the Cayman Islands and/or Bermuda, and it asked for additional clarity on those specific concerns.
- Nauheimer responded that the Working Group never stated concerns with these jurisdictions. He added that the Working Group met with these jurisdictions to better understand their regulatory regime and their process for reviewing reinsurance deals to better coordinate with them.
- Swiss Re said the NAIC has already established a process for evaluating qualified and reciprocal jurisdictions, which is a means to recognize key NAIC solvency initiatives, including group supervision and group capital standards, and it recommends involving the established process and expertise of other NAIC groups.
- Nauheimer responded that the Task Force agrees that any broader issues that arise during a specific transaction approval should be raised to the groups responsible for the qualified and reciprocal process. He added that the Working Group is also closely coordinating with the Reinsurance (E) Task Force, but it is merely overseeing the 13 private equity (PE) and other considerations.
- The ACLI said the Reinsurance Worksheet should not be duplicative of other sources already available to state insurance regulators, and established confidentiality protections should be maintained.
- Nauheimer responded that the Working Group data may be used to complete a Form D, not in addition to, and it would be confidential under existing confidentiality state laws and regulations in place to assess such transactions; i.e., a tool for state insurance regulators to use and not filed with the NAIC.
- The BILTIR agreed with the ACLI letter, so Nauheimer said no additional response is needed.
- The RAA, the APCIA, and NAMIC recommended the following suggestions:
 - The Working Group should identify and limit the proposal to the types of cross-border reinsurance transactions that are of concern to state insurance regulators.
 - Simple and straightforward reinsurance transactions should not be subject to data requested in the Reinsurance Worksheet.
 - The brief introductory guidance on page 1 of the Reinsurance Worksheet is insufficient and should not be adopted until additional guidance in the *Financial Analysis Handbook* or a similar reference document is developed to provide context on the information that state insurance regulators need.
 - P/C reinsurance contracts subject to existing requirements from the scope of contracts should be exempt from the Reinsurance Worksheet.
 - The Reinsurance Worksheet appears to be required to be completed by the ceding company, but it is unclear whether the option to request it resides primarily with the domestic state of the cedent or whether the option is available to any state in which the cedent is licensed.

- Clarification is needed regarding the date the balance sheet effects are measured, the time period, and the intended retrocession details of the Reinsurance Worksheet.
- Consider whether the Working Group considered the Reinsurance Summary Supplemental Filing and related Reinsurance Attestation Supplement in its development of the Reinsurance Worksheet.
- It is unclear whether the proposal is intended to apply to only affiliated off-shore reinsurance transactions or to any cessions to third parties.
- Provide a reasonable minimum timeframe for the completion of the worksheet.
- Nauheimer responded that state insurance regulators may use the Reinsurance Worksheet as they see fit, as it is a tool for states, and the clarification summary should address those concerns. He added that:
 - The Working Group will enhance guidance and instructions, but it is not intended for the *Financial Analysis Handbook*.
 - Companies should add the transaction date and specify before and immediately after the reinsurance transaction, and the retrocession details are intended to understand the structure.
 - The clarification summary should address the other comments.
 - The Reinsurance Worksheet:
 - May be used for any purpose (e.g., affiliated and unaffiliated deals).
 - Would be confidential under existing confidentiality state laws and regulations in place to assess such transactions.
 - Is for state insurance regulator use and not intended to be required filing by a company with a filing deadline.
- The ABIR recommends:
 - Avoiding impeding the solid work on the existing and future U.S. Covered Agreements and NAIC qualified reinsurance designation by one-off interventions into international reinsurance.
 - Assigning further considerations of the Reinsurance Worksheet exclusively to the Reinsurance (E) Task Force.
 - Using the Reinsurance Worksheet in traditional, unaffiliated P/C reinsurance transactions has not been identified as necessary.
 - Further consultation and discussion are required to address:
 - Questions on context and clarity are needed before being considered further by state insurance regulators, i.e., where the Reinsurance Worksheet would reside in the regulatory framework.
 - Whether the Reinsurance Worksheet should be part of the *Financial Condition Examiners Handbook*.
 - Whether the Reinsurance Worksheet should be considered a desk drawer rule; i.e., what outcomes of the calculations suggest.
 - What action is being considered upon completion of the Reinsurance Worksheet.
 - What the safeguards are to protect confidential and proprietary information.
- Nauheimer responded that the Reinsurance Worksheet will not be part of the *Financial Condition Examiners Handbook*, and it will not be considered a desk drawer rule. He added that the Reinsurance Worksheet may be used as state insurance regulators deem necessary, and it will be used to educate state insurance regulators on the economics of a deal and to analyze a transaction. He said as noted earlier, the Reinsurance Worksheet will be confidential under the existing confidentiality state laws and regulations in place to assess such transactions.

Mayhew made a motion, seconded by Arfanis, to adopt the Reinsurance Worksheet. The motion passed unanimously by the Working Group.

Yanacheak made a motion, seconded by Sherman, to adopt the Reinsurance Worksheet (Attachment One-A). The motion passed unanimously by the Task Force.

Commissioner Houdek said there is no urgency after adopting the Reinsurance Worksheet, as the Financial Condition (E) Committee will consider it for adoption during its Summer National Meeting and due to it being an optional tool that state insurance regulators may already choose to use if needed.

Having no further business, the Financial Stability (E) Task Force and Macprudential (E) Working Group adjourned.

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Cross-border Affiliated Reinsurance Comparison Worksheet - by Treaty					
	Date:				
Category	US Stat. Pre-Transaction	Impacts of Transaction (Col's B-D)	US Stat. Post-Transaction	Other Jurisdiction	(Alternate Method) - Other Jurisdiction
Other Jurisdiction Name					
BALANCE SHEET COMPARISON:					
Asset Grouping 1 (e.g., Cash/Investments)					
Asset Grouping 2 (e.g., Policy Loans)					
Asset Grouping3 (e.g., Separate Accounts)					
Other Assets					
TOTAL ASSETS *					
Liab. Grouping1 (e.g., Gen. Acct. Reserves)					
Liab. Grouping2 (e.g., Gen. Acct. Policy Loan Reserves)					
Liab. Grouping3 (e.g., Separate Accounts)					
Unauthorized Reinsurance Liability					
Other Liabilities (See NOTES SECTION)					
TOTAL LIABILITIES					
TOTAL ASSET REQUIREMENT COMPARTISON:					
Reserve Grouping1 (e.g., Separate Account Reserves)					
Reserve Grouping2 (e.g., GA Policy Loan Reserves)					
Reserve Grouping3 (e.g., GA Policy Reserves)					
TOTAL RESERVES					
Capital Grouping1 (e.g., Required Capital)					
Capital Grouping2 (e.g., Add'l Capital for Rating Agency)					
Capital Grouping3 (e.g., in Excess of Rating Agency Cap.)					
TOTAL CAPITAL					
TOTAL ASSET REQUIREMENT					
CHANGE IN CAPITAL AND SURPLUS:					
Capital and Surplus					
Net Income					
Change in Liability for Unauthorized Reinsurance					
Aggregate Write Ins for gains and losses in surplus					
Capital Contribution/(Dividends)					
Other Changes in surplus					
TOTAL LIABILITIES & CAPITAL					
SOLVENCY RATIO					
* Supported by listings of asset categories and amounts to highlight differences in supporting assets after the transaction.					
NOTES SECTION:					
(e.g., explain product line, describe transaction and any unique aspects)					
(If Asset Adequacy Testing is included in "Other Liabilities," additional regulatory guidance may be needed, e.g., on counterparty asset assumptions where access is limited.)					

Transaction Details			
Please identify the following transaction details if applicable:			
Contract 1 (if needed)	Contract 2 (if needed)	Contract 3 (if needed)	Contract 4 (if needed)
Which party of the contract are you (assuming or retroceding)?			
Description risk category covered (mortality, longevity, Cat Risk, etc.)			
Start date			
End date			
Currency			
Sum Insured / Gross Notional amount / PML			
Capital at risk			
Line of Business (e.g. annuities, term, participating guarantee, etc.)			
Risks covered (e.g. longevity, mortality, etc.)			
Type of reinsurance treaty (XOL, Quota share – proportionate, etc.)			
Collateral value			
Value of guarantee			
Names(s) of the reinsurer(s) (please only include top 3 by premium share if more than one)			
Rating of reinsurer(s)			
Countries of reinsurer(s)			
Assets pledged by reinsurer			
Initial premium			
Initial fees			
Value of reserves			
Ceding commission structure			
Any experience refund or loss carryforward features			
Do you use or plan to use any form of derivatives for reinsurance purposes (e.g. longevity or mortality swaps)?			
If yes, please provide a brief description			
Was any debt or surplus note issued in connection with the transaction? Ex: Such as in an embedded value securitization			
If yes, please provide a brief description			
If yes, provide description of these derivatives			
If yes, please provide a brief description			
Please describe Exit mechanism if known			
Please identify and describe if any of the following types of arrangements are associated with this transaction:			
Trust			
Funds Withheld			
Coinsurance			
Modified Coinsurance			
Sidecars			
Any other Joint Venture or SPV			
Third-party capital			
Ceded and Retroceded Details			
If ceding to an offshore affiliate please identify the assuming affiliated reinsurer(s) and their regulatory jurisdiction			
If ceding to an offshore affiliate and that affiliate is going to retrocede to another reinsurer, please identify the ultimate assuming reinsurer(s) and their regulatory jurisdiction			
Key Definitions			
PML-Probable Maximum Loss			
Capital at risk-required capital or capital charge.			
Collateral value-the market value of securities pledged as collateral if a trust is set up in connection with the transaction.			
Value of the guarantee - For example, third party guarantees in non-standard types of reinsurance e.g. an MGA owns affiliated insurers, an unaffiliated reinsurer reinsures with the MGA affiliate with a guarantee from the MGA.			

Plan for the List of MWG Considerations – PE Related and Other

Some of these Working Group projects will continue for several years. The status of the 13 MWG Considerations is as follows as of **August 13, 2023**:

1. Holding Company Structures:

Sent a referral for new work to the Group Solvency Issues (E) Working Group.

GSIWG Update 3/22/23: *The GSIWG plans to discuss this issue at its Dec. 14 meeting to determine next steps in addressing the referral.*

GSIWG Update 8/13/23: *The GSIWG formed a drafting group to develop best practices for regulatory review in this area. The drafting group has met multiple times and continues to work on the development of written best practices. After the best practices are developed, the drafting group will consider whether any should be proposed for inclusion in NAIC Handbooks or other action should be considered.*

2. Ownership and Control:

Sent a referral for new work to the Group Solvency Issues (E) Working Group.

GSIWG Update 3/22/23: *The GSIWG plans to discuss this issue at its Dec. 14 meeting to determine next steps in addressing the referral.*

GSIWG Update 8/13/23: *The GSIWG formed a drafting group to develop best practices for regulatory review in this area. The drafting group has met multiple times and continues to work on the development of written best practices. After the best practices are developed, the drafting group will consider whether any should be proposed for inclusion in NAIC Handbooks or other action should be considered.*

3. Investment Management Agreements (IMAs):

Sent a referral to the Risk-Focused Surveillance (E) Working Group to add this consideration to existing work involving affiliated agreements and Form D filings. Also sent a referral to the Valuation of Securities (E) Task Force (VOSTF) to highlight the regulatory discussion involving topics it administers.

RFSWG Update 3/22/23: *The RFSWG received and discussed this referral during its Nov. 1 interim meeting. During the meeting, the RFSWG agreed to defer further work on this issue until its*

ongoing project to update general guidance in NAIC handbooks related to affiliated service agreements is completed in early 2023.

RFSWG Update 8/13/23: *The RFSWG is nearing the completion of its project to update general guidance in NAIC handbooks related to affiliated service agreements, which is expected to be completed by the 2023 Summer National Meeting. After the general guidance is completed, the Working Group plans to begin work on more targeted guidance related to affiliated investment management agreements.*

4. Owners of Insurers with Short-Term Focus and/or Unwilling to Support a Troubled Insurer:

Sent a referral to the Risk-Focused Surveillance (E) Working Group to add this consideration to existing work involving affiliated agreements and fees. Also sent a referral to the Life Actuarial (A) Task Force recognizing its existing work to ensure the long-term life liabilities (reserves) and future fees to be paid out of the insurer are supported by appropriately modeled assets.

RFSWG Update 3/22/23: *The RFSWG received and discussed this referral during its Nov. 1 interim meeting. During the meeting, the RFSWG agreed to defer further work on this issue until its ongoing project to update general guidance in NAIC handbooks related to affiliated service agreements is completed in early 2023.*

RFSWG Update 8/13/23: *No update.*

LATF Update 3/22/23: *Asset adequacy analysis requirements in NAIC Model #820 and VM-30 require that company Appointed Actuaries perform testing to ensure that the reserves held for the company's liabilities are adequate in light of the assets supporting the business. Regulators review associated company Statements of Actuarial Opinion periodically.*

LATF Update 8/13/23: *Actuarial Guideline 53 – Application of the Valuation Manual for Testing the Adequacy of Life Insurer Reserves (AG 53) became effective for year-end 2022. AG 53 requires additional disclosures related to life insurance and annuity company investment return assumptions for complex and high yielding assets. Regulators are conducting targeted reviews of the AG 53 disclosures to ensure that company investment returns for complex and high-yielding assets are not overly optimistic.*

5. Operational, Governance and Market Conduct Practices:

The MWG will keep developing more specific suggestions before likely referring this consideration to the Risk-Focused Surveillance (E) Working Group.

MWG Update 3/22/23: *No new action has occurred for this consideration as the regulators have focused on the reinsurance consideration.*

MWG Update 8/13/23: *No new action has occurred for this consideration as the regulators have focused on the reinsurance consideration.*

6. Definition of Private Equity (PE):

No action was deemed necessary for this consideration.

No update.

7. Identifying Related Party-Originated Investments (Including Structured Securities):

Sent a referral to the Statutory Accounting Principles (E) Working (SAPWG) Group recognizing its existing work regarding disclosures for related-party issuance/acquisition. Once MWG regulators work with these SAPWG disclosures and regulatory enhancements from referrals to other groups, further regulatory guidance may be considered as needed.

SAPWG Completed Actions 3/22/23:

- *Ref #2021-21 included revisions that clarified guidance for related parties and developed a blanks proposal which provided new investment schedule column with reporting codes to identify investments that involve related parties. (Adopted May 2022)*
- *Ref #2021-22BWG added six related party reporting codes effective for year-end 2022. The investment schedule disclosures include codes that identify the role of the related party in the investment, e.g., a code to identify direct credit exposure as well as codes for relationships in securitizations or similar investments. (Adopted May 2022)*

SAPWG Completed Actions 8/13/23:

- *Ref #2022-15, included revisions to clarify that any invested asset held by a reporting entity which is issued by an affiliated entity, or which includes the obligations of an affiliated entity, is an affiliated investment. (Adopted March 2023)*

8. Identifying Underlying Affiliated/Related Party Investments and/or Collateral in Structured Securities:

Sent a referral to the Statutory Accounting Principles (E) Working Group in recognition of existing work to develop disclosures to identify the role of the related party in the investment and codes for relationships in securitizations or similar investment. Also sent a referral for new work to the Examination Oversight (E) Task Force for the CLO/structured security considerations.

SAPWG Completed Actions 3/22/23:

- See above descriptions (Ref # 2021-21 and Ref #2021-22 BWG) on investment reporting codes for year end 2022 reporting.
- Ref #2019-34 included revisions that clarify: 1) identification of related parties; 2) a non-controlling ownership over 10% results in a related party classification regardless of any disclaimer of control or affiliation; 3) a disclaimer of control or affiliation does not eliminate the classification as a “related party” and the disclosure of material transactions. This agenda item also resulted in the creation of a new Schedule Y Part 3, which was effective for year-end 2021. This schedule identifies all entities with greater than 10% ownership – regardless of any disclaimer of affiliation - and whether there is a disclaimer of control/disclaimer of affiliation and identifies the ultimate controlling party. (Ref #2019-34 and Ref #2020-37BWG, both adopted March 2021)

SAPWG Completed Actions 8/13/23:

- See above descriptions (Ref # 2021-21, Ref #2022-15 and Ref #2021-22 BWG).

EOTF Update 3/22/23: The EOTF delegated work on this referral to its Financial Analysis Solvency Tools (E) Working Group and its Financial Examiners Handbook (E) Technical Group. Both groups developed new guidance for inclusion in 2023 NAIC handbooks related to the new related party investment disclosures developed by SAPWG and the AG 53 standards developed by LATF that will be in place for 12/31/22 reporting. The groups may develop additional guidance for NAIC handbooks, as well as supporting regulatory reports and tools, as work proceeds in this area.

9. Asset Manager Affiliates and Disclaimers of Affiliation:

MWG regulators are comfortable waiting to realize the benefits of the recently implemented Schedule Y, Part 3, along with the changes other NAIC committee groups will make for several of the previously listed referrals, before determining if additional work is needed. Also, a referral was sent to the Statutory Accounting Principles (E) Working Group recognizing its existing work to

revamp Schedule D reporting along with the previously mentioned code disclosures will assist with this consideration.

SAPWG Completed Actions 3/22/23:

- See above descriptions of Schedule Y Part 3. (Ref #2019-34 and Ref #2020-37BWG).

SAPWG Ongoing Work 3/22/23:

- Ref #2022-15, which clarifies affiliated investment reporting, is planned for exposure at the 2022 Fall National Meeting. It adds guidance on reporting of affiliated investments.
- As part of a project known as the bond project, the SAPWG is developing a proposal to revise Schedule D reporting, which intends to determine what is considered a qualifying bond and to identify different types of investments more clearly. For example, the current bond proposal would divide Schedule D-1 into a Schedule D-1-1 for issuer credit obligations and a Schedule D-1-2 for asset-backed securities. The proposal includes more detailed reporting lines to provide more granularity on the actual types of investments held. The effective date of the bond proposal, and the reporting changes, is anticipated for January 1, 2025. The Ref #2019-21 is the primary Form A; however, the project has several documents.
- Ref #2022-17, which clarifies interest income disclosures, is planned for exposure at the 2022 Fall National Meeting.

SAPWG Completed Actions 8/13/23:

- See above descriptions Ref # 2021-21, Ref #2022-15 and Ref #2021-22 BWG; Ref #2022-17, incorporated revisions to data-capture interest income disclosures, and established new disclosures for aggregate paid-in-kind interest and deferred interest. (Adopted March 2023). SAPWG Ongoing Work: Reporting changes to reflect the Schedule D-1 proposed changes were exposed by the Blanks (E) Working Group on March 7, 2023, and updated revisions are anticipated for exposure shortly after the 2023 Summer National Meeting. The statutory accounting revisions to incorporate a new principles-based bond definition in SSAP No. 26R—Bonds and SSAP No. 43R—Asset Backed Securities will be presented for adoption at the 2023 Summer National Meeting.

10. Privately Structured Securities:

Sent a referral to the Life Actuarial (A) Task Force recognizing its existing work on an Actuarial Guideline including disclosure requirements for the risks of privately structured securities and how the insurer is modeling the risks. Sent a referral to the VOSTF highlighting the MWG

regulators' support for the blanks proposal to add market data fields for private securities being considered by the Valuation of Securities (E) Task Force (VOSTF). MWG regulators will wait on any further work or referrals until they have an opportunity to work with the results of the VOSTF proposal and the SAPWG Schedule D revamp project. Sent a referral for new work to the RBC Investment Risk and Evaluation (E) Working Group to address the tail risk concerns not captured by reserves.

LATF Update 3/22/23: *Actuarial Guideline 53 (AG 53) has been adopted by the Life Actuarial (A) Task Force and will be effective for year-end 2022 reporting. Regulators on the Valuation Analysis (E) Working Group will be conducting AG 53 reviews.*

VOSTF Update 3/22/23: *The VOSTF will be sending referrals to a number of NAIC committee groups requesting feedback on a replacement proposal to have the NAIC produce analytical risk metrics for bond investments. These groups will also be asked if they support the proposal and to describe different ways they envision being able to take advantage of such a capability within the NAIC.*

SAPWG Ongoing Work 8/13/23:

- *As discussed above, the Schedule D bond proposal is planned for 2025 reporting.*

RBCIREWG Update 8/13/23: *The Risk-Based Capital Investment Risk and Evaluation (E) Working Group added this item to its working agenda. While not specifically addressing privately structured securities, the Working Group's current work on collateralized loan obligations may contribute to addressing this item.*

11. Reliance on Rating Agencies:

Sent a referral to the VOSTF indicating the MWG regulators' agreement to monitor the work of its ad hoc group addressing various rating agency considerations.

VOSTF Update 3/22/23:

- *The Task Force adopted an amendment at its Feb. 21 meeting that effective Jan. 1, 2024, financially modeled collateralized loan obligations (CLO) will not be eligible to use credit rating provider ratings to determine an NAIC Designation.*

- *The Task Force has drafted a list of questions to discuss with each rating agency in future regulatory-only meetings. The questions are in the materials for the Spring National Meeting and will likely being exposed for public comment.*
- *The Securities Valuation Office (SVO) has proposed an amendment to remove Structured Equity and Funds transactions from being eligible to use credit rating provider (CRP) ratings to assign an NAIC Designation. The SVO has proposed defining Structured Equity and Funds investments as investments which, through the insertion of an intervening entity such as a special purpose vehicle (SPV) or limited partnership, enable underlying assets that may not qualify as 'bonds' or be eligible to receive an NAIC Designation under the current regulatory guidance, to be reported as 'bonds' because the intervening entity issues notes and those notes receive a credit rating provider rating. The SVO identified multiple regulatory reporting arbitrage opportunities with these investments that circumvent regulatory guidance using a CRP rating to accomplish that result.*
- *The Task Force adopted a new charge for 2023 to stablish criteria to permit staff's discretion over the assignment of NAIC designations for securities subject to the FE process (the use of CRP ratings to determine an NAIC designation) to ensure greater consistency, uniformity, and appropriateness to achieve the NAIC's financial solvency objectives. The criteria have not yet been proposed.*

VOSTF Update 8/13/23:

- *VOSTF received referral responses from the Financial Condition (E) Committee, the Life Actuarial (A) Task Force, the Financial Analysis (E) Working Group and the Valuation Analysis (E) Working Group. The Life Actuarial Task Force and Valuation Analysis Working Group supported the proposal and provided examples of risk metrics which would be useful to their groups. The Financial Analysis Working Group supported the VOSTF investigating various products because it said the risk metrics could be more effective in helping financial analysts and examiners to fully evaluate and assess investment risks. The Financial Condition Committee said it was worthwhile for the VOSTF to continue to investigate the various products which could be made available to the SVO staff and state regulators that provide some of the alternative investment risk measures as they could obviate the need for the NAIC to collect that information form NAIC Annual Statements. However, the E Committee said that before it could sponsor the proposal it would need more information to fully understand the costs and benefits of such products. This is an ongoing initiative.*

- *VOSTF has drafted a list of questions to discuss with each rating agency in future regulator-only meetings. The SVO has received comments from certain rating agencies and is incorporating those comments into a final list of questions to be agreed to by the Task Force. At the 2023 Spring National, during the discussion of the proposed amendment on Structured Equity and Funds, the Task Force deferred action on the Structured Equity and Funds amendment and directed the SVO staff to draft a distinct process on how it would recommend challenging an NAIC Designation assigned from a credit rating provider (“CRP”) rating pursuant to the Filing Exemption (“FE”) process which the SVO thinks is not a reasonable assessment of risk for regulatory purposes. The SVO subsequently proposed an amendment which would grant the SVO staff a limited amount of discretion over the FE process to address the NAIC’s current blind reliance on credit ratings. The amendment would establish strict due process requirements before the SVO could over-ride a CRP rating including a materiality threshold of a 3-notch difference in order to flag a CRP rating and sufficient notice to insurers to provide time for insurers to appeal SVO assessments. This amendment will continue to be discussed by the Task Force and interested parties.*

12.

Pension Risk Transfer (PRT) Business Supported by Complex Investments.

a. LATF’s Actuarial Guideline:

Sent a referral to the LATF recognizing its work on an Actuarial Guideline which should address the reserve considerations of pension risk transfer (PRT) business. Sent a referral to the SAPWG to address the related disclosure considerations as the goal was to have them in the Notes to Financial Statements.

LATF Update 3/22/23: *The PRT Drafting Group of the VM-22 SG is considering the development of PRT/longevity risk mortality factors. The DG hopes to share data with the Longevity Risk Subgroup of LATF that the Subgroup could consider for C-2 RBC for PRT products and longevity risk transactions.*

SAPWG Completed Actions 3/22/23:

- *Ref #2020-37: Separate Account – Product Identifiers and Ref #2020-38: Pension Risk Transfer - Separate Account Disclosure, which did not result in statutory accounting revisions but instead resulted in modifications to the reporting of PRT transactions in the annual financial statements, was adopted by the SAPWG May 2021. Ref #2021-03BWG was adopted by Blanks (E) Working Group in 2021.*

Comment – *The 2022 review of the initial 2021 disclosures noted that although the instructions were clarified to require by product reporting including the use of a distinct disaggregated product identifier for each product represented; most entities are still broadly grouping PRT activity in the disclosures.*

LATF Update 8/13/23: *The PRT drafting group hasn't met since January, and the Longevity Risk Subgroup is holding off on meeting until the VM-22 Subgroup finalizes the VM-22 methodology*

b. Department of Labor Protections:

MWG Update 8/13/23: *Discussions with DoL continue. DoL is in the process of updating their fiduciary requirements under 95-1, which require due diligence in assessing an insurer prior to a PRT transaction.*

c. State Guaranty Funds Compared to PBGC Protection – NOLHGA 2016 Study:

No further action was deemed necessary.

MWG Update 8/13/23: *No update necessary.*

d. RBC Treatment of PRT Business:

Sent a referral to the Longevity Risk (E/A) Subgroup recognizing its work will also address PRT business and indicating the MWG regulators will monitor this work.

LATF Update 3/22/23: *The Longevity Risk (E/A) Subgroup has not met since the Summer National Meeting. The subgroup will resume the meetings once the currently exposed VM-22 PBR methodology is finalized and adopted to develop and recommend longevity risk factor(s) for the product(s) that were excluded from the application of the current longevity risk factors.*

LATF Update 8/13/23: *No change in this item as the VM-22 framework is not final yet.*

13.

Offshore/Complex Reinsurance:

MWG Update 12/13/22: *MWG regulators are wrapping up the confidential discussions with industry participants and other jurisdictions regarding the use of offshore reinsurers and complex affiliated reinsurance vehicles. They are continuing discussions to identify the best mechanism to ensure reviewing/approving regulators can identify the true economic impacts of the reinsurance*

transaction. MWG regulators will consider further work and/or referrals once they have concluded these discussions.

MWG Update 3/22/23: *At the Spring NM 2023 The Working Group released for comment the reinsurance comparison worksheet designed for regulators to assess cross-border reinsurance treaties where there are different regulatory systems involved. We believe the cross-border reinsurance worksheet will enhance state insurance regulators' ability to monitor these transactions. The comment period ended Apr 28 and the MWG is in the process of addressing comments received.*

MWG Update 8/13/23: *The Reinsurance Worksheet was adopted on a joint FSTF/MWG virtual meeting on June 20, 2023.*

Updates on Actuarial Guideline 53

Fred Andersen, FSA, MAAA

8/13/2023



AG 53 provides uniform guidance for the asset adequacy testing applied to life insurers and is effective for reserves reported with respect to the Dec. 31, 2022, and subsequent annual statutory financial statements. A statement of actuarial opinion on the adequacy of the reserves and assets supporting reserves after the operative date of the Valuation Manual is required under Section 38 of the NAIC Standard Valuation Law (#820) and VM-30 of the Valuation Manual. Section 14A of Model #820 provides that actuarial opinions and related supporting documents are to be prepared in accordance with the NAIC Actuarial Guideline 53. The asset adequacy analyses required under AG 53 reviewed in the preparation of this report were shared with the Valuation Analysis (E) Working Group and the NAIC in accordance with these requirements and continue to remain confidential in nature.

AG 53 Background

- Actuarial Guideline 53 was adopted in 2022
- Main purpose: help ensure claims paying ability even if complex assets do not perform as expected
- Requires disclosures and asset-related information for most life insurers over a size threshold
 - An opportunity for companies to tell their stories regarding:
 - Their complex assets & associated risks
 - How their cash-flow testing models address those risks
- First submissions were due April 2023



AG 53 provides uniform guidance for the asset adequacy testing applied to life insurers and is effective for reserves reported with respect to the Dec. 31, 2022, and subsequent annual statutory financial statements. A statement of actuarial opinion on the adequacy of the reserves and assets supporting reserves after the operative date of the Valuation Manual is required under Section 36 of the NAIC Standard Valuation Law (#620) and VM-30 of the Valuation Manual, Section 34A of Model #820 provides that actuarial opinions and related disclosures are required to be reviewed by the appropriate regulatory agencies of the NAIC. The asset adequacy analyses required under AG 53 reviewed in the preparation of this report were shared with the Valuation Analysis (E) Working Group and the NAIC in accordance with these requirements and continue to remain confidential in nature.

AG 53 Reviews – activity to date

Done:

- ✓ AG 53 filings received from 246 life insurers
- ✓ AG 53 Review Group (within the Valuation Analysis Working Group) formed
 - Team of actuaries, investment experts, and other financial staff to perform reviews
- ✓ Review process started with company prioritization, based on prior knowledge and template information

In Progress:

- AG 53 Review Group meeting frequently, with various state regulators-presenting their review findings
- Identifying companies with outlier net yield assumptions
- Engaging with domestic regulators with the goal of decreasing highest net yield assumptions to remove companies from outlier list



AG 53 provides uniform guidance for the asset adequacy testing applied to life insurers and is effective for reserves reported with respect to the Dec. 31, 2022, and subsequent annual statutory financial statements. A statement of actuarial opinion on the adequacy of the reserves and assets supporting reserves after the operative date of the Valuation Manual is required under Section 38 of the NAIC Standard Valuation Law (#820) and VM-30 of the Valuation Manual. Section 14A of Model #820 provides that actuarial opinions and related supporting information are to be prepared in accordance with the NAIC's asset adequacy testing and reporting requirements. The asset adequacy analyses required under AG 53 reviewed in the preparation of this report were shared with the Valuation Analysis (E) Working Group and the NAIC in accordance with these requirements and continue to remain confidential in nature.

Implications of Higher Investment Net Yield Assumptions

- More favorable asset adequacy analysis results
- Lower amounts of assets needed for reserves to be considered adequate
 - A signal that more money could be released (dividends or other)
- Concern is, if risk is understated and assets underperform, reserves will turn out to be inadequate and that previously released money may have been needed

Amount to fund \$1 Billion liability in 15 years

Company assumption type	Assumed net yield for high-yield assets	Adequate reserve per company's CFT	Adequate reserve per average conservative company's CFT	Amount (in excess of adequate reserve) available to be released per company's CFT
Most conservative	4.5%	\$ 520,000,000	\$ 520,000,000	\$ -
Moderately conservative	5.8%	\$ 430,000,000	\$ 520,000,000	\$ 90,000,000
Fairly aggressive	6.5%	\$ 390,000,000	\$ 520,000,000	\$ 130,000,000
Outlying / aggressive	7.8%	\$ 320,000,000	\$ 520,000,000	\$ 200,000,000

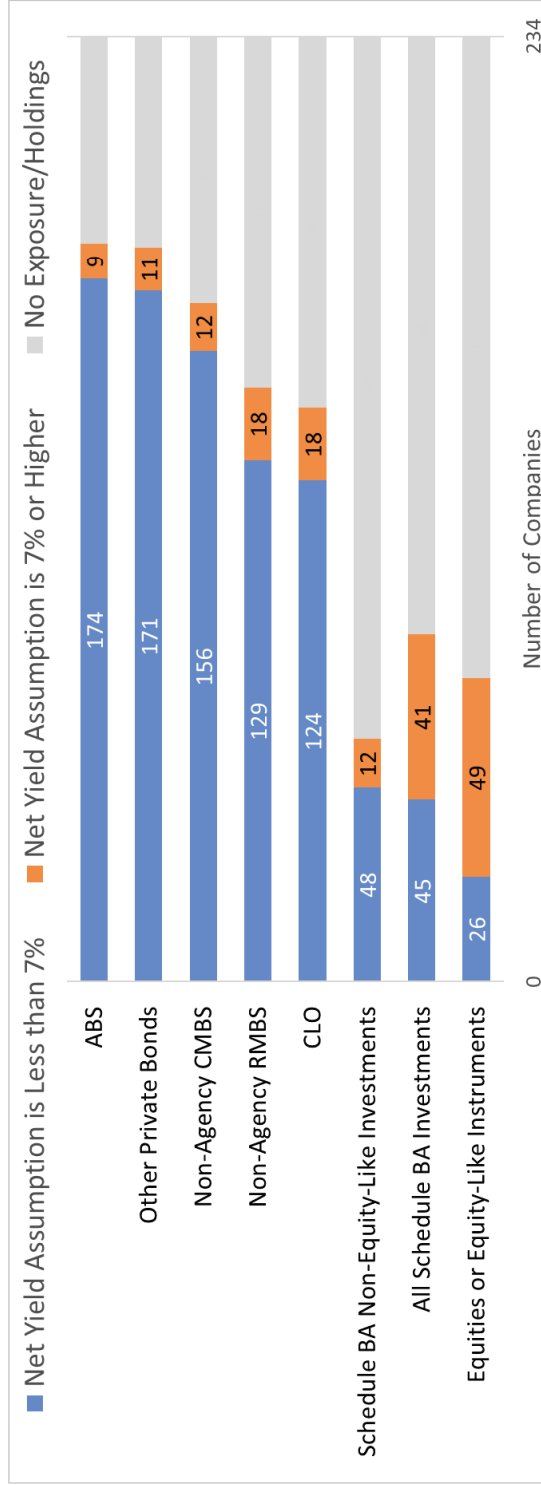


8/13/2023

AG 53 provides uniform guidance for the asset adequacy testing applied to life insurers and is effective for reserves reported with respect to the Dec. 31, 2022, and subsequent annual statutory financial statements. A statement of actuarial opinion on the adequacy of the reserves and assets supporting reserves after the operative date of the Valuation Manual is required under Section 38 of the NAIC Standard Valuation Law (#820) and VM-30 of the Valuation Manual. Section 14A of Model #820 provides that actuarial opinions and related analyses are to be prepared in accordance with the NAIC. The asset adequacy analyses required under AG 53 reviewed in the preparation of this report were shared with the Valuation Analysis (E) Working Group and the NAIC in accordance with these requirements and continue to remain confidential in nature.

Net Yield Assumptions

A majority of companies assumed Net Yields < 7% for Initial Assets,
but a sizable number of companies assumed Net Yields ≥ 7%



AG 53 provides uniform guidance for the asset adequacy testing applied to life insurers and is effective for reserves reported with respect to the Dec. 31, 2022, and subsequent annual statutory financial statements. A statement of actuarial opinion on the adequacy of the reserves and assets supporting reserves after the operative date of the Valuation Manual is required under Section 38 of the NAIC Standard Valuation Law (#820) and VM-30 of the Valuation Manual. Section 14A of Model #820 provides that actuarial opinions and related supporting documents are to be reviewed by the appropriate regulatory agencies and the NAIC. The asset adequacy analyses required under AG 53 reviewed in the preparation of this report were shared with the Valuation Analysis (E) Working Group and the NAIC in accordance with these requirements and continue to remain confidential in nature.

AG 53 Reviews – upcoming activities

- Review reinsurance counterparty risk
 - Send requests for additional information, as relevant:
 - Description and reason for significant reinsurance ceded transactions
 - Process and metrics used to evaluate the counterparty's asset risk and financial health
- Review other AG 53-related issues



AG 53 provides uniform guidance for the asset adequacy testing applied to life insurers and is effective for reserves reported with respect to the Dec. 31, 2022, and subsequent annual statutory financial statements. A statement of actuarial opinion on the adequacy of the reserves and assets supporting reserves after the operative date of the Valuation Manual is required under Section 38 of the NAIC Standard Valuation Law (#820) and VM-30 of the Valuation Manual. Section 14A of Model #820 provides that actuarial opinions and related supporting information are to be prepared in accordance with the requirements of the Valuation Manual. The asset adequacy analyses required under AG 53 reviewed in the preparation of this report were shared with the Valuation Analysis (E) Working Group and the NAIC in accordance with these requirements and continue to remain confidential in nature.

RECEIVERSHIP AND INSOLVENCY (E) TASK FORCE

Receivership and Insolvency (E) Task Force Aug. 14, 2023, Minutes..... 9-867

Revised Receivership and Insolvency (E) Task Force March 23, 2023, Minutes (Attachment One) 9-872

Patrick Cantilo Comment Letter (Attachment Two) 9-875

Receivership Law (E) Working Group July 24, 2023, Minutes (Attachment Three) 9-908

Receivership Law (E) Working Group May 23, 2023, Minutes (Attachment Three-A) 9-912

Property and Casualty Insurance Guaranty Association Model Act (#540) Proposed

 Amendments (Attachment Three-A1)..... 9-915

 Model #540 Amendments Explanation Document (Attachment Three-A2) 9-937

 National Conference of Insurance Guaranty Funds (NCIGF) Comment Letter

 (Attachment Three-A3) 9-940

 Model #540 Proposed Amendments Version Two (Attachment Three-A4)..... 9-941

 Model #540 Proposed Amendments Explanation Document Version Two

 (Attachment Three-A5) 9-963

 NCIGF’s Proposed Amendments for Cybersecurity Insurance (Attachment Three-A6) 9-964

Cantilo & Bennett LLP Comment Letter (Attachment Three-B)..... 9-1009

Fairfax (US) Inc. Comment Letter (Attachment Three-C) 9-1015

NCIGF Comment Letter (Attachment Three-D)..... 9-1017

Model #540 (Attachment Three-E) 9-1019

Arcina NAIC Records Preservation Presentation (Attachment Three-F)..... 9-1048

Draft: 8/21/23

Receivership and Insolvency (E) Task Force
Seattle, Washington
August 14, 2023

The Receivership and Insolvency (E) Task Force met in Seattle, WA, Aug. 14, 2023. The following Task Force members participated: James J. Donelon, Chair (LA); Glen Mulready, Vice Chair, represented by Donna Wilson and Jamin Dawes (OK); Mark Fowler represented by Ryan Donaldson (AL); Andrew N. Mais represented by Jane Callanan (CT); Doug Ommen represented by Kim Cross and Daniel Mathis (IA); Dana Popish Severinghaus represented by Jacob Stuckey, Bruce Sartain and Susan Berry (IL); Vicki Schmidt represented by Philip Michael (KS); Sharon P. Clark represented by Jeff Gaither (KY); Gary D. Anderson represented by Christopher Joyce (MA); Timothy N. Schott represented by Robert Wake (ME); Chlora Lindley-Myers represented by Shelley Forrest (MO); Mike Causey represented by Tracy Biehn (NC); Jon Godfread represented by Colton Schulz (ND); Eric Dunning represented by Lindsay Crawford (NE); Justin Zimmerman represented by David Wolf (NJ); Judith L. French represented by Matt Walsh (OH); Andrew R. Stolfi represented by Brian Fjeldheim (OR); Michael Humphreys represented by Laura Lyon Slaymaker and Crystal McDonald (PA); Elizabeth Kelleher Dwyer represented by Matt Gendron (RI); Michael Wise represented by Ryan Basnett (SC); Carter Lawrence represented by Stephanie Cope (TN); Cassie Brown represented by Brian Riewe (TX); Mike Kreidler represented by Charles Malone (WA); and Nathan Houdek represented by Levi Olson (WI).

1. Adopted its Spring National Meeting Minutes

Crawford made a motion, seconded by Biehn, to adopt the Task Force's March 23 minutes, which includes one edit (Attachment One). The motion passed unanimously.

2. Adopted the Report of the Receivership Financial Analysis (E) Working Group

Wilson said the Receivership Financial Analysis (E) Working Group plans to meet Aug. 14 in regulator-to-regulator session, pursuant to paragraph 3 (specific companies, entities or individuals) of the NAIC Policy Statement on Open Meetings, to discuss companies in receivership.

Slaymaker made a motion, seconded by Biehn, to adopt the report of the Receivership Financial Analysis (E) Working Group. The motion passed unanimously.

3. Adopted the Report of the Receivership Law (E) Working Group

Slaymaker said the Receivership Law (E) Working Group held two conference calls on July 24 and May 23. On the May 23 call, the Working Group exposed amendments to the *Property and Casualty Insurance Guaranty Association Model Act (#540)* related to coverage of policies that are subject to restructuring mechanisms, specifically insurance business transfers (IBTs) and corporate divisions (CDs), as well as revisions related to clarifying coverage for cybersecurity insurance.

Slaymaker said the Working Group received comments from three interested parties on the restructuring mechanisms amendments, which were discussed on the July 24 call. The focus of those comments was primarily on the assumed claims transaction provisions that are removed and the inclusion of related optional provisions for the few states that feel the need to include that language. The Working Group adopted the amendments to Model #540 on the July 24 call. Slaymaker said the Working Group is not asking the Task Force to adopt the amendments at this meeting.

Slaymaker said on the July 24 call, the Working Group also heard a presentation from a data archeologist that requested that states consider extending their records retention of closed receivership estate records or transferring records to university libraries after the estate closes. The presentation raised some interesting topics, but no action was discussed.

Patrick Cantilo (Cantilo and Bennett LLP) said he submitted comments on the amendments to Model #540 (Attachment Two). He said his views are his own and not his clients. He said the goals of the IBT and CD amendments are to assure that the implementation of those transactions does not result in the loss of guaranty association coverage for policyholders. He said he supports that goal. The second goal, which will not be found in the description of the proposed amendments is to create an optional removal of amendments already adopted in 2009 for providing policyholder's guaranty association coverage in what are called assumed claims transactions. If this Task Force or the Receivership Law (E) Working Group has determined that there should be consideration of reversing the 2009 amendments, that should be described openly. He said the amendments that are represented do not readily identify that the purpose is to remove that 2009 coverage. He said he submitted to the Working Group a much simpler amendment that would accomplish the charge. He said the amendments as proposed go much further and create a mechanism to remove the 2009 extension of protection for the assumed claims transactions. He said that should be deliberated and interested parties encouraged to express their views on the removal of those protections.

Joe Torti (Fairfax U.S.) said he is vice president of regulatory affairs for Fairfax U.S. and chairman of the board of directors for the National Conference of Insurance Guaranty Funds (NCIGF). He said he is speaking at this meeting on behalf of the American Property Casualty Insurance Association (APCIA) and the National Association of Mutual Insurance Companies (NAMIC). He said he urges the Task Force to expose the draft restructuring and cyber amendments and move forward to adoption expeditiously. He said he is in favor of the coverage neutrality concept for claims resulting from restructured business, such that the guaranty association coverage should remain in place for claims that would have had guaranty association coverage if they had not been transferred from the original issuer, or conversely, coverage should not be created for claims that would not have been covered before the transaction. This concept is embodied in the draft amendments presented at this meeting. Restructuring transactions, while a useful tool, were never intended to afford coverage by guaranty associations on policy claims that were not covered before the transaction.

Cope made a motion, seconded by Biehn, to adopt the report of the Receivership Law (E) Working Group (Attachment Three). The motion passed unanimously.

4. Exposed Model #540 Amendments

Slaymaker said subsequent to the Receivership Law (E) Working Group call on July 24, Wake, a member of the drafting group, identified a few conflicts where certain assumed claims language in the drafting notes conflicts with the new optional provisions in Section 5G(3) and Section 8A(3). The exposure draft reflects removing those conflicting paragraphs, while still maintaining the key portions of the 2009 assumed claims transaction language in the drafting notes. The exposure draft also includes the correction of references in certain sections. She said while most of these changes are only to drafting notes, given past discussion over the assumed claims provisions, she recommends exposing these subsequent edits for a further 30-day public comment period.

Commissioner Donelon said hearing no objection, the amendments to Model #540 would be exposed for a 30-day public comment period ending Sept. 14, 2023.

5. Exposed a U.S. Resolution Template

Jane Koenigsman (NAIC) said a template has been drafted that may be used by a U.S. lead state to describe the U.S. receivership regime within resolution plans or to facilitate dialogue with international supervisors during supervisory colleges and crisis management group (CMG) discussions. It is intended to be a summary to provide enough information to the international jurisdiction to gain an understanding of the U.S. receivership process. The template does not constitute a complete resolution plan. There are other aspects of a resolution plan that are specific to a company and its unique risks. It is the responsibility of the group-wide supervisor in consultation with the CMG to determine if the group-wide supervisor should develop a resolution plan and what to include in it.

Koenigsman said a state would need to modify the template for the individual state's laws, regulations, and receivership practices and supplement it with any regulations that apply to the insurer (e.g., life insurance versus property insurance, product types, or investment types).

Koenigsman asked states to review and provide feedback on the template, especially if the state has an internationally active insurer and understands what information would be most valuable to share with international regulators.

Commissioner Donelon said hearing no objection, the draft U.S. resolution template would be exposed for a 30-day public comment period ending Sept. 14, 2023.

6. Heard an Update on International Activities

Wake said the International Association of Insurance Supervisors (IAIS) Resolution Working Group met at the end of May 2023 to work on the policyholder protection issues paper. The Working Group has also been discussing updates to the IAIS Insurance Core Principles (ICPs) that deal with resolution. Wake said this review of ICPs is in progress, and the Working Group is near to reaching a consensus to have a more topic-focused and outcomes-oriented approach to the appropriate resolution powers rather than a list of resolution powers.

Wake said he is pleased to welcome William Arfanis (CT) as a second NAIC representative on the IAIS Resolution Working Group. The Working Group is meeting next in September 2023.

Wake said the work on the holistic framework progress monitoring continues. One accomplishment is the work in progress that we exposed today on the U.S. resolution template.

7. Discussed Part A Financial Regulation and Accreditation Standards for Receivership and Guaranty Association Laws

Commissioner Donelon asked NAIC staff to explain the Part A Financial Regulation and Accreditation standards for states' receivership and guaranty association laws and the historical review performed by the Task Force.

Koenigsman said the Task Force has undertaken a review of the *Insurer Receivership Model Act* (#555), the *Life and Health Insurance Guaranty Association Model Act* (#520), and Model #540. Beginning in 2009, the former Critical Elements (E) Advisory Group reviewed these models to identify provisions that were non-controversial and critical for states to adopt. In 2014, the former Receivership Model Law (E) Working Group began with the previous work and narrowed the focus of the review to those provisions that were specific to a multi-state receivership. The Working Group further focused on reviewing U.S. laws in comparison to the Financial Stability Board's (FSB) *Key Attributes of Effective Resolution Regimes for Financial Institutions*. A memo was sent to states by the Financial Condition (E) Committee in 2017 to provide guidance and encourage states to adopt improvements in state laws regarding the recognition of stays and injunctions.

Koenigsman said in 2018, the Task Force undertook further review of the U.S. receivership laws related to macroprudential surveillance. This work resulted in several recommendations, including:

- The new *Guideline for Definition of Reciprocal State in Receivership Laws* (#1985).
- Amendments to the *Insurance Holding Company System Regulatory Act* (#440) for the continuity of essential services and functions by affiliated entities.
- Updated guidance in the *Receiver's Handbook for Insurance Company Insolvencies*.
- Updated guidance for the implementation of the Common Framework for the Supervision of Internationally Active Insurance Groups (ComFrame), including resolution plans, which include the U.S. resolution template the Task Force exposed for public comment during this meeting.

Koenigsman said in 2020, an ad hoc group was formed to discuss Part A Financial Regulation and Accreditation standards, specifically interpretive guidance in the accreditation interlineations. Concerns were raised at that time that making any changes could be misinterpreted or have unintended consequences. The Task Force did not make any proposals to clarify the accreditation interlineations at that time.

Dan Schelp (NAIC) summarized the Part A Financial Regulation and Accreditation standards for receivership and guaranty association laws. He said substantially similar standards mean a state's laws, regulations, or administrative practices are substantially similar to the significant elements identified in the model. Receivership and guaranty association laws do not fit into this category. Substantially similar does not mean a state is required to adopt every significant element of the law or regulation. He said the standards are not a uniformity requirement but rather a minimum financial standards requirement. It is required that states demonstrate that the law, regulation, or administrative practice results in solvency regulation that is similar in force and no less effective than the model upon which it is based. A substantially similar standard does not result in uniformity; although, in a practical matter, that is often the case. There are some Part A standards that do not require substantially similar standards. These are regulatory framework standards, which include the guaranty fund models. A regulatory framework provides for a state to detect the occurrence of the solvency-related event or activity contemplated by the model law and to exercise appropriate oversight when such an activity or event occurs. It also states that if potential harm or activity occurs, a regulatory framework would have sufficient resources, including regulatory tools, vested in the state insurance department to take appropriate action.

Schelp said with respect to the guaranty fund models, a state must have a regulatory framework that addresses the payment of policyholder obligations when a company is deemed to be insolvent. There is a requirement that a guaranty fund addresses obligations owed to policyholders, but there is no significant element as to the amount of the obligation. Although many states are uniform, there is some variation among states on claims limits, as some are higher or lower than the model.

Schelp said the receivership standard is not substantially similar, nor is it a regulatory framework. State law must set forth a receivership scheme for the administration of an insurance company found to be insolvent, similar to Model #555. Although there is not much guidance on the definition of a scheme, historically, it has been interpreted to mean a regulatory framework. The benefit limit in Model #540 is \$500,000.

Commissioner Donelon asked what the lowest and highest guaranty association benefit limit is in states for property/casualty (P/C) insurance.

Doug Hartz (Private Citizen) said worker's compensation is unlimited.

Barbara Cox (Barbara Cox LLP), outside counsel for the NCIGF, said Michigan has a benefit limit that is a certain percentage of direct written premium, which could be upwards of \$5 million. New York has a \$1 million benefit

limit. California has a homeowners benefit limit that includes various coverage components of \$1 million, resulting from recent catastrophe activity. Cox said workers' compensation has no limit in the 50 U.S. states.

8. Heard an Update on a Receivership Tabletop Exercise

Koenigsman said the NCIGF, and the National Organization of Life and Health Guaranty Associations (NOLHGA) proposed a receivership tabletop exercise at the Spring National Meeting. NAIC staff reached out to the states to get feedback on their interest and preferences for an exercise. Koenigsman said of the 29 states that responded most preferred an in-person session at the beginning of an NAIC national meeting. She said NAIC staff will look at the availability of time and space to schedule the exercise at the Fall National Meeting.

9. Heard an Announcement of the IAIR Technical Development Series

Wilson said the International Association of Insurance Receivers (IAIR) will host its annual Technical Development Series (TDS) Sept. 27–29 in San Diego, CA. TDS topics will include legal challenges in receivership, how to resolve them, and other issues of interest to receivers.

Having no further business, the Receivership and Insolvency (E) Task Force adjourned.

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Draft: 3/28/23

Receivership and Insolvency (E) Task Force
Louisville, Kentucky
March 23, 2023

The Receivership and Insolvency (E) Task Force met in Louisville, KY, March 23, 2023. The following Task Force members participated: James J. Donelon, Chair, and Stewart Guerin (LA); Glen Mulready, Vice Chair, represented by Donna Wilson and Jamin Dawes (OK); Mark Fowler represented by Ryan Donaldson (AL); Michael Conway represented by Rolf Kaumann (CO); Andrew N. Mais (CT) ~~represented by Jon Arsenaault~~; Doug Ommen represented by Daniel Mathis (IA); Dana Popish Severinghaus represented by Kevin Baldwin and Bruce Sartain (IL); Vicki Schmidt represented by Levi Nwasoria (KS); Sharon P. Clark represented by Rodney Hugle (KY); Gary D. Anderson represented by Christopher Joyce (MA); Timothy N. Schott represented by Robert Wake (ME); Chlora Lindley-Myers represented by Shelley Forrest (MO); Troy Downing represented by Steve Matthews (MT); Mike Causey represented by Monique Smith (NC); Jon Godfread represented by Colton Schulz (ND); Eric Dunning represented by Lindsay Crawford (NE); Marlene Caride represented by David Wolf (NJ); Andrew R. Stolfi represented by Doug Hartz (OR); Michael Humphreys represented by Laura Lyon Slaymaker and Crystal McDonald (PA); Elizabeth Kelleher Dwyer represented by Matt Gendron (RI); Michael Wise represented by Ryan Basnett (SC); Cassie Brown represented by Brian Riewe (TX); and Nathan Houdek represented by Mark McNabb (WI).

1. Adopted its 2022 Fall National Meeting Minutes

Smith made a motion, seconded by Donaldson, to adopt the Task Force's Dec. 14, 2022, minutes (*see NAIC Proceedings – Fall 2022, Receivership and Insolvency (E) Task Force*). The motion passed unanimously.

2. Adopted the Report of the Receiver's Handbook (E) Subgroup

Baldwin said the Receiver's Handbook (E) Subgroup met Dec. 21, 2022, and took the following action: 1) adopted revisions to Chapters Three, Four, and Five of the *Receiver's Handbook for Insurance Company Insolvencies* (Receiver's Handbook); and 2) exposed Chapters Six and Seven of the Receiver's Handbook for a 45-day public comment period ending Feb. 6, 2023. The Subgroup received helpful clarifications.

The Subgroup plans to schedule a meeting to adopt Chapters Six and Seven. The drafting groups are continuing their work to complete the remaining chapters. The Subgroup is expected to complete the Receiver's Handbook project by the fall of 2023.

Hartz made a motion, seconded by Slaymaker, to adopt the report of the Receiver's Handbook (E) Subgroup, including its Dec. 21, 2022, minutes (Attachment One). The motion passed unanimously.

3. Adopted the Report of the Receivership Financial Analysis (E) Working Group

Wilson said the Receivership Financial Analysis (E) Working Group plans to meet March 23 in regulator-to-regulator session, pursuant to paragraph 3 (specific companies, entities or individuals) of the NAIC Policy Statement on Open Meetings, to discuss companies in receivership.

Matthews made a motion, seconded by Crawford, to adopt the report of the Receivership Financial Analysis (E) Working Group. The motion passed unanimously.

4. Adopted the Report of the Receivership Law (E) Working Group

Slaymaker said the Receivership Law (E) Working Group exposed amendments to the *Property and Casualty Insurance Guaranty Association Model Act* (#540) related to the coverage of policies that are subject to restructuring mechanisms, specifically insurance business transfers (IBTs) and corporate divisions (CDs). The Working Group received comments and alternative amendments. The comments raised some additional considerations and scenarios specifically around novation and assumptions, as well as which sections of the model may also be affected. A drafting group comprised of Working Group members, the National Conference of Insurance Guaranty Funds (NCIGF), and interested parties was formed. The drafting group met March 6 to discuss a revised draft of amendments. There is a remaining item to resolve, therefore, the drafting group plans to meet again before sending the draft to the Working Group.

Slaymaker said if the Executive (EX) Committee approves the Request for NAIC Model Law Development related to cybersecurity insurance at its meeting on March 23, the Working Group will also schedule a call to discuss and expose draft amendments to Model #540 for cybersecurity insurance.

Hartz made a motion, seconded by Kaumann, to adopt the report of the Receivership Law (E) Working Group. The motion passed unanimously.

5. Heard an Update on International Activities

Wake said the International Association of Insurance Supervisors (IAIS) Resolution Working Group released for public consultation the application paper on policyholder protection schemes. Comments on the public consultation are due to the IAIS on April 14. The International Insurance Relations (G) Committee will hold a meeting on April 13 to consider comments from the NAIC. Anyone wishing to submit comments for the Committee to consider should send them to NAIC staff by March 27.

Wake said in follow-up to the IAIS's Targeted Jurisdictional Assessment (TJA) for which the U.S. participated and was assessed, the IAIS will conduct a follow-up to assess each jurisdiction's progress in addressing the findings where a jurisdiction did not receive a "fully observed" assessment.

Wake said the IAIS is expected to begin a project to update the IAIS Insurance Core Principles (ICPs) and Common Framework for the Supervision of Internationally Active Insurance Groups (ComFrame) provisions related to resolution and recovery issues. The ICPs and the related issue papers will be discussed at the IAIS meeting in May 2023.

6. Heard a Presentation on a Proposed Receivership Tabletop Exercise

Peter G. Gallanis (National Organization of Life and Health Insurance Guaranty Associations—NOLHGA) presented a tabletop receivership proposal. He said the NOLHGA and the NCIGF conducted a tabletop exercise on how to respond to the insolvencies of hypothetical insurance carriers. He said there has been a lot of turnover in the receivership community, and many have not had hands-on experience with how troubled insurers are identified by the financial regulators, how the domiciliary commissioner determines remediation steps, developing a rehabilitation plan, liquidation, developing a response to a nationally significant company that triggers the guaranty associations, and management of an insolvency case. The tabletop is a hands-on interactive participatory exercise to talk through various issues. Gallanis said the NOLHGA membership found it to be a very helpful training exercise. He said he spoke with Commissioner Donelon and Tom Travis (LA) about this exercise. State insurance

regulators have also seen some turnover. He said he discussed with Commissioner Donelon about the tabletop being an exercise that could provide training to financial regulators, commissioners, and states' receivership staff who may wish to participate and who attend other educational programs or the NAIC national meetings.

Gallanis said he was asked by Louisiana to develop a timeline, provide more details on how to move forward with the proposal, provide more details on who from the financial regulators, receivership staff, and possibly industry would participate, and work with the NAIC to identify a date and time for a presentation such as this (Attachment Two).

Roger Schmelzer (NCIGF) said this is a time of relative strong agreement between state insurance regulators, guaranty funds, and receivers. He said it would be important to go through issues and figure out where the disagreement is before having a real insolvency scenario where stakes become extremely high. The recent banking industry issues with Silicon Valley Bank and others and the actions of the federal banking regulators indicate an inclination for the federal government to be more involved in financial services that are regulated at the state level. This program is a way to take that seriously and be more prepared for what might come.

Bill O'Sullivan (NOLHGA) said as more practical knowledge is gained from the program, as well as a better understanding of the tools, relationships and collegiality are built to be able to better share information and strategies and agree on a common approach to protect policyholders. This program builds the foundation for those kinds of critical relationships.

Schmelzer said the NCIGF is doing more work to plan what a program would look like and get input. Connecting this program with an NAIC meeting or event would facilitate attendance by the state insurance regulators. Regarding timing, Schmelzer said some time in the fall would work if everything can be pulled together. He said the NCIGF welcomes the Task Force's support in this effort.

Guerin said he agrees that this training would be beneficial for the reason of staff turnover. He said Louisiana had not had a receivership for over 15 years and suddenly had multiple receiverships due to a hurricane. He said this training would have been beneficial and allowed Louisiana to work more expeditiously through some of the issues.

Commissioner Donelon said the receiverships in Louisiana over the past year have the Louisiana legislature and industry looking at modifications to its guaranty fund law and, in particular, the assessments and recoupment of those assessments. He said he agrees with Guerin, and he said Louisiana has been able to contract with receivership experts that have decades of experience doing receiverships. He said the banking challenge Schmelzer referenced is one that state insurance regulators need to gear-up for to be prepared.

Guerin said as the program is still in development, he requested an update at a future time. He said to let the Task Force know if the NOLGHA or the NCIGF have any requests of the Task Force.

Having no further business, the Receivership and Insolvency (E) Task Force adjourned.

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August 10, 2023

The Honorable James J. Donelon, Chair
The Honorable Glen Mulready, Vice Chair
Receivership and Insolvency (E) Task Force
C/O Jane Koenigsman
Sr. Manager - Life/Health Financial Analysis
National Association of Insurance Commissioners
1100 Walnut Street
Suite 1500
Kansas City, MO 64106-2197

BY ELECTRONIC MAIL

RE: MODEL 540 COMMENTS

Dear Commissioners Donelon and Mulready and members of the Task Force:

Please accept this letter as my comments regarding the August 7, 2023 amendments to the Property and Casualty Insurance Guaranty Association Model Act (# 540) Exposure Draft proposed by the Receivership Law (E) Working Group (RLWG). The proposed amendments address two main issues: (1) a request by the Restructuring Mechanism (E) Working Group (RMWG) that the RLWG propose amendments to Model 540 if necessary to assure that implementation of Insurance Business Transfer (IBT) and Corporate Division (CD) transactions will not result in loss by policyholders of guaranty association protection, and (2) coverage of cybersecurity insurance, approved by the Executive (EX) Committee. I address only the first issue, regarding IBT and CD transactions. I offer no comment as to the second issue, related to cybersecurity insurance.

EXECUTIVE SUMMARY

With respect to the first issue, I submit respectfully that the proposed amendments (called Version 1 by the RLWG):

1. Go far beyond the charge to the Working Group,
2. Unnecessarily scale back guaranty association protection for policyholders in certain insolvencies unrelated to IBT and CD transactions by reversing amendments of Model 540 adopted by the NAIC in 2009,

**Receivership and Insolvency (E) Task Force
August 10, 2023, page 2**

3. Solely for that reason, are unduly complicated (amending 278 lines of text and comment in Model 540), and
4. Create illogical outcomes.

The proposed amendments contrast with amendments (called Version 2 by the RLWG) I offered for the same purpose that I submit respectfully:

1. Were much simpler (4 lines of amendment compared to 278 in Version 1),
2. Would accomplish fully the charge to preserve guaranty association coverage in IBT and CD transactions,
3. Would not roll back any coverage already adopted by the NAIC, and
4. Would not have created the illogical outcomes.

The details are provided below. In evaluating this issue, I would suggest that the Task Force pose the following questions to the Working Group:

1. Would Version 2's 4-line amendment accomplish fully the preservation of guaranty association coverage in IBT and CD transactions requested by the RMWG?
2. What advantage does the adopted Version 1's 278-line proposed amendment provide?
3. Would the proposed Version 1 reverse amendments adopted the NAIC in 2009?
4. If so, who proposed this reversal to the Working Group and who charged the Working Group with taking on an amendment for this reversal?
5. On what empirical data is the Working Group basing its recommendation for this reversal and scale back in guaranty association coverage?

BACKGROUND

Last summer, the RMWG requested that the RLWG propose amendments to Model 540, if necessary to assure that implementation of IBT and CD transactions, will not result in loss by policyholders of guaranty association protection. That was the entire charge to the RLWG. Two competing proposals were submitted to RLWG by a drafting group appointed for that purpose. The first (Version 1) was drafted by Barbara Cox and Rowe Snider - associated with the National Conference of Insurance Guaranty Funds (NCIGF) - and Robert Wake of the Maine Bureau of Insurance. Concerned about issues presented by this proposal, I offered a separate proposal (Version 2). After several discussions and edits, the RLWG voted to forward Version 1, but not Version 2, to this Task Force.

I submit respectfully that this Task Force should not adopt Version 1 and should not recommend its adoption to the E Committee. There are three principal reasons for this conclusion.

First, the proposal adopted by the RLWG deliberately goes far beyond the RMWG charge, choosing to also address a self-appointed issue regarding guaranty association coverage of "assumed claims". This additional issue was not referred to it by the Task Force or the RMWG and is unrelated to assuring the continuity of guaranty association protection for policyholders in IBT and CD transactions.

Receivership and Insolvency (E) Task Force
August 10, 2023, page 3

Second, Version 1 creates a mechanism for reversing amendments to Model 540 adopted by the NAIC in 2009 that provide guaranty fund coverage for policyholders in “assumed claims” transactions (described in more detail below). Neither this Task Force nor the RMWG requested that the RLWG address this matter, let alone reverse amendments approved by the NAIC in 2009. The Working Group took on this task *sua sponte*. Not only is there no reason to “peel back” this policyholder coverage in order to assure continued protection in the case of IBTs and CDs, I submit that there is no defensible public policy in support of this reduction in policyholder coverage.

Third, Version 1 is very complicated and contemplates editing 278 lines in the Model Act text and comments. It would delete 180 lines of current text and 15 lines of current comment, add 75 lines of new text and 5 lines of new comment, and amend another 3 lines of text. In contrast, Version 2 accomplishes fully the goal of the referral, but only requires editing 4 lines of the Model Act to do so. Among other things, this unnecessary complexity will make it more difficult for individual departments to propose these changes to their own legislatures. This complexity is made necessary only by the effort to roll back “assumed claims” coverage. As demonstrated by Version 2, accomplishing the referral’s goals is much, much simpler.

Further, in scaling back guaranty fund coverage for assumed claims, Version 1 would inject new potential problems and ambiguities into Model 540. For example, Version 1:

1. Proposes to delete language (Subsection D) that already goes a long way in assuring continuity of guaranty fund coverage in the case of IBTs and CDs. In fact, it is likely that policyholders would retain guaranty fund coverage in most IBT and CD transactions without making ANY change to Model 540. But if language is desired to avoid any uncertainty, the four lines of Version 2 would accomplish this goal.
2. Gives rise to illogical outcomes. For example, consider this scenario:
 - a. Insurer A assumes a workers compensation block, (including open workers compensation claims), from a self insured trust in year 1;
 - b. In years 2 through 15, Insurer A pays premium taxes and guaranty association assessments on the workers compensation policies assumed with the block, including those under which open claims had arisen that were also assumed;
 - c. In year 16, Insurer A becomes insolvent.
 - d. Under Version 1, those assumed workers compensation claims would not be covered by the guaranty funds because the policy had not been issued originally by a member insurer. See Version 1, section G(1). It would make no difference that Insurer A will have been paying premium taxes and assessments on these policies for fifteen years.
 - e. Moreover, at that point, the assumed claim and policy are likely to be all but indistinguishable from Insurer A’s other policies and claims. Yet, Version 1 will create two classes of business, one covered the other not, though they be otherwise largely indistinguishable.

**Receivership and Insolvency (E) Task Force
August 10, 2023, page 4**

3. In response to my opposition to scaling back assumed claims coverage, the drafters of Version 1 then added a new optional section G(3) intended to revive the coverage they removed in section G(1). Notably, this optional section is opposed by NCIGF. See June 20, 2023, letter from NCIGF to RLWG. Of course, there is no justification for the convoluted complexity of the 278 line amendment that takes away assumed claims coverage in section G(1) and then adds it back in section G(3) unless the hope is that, as NCIGF advocates, section G(3) will not be adopted.

The full text of Version 1, as adopted by RLWG, is included beginning at page 7 of the August 3 materials for the Task Force’s August 14 meeting in Seattle. Despite my request, Version 2 and my comments are not included in those materials. I thank NAIC staff for distributing them now.

PROPOSED VERSION 2

Here is the entire text of Version 2, what I propose as the amendment of Model 540 to assure the continuity of guaranty association coverage for policyholders in an IBT or CD transaction. The proposed edits are underlined and in blue print.

H. *“Covered claim” means the following:*

- (1) *An unpaid claim, including one for unearned premiums, submitted by a claimant, which arises out of and is within the coverage and is subject to the applicable limits of an insurance policy to which this Act applies, if the insurer becomes an insolvent insurer after the effective date of this Act and the policy was either issued by the insurer or assumed by, or allocated to, the insurer in an assumed claims transaction or in an Insurance Business Transfer or Corporate Division transaction that was approved by the chief insurance regulator in the insurer’s state of domicile and, if required, by the [Commissioner/Director/Superintendent]; and ...*

No other change to the Act would be needed to fulfill the goal of the referral to the RLWG. The NAIC could adopt this simple amendment thereby assuring that IBT and CD transactions would not result in the loss of guaranty association coverage.

In my effort to be as helpful to the RLWG as possible, I did note that Model 540 does not define IBT or CD transactions and offered a suggestion for doing so if it were deemed desirable.

- (c) *For purposes of this Act, an Insurance Business Transfer or Corporate Division transaction shall mean a transaction [ALTERNATIVE 1] as described in [INSERT STATE STATUTORY CITATIONS] [OR ALTERNATIVE 2] authorized by the laws of another state authorizing such transactions and as the result of which, apart from other provisions, the insurer assumed all of the obligations under the policy from a transferor which was thereby discharged from such obligations.*

To be clear, however, this definition is an optional suggestion, unrelated to the assumed claims issue and not strictly necessary to achieve the stipulated purpose.

**Receivership and Insolvency (E) Task Force
August 10, 2023, page 5**

During the discussions of my proposed Version 2, the Chair observed that, since many states have not adopted the assumed claims provisions added to Model 540 in 2009, Version 2 might not make sense in those states. That is true because Version 2 (like Version 1) was intended to amend Model 540 as it exists currently. However, given the importance of preserving guaranty association coverage in IBT and CD transactions in every state, regardless of whether they had adopted the 2009 amendments, I offered an alternative to Version 2, that could be used in states that have not adopted the 2009 assumed claims amendment:

- (1) *An unpaid claim, including one for unearned premiums, submitted by a claimant, which arises out of and is within the coverage and is subject to the applicable limits of an insurance policy to which this Act applies, if the insurer becomes an insolvent insurer after the effective date of this Act and the policy was either issued by the insurer or assumed by, or allocated to, the insurer in an Insurance Business Transfer or Corporate Division transaction that was approved by the chief insurance regulator in the insurer's state of domicile and, if required, by the [Commissioner/Director/Superintendent]; and ...*

I also offered two other two alternatives (not salient to this discussion) that would have enabled states to adopt Version 2 to preserve coverage for IBT and CD transactions depending on whether or not they also wanted to include guaranty association coverage for transactions in which the recipient company is not a member insurer. Because that essentially would mean that the recipient company would not be a licensed insurer, it is difficult for me to conceive of circumstances in which commissioners would want blocks of insurance for consumers (those implicating guaranty association coverage) transferred to them.

What is important is that all of the alternative iterations of Version 2 I offered the RLWG have the same virtue as the basic proposal: they only envision limited (3 or 4 lines) edits to Section H(1). Thus, no matter what its preference, under Version 2, a state could accomplish very simply the referral's goal of preserving coverage in the case of IBTs or CDs, whether or not they had adopted the 2009 assumed claims amendments.

The simple explanation for the difference between these competing proposals is that, unlike my Version 2, NCIGF's Version 1 is structured to permit the NAIC to reverse course now and remove the assumed claims coverage added in 2009. If it were not for that new goal, there would be no reason to prefer the 287 line edits of Version 1. That new goal, of course, was not part of the charge to the Working Group.

This point merits a bit of further explanation. Version 2 DOES enable an individual state to provide guaranty association coverage for IBT and CD transactions WITHOUT assumed claims coverage. Where it differs from Version 1, adopted by the Working Group, is that the latter enables amendment of the Act to ELIMINATE EVEN THE POSSIBILITY of assumed claims coverage for states adopting the Model. I submit respectfully that there is no public policy justification for this *sotto voce volte-face*.

**Receivership and Insolvency (E) Task Force
August 10, 2023, page 6**

THE ASSUMED CLAIMS COVERAGE

What is the assumed claims coverage that has given rise to this spirited debate? The 2009 amendments adding that coverage were the result of the Virginia receivership for Reciprocal of America (ROA), a workers compensation and professional liability insurer doing business primarily in the southeast. In the 1990s, when the workers compensation market tightened and rates increased, a number of institutional ROA workers compensation insureds moved their coverage to existing or newly formed self insured vehicles. By the turn of the millennium, when the market softened, those blocks were once again assumed by ROA in assumption reinsurance, loss portfolio transfers, or similar transactions. In 2003, ROA was placed in receivership and eventually in liquidation. A number of guaranty associations declined to provide coverage for claims arising under these blocks because they had been assumed from non-member insurers. Even more, they objected to the liquidator using estate assets to pay those same claims, asserting that they were not entitled to policyholder priority and therefore could not be paid from estate assets until guaranty association had been fully reimbursed for their payment of covered claims. The issue was litigated vigorously in Virginia courts, resulting in a ruling that these claims were obligations to policyholders just as those arising under policies issued directly by ROA. See August 24, 2005, Final Order of the Virginia State Corporation Commission, attached. While an appeal was lodged from this order, it was later abandoned. See December 22, 2005, Withdrawal of Appeal, also attached.

This litigation proved expensive for the ROA receivership and extremely injurious and disruptive to injured workers whose workers compensation benefits were interrupted by the guaranty association challenge. In an effort to avoid repetition, in 2004 the Virginia General Assembly adopted amendments to Virginia Code Section 38.2-1603, the “covered claims” definition of the Virginia Property and Casualty Insurance Guaranty Association Act (the Virginia version of Model 540). The amendments specified that assumed claims, such as those at issue in ROA, were within the scope of guaranty association coverage.

There followed efforts to accomplish the same result for the entire country, which took the form of the amendment of Model 540 adopted by the NAIC in 2009 over vigorous opposition from the NCIGF. Without speculating as to the opposition or other cause for this, it is true that few states have since adopted these amendments, just as even fewer states have done so for the Insurance Receivership Model Act (Model 555), adopted by the NAIC in 2005. Nonetheless, as of this writing, Models 540 and 555 represent the judgment of the NAIC as to how insurance insolvencies should be managed.

THE RENEWED ATTACK

Under the banner of “coverage neutrality”, the NCIGF has seized on the IBT/CD referral to the RLWG as the opportunity to renew its attacks on the assumed claims coverage incorporated by the NAIC in 2009. What is remarkable, of course, is that the assumed claims coverage issue has nothing to do with preservation of guaranty association protection for policyholders in IBT and CD transactions. Arguably, Model 540 already does that without the need for any amendment at all. It does so precisely because of the amendments adopted in 2009, though they were intended for the

**Receivership and Insolvency (E) Task Force
August 10, 2023, page 7**

narrower circumstances than in controversy. This much I pointed out to the RLMG on November 9, 2022, when I suggested that,

“[a]t most, if one wanted to adopt a “belt and suspenders” approach, the language in Section D(2) (or subsection (3) of Alternative 2) could be amended as follows:

***An assumption reinsurance or other transaction in which all of the following occurred:*”**

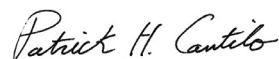
Among the responses to this argument, was that few states had adopted the 2009 amendments. That led me to propose the simple 4-line Version 2 that could be used in states that had not adopted the assumed claims language to assure that IBT and CD transactions would not result in loss of guaranty association protection.

So, what is really at issue in today’s debate is whether the Task Force, without having been asked to do so, wants to propose to the E Committee and then to the NAIC that it revoke its 2009 decision to provide in Model 540 the possibility of guaranty association coverage to claimants like the ROA workers compensation insureds described above. I submit respectfully that there is no defensible public policy that would be served by such an about face. I urge this Task Force to continue putting policyholder interests at the top of its list of priorities and adopt my proposed Version 2 in response to te RMWG referral.

As usual, my firm and I are not compensated for our contributions to the deliberations of the Task Force. We do not, in this matter, represent the interests of any constituency other than our effort to protect policyholders who are otherwise largely unrepresented in these discussions. The views I express are strictly my own and not offered on behalf of any client or organization. They are informed generally by my experience with troubled insurers during the last four decades, and specifically by my work on behalf of policyholders of failed insurers. I would be happy to answer any questions about these matters.

I thank you for your kindness in considering my comments.

Very truly yours,



Patrick H. Cantilo

COMMONWEALTH OF VIRGINIA
STATE CORPORATION COMMISSION
AT RICHMOND, AUGUST 24, 2005

APPLICATION OF
RECIPROCAL OF AMERICA and
THE RECIPROCAL GROUP

CASE NO. INS-2003-00239

For a Determination Whether Certain Workers'
Compensation Insurance Policy Payments May be
Made to Claimants Formerly Covered by SITs and GSIAs

FINAL ORDER

On July 11, 2003, the Deputy Receiver of Reciprocal of America¹ filed an Application for Order Authorizing the Continuation of Workers' Compensation Disability Payments by Reciprocal of America and The Reciprocal Group for Workers' Compensation Claims Denied Coverage by State Guaranty Associations ("Application") in Case No. INS-2003-00024. Therein, the Deputy Receiver of ROA sought an order from the State Corporation Commission ("Commission") authorizing him to continue payment of medical and recurring partial or total disability payments for workers' compensation claims that were assumed by ROA through assumption reinsurance, or similar transactions, and denied or likely to be denied coverage by the applicable state guaranty associations.²

In the Application, the Deputy Receiver of ROA asserted that the guaranty associations of the applicable states have refused, or likely will refuse, to make certain workers' compensation insurance policy payments for workers' compensation claims that ROA assumed from Self-Insured Trusts ("SITs") in Alabama, Arkansas, Kentucky, and Missouri and Group Self-

¹ Reciprocal of America and The Reciprocal Group are collectively referred to herein as "ROA."

² Application at 1.

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Insurance Associations ("GSIAs") in Mississippi, North Carolina, Tennessee, and Virginia (collectively referred to as the "Assumed Businesses") as a result of assumption reinsurance or similar transactions ("Assumed Claims").³ The Deputy Receiver of ROA noted that the Assumed Claims likely will not be paid because the Assumed Businesses were not member insurers and/or the policies under which the claims arose were not ROA policies. The payments purportedly totaled approximately \$125,139 weekly.

The Deputy Receiver of ROA further contended that the insureds of the Assumed Businesses are direct insureds of ROA and, due to the necessity for continued payment by the recipients thereof, requested authorization from the Commission to continue making such payments.⁴ The Deputy Receiver of ROA classified the Agreements as "assumption reinsurance."⁵ The Deputy Receiver of ROA further asserted that the livelihood of many injured workers is dependent upon continued receipt of the payments and that a discontinuation of such payments would cause the recipients to suffer a substantial hardship.⁶ Accordingly, the Deputy Receiver of ROA sought an order from the Commission authorizing the continued payment of workers' compensation insurance policy claims assumed by ROA through assumption reinsurance or similar transactions and denied or likely to be denied coverage by the applicable state insurance guaranty associations.

On August 14, 2003, the Commission entered an Order Scheduling Hearing on Application, and on August 18, 2003, the Commission entered an Order Clarifying Previous

³ Such Assumed Claims and assets of the Assumed Businesses were purportedly assumed by ROA through merger agreements or different forms of assumption agreements ("Agreements"). Application at 4.

⁴ Id.

⁵ Id. at 6-7.

⁶ Id. at 9. The Deputy Receiver stated that payments to approximately 450 injured workers are at stake. Id. at 10.

Order ("Orders"). In the Orders, the Commission scheduled a hearing for September 17, 2003, to determine whether the insureds of the Assumed Businesses are direct insureds of ROA and therefore a direct responsibility of ROA or, if not, whether such insureds' claims should be treated as "hardship" claims. The Commission further ordered that the Deputy Receiver of ROA is not directed or authorized to make any workers' compensation insurance policy payments to claimants of the SITs or GSIAAs until further order of the Commission.

A number of other parties, including the SDRs of the Tennessee Companies,⁷ the Virginia Property and Casualty Insurance Guaranty Association ("VPCIGA"), the Indiana Insurance Guaranty Association, the Kansas Insurance Guaranty Association, the Mississippi Insurance Guaranty Association, the Tennessee Insurance Guaranty Association, and the Texas Property and Casualty Insurance Guaranty Association (collectively, "Guaranty Associations"),⁸ the Coastal Region Board of Directors and the Alabama Subscribers it represents ("Coastal"), the Kentucky Hospitals,⁹ and the Virginia Workers' Compensation Commission's Uninsured

⁷ The Special Deputy Receivers of Doctors Insurance Reciprocal ("DIR"), Risk Retention Group ("RRG"), American National Lawyers Insurance Reciprocal ("ANLIR"), RRG, and The Reciprocal Alliance ("TRA"), RRG are referred to herein as the "SDRs." DIR, ANLIR, and TRA are referred to herein collectively as the "Tennessee Companies."

⁸ The Guaranty Associations no longer include the Texas Property and Casualty Insurance Guaranty Association, which was permitted to withdraw from this proceeding on April 27, 2004.

⁹ The "Kentucky Hospitals" include Appalachian Regional Healthcare, Caverna Memorial Hospital, Clinton County Hospital, Crittenden Health System, Cumberland County Hospital, Gateway Regional Medical Center, Hardin Memorial Hospital, Highlands Regional Medical Center, Jane Todd Crawford Hospital, Lincoln Trail Hospital, Livingston Hospital & Healthcare Service, Marcum & Wallace Memorial Hospital, Marshall County Hospital, Monroe County Medical Center, Murray-Calloway County Hospital, Ohio County Hospital, Owensboro Mercy Health System, Pattie A. Clay Hospital, Pineville Community Hospital, Regional Medical Center/Trover Clinic Foundation, Rockcastle Hospital, St. Claire Medical Center, T.J. Samson Community Hospital, Twin Lakes Regional Medical Center, and Westlake Regional Hospital.

Employers' Fund ("UEF")¹⁰ all joined this proceeding and have participated in some fashion, either in support of, or in opposition to, the Application.

The Commission held a hearing on this matter on September 17, 2003. Briefs were subsequently filed by the Deputy Receiver of ROA, the Guaranty Associations, the VPCIGA, Coastal, the Kentucky Hospitals, and the UEF.

On November 12, 2003, the Commission entered an Order, in which it directed the Deputy Receiver of ROA to pay the Assumed Claims insofar as they constitute indemnity and wage-replacement payments but did not authorize the payment of physician or hospital bills. In the same Order, the Commission assigned the determination of whether the SITs and GSIA's or employers thereof constitute "other policyholders arising out of insurance contracts" pursuant to § 38.2-1509 B 1 ii of the Code of Virginia¹¹ ("Code") to a hearing examiner and docketed the proceeding as Case No. INS-2003-00239.¹²

On January 8, 2004, the Commission entered an Order on Reconsideration, in which we denied the Guaranty Associations' request that we reverse our November 12, 2003 Order. The Commission also denied their request to suspend the execution of that Order pending an appeal.

¹⁰ On September 17, 2003, the Virginia Workers' Compensation Commission ("VWCC") filed a Motion to Intervene. Therein, the VWCC asserted that the UEF, which is administered by the VWCC, may become a significant creditor of ROA. On October 2, 2003, counsel for the VWCC and UEF filed a letter in which he stated that the VWCC's pleadings in this case were filed for the VWCC solely in its capacity as the administrator of the UEF, and not in its role as an adjudicative body. He stated his intention to submit future pleadings on behalf of the UEF, rather than the VWCC. The Commission granted the Motion to Intervene on October 16, 2003. For convenience of reference, the Commission will refer to the "UEF" in the remainder of this Order when discussing the "VWCC" or the "UEF."

¹¹ Statutory references are to the Code of Virginia.

¹² All three commissioners agreed with the decision to refer the underlying question involving § 38.2-1509 B 1 ii of the Code to a hearing examiner. One commissioner dissented from the decision to permit disbursements from the ROA estate to pay the Assumed Claims while such question was pending.

We reinstated our Order dated November 12, 2003, effective as of January 8, 2004.¹³ Hence, the Deputy Receiver of ROA was authorized to pay the Assumed Claims insofar as they constitute indemnity and wage-replacement payments as of January 8, 2004.¹⁴

Subsequent to the referral of this case to a hearing examiner and without objection from any party, this proceeding was expanded to include, in addition to the nine agreements involving workers' compensation coverage, two agreements covering other liability coverage.¹⁵ Unlike with the workers' compensation insurance policy payments, the Deputy Receiver of ROA did not seek to make any payment on the liability policy Assumed Claims but noted that there were approximately 128 such claims.¹⁶ The assumed workers' compensation SITs were the Healthcare Workers Compensation Self-Insured Fund (Alabama) ("HWCF"), the Arkansas Hospital Association Workers' Compensation Self-Insured Trust ("AWCT"), Compensation Hospital Association Trust (Kentucky) ("C-HAT"), and MHA/MSA Compensation Trust (Missouri) ("MHA/MSA"). The assumed liability SITs were the Alabama Hospital Association Trust ("A-HAT") and the Kentucky Hospital Association Trust ("K-HAT"). The assumed workers' compensation GSAs were MHA Private Workers' Compensation Group (Mississippi) ("MHA

¹³ By Order entered on December 2, 2003, the Commission prohibited the Deputy Receiver of ROA from making any payments pursuant to the November 12, 2003 Order until it had ruled on the Guaranty Associations' Petition for Rehearing or Reconsideration.

¹⁴ One commissioner dissented from the January 8, 2004, Order permitting payments to be made from the ROA estate prior to a decision being rendered in the INS-2003-00239 case.

¹⁵ See Amendment to Application for Order Authorizing the Continuation of Workers' Compensation Disability Payments by Reciprocal of America and The Reciprocal Group for Workers' Compensation Claims Denied Coverage by State Guaranty Associations ("Amendment") filed by the Deputy Receiver of ROA on January 21, 2004; and Order entered on January 29, 2004, in which the Commission accepted the Amendment to the Application and directed the hearing examiner to also consider and make a determination as to whether or not the liability assumed claims of ROA constitute claims of "other policyholders arising out of insurance contracts," in accordance with § 38.2-1509 B 1 ii of the Code. "Assumed Claims" hereinafter will include both the liability assumed claims and the workers' compensation assumed claims.

¹⁶ Amendment at 6.

Private"), MHA Public Workers' Compensation Group (Mississippi) ("MHA-Public"), SunHealth Self-Insurance Association of North Carolina ("SunHealth"), THA Workers' Compensation Group (Tennessee) ("THA"), and Virginia Healthcare Providers Group ("HPG").

The Guaranty Associations and the VPCIGA pursued an appeal of the November 12, 2003, and January 8, 2004, Orders to the Supreme Court of Virginia, which dismissed their appeal on July 9, 2004.¹⁷ The litigation before the hearing examiner continued while such appeal was pending. An evidentiary hearing was convened on September 22, 2004, and continued for six days thereafter. The Deputy Receiver of ROA, the Guaranty Associations, the VPCIGA, the Kentucky Hospitals, Coastal, the SDRs of the Tennessee Companies, the UEF, the Children's Hospital of Alabama, the Bureau of Insurance, and Richard W.E. Bland all participated in the hearing in one form or another. Post-hearing briefs were filed by the Deputy Receiver of ROA, the Kentucky Hospitals, Coastal, the UEF, the VPCIGA, and the Guaranty Associations.

On April 21, 2005, the hearing examiner filed his report ("Report"). The 130-page Report contains an exhaustive summary of the record of this proceeding, as well as the hearing examiner's discussion of the legal issues involved in this case, along with his findings and recommendations. The hearing examiner made the following findings and recommendations:

- (1) Virginia substantive law should control in this case to avoid exposing the ROA receivership estate to a myriad of possible conflicting state laws, to provide for the equitable payment of claims and distribution of the assets of the ROA estate among creditors of the same class no matter where the creditors may reside, and to provide for the orderly administration and wind down of the ROA estate;
- (2) Virginia law recognizes that entities such as the SITs and GSIAAs transact the business of insurance, but are exempt from regulation as insurance companies under Title 38.2 of the

¹⁷ The Supreme Court of Virginia found that the two aforesaid Orders were not final Orders and dismissed the appeals without prejudice. Indiana Ins. Guar. Ass'n v. Gross, 268 Va. 220 (2004).

- Code of Virginia, except as specifically provided for in statutes adopted by the General Assembly;
- (3) The Commission is not bound by the erroneous legal conclusions of a member of the staff in the Bureau of Insurance;
 - (4) There is no basis for judicially estopping ROA and the SITs and GSIAAs from arguing that they were self-insured trusts or group self-insurance associations that issued contracts of insurance providing coverage for their employer-members' liability or workers' compensation risks;
 - (5) The employer-members of SITs and GSIAAs pooled their risk of loss for the purpose of transferring an individual employer-member's risk of loss to the group;
 - (6) The SITs and GSIAAs were a type of reciprocal insurer in which the employer-members were both the insurer and the insured;
 - (7) The arrangement in which HWCF provided its employer-members workers' compensation liability coverage was an insurance contract under Virginia law;
 - (8) The arrangement in which A-HAT provided its employer-members medical professional liability, general liability, and personal injury liability coverage was an insurance contract under Virginia law;
 - (9) The arrangement in which C-HAT provided its employer-members workers' compensation liability coverage was an insurance contract under Virginia law;
 - (10) The arrangement in which K-HAT provided its employer-members hospital professional and general liability coverage was an insurance contract under Virginia law;
 - (11) The arrangement in which MHA Public provided its employer-members workers' compensation liability coverage was an insurance contract under Virginia law;
 - (12) The arrangement in which MHA Private provided its employer-members workers' compensation liability coverage was an insurance contract under Virginia law;
 - (13) The arrangement in which THA provided its employer-members workers' compensation liability coverage was an insurance contract under Virginia law;
 - (14) The arrangement in which HPG provided its employer-members workers' compensation liability coverage was an insurance contract under Virginia law;
 - (15) The arrangements in which AWCT and MHA/MSA provided their employer-members workers' compensation liability coverage were insurance contracts under Virginia law;
 - (16) The fortuity and known loss doctrines are inapplicable in this case;

- 17) The Acquisition of Assets and Assumption of Liabilities and Merger Agreements effected an assumption reinsurance transaction in which ROA assumed the then existing insurance obligations of the SITs, GSIAAs, and their employer-members on the policies of insurance that had been written by the SITs and GSIAAs;
- 18) A novation occurred in which ROA was substituted as the insurer of the former insurance obligations of the SITs, GSIAAs, and their employer members;
- 19) The Assumed Claims are "claims of other policyholders arising out of insurance contracts" pursuant to § 38.2-1509 B 1 ii of the Code; and
- 20) The Deputy Receiver of ROA may pay the workers' compensation Assumed Claims at 100% without creating an unlawful preference.

The hearing examiner also concluded that the arrangement in which SunHealth provided its employer-members workers' compensation liability coverage was an insurance contract under Virginia law,¹⁸ even though he omitted such conclusion from his list of findings and recommendations. We thus treat it as an additional finding for purposes of our analysis. The hearing examiner recommended that the Commission adopt his findings, direct the Deputy Receiver of ROA to pay the workers' compensation Assumed Claims at 100%, and direct the Deputy Receiver of ROA to pay the Liability Assumed Claims at the same percentage as the claims of the Guaranty Associations and the VPCIGA.¹⁹

On April 26, 2005, the VPCIGA filed a Consented to Joint Motion for Extension of Time to File Responses and Objections to Hearing Examiner's Report ("Joint Motion"). On April 28, 2005, the Commission entered an Order Extending Time for Filing Comments, in which it

¹⁸ See Report at 116.

¹⁹ Report at 130. On July 20, 2004, the Deputy Receiver of ROA filed his Application for Approval of Agreement to Stay Proceedings and Tolling Agreement, in which he requests, among other things, the Commission to approve payment by the Deputy Receiver of ROA of claims of ROA direct policyholders and insureds at a 17% percentage, subject to certain limitations, conditions, and exclusions. That case is currently before a hearing examiner. See *Application of Reciprocal of America and The Reciprocal Group For Approval of Agreement to Stay Proceedings and Tolling Agreement*, Case No. INS-2004-00244 ("Case No. INS-2004-00244").

granted the Joint Motion and provided all parties with an extension to file comments on the Report until June 1, 2005.

Comments to the Report were filed by the VPCIGA, the Guaranty Associations, Coastal and the Kentucky Hospitals (comments filed jointly), and the Deputy Receiver of ROA. Generally, the VPCIGA and the Guaranty Associations requested that the hearing examiner's findings and recommendations be rejected, while the Kentucky Hospitals, Coastal, and the Deputy Receiver supported the hearing examiner's findings and recommendations. We have thoroughly considered the entire record in this proceeding.

NOW THE COMMISSION, having considered the evidence and arguments of the parties, the pleadings, the Report and the comments thereto, and the applicable law, finds as follows. We agree with the hearing examiner that the Assumed Claims, and thus the claims of the SITs and GSIA's or employers thereof, constitute "claims of other policyholders arising out of insurance contracts," pursuant to § 38.2-1509 B 1 ii of the Code. We do not agree, however, that the Code permits us to pay the Assumed Claims at 100%. Unfortunately, we find that we are constrained by the law to pay the Assumed Claims, so that such payment is "apportioned without preference." Accordingly, the Assumed Claims may not be paid until such time as the payment percentage is finalized and approved in Case No. INS-2004-00244. If and when such payment percentage is approved by the Commission, the Assumed Claims may be paid a like percentage. Accordingly, we adopt findings 1, 5-15,²⁰ and 19. We reject finding 20, as we believe it to be inconsistent with applicable law. We take no action with respect to findings 2-4 and 16-18 as they are not necessary to our decision in this case.

²⁰ We also adopt the additional finding regarding SunHealth. See note 18 and accompanying text.

Discussion

In our November 12, 2003, Order, we ordered that "[t]he determination of whether the SITs and GSIA's or employers thereof constitute 'other policyholders arising out of insurance contracts' pursuant to § 38.2-1509 B 1 ii is hereby assigned to a Hearing Examiner and is assigned Case No. INS-2003-00239." Thus, we agree with the hearing examiner that "the issue of whether the Assumed Claims are 'covered claims' may be saved for another day," and do not decide such issue here.²¹ The narrow question that we referred to the hearing examiner has spawned nearly two years of litigation before this Commission.

Section 38.2-1509 B 1 ii of the Code provides, in pertinent part, that "[t]he Commission shall disburse the assets of an insolvent insurer as they become available in the following manner: 1. Pay, after reserving for the payment of the costs and expenses of administration, according to the following priorities: . . . (ii) claims of the associations for "covered claims" and "contractual obligations" as defined in §§ 38.2-1603 and 38.2-1701 and *claims of other policyholders arising out of insurance contracts apportioned without preference. . .*" (emphasis added). We must determine if the SITs and GSIA's or employers thereof constitute "policyholders arising out of insurance contracts" to determine whether they fall within this category of the asset disbursement scheme for insolvent insurers crafted by the General Assembly.

We first determine whether the contracts between and among the SITs and GSIA's and employers thereof constitute "insurance contracts." Neither Chapter 15 nor Chapter 1 of

²¹ Report at 127. We also do not decide here whether or not the Commission has jurisdiction to determine the "covered claims" issue.

Title 38.2 of the Code contains a definition for "policyholder" or "insurance contracts."²² We find the hearing examiner's analysis employing the tests in American Surety Co. v. Commonwealth, 180 Va. 97 (1942) and Group Hospitalization Medical Service, Inc. v. Smith, 236 Va. 228 (1988), to be convincing. Both of those cases provide the essential terms of a contract of insurance. "The essential terms of a contract of insurance are (1) the subject matter to be insured; (2) the risk insured against; (3) the commencement and period of the risk undertaken by the insurer; (4) the amount of insurance; and (5) the premium and time at which it is to be paid." 180 Va. at 105, 236 Va. at 230-231. As aptly explained by the hearing examiner, each of the coverage documents issued by the SITs and the GSIA to their member-employers satisfied the American Surety and Group Health tests.²³ Accordingly, we find that those agreements constituted "insurance contracts," as those words are used in § 38.2-1509 B 1 ii of the Code.

The VPCIGA and the Guaranty Associations contend, however, that, the Commission must first determine that insurance exists before it even gets to the American Surety and Group Hospitalization tests for determining whether an insurance contract exists.²⁴ We agree that there must be insurance for an insurance contract to exist. However, we disagree with the Guaranty Associations' and the VPCIGA's arguments that no insurance existed here.

Section 38.2-100 of the Code provides a definition for insurance:

'Insurance' means the business of transferring risk by contract wherein a person, for a consideration, undertakes (i) to indemnify another person, (ii) to pay or provide a specified or ascertainable amount of money, or (iii) to provide a benefit or service upon the

²² Section 38.2-100 of the Code does provide that "[w]ithout otherwise limiting the meaning of or defining the following terms, 'insurance contracts' or 'insurance policies' shall include contracts of fidelity, indemnity, guaranty and suretyship." Because of the language "[w]ithout otherwise limiting the meaning of or defining," we must search elsewhere in order to define "insurance contracts" in the context of § 38.2-1509 B 1 ii of the Code.

²³ See Report at 114-117.

²⁴ See, e.g., Response and Objections of VPCIGA to Report of Hearing Examiner, at 14.

occurrence of a determinable risk contingency. . . . 'Insurance' shall not include any activity involving an extended service contract that is subject to regulation pursuant to Chapter 34 (§ 59.1-435 et seq.) of Title 59.1 or a warranty made by a manufacturer, seller, lessor, or builder of a product or service.

Unlike the exclusion of warranties from this definition, the General Assembly chose not to exclude specifically any of the types of contracts at issue in this case.

The essence of the definition is a contract by a *person* to indemnify or pay another upon the occurrence of a determinable risk contingency. We believe it important that the General Assembly chose to use the word "person" here, rather than "insurer." Thus, we do not take a position on whether the SITs or GSIAAs were "insurers" under any provision of the Code, as it is unnecessary for us to do so to find that "insurance" existed here.²⁵ An "insurer" is not a necessary party to an "insurance contract" under § 38.2-1509 B 1 ii of the Code.

What is required is a transfer or shifting of the risk. See Lawyers Title Ins. Corp. v. Norwest Corp., 254 Va. 388, 390, 392 (1997) (Supreme Court of Virginia affirmed Commission's determination that Title Option Plus was not insurance and stated that a "shifting of the risk is the essence of insurance."); Hilb, Rogal and Hamilton Co. v. DePew, 247 Va. 240,

²⁵ We have reviewed a number of cases in reaching our conclusion, including authorities cited by the parties. We read the Iowa Supreme Court's decision in Iowa Contractors Workers' Compensation Group v. Iowa Ins. Guar. Ass'n, 437 N.W.2d 909 (Iowa 1989) to be inapposite to our conclusion. There, the Supreme Court of Iowa found, among other things, that a self-insured group was not an "insurer" under Iowa law. The result of such finding, of course, was that the Iowa Insurance Guaranty Association was liable for certain claims. 437 N.W.2d at 916. We decline to adopt the Supreme Court of Iowa's reasoning to the extent the court determined that no risk is transferred unless all of the risk is transferred. See, 437 N.W.2d at 917.

Similarly, in South Carolina Property and Cas. Ins. Guar. Ass'n v. Carolinas Roofing and Sheet Metal Contractors Self-Insurance Fund, 446 S.E.2d 422 (S.C. 1994), the Supreme Court of South Carolina found that the self-insured roofers' fund was an "insurer" under that state's law. The court's analysis differed from the Iowa court's in that the Supreme Court of South Carolina found that the members of the group self-insurer did transfer a portion of their risk. 446 S.E.2d at 425.

In California Plant Protection, Inc. v. Zayre Corp., 659 N.E.2d 1202 (Mass. App. Ct. 1996), the court found that the self-insured group was not an "insurer" and was therefore entitled to guaranty fund protection. Id. at 1205. We are not required to decide in this case whether the SITs or GSIAAs constitute an "insurer" under our law.

248 (1994) ("Such shifting of the risk is the essence of insurance."). We find that such a risk transfer or shift took place here.

We do not believe that the existence of joint and several liability served to nullify any risk transfer that occurred among the members' pooling of their liabilities. Nor does the fact that the members could have been assessed under their policies nullify the transfer or shifting of risk. We find the hearing examiner's discussion to be persuasive in this regard. While we decline to adopt *in toto* the reasoning of the Supreme Court of South Carolina or the Supreme Court of Iowa, we agree that, in Virginia, insureds may be assessed under an insurance policy without altering the policy's essential nature as an insurance contract.

We find further support for our decision in the Court of Appeals of Maryland's decision in Maryland Motor Truck Ass'n Workers' Compensation Self-Insurance Group v. Property & Cas. Ins. Guar. Corp., 871 A.2d 590 (Md. 2005), a decision filed after the hearing examiner filed his report, but before the deadline for filing comments in this case.

In Maryland Motor Truck, the Court of Appeals of Maryland, its highest court, was faced with the question of whether the Maryland Motor Truck Association Workers' Compensation Self-Insurance Group ("MMTA") was an "insurer" under Maryland law. If the MMTA was an "insurer," the Property and Casualty Insurance Guaranty Corporation ("PCIGC") was not responsible for paying the claims of the members of the MMTA, which had an excess insurance policy with Reliance National Indemnity Company, an insurance company declared insolvent by a Pennsylvania court. The members of the MMTA were each jointly and severally liable for the workers' compensation obligations of the group and its members that were incurred during their period of membership.²⁶

²⁶ 871 A.2d at 592.

In discussing differences between self-insurance with only one entity insuring itself, and group self-insurance, with multiple members, the Maryland Court of Appeals stated,

[i]n reality, because in that situation there is no spreading of the risk for that part of a loss that is either within a deductible or over the policy limit, the policyholder is more likely *non*-insured for that segment. As we shall explain later, that is not necessarily the case with group self-insurance. There, the retained risk is transferred from the individual (member) to the group and is spread throughout the group. The member may share with the other members joint and several liability for the overall, aggregate combinations of the group, but is relieved of any direct obligation for payment of particular claims made against it. That is much more akin to the nature and concept of insurance than to that of non-insurance.

871 A.2d at 596 (emphasis in original). The Maryland Court of Appeals continued by analyzing the contract and concluded that "[t]he mere fact that the members retain joint and several liability for any remaining obligations of the [self-insured] Group does not suffice to preclude the Agreement from constituting an insurance contract. . . . Such an arrangement—joint and several liability for a deficiency and the right to recover part of the surplus funds in the form of dividends—is a traditional characteristic of assessment mutual insurance companies." *Id.* at 598.

The Court of Appeals of Maryland found that, because the contracts were insurance contracts, the self-insured group was an "insurer," and the PCIGC was not responsible for the claims under Maryland law. While we are not determining the precise question of whether the SITs or GSIAAs constitute an "insurer," and specifically decline to do so here, we find the reasoning of the Court of Appeals of Maryland persuasive as it relates to the determination that the underlying contracts were insurance contracts. Simply put, we do not believe that the existence of joint and several liability, when analyzed in the context of the remainder of the contracts among the members and the SITs and GSIAAs, nullifies the fact that risk was shifted or transferred. The VPCIGA argues that "[t]his agreement by each member to assume an obligation

it did not otherwise have and to pay and discharge the liability of every other member cannot be characterized as a transfer of risk."²⁷ We think the opposite is true. Each member assumed an obligation it did not otherwise have (accepted risk) and agreed to pay and discharge the liability of every other member (accepted risk). By the same token, each member transferred a portion of its risk to the group, while retaining or receiving back a portion of, or possibly all, of such risk upon the occurrence of certain contingencies. Nothing in the definition of "insurance" in the Code, or case law from the Supreme Court of Virginia, supports the notion that, without a complete transfer or shift of all the risk, no risk is transferred at all. We think, to the contrary, that sufficient indicia of risk transfer or shift was present here for the contracts to be insurance contracts.

Having determined that risk was transferred or shifted and shared or pooled among and between the members and the SITs and GSIAAs, we then apply the American Surety and Group Hospitalization tests to determine whether the contracts were insurance contracts under Virginia law. In this regard, we agree with the hearing examiner's analysis and findings that all 11 of the SITs' and GSIAAs' coverage documents constituted "insurance contracts."²⁸ Finally, we believe that the Assumed Claims are those of "policyholders." In this regard, while the "policyholders" may have been the employers-members of the SITs and GSIAAs rather than a third-party claimant or employee, we believe the language "arising out of" is broad enough to encompass the Assumed Claims.²⁹ Having found that the contracts between and among the SITs and GSIAAs

²⁷ Response and Objections of VPCIGA to Report of Hearing Examiner, at 20.

²⁸ Report at 114 -117, 128-129 (findings and recommendations 7-15). See also Report at 116 and note 18 and accompanying text, *supra*, regarding SunHealth.

²⁹ The parties did not spend much, if any, time disputing whether the employers-members were "policyholders" under § 38.2-1509 B 1 ii of the Code. While the employers-members were technically the "policyholders" under the contracts, see Atkinson v. Penske Logistics, LLC, 268 Va. 129, 135 (2004) ("... 'named insured' is the policyholder."), we think it is patently obvious, and the parties apparently agreed, that the employees thereof were

and their employers-members were "insurance contracts," and that the Assumed Claims constituted claims of "policyholders arising out of insurance contracts," we find it unnecessary to decide whether the Agreements constituted assumption reinsurance or whether a novation occurred. Accordingly, it is also unnecessary for us to decide whether ROA assumed "known losses" through the Agreements.

Apportioned without preference

The remaining pertinent language is that the Commission must pay "the claims of other policyholders arising out of insurance contracts *apportioned without preference*." Section 38.2-1509 B 1 ii of the Code (emphasis added). We cannot agree with the hearing examiner here that we have the authority to pay the Assumed Claims at 100%. Hence, the Assumed Claims may not be paid until a decision is rendered in the INS-2004-00244 case and then only at the percentage arrived at in such case.³⁰

The hearing examiner concluded that the General Assembly's preference for paying the full amount of a workers' compensation claim that is a "covered claim" under § 38.2-1606 A 1 a i of the Code indicates that the General Assembly "never intended that one group of workers' compensation policyholders of an insolvent insurer should receive 100% payment of their

also "policyholders" as they were the beneficiaries of the contracts. The language "arising out of" appears to be broad enough to include such claimants as "policyholders." See Trex Co., Inc. v. ExxonMobil Oil Corp., 234 F. Supp. 2d 572, 576 (E.D. Va. 2002) ("In the insurance context 'arising out of' is broader than 'caused by,' and ordinarily means 'originating from,' 'having its origin in,' 'growing out of,' 'flowing from,' or 'incident to or having connection with.'"); St. Paul Fire and Marine Ins. Co. v. Insurance Co. of North America, 501 F. Supp. 136, 138 (W.D. Va. 1980) (same, applying Virginia law).

³⁰ We recognize, and are not unmindful of the fact, that the injured workers may suffer a serious hardship as a result of our decision. We also recognize the apparent inequity in certain workers' compensation claimants receiving 100% of their claim (those that are eventually deemed "covered claims" under § 38.2-1606 A 1 a i of the Code) while others (for example, those impacted by our decision today) receive a substantially smaller percentage. Without deciding the "covered claim" issue, we note that the priority scheme for workers' compensation claimants in Chapter 16 of Title 38.2 of the Code could have been utilized in the disbursement scheme in Chapter 15 of Title 38.2 of the Code. The General Assembly, however, for whatever reason, chose not to do so.

claims; while an identical group of workers' compensation policyholders from the same insolvent insurer might receive less than 100% payment of their claims."³¹ We do not agree with the hearing examiner's *in para materia* analysis, however, as we believe that Chapters 15 and 16 of Title 38.2 of the Code, while related, pertain to different matters.

Section 38.2-1509 of the Code is part of a carefully crafted scheme for handling the disbursements of the assets of an insolvent insurer's estate, while § 38.2-1606 deals with the duties and powers of the Virginia Property and Casualty Insurance Guaranty Association. Section 38.2-1509 B of the Code controls the manner in which the Commission will pay claims out of the estate of the insolvent insurer. See Swiss Re Life Co. America v. Gross, 253 Va. 139, 146 (1997). That statute does not provide for the payment of one class of policyholders at 100%, while another policyholder receives whatever percentage may be paid by the estate as "available." Instead, it provides that all policyholder claims are to be "apportioned without preference."

The General Assembly has enumerated the order in which claimants of the insolvent insurer's assets may be paid, and we may not deviate from such legislative scheme. "When a legislative enactment limits the manner in which something may be done, the enactment also evinces the intent that it shall not be done another way." Grigg v. Commonwealth, 224 Va. 356, 364 (1982). We are not permitted to exercise our discretion here to override the General Assembly's priority scheme, because of the General Assembly's policy judgment set forth in an

³¹ Report at 127.

entirely different chapter of Title 38.2 of the Code.³² Had the General Assembly wanted to incorporate a super-priority for workers' compensation policyholders in Chapter 15 of the Code, it could have done so.³³ The legislature's determination instead that the assets are to be paid to satisfy the "claims of other policyholders apportioned without preference" is a clear command not to create exceptions for certain policyholders.

Conclusion

We find that the Assumed Claims are "claims of other policyholders arising out of insurance contracts." We also conclude that such claims must be "apportioned without preference" in accordance with the priority scheme established by the General Assembly set forth in § 38.2-1509 of the Code. Hence, we adopt findings 1, 5-15,³⁴ and 19 of the Report. We reject finding 20, as we believe it to be inconsistent with applicable law. We take no action with respect to findings 2-4 and 16-18 as they are not necessary to our decision in this case.

Accordingly, IT IS ORDERED THAT:

(1) The Application of the Deputy Receiver of ROA is APPROVED, except as modified herein.

³² If we ultimately determine that the Assumed Claims are "covered claims," as have the North Carolina Industrial Commission and the North Carolina Court of Appeals, see, Bowles v. BCJ Trucking Services, Inc., I.C. No. 821763 (North Carolina Ind. Comm'n, July 17, 2003) (Opinion of Douglas Berger, Deputy Commissioner), *aff'd*, Bowles v. BCJ Trucking Services, Inc., I.C. No. 821763 (North Carolina Indus. Comm'n, April 16, 2004) (2-1 decision by full commission), *aff'd*, Bowles v. BCJ Trucking Services, Inc., 615 S.E.2d 724 (N.C. Ct. App. 2005); In re: SunHealth GSIA/The Reciprocal Group, I.C. Nos. 402156, 467439, 822818, 734242, 902560, 426774, 705360, 616611, 734300 & 944966 (N.C. Indus. Comm'n, July 19, 2004), then the injured employees ultimately may receive 100%. We make no such determination today as the question of whether the "Assumed Claims" are "covered claims" is not before us.

³³ The General Assembly created such a super-priority for workers' compensation claimants in § 38.2-1606 of the Code.

³⁴ We also adopt the additional finding regarding SunHealth. See note 18 and accompanying text.

(2) The Assumed Claims constitute "claims of other policyholders arising out of insurance contracts" pursuant to § 38.2-1509 B 1 ii of the Code.

(3) The Deputy Receiver may not pay the Assumed Claims until such time as a payment percentage is determined by the Commission in Case No. INS-2004-00244.

(4) This matter is closed and the papers herein be passed to the file for ended causes.

AN ATTESTED COPY hereof shall be sent by the Clerk of the Commission to all persons on the official Service List in this matter. The Service List is available from the Clerk of the State Corporation Commission, c/o Document Control Center, 1300 East Main Street, First Floor, Tyler Building, Richmond, Virginia 23219.

— TROUTMAN SANDERS LLP —

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December 22, 2005

Via Hand Delivery

Joel H. Peck, Esquire
Clerk
State Corporation Commission
Tyler Building, 1st Floor
1300 East Main Street
Richmond, Virginia 23219

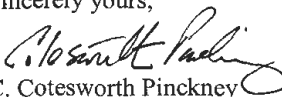
Re: Application of Reciprocal of America and the Reciprocal Group; For a
Determination Whether Certain Worker's Compensation Insurance Policy
Payments May be Made to Claimants Formerly Covered by SITs and GSIA's,
Case No. INS-2003-00239; Notice of Withdrawal of Appeal

Dear Mr. Peck:

Enclosed for filing in the above-referenced matter are the original and fifteen copies of a Notice of Withdrawal of Appeal which has been executed in counterparts by counsel for the Guaranty Associations, the Virginia Association, the Alabama Claimants and the Kentucky Hospitals.

Thank you for your assistance in this matter.

Sincerely yours,


C. Cotesworth Pinckney

Enclosures

cc: Gregory P. Deschenes, Esquire
Wiley F. Mitchell, Jr., Esquire
Greg E. Mitchell, Esquire

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RICHMOND • TYSONS CORNER • VIRGINIA BEACH • WASHINGTON, D.C.

COMMONWEALTH OF VIRGINIA
STATE CORPORATION COMMISSION

APPLICATION OF)	
)	
RECIPROCAL OF AMERICA and)	
THE RECIPROCAL GROUP)	
	)	Case No. INS-2003-00239
For a Determination Whether Certain Workers')	
Compensation Insurance Policy Payments)	
May be Made to Claimants Formerly)	
Covered by SITs and GSIAs)	

NOTICE OF WITHDRAWAL OF APPEAL

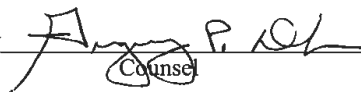
The Indiana Insurance Guaranty Association, Kansas Insurance Guaranty Association, Mississippi Insurance Guaranty Association and Tennessee Insurance Guaranty Association (the "Guaranty Associations"), the Virginia Property and Casualty Insurance Guaranty Association (the "Virginia Association"), the Coastal Region Board of Directors and the Alabama Subscribers (the "Alabama Claimants") and the Appalachian Regional Healthcare, Clinton County Hospital, Crittenden Health System, Cumberland County Hospital, Gateway Regional Medical Center, Hardin Memorial Hospital, Highlands Regional Medical Center, Livingston Hospital & Healthcare Service, Marcum & Wallace Memorial Hospital, Marshall County Hospital, Monroe County Medical Center, Murray-Calloway County Hospital, Ohio County Hospital, Owensboro Mercy Health System, Pattie A. Clay Hospital, Pineville Community Hospital, Regional Medical Center/Trover Clinic Foundation, Rockcastle Hospital, St. Claire Medical Center, T.J. Samson Community Hospital, Twin Lakes Regional Medical Center, and Westlake Regional Hospital (the "Kentucky Hospitals") each filed with the Clerk of the State Corporation Commission a notice of appeal from the Final Order of the State Corporation Commission entered on August 24, 2005 in Case No. INS-2003-00239 (the "Order").

Each of the Guaranty Associations, the Virginia Association, the Alabama Claimants and the Kentucky Hospitals (collectively, the "Claimants") has agreed with each of the other Claimants, in consideration of the similar agreements of such other Claimants, that it will abandon its appeal from the Order.

ACCORDINGLY, each of the Claimants by counsel hereby gives notice of its withdrawal of its appeal from the Order. Each of the Claimants acknowledges that this Notice of Withdrawal of Appeal may be executed in any number of counterparts (and by different parties hereto in different counterparts) each of which when so executed and delivered shall be deemed to be an original and all of which taken together shall constitute but one and the same instrument.

Dated December 21, 2005.

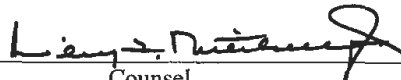
INDIANA INSURANCE GUARANTY
ASSOCIATION, KANSAS INSURANCE
GUARANTY ASSOCIATION, MISSISSIPPI
INSURANCE GUARANTY ASSOCIATION, and
TENNESSEE INSURANCE GUARANTY
ASSOCIATION

By  _____
Counsel

VIRGINIA PROPERTY AND CASUALTY
INSURANCE GUARANTY ASSOCIATION

By  _____
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COASTAL REGION BOARD OF DIRECTORS
AND THE ALABAMA SUBSCRIBERS

By 
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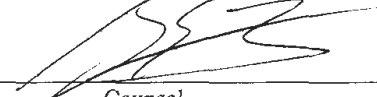
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CERTIFICATE OF SERVICE

I hereby certify that on the 22nd day of December, 2005, the original foregoing Notice of Withdrawal of Appeal executed in counterparts and fifteen copies thereof were delivered by hand to:

Joel H. Peck, Esquire
Clerk of the Commission
State Corporation Commission
Tyler Building
1300 East Main Street
Richmond, Virginia 23219

and photocopies thereof were mailed by first class mail to:

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State Corporation Commission
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Richmond, Virginia 23218

Judith W. Jagdmann
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Richmond, Virginia 23219

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The Reciprocal Group
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1424281

Draft: 8/16/23

Receivership Law (E) Working Group
Virtual Meeting
July 24, 2023

The Receivership Law (E) Working Group of the Receivership and Insolvency (E) Task Force met July 24, 2023. The following Working Group members participated: Kevin Baldwin, Co-Chair (IL); Laura Lyon Slaymaker, Co-Chair (PA); Michael Surguine (AR); Joe Holloway (CA); Jane Callanan (CT); Lorrie Arterburn (FL); Kim Cross (IA); Tom Travis (LA); Christopher Joyce (MA); Robert Wake (ME); Tom Mitchell (MI); Shelley Forrest (MO); Lindsay Crawford (NE); Brian Riewe (TX); and Charles Malone (WA). Also participating was: Dan Bumpus (VA).

1. Adopted its May 23 Minutes

Slaymaker said the Working Group met May 23 to expose proposed amendments to the *Property and Casualty Insurance Guaranty Association Model Act (#540)* for a 30-day comment period ending June 23.

Crawford made a motion, seconded by Arterburn, to adopt the Working Group's May 23 minutes (Attachment Three-A). The motion passed unanimously.

2. Adopted Amendments to Model #540

Slaymaker said the amendments to Model #540 aim to address guaranty fund coverage for policies included in insurance business transfers (IBTs) and corporate divisions (CDs) and to clarify guaranty association coverage of cybersecurity insurance. Regarding the IBT and CD amendments, the exposure included the optional language and a drafting note in Section 5G(3), as well as in other sections that were proposed for those states that may want to keep the assumed language that is proposed to be deleted. Slaymaker said NAIC staff made a few edits to section references, which are included in the materials. No comments were received on the cybersecurity insurance amendments. Three comment letters were received on the IBT and CD amendments.

Patrick Cantilo (Cantilo & Bennett LLP) summarized his comments (Attachment Three-B). Cantilo said the change necessary to accomplish the charge, which is to avoid the loss of coverage, is straightforward and can be done with the changes proposed in his comment letter. Cantilo said the only difference between his approach and the approach in the draft is that the draft allows the removal of the assumed claims coverage that was adopted in 2009, which is not necessary to assure guarantee association coverage remains for a CD transaction.

Slaymaker said a comment letter was received from Joe Torti (Fairfax (US) Inc.) (Attachment Three-C).

Barbara F. Cox (Barbara F. Cox LLC) summarized the National Conference of Insurance Guaranty Funds' (NCIGF's) comments (Attachment Three-D). She said NCIGF does not support the addition of Section 5G(3) in the covered claim definition, as it is contrary to NCIGF's adopted policy that if there were coverage before the transaction, there should be coverage after, and if there were no coverage, coverage should not be created. She said Fairfax (US) Inc. is not attending this meeting, but she believes it agrees with NCIGF. She said the 2009 amendments to Model #540, which are deleted throughout the draft, have only been adopted in three states. She said 12 states have adopted either IBT or CD transaction statutory authority. She said NCIGF supports the deletion of the 2009 amendments.

Joyce said his primary concern is that the 2009 assumed claims language in the current draft of Model #540 appears to contemplate potential coverage for situations that the Working Group would now be removing in these

amendments. He said he does not know what has changed since 2009 to warrant removing the language. He said he understands that part of the concern is that state insurance regulators will likely see more of these IBT and CD transactions where one party is assuming business from another due to the adoption of IBT and CD statutes in various states. If the need for the assumed claims transaction language was recognized in 2009, he is unsure what has changed. He said he is not convinced that the referral obligates the removal of potential coverage from the current Model #540 for policyholders who are subject to IBT and CD transactions to maintain their coverage. He said he very much supports the inclusion of some sort of optional language as proposed. Baldwin asked Joyce if optional Section 5G(3) would satisfy his concern with preserving the ability to cover the assumed transaction. Joyce said it would.

Cantilo said the referral is easily met by his proposal, which preserves guarantee association coverage for IBTs and CDs. He said he does not believe that anyone has suggested to the drafting group that it does not. The contrast between the two options is simply that one does what was intended, which is to preserve guarantee association coverage for these transactions, and the other option, which affects Section 5G(2) and other changes, is intended to also remove the assumed claims coverage, which is not necessary for the purpose of discharging what the referral intended. Cantilo said guarantee association coverage could be preserved both with and without the assumed claims language depending on what a state proposes by the amendment to the definition that is described in his comment letter.

Cox said Section 5G(3) does preserve some of the assumed claim business language. Section 5G(2) also preserves it to the extent the assumed claim transaction would flow from member to member or member to non-member.

Wake said Section 5G(3) captures everything substantively that was in all of the 2009 amendments that are proposed to be deleted. This puts back the substance in a much shorter paragraph.

Wake said he would be happy with either version of the proposed amendment, either with Section 5G(3) being optional or without it.

Bumpus said he supports the language, alternative language, and the comments that Cantilo raised, as they may be a workable solution. He said the issue of assumed claims came up in Virginia with a receivership 15 years ago, and it is covered in Virginia by the guarantee funds. He said he thinks that the proposed language from Cantilo most closely aligns with the charge to make sure that the guarantee fund coverage is unchanged. He said he has not had a chance to review the proposal with the optional language.

Cantilo asked what the more extensive revision to Model #540 accomplishes that is not also accomplished by his simpler, single-paragraph edition.

Wake said Cantilo's proposal looks more like the current version of Model #540, but compared to the current draft, Cantilo's proposal has four versions of a lengthy paragraph. He said he has stated in previous comments that he does not agree with Cantilo's explanation of his language and that it would need more editing. He said that, substantively, if a state insurance department adopts the optional Section 5G(3), the state insurance department would get the substance of Cantilo's proposal. If the state insurance department does not adopt Section 5G(3), it would get what NCIGF and Torti have proposed. He said this is a topic that has already been discussed.

Cox said NCIGF continues to support Section 5G(2) as a standalone provision. While NCIGF does not support Section 5G(3), it is preferable to the 2009 draft with the modifications. If state insurance departments want to adopt the optional Section 5G(3), that gives them a choice of how far they want to go to resolving restructuring transactions.

Slymaker said the amendments were exposed with the optional language, and based on the discussion, including the optional language may be the approach to move forward with. She asked for a motion to adopt either with or without the optional language.

Wake made a motion, seconded by Travis, to adopt the amendments to Model #540 (Attachment Three-E), including the optional language. The motion passed unanimously.

3. Heard a Presentation from Arcina Risk Group on Receivership Estate Records Retention

Richard Janisch (Arcina Risk Group) said Arcina is a 15-year-old company with roots in insurance archaeology, which is mostly uncovering old insurance liability policies. However, it could involve other types of coverage, such as maritime policies and workers' compensation programs. Driving Arcina's business are legacy claims, asbestos liabilities, other emerging legacy tort matters, and other emerging claims related to polyfluoroalkyl substances (PFAS) standards that are being imposed on states involving firefighting foam and other consumer products that include PFAS.

Janisch said Arcina's objective is to ask for some guidance and present a concept for preserving insolvent insurance estate records. He said he believes there is a labor force, sophisticated technology, and data tools to preserve these records more cost-efficiently than in the past. Legacy insurance policies are current space policies. Because of claims activities in the past, the primary coverages are exhausted or insolvent, which then means moving into excess layers. The excess insurance is dependent on what the policy form language was for the underlying coverage. When the underlying coverage is with an insolvent insurer, and those records are destroyed, it becomes a difficult archaeological task to try to uncover. He said he believes preserving the insolvent estate records for the long term would be a great public service with which Arcina would like to assist.

Janisch said some universities have risk management departments or risk management schools of study that have libraries and would be willing to accept some of these historical records and provide the labor to help support organizing those records. He said Arcina is interested in the policies. Other proprietary information in these records could be filtered out, and that is where Arcina would want some guidance on how that could be done and what nuances exist. There are some key states that are very active in liquidation proceedings that could provide guidance in that regard. There are emerging risks that still implicate policies, and he believes there will be more of these kinds of claims.

Rejo Mathew (Arcina) said that having reviewed the state statutes for California, Pennsylvania, and Texas, as well as the *Insurer Receivership Model Act* (#555), Arcina believes that commissioners/receivers are bestowed with broad authorities regarding estate records and that instead of destroying them, the records should be given to libraries and other public institutions for their preservation and future use. He said the purpose is to aid the public with future claims.

Mathew said the presentation materials include the next steps that Arcina would like the Working Group to consider, including stopping the destruction of any estate records that are pending or near closure (Attachment Three-F).

Mathew described an example of the loss of records from the Reliance Insurance Company estate and United Pacific Insurance Company, which wrote business to school districts. There are no longer records of how those programs were set up or the participants in the program. He said their work helps to diversify the risk absorbed by these entities and ease the impact across the industry. He said Arcina believes there is just cause for this, specifically through the verbiage of the insurance contract.

Janisch asked if it is due to cost versus the benefit that once the estate closes and distributions are made, there is no need to retain personnel, and records are shredded. Baldwin said the Working Group may not be able to answer that question for the states. A survey might be a way to compile answers.

Baldwin asked if policyholders or brokers have copies of these policies. Janisch said they do, but not all the time. He said that most of the time, they do not find the complete policy, correspondence, or past claims activity. For brokers, it is hit and miss, as they have a 10-year document destruction policy. On occasion, certain large brokers can uncover some of the placements for these claims.

Baldwin asked if, in contemplation of the concept of archaeology libraries, Arcina has undertaken any consideration of data privacy laws that might be applicable to those policyholders. Mathew said it is covered within Model #555. He said Arcina has reviewed it in terms of evidentiary standard considerations. As received by the commissioner, the policyholder record is considered prima facie evidence of coverage. Records should not be used against an insured or have the policy affected. However, Arcina hopes to maintain policyholder protections. If the category or designation the record is recognized as were to be changed from prima facie evidence to statistical, Arcina would have a better stance on this issue. This discussion concerns legacy claims that would probably be past most statutes of limitation. He asked if a plaintiff were to bring this documentation against the defendant that they had located these records, it is not actionable by its plaintiff. It is actionable by the defendant or the insured. The contract, because of the laws of privacy, is not going to act as a shield. This is why Arcina thinks this needs further discussion of what the specific rules are. This could also be access to records for clients who would be best served.

Janisch said that regarding data privacy, the Working Group would have to come up with some sort of gatekeeper protocol. He said data privacy is state-by-state driven, and he does not want to turn this into free access for the plaintiff's bar. The libraries would need to have safeguards with parameters of access or limitations.

Surguine asked how and by whom the expansion of scanning records to an electronic format would be paid. Janisch said that universities and some private sector funds may cover it. He said he didn't know if the liquidation office would be a partial funding source. He said it is prominent for these libraries to hold these collections. They have a student workforce. Fees could be charged for the duplication of these records to essentially sustain the maintenance of this collection. He said that he did not think the cost would be a factor. He said there is also an educational purpose in looking at these insolvencies later through data analytics.

Baldwin said the Working Group would take note of the topics in the presentation. No further Working Group members had comments or questions for the presenters. Baldwin asked Arcina to send any further comments it wishes to share with the Working Group.

Having no further business, the Receivership Law (E) Working Group adjourned.

SharePoint/NAIC Support Staff Hub/Member Meetings/2023 NAIC Meetings/Summer National Meeting/E Committee/RITF/
072423_RLWGmin.docx

Draft: 6/20/23

Receivership Law (E) Working Group
Virtual Meeting
May 23, 2023

The Receivership Law (E) Working Group of the Receivership and Insolvency (E) Task Force met May 23, 2023. The following Working Group members participated: Kevin Baldwin, Co-Chair (IL); Laura Lyon Slaymaker, Co-Chair (PA); Michael Sarguine (AR); Joe Holloway (CA); Jack Broccoli (CT); Miriam Victorian (FL); Kim Cross (IA); Tom Travis (LA); Christopher Joyce (MA); Robert Wake (ME); Tom Mitchell (MI); Shelley Forrest (MO); Lindsay Crawford (NE); Shawn Martin (TX); and Charles Malone (WA).

1. Exposed Amendments to Model #540A. ITBs and CDs Amendments

Baldwin said the Working Group met Nov. 7, 2022, to discuss comments from Maine on the original exposure of proposed amendments to the *Property and Casualty Insurance Guaranty Association Model Act* (#540). The purpose of the amendments is to address guaranty fund coverage for policies that are included in insurance business transfers (IBTs) and corporate divisions (CDs). The Working Group formed a drafting group that met four times, had many email exchanges, and went through several drafts. The drafting group has two new versions of the amendments to present to the Working Group and seeks feedback on each version to settle on a single version.

Wake summarized the proposed amendments in version one (Attachment Three-A1) and the document describing the amendments (Attachment Three-A2). He said the drafting group considered four different points of entry. There are various ways to get to the results, such as by amending the definitions of covered claim, insolvent insurer, or assumed claims transaction, or by expanding membership. The National Conference of Insurance Guaranty Funds (NCIGF) showed him a definition of a New Hampshire law that was simple and clean. After some technical work, proposed paragraph 5G(2) could be added to the definition of covered claim. He said he did not distinguish between other types of transactions because, with few exceptions, there was not any point in choosing which would get coverage preserved and which would not. He said the mandate was to start with IBTs and CDs, but he feels there is strong public policy consensus that the same thing is wanted for transactions like mergers and common law novation, except transactions where policies are commuted into a captive and still have guaranty fund coverage. Wake said the one complexity with version one is that he was asked to consider other transactions where a member insurer did not write the original coverage. Either it was self-insured or written in surplus lines or by a captive. He has not seen any real-life examples of such a transaction. Generally speaking, if an insurer wanted to bring something into the admitted market, it would write a substitute policy. Because some asked for language that did not take away anything, optional language was added with a long drafting note in paragraph 5G(3). He said version one is simpler because it gets rid of some definitions, but it does make a lot of changes to the existing model by deleting verbiage. He said his summary document includes a comparison matrix like the matrix provided for version two. He said he disagrees with what transactions in version two are covered.

Barbara F. Cox (Barbara F. Cox LLC) summarized the NCIGF comments on version one (Attachment Three-A3). She said NCIGF supports a stand-alone paragraph 5G(2) in the first paragraph of version one to the covered claim definition. She said NCIGF does not support 5G(3). She said NCIGF feels it goes beyond the charge. She said version two allows coverage for an IBT started with a nonmember insurer to a member. That is not consistent with the charge that says guaranty fund coverage should be unchanged or retained, nor is it consistent with the Restructuring Mechanisms (E) Working Group's latest drafts, which it has not finalized. She said every discussion

and document she has reviewed calls for guaranty fund coverage to remain unchanged. In the context of IBTs and CDs, version two goes beyond that. It is more than what is needed. NCIGF's support is for a stand-alone paragraph 5G(2). NCIGF does not support paragraph 5G(3). NCIGF is neutral on any idea of assessing a nonmember that becomes a member in a post-insolvency assessment context. That does not make sense. If the claim started in a member insurer, they would pay the assessment if any was due in the year the policy was issued. Version one includes an optional concept to look at the claim volume that is transferred and assess based on some percentage of that amount if it is unclear whether there was an assessment and the percentage the assessment should have been.. NCIGF is neutral on that idea and observes that it adds some complexity that would be cleaner with just a stand-alone 5G(2). Wake added that the optional assessment language was added as part of the request to keep the substance of everything in the existing model. He does not feel it is needed since few states have adopted that language.

Patrick Cantilo (Cantilo and Bennett LLP) summarized the proposed amendments in version two (Attachment Three-A4) and the document describing the amendments (Attachment Three-A5). He said version two entails only changing paragraph 5H(1). It adds the language required to include IBTs and CDs so that claims arising under a policy assumed by doing IBTs or CDs would be covered. He said version two offers alternative language that works the same way in that they amend the same section. He said the reason for the alternatives in version two is that most states have not adopted the assumed claims language. He said if a state wants to have a version of the statute that does not refer to assumed claims language, then alternatives one and two accomplish that. Alternatives also address if the transferee is a nonmember and the transferor is a nonmember. Each alternative only amends paragraph 5H(1). He said he also offers a definition for IBT and CD that may or may not be necessary. Cantilo said the main difference between his version two and Wake's version one, aside from whether one is viewed as simpler, is that version two does not overtly eliminate the possibility of coverage that arose from a non-member to within guaranty association coverage once a member assumes it. Those transactions may be rare. It was an issue for the Reciprocal of America situation in which half of the workers' compensation business had been assumed from a self-insured trust. Reciprocal of America became insolvent before replacement policies were issued for much of that business. In that case, it eventually became a covered business and was treated like any other business. That situation may or may not happen again. Cantilo said if the Working Group only wants to ensure that Model #540 preserves coverage for IBTs and CDs, version two accomplishes that. If the Working Group wants to go further and eliminate the possibility of having assumed claim language, then additional amendments would be required. He said he does not believe that is part of the charge.

Cox asked if version two carves out guaranty fund coverage for an IBT or CD originating with a nonmember going to a member. Cox said the matrix in Cantilo's explanation document shows nonmember to member would be guaranty fund covered, so she said it does include that. Cantilo said he did not think it was part of the charge, but it would be a simple change to make if the Receivership and Insolvency (E) Task Force wants to take that track.

Wake said his understanding of alternatives two and three in version two address member-to-nonmember transactions because otherwise, the insurer must be an insolvent insurer to have coverage, which means the transferee must be a member insurer to become an insolvent insurer. Cantilo said the question is if there are states that do not want to cover member-to-nonmember. The other three alternatives allow states to adopt such language consistent with their views. The first alternative for a member-to-nonmember transfer is covered. Wake said that regarding Reciprocal of America, he received from Cantilo a Virginia opinion where the insurer had issued replacement policies even if the document did not say it was a replacement policy.

Wake made a motion, seconded by Mitchell, to expose version one without the optional language for a 30-day comment period ending June 23. The motion passed with Massachusetts opposing. Joyce said he understands Cantilo's position and has concerns about exposing version one without the optional language. Wake said he could expose it either way. Mitchell said he echoes Cox's comments referring to the scope of the original request to

modify the law. It seems outside the scope to create coverage rather than retain and continue coverage. However, if it is the will of the Working Group, he does not oppose exposing the optional language. Surguine said he liked the procedure under the assumption of reinsurance laws where policyholders get notice. A transaction does not bind policyholders unless they get notice and opt-in. He does not like the part of IBT laws that can force policyholders into a transaction. However, Arkansas has already enacted an IBT statute. Wake said he is sympathetic to Surguine. He said that even if a state has not passed an IBT statute, other states have adopted such statutes. He said policyholders should not be penalized.

Wake made a motion, seconded by Joyce, to expose version one with the optional language for a 30-day comment period ending June 23. The motion passed unanimously.

B. Cybersecurity Insurance Amendments

Baldwin said the Request for NAIC Model Law Development to amend Model #540 to clarify guaranty fund coverage of cybersecurity insurance was approved by the Executive (EX) Committee at the 2023 Spring National Meeting.

Cox summarized the NCIGF's proposed amendments to Model #540 for cybersecurity insurance (Attachment Three-A6). She said cybersecurity insurance is different from what has been dealt with before in insolvencies. Along with indemnity coverage, cybersecurity insurance also includes various services such as mitigation of losses, notices to potential persons whose data have been breached, and even ransom negotiations and payments. One of the characteristics is the immediacy of the insurance company to respond. A member insurer presented to NCIGF and said the insurer is the firehouse, not the clean-up crew. If a breach occurs, the insurer needs to be prepared to respond immediately. The proposed amendments include:

- Clarification of coverage. Some may conclude that cyber may not be covered.
- A definition of cybersecurity insurance.
- Powers and duties to tie all losses paid by the guaranty funds triggered by the cyber event not to exceed \$500,000. There was no claim loss volume reporting to use. NCIGF had to use other sources to determine whether this covered claim cap would cover a small to medium size business.
- Clarification that the guaranty funds have the right to appoint and direct other services providers, such as legal, notice, mitigation, forensics, etc.
- Provides that coverage may be paid for high-net-worth insureds even if the state has high-net-worth exclusion due to the immediacy of the need to address claims. If the insured is later determined to exceed the net worth limitation, that loss could be addressed later.

Wake asked if a definition of covered services is needed and how that affects the claim limit. Cox said NCIGF would not object to further clarification on covered services. She said the \$500,000 limit is intended to be all-inclusive. Any residual amount is turned over to the estate and settled in due course. Wake said there are services under other policies, so it may not be an issue. Cox said some states have limits on defense costs.

Wake made a motion, seconded by Kaumann, to expose the proposed amendments for cybersecurity insurance for a 30-day comment period ending June 23. The motion passed unanimously.

Having no further business, the Receivership Law (E) Working Group adjourned.

IBT/CD DRAFT VERSION #1
5/23/23

NAIC Model Laws, Regulations, Guidelines and Other Resources—April 2009

PROPERTY AND CASUALTY INSURANCE GUARANTY ASSOCIATION MODEL ACT**Table of Contents**

Section 1.	Title
Section 2.	Purpose
Section 3.	Scope
Section 4.	Construction
Section 5.	Definitions
Section 6.	Creation of the Association
Section 7.	Board of Directors
Section 8.	Powers and Duties of the Association
Section 9.	Plan of Operation
Section 10.	Duties and Powers of the Commissioner
Section 11.	Coordination Among Guaranty Associations
Section 12.	Effect of Paid Claims
Section 13.	[Optional] Net Worth Exclusion
Section 14.	Exhaustion of Other Coverage
Section 15.	Prevention of Insolvencies
Section 16.	Tax Exemption
Section 17.	Recoupment of Assessments
Section 18.	Immunity
Section 19.	Stay of Proceedings

Section 1. Title

This Act shall be known as the [State] Insurance Guaranty Association Act.

Section 2. Purpose

The purpose of this Act is to provide a mechanism for the payment of covered claims under certain insurance policies, to avoid excessive delay in payment and to the extent provided in this Act minimize financial loss to claimants or policyholders because of the insolvency of an insurer, and to provide an association to assess the cost of such protection among insurers.

Section 3. Scope

This Act shall apply to all kinds of direct insurance, but shall not be applicable to the following:

- A. Life, annuity, health or disability insurance;
- B. Mortgage guaranty, financial guaranty or other forms of insurance offering protection against investment risks;
- C. Fidelity or surety bonds, or any other bonding obligations;
- D. Credit insurance, vendors' single interest insurance, or collateral protection insurance or any similar insurance protecting the interests of a creditor arising out of a creditor-debtor transaction;
- E. Insurance of warranties or service contracts including insurance that provides for the repair, replacement or service of goods or property, indemnification for repair, replacement or service for the operational or structural failure of the goods or property due to a defect in materials, workmanship or normal wear and tear, or provides reimbursement for the liability incurred by the issuer of agreements or service contracts that provide such benefits;

MO-540-1

Property and Casualty Insurance Guaranty Association Model Act

- F. Title insurance;
- G. Ocean marine insurance;
- H. Any transaction or combination of transactions between a person (including affiliates of such person) and an insurer (including affiliates of such insurer) which involves the transfer of investment or credit risk unaccompanied by transfer of insurance risk; or
- I. Any insurance provided by or guaranteed by government.

Drafting Note: This Act focuses on property and liability kinds of insurance and therefore exempts those kinds of insurance deemed to present problems quite distinct from those of property and liability insurance. The Act further precludes from its scope certain types of insurance that provide protection for investment and financial risks. Financial guaranty is one of these. The NAIC Life and Health Insurance Guaranty Association Model Act provides for coverage of some, of the lines excluded by this provision.

For purposes of this section, "Financial guaranty insurance" includes any insurance under which loss is payable upon proof of occurrence of any of the following events to the damage of an insured claimant or obligee:

1. Failure of any obligor or obligors on any debt instrument or other monetary obligation, including common or preferred stock, to pay when due the principal, interest, dividend or purchase price of such instrument or obligation, whether failure is the result of a financial default or insolvency and whether or not the obligation is incurred directly or as guarantor by, or on behalf of, another obligor which has also defaulted;
2. Changes in the level of interest rates whether short term or long term, or in the difference between interest rates existing in various markets;
3. Changes in the rate of exchange of currency, or from the inconvertibility of one currency into another for any reason;
4. Changes in the value of specific assets or commodities, or price levels in general.

For purposes of this section, "credit insurance" means insurance on accounts receivable.

The terms "disability insurance" and "accident and health insurance," and "health insurance" are intended to be synonymous. Each State will wish to examine its own statutes to determine which is the appropriate phrase.

A State where the insurance code does not adequately define ocean marine insurance may wish to add the following to Section 5, Definitions: "Ocean marine insurance" means any form of insurance, regardless of the name, label or marketing designation of the insurance policy, which insures against maritime perils or risks and other related perils or risks, which are usually insured against by traditional marine insurance, such as hull and machinery, marine builders risk, and marine protection and indemnity. Perils and risk insured against include without limitation loss, damage, expense or legal liability of the insured for loss, damage or expense arising out of or incident to ownership, operation, chartering, maintenance, use, repair or construction of any vessel, craft or instrumentality in use in ocean or inland waterways for commercial purposes, including liability of the insured for personal injury, illness or death or for loss or damage to the property of the insured or another person.

Section 4. Construction

This Act shall be construed to effect the purpose under Section 2 which will constitute an aid and guide to interpretation.

Section 5. Definitions

As used in this Act:

[Optional:

- A. "Account" means any one of the three accounts created by Section 6.]

Drafting Note: This definition should be used by those States wishing to create separate accounts for assessment purposes. For a note on the use of separate accounts for assessments see the Drafting Note after Section 6. If this definition is used, all subsequent subsections should be renumbered.

- A. "Affiliate" means a person who directly, or indirectly, through one or more intermediaries, controls, is controlled by, or is under common control with another person on December 31 of the year immediately preceding the date the insurer becomes an insolvent insurer.
- B. "Association" means the [State] Insurance Guaranty Association created under Section 6.
- C. "Association similar to the association" means any guaranty association, security fund or other insolvency mechanism that affords protection similar to that of the association. The term shall also include any property

MO-540-2

IBT/CD DRAFT VERSION #1
5/23/23

NAIC Model Laws, Regulations, Guidelines and Other Resources—April 2009

and casualty insolvency mechanism that obtains assessments or other contributions from insurers on a pre-insolvency basis.

Drafting Note: There are two options for handling claims assumed by a licensed carrier from an unlicensed carrier or self-insurer. Alternative 1 provides that these claims shall be covered by the guaranty association if the licensed insurer becomes insolvent subsequent to the assumption. Alternative 2 provides coverage only if the assuming carrier makes a payment to the guaranty association in an amount equal to that which the assuming carrier would have paid in guaranty association assessments had the insurer written the assumed business itself. If a State wishes to adopt Alternative 1, it must select Alternative 1 in Section 5D and Alternative 1a or 2a in Section 8A(3). If a State wishes to adopt Alternative 2, it must select Alternative 2 in Section 5D and Q and Alternative 1b or 2b in Section 8A(3).

Policy obligations that have been assumed by the insolvent insurer, prior to the entry of a

D. ~~_____~~ [Alternative 1] “Assumed claims transaction” means the following:

- (1) ~~_____~~ Policy obligations that have been assumed by the insolvent insurer, prior to the entry of a final order of liquidation, through a merger between the insolvent insurer and another entity obligated under the policies; or
- (2) ~~_____~~ An assumption reinsurance transaction in which all of the following has occurred:
 - (a) ~~_____~~ The insolvent insurer assumed, prior to the entry of a final order of liquidation, the claim or policy obligations of another insurer or entity obligated under the claims or policies; and
 - (b) ~~_____~~ The assumption of the claim or policy obligations has been approved, if such approval is required, by the appropriate regulatory authorities; and
 - (c) ~~_____~~ As a result of the assumption, the claim or policy obligations became the direct obligations of the insolvent insurer through a novation of the claims or policies

~~_____~~ [Alternative 2] “Assumed claims transaction” means the following:

- (1) ~~_____~~ Policy obligations that have been assumed by the insolvent insurer, prior to the entry of a final order of liquidation, through a merger between the insolvent insurer and another entity obligated under the policies, and for which Assumption Consideration has been paid to the applicable guaranty associations, if the merged entity is a non-member insurer; or
- (2) ~~_____~~ Policy obligations that have been assumed by the insolvent insurer, prior to the entry of a final order of liquidation, pursuant to a plan, approved by the domestic commissioner of the assuming insurer, which:
 - (a) ~~_____~~ Transfers the direct policy obligations and future policy renewals from one insurer to another insurer; and
 - (b) ~~_____~~ For which Assumption Consideration has been paid to the applicable guaranty associations, if the assumption is from a non-member insurer.
 - (c) ~~_____~~ For purposes of this section the term non-member insurer also includes a self-insurer, non-admitted insurer and risk retention group; or
- (3) ~~_____~~ An assumption reinsurance transaction in which all of the following has occurred:
 - (a) ~~_____~~ The insolvent insurer assumed, prior to the entry of a final order of liquidation, the claim or policy obligations of another insurer or entity obligated under the claims or policies;
 - (b) ~~_____~~ The assumption of the claim or policy obligations has been approved, if such approval is required, by the appropriate regulatory authorities; and As a result of the assumption, the claim or policy obligations became the direct obligations of the insolvent insurer through a novation of the claims or policies.

MO-540-3

Property and Casualty Insurance Guaranty Association Model Act

D.E. "Claimant" means any person instituting a covered claim, provided that no person who is an affiliate of the insolvent insurer may be a claimant.

E.F. "Commissioner" means the Commissioner of Insurance of this State.

Drafting Note: Use the appropriate title for the chief insurance regulatory official wherever the term "commissioner" appears.

F.G. "Control" means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or nonmanagement services, or otherwise, unless the power is the result of an official position with or corporate office held by the person. Control shall be presumed to exist if a person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing, ten percent (10%) or more of the voting securities of any other person. This presumption may be rebutted by a showing that control does not exist in fact.

G.H. "Covered claim" means the following:

(1) An unpaid claim, including one for unearned premiums, submitted by a claimant, which arises out of and is within the coverage and is subject to the applicable limits of an insurance policy to which this Act applies, if the policy was issued by an insurer that becomes an insolvent insurer after the effective date of this Act and: ~~the policy was either issued by the insurer or assumed by the insurer in an assumed-claims transaction; and and~~

- (a) The claimant or insured is a resident of this State at the time of the insured event, provided that for entities other than an individual, the residence of a claimant, insured or policyholder is the State in which its principal place of business is located at the time of the insured event; or
- (b) The claim is a first party claim for damage to property with a permanent location in this State.

(2) ~~"Covered claim" includes claim obligations that arose through the issuance of an insurance policy by a member insurer, which are later allocated, transferred, merged into, novated, assumed by, or otherwise made the sole responsibility of a member or non-member insurer if:~~

- ~~(a) The original member insurer has no remaining obligations on the policy after the transfer;~~
- ~~(b) A final order of liquidation with a finding of insolvency has been entered against the insurer that assumed the member's coverage obligations by a court of competent jurisdiction in the insurer's State of domicile;~~
- ~~(c) The claim would have been a covered claim, as defined in Paragraph (1), if the claim had remained the responsibility of the original member insurer and the order of liquidation had been entered against the original member insurer, with the same claim submission date and liquidation date; and~~
- ~~(d) In cases where the member's coverage obligations were assumed by a non-member insurer, the transaction received prior regulatory or judicial approval.~~

Optional:

(3) *"Covered claim" includes claim obligations that were originally covered by a non-member insurer, including but not limited to a self-insurer, non-admitted insurer or risk retention group, but subsequently became the sole direct obligation of a member insurer before the entry of a final order of liquidation with a finding of insolvency against the member insurer by a court of competent jurisdiction in its State of domicile, if the claim obligations were assumed by the member insurer in a transaction of one of the following types:*

Commented [Staff1]: If the Working Group agrees to include a second alternative or optional "covered claim" provision, it would be labeled as "Alternative" provisions.

MO-540-4

IBT/CD DRAFT VERSION #1
5/23/23

NAIC Model Laws, Regulations, Guidelines and Other Resources—April 2009

- (a) *A merger in which the surviving company was a member insurer immediately after the merger;*
- (b) *An assumption reinsurance transaction that received any required approvals from the appropriate regulatory authorities; or*
- (c) *A transaction entered into pursuant to a plan approved by the member insurer's domiciliary regulator.*

Drafting Note for Covered Claims definition:- TBD

Drafting Note for Alternative Two: Optional Subsection G(3) provides coverage for certain that are not within the scope of Paragraphs (1) or (2) because the original coverage was not provided by a member insurer. Subparagraphs (a) and (b) are based on Alternative 1 for the former definition of "assumed claims transaction." (below) and Subparagraph (3) is based on the additional scenario included in Alternative 2.

Regarding the Definition of "Assumed Claims Transaction": There are two options for handling claims assumed by a licensed carrier from an unlicensed carrier or self insurer. Alternative 1 provides that these claims shall be covered by the guaranty association if the licensed insurer becomes insolvent subsequent to the assumption. Alternative 2 provides coverage only if the assuming carrier makes a payment to the guaranty association in an amount equal to that which the assuming carrier would have paid in guaranty association assessments had the insurer written the assumed business itself. If a State wishes to adopt Alternative 1, it must select Alternative 1 in Section 5D and Alternative 1a or 2a in Section 8A(3). If a State wishes to adopt Alternative 2, it must select Alternative 2 in Section 5D and O and Alternative 1b or 2b in Section 8A(3).

Policy obligations that have been assumed by the insolvent insurer, prior to the entry of a

[Assumed Claims Transaction Definition Alternative 1] "Assumed claims transaction" means the following:

- (1) Policy obligations that have been assumed by the insolvent insurer, prior to the entry of a final order of liquidation, through a merger between the insolvent insurer and another entity obligated under the policies; or
- (2) An assumption reinsurance transaction in which all of the following has occurred:
 - (a) The insolvent insurer assumed, prior to the entry of a final order of liquidation, the claim or policy obligations of another insurer or entity obligated under the claims or policies; and
 - (b) The assumption of the claim or policy obligations has been approved, if such approval is required, by the appropriate regulatory authorities; and
 - (c) As a result of the assumption, the claim or policy obligations became the direct obligations of the insolvent insurer through a novation of the claims or policies

[Assumed Claims Transaction Definition Alternative 2] "Assumed claims transaction" means the following:

- (1) Policy obligations that have been assumed by the insolvent insurer, prior to the entry of a final order of liquidation, through a merger between the insolvent insurer and another entity obligated under the policies, and for which Assumption Consideration has been paid to the applicable guaranty associations, if the merged entity is a non-member insurer; or
- (2) Policy obligations that have been assumed by the insolvent insurer, prior to the entry of a final order of liquidation, pursuant to a plan, approved by the domestic commissioner of the assuming insurer, which:
 - (a) Transfers the direct policy obligations and future policy renewals from one insurer to another insurer; and
 - (b) For which Assumption Consideration has been paid to the applicable guaranty associations, if the assumption is from a non-member insurer;
 - (c) For purposes of this section the term non-member insurer also includes a self-insurer, non-admitted insurer and risk retention group; or
- (3) An assumption reinsurance transaction in which all of the following has occurred:
 - (a) The insolvent insurer assumed, prior to the entry of a final order of liquidation, the claim or policy obligations of another insurer or entity obligated under the claims or policies;
 - (b) The assumption of the claim or policy obligations has been approved, if such approval is required, by the appropriate regulatory authorities; and

Commented [Staff2]: If the Working Group agrees to include both G(3) options above rather than selecting one, they would be labeled Alternative One and Alternative Two. Staff recommends including an explanation of the differences between the two alternatives. (Yet to be drafted)

MO-540-5

Property and Casualty Insurance Guaranty Association Model Act

~~(c) As a result of the assumption, the claim or policy obligations became the direct obligations of the insolvent insurer through a novation of the claims or policies.~~

(32) Except as provided elsewhere in this section, “covered claim” shall not include:

- (a) Any amount awarded as punitive or exemplary damages;
- (b) Any amount sought as a return of premium under any retrospective rating plan;
- (c) Any amount due any reinsurer, insurer, insurance pool or underwriting association, health maintenance organization, hospital plan corporation, professional health service corporation or self-insurer as subrogation recoveries, reinsurance recoveries, contribution, indemnification or otherwise. No claim for any amount due any reinsurer, insurer, insurance pool, underwriting association, health maintenance organization, hospital plan corporation, professional health service corporation or self-insurer may be asserted against a person insured under a policy issued by an insolvent insurer other than to the extent the claim exceeds the association obligation limitations set forth in Section 8 of this Act;
- (d) Any claims excluded pursuant to Section 13 due to the high net worth of an insured;
- (e) Any first party claims by an insured that is an affiliate of the insolvent insurer;
- (f) Any fee or other amount relating to goods or services sought by or on behalf of any attorney or other provider of goods or services retained by the insolvent insurer or an insured prior to the date it was determined to be insolvent;
- (g) Any fee or other amount sought by or on behalf of any attorney or other provider of goods or services retained by any insured or claimant in connection with the assertion or prosecution of any claim, covered or otherwise, against the association;
- (h) Any claims for interest; ~~or~~
- (i) ~~(+)~~ Any claim filed with the association or a liquidator for protection afforded under the insured’s policy for incurred-but-not-reported losses.

Drafting note: The language in this provision referring to claims for incurred-but-not-reported losses has been inserted to expressly include the existing intent of this provision and make it clear that “policyholder protection” proofs of claim, while valid to preserve rights against the ~~State-estate~~ of the insolvent insurer under the Insurer Receivership Model Act, are not valid to preserve rights against the association.

II. “Insolvent insurer” means an insurer that is licensed to transact insurance in this State, either at the time the policy was issued, ~~when the obligation with respect to the covered claim was assumed under an assumed claims transaction,~~ or when the insured event occurred, and against whom a final order of liquidation has been entered after the effective date of this Act with a finding of insolvency by a court of competent jurisdiction in the insurer’s State of domicile.

Drafting Note: “Final order” as used in this section means an order which has not been stayed. States in which the “final order” language does not accurately reflect whether or not the order is subject to a stay should substitute appropriate language consistent with the statutes or rules of the State to convey the intended meaning.

II. “Insured” means any named insured, any additional insured, any vendor, lessor or any other party identified as an insured under the policy.

III. (1) “Member insurer” means any person who:

- (a) Writes any kind of insurance to which this Act applies under Section 3, including the exchange of reciprocal or inter-insurance contracts; and

MO-540-6

IBT/CD DRAFT VERSION #1
5/23/23

NAIC Model Laws, Regulations, Guidelines and Other Resources—April 2009

- (b) Is licensed to transact insurance in this State (except at the option of the State).
- (2) An insurer shall cease to be a member insurer effective on the day following the termination or expiration of its license to transact the kinds of insurance to which this Act applies, however, the insurer shall remain liable as a member insurer for any and all obligations, including obligations for assessments levied prior to the termination or expiration of the insurer's license and assessments levied after the termination or expiration, which relate to any insurer that became an insolvent insurer prior to the termination or expiration of the insurer's license.

~~KL.~~ "Net direct written premiums" means direct gross premiums written in this State on insurance policies to which this Act applies, including policy and membership fees, less the following amounts: (1) return premiums, (2) premiums on policies not taken, and (3) dividends paid or credited to policyholders on that direct business. "Net direct written premiums" does not include premiums on contracts between insurers or reinsurers.

~~[Optional]~~

~~K.~~ "Net direct written premiums" means direct gross premiums written in this State on insurance policies to which this Act applies, including policy and membership fees and including all premiums and other compensation collected by a member insurer for obligations assumed under a transaction described in Subsection G(3), less the following amounts: (1) return premiums, (2) premiums on policies not taken, and (3) dividends paid or credited to policyholders on that direct business. "Net direct written premiums" does not include premiums on contracts between insurers or reinsurers, other than compensation received for entering into a transaction described in Subsection G(3).

Commented [Staff3]: Similar comment as above. The RLWG can determine to keep two alternative definitions of K or select one corresponding to G(3).

Drafting Note: The optional version of Subsection K is for states that have adopted optional Subsection G(3).

~~LLM.~~ "Novation" means that the assumed claim or policy obligations became the direct obligations of the insolvent insurer through consent of the policyholder and that thereafter the ceding insurer or entity initially obligated under the claims or policies is released by the policyholder from performing its claim or policy obligations. Consent may be express or implied based upon the circumstances, notice provided and conduct of the parties.

~~MN.~~ "Person" means any individual, aggregation of individuals, corporation, partnership or other entity.

~~MNO.~~ "Receiver" means liquidator, rehabilitator, conservator or ancillary receiver, as the context requires.

Drafting Note: Each State should conform the definition of "receiver" to the definition used in the State's insurer receivership act.

~~PON.~~ "Self-insurer" means a person that covers its liability through a qualified individual or group self-insurance program or any other formal program created for the specific purpose of covering liabilities typically covered by insurance.

~~Q.~~ ~~[Alternative 2b]~~ "Assumption Consideration" shall mean the consideration received by a guaranty association to extend coverage to the policies assumed by a member insurer from a non-member insurer in any assumed claims transaction including liabilities that may have arisen prior to the date of the transaction. The Assumption Consideration shall be in an amount equal to the amount that would have been paid by the assuming insurer during the three calendar years prior to the effective date of the transaction to the applicable guaranty associations if the business had been written directly by the assuming insurer.

~~In the event that the amount of the premiums for the three year period cannot be determined, the Assumption Consideration will be determined by multiplying 130% against the sum of the unpaid losses, loss adjustment expenses, and incurred but not reported losses, as of the effective date of the Assumed claims transaction, and then multiplying such sum times the applicable guaranty association assessment percentage for the calendar year of the transaction.~~

~~The funds paid to a guaranty association shall be allocated in the same manner as any assessments made during the three year period. The guaranty association receiving the Assumption Consideration shall not be~~

MO-540-7

Property and Casualty Insurance Guaranty Association Model Act

~~required to recalculate or adjust any assessments levied during the prior three calendar years as a result of receiving the Assumption Consideration. Assumption Consideration paid by an insurer may be recouped in the same manner as other assessments made by a guaranty association.~~

Section 6. Creation of the Association

There is created a nonprofit unincorporated legal entity to be known as the [State] Insurance Guaranty Association. All insurers defined as member insurers in Section 5K shall be and remain members of the association as a condition of their authority to transact insurance in this State. The association shall perform its functions under a plan of operation established and approved under Section 9 and shall exercise its powers through a board of directors established under Section 7.

[Alternate Section 6. Creation of the Association

There is created a nonprofit unincorporated legal entity to be known as the [State] Insurance Guaranty Association. All insurers defined as member insurers in Section 5K shall be and remain members of the association as a condition of their authority to transact insurance in this State. The association shall perform its functions under a plan of operation established and approved under Section 9 and shall exercise its powers through a board of directors established under Section 7. For purposes of administration and assessment, the association shall be divided into three separate accounts:

- A. *The workers' compensation insurance account;*
- B. *The automobile insurance account; and*
- C. *The account for all other insurance to which this Act applies.]*

Drafting Note: The alternate Section 6 should be used if a State, after examining its insurance market, determines that separate accounts for various kinds of insurance are necessary and feasible. The major consideration is whether each account will have a base sufficiently large to cover possible insolvencies. Separate accounts will permit assessments to be generally limited to insurers writing the same kind of insurance as the insolvent company. If this approach is adopted the provision of alternate Sections 8A(3) and 8B(6) and optional Section 5A should also be used.

Commented [Staff4]: Drafter Comment: This drafting note was written before the assumed claims provisions created a pair of "alternative alternatives." For consistency with the drafting note and "Alternate 8B(6), we should probably restore the original schematic for 8B(3)"

Section 7. Board of Directors

- A. The board of directors of the association shall consist of not less than five (5) nor more than [insert number] persons serving terms as established in the plan of operation. The insurer members of the board shall be selected by member insurers subject to the approval of the commissioner. Vacancies on the board shall be filled for the remaining period of the term by a majority vote of the remaining insurer members subject to the approval of the commissioner. If no members are selected within sixty (60) days after the effective date of this Act, the commissioner may appoint the initial members of the board of directors. Two (2) persons, who must be public representatives, shall be appointed by the commissioner to the board of directors. Vacancies of positions held by public representatives shall be filled by the commissioner. A public representative may not be an officer, director or employee of an insurance company or any person engaged in the business of insurance. For the purposes of this section, the term "director" shall mean an individual serving on behalf of an insurer member of the board of directors or a public representative on the board of directors.

Drafting Note: A State adopting this language should make certain that its insurance code includes a definition of "the business of insurance" similar to that found in the NAIC Insurer Receivership Model Act.

- B. In approving selections to the board, the commissioner shall consider among other things whether all member insurers are fairly represented.
- C. Members of the board of directors may be reimbursed from the assets of the association for reasonable expenses incurred by them as members of the board of directors.
- D. Any board member who is an insurer in receivership shall be terminated as a board member, effective as of the date of the entry of the order of receivership. Any resulting vacancies on the board shall be filled for the remaining period of the term in accordance with the provisions of Subsection A.
- E. In the event that a director shall, because of illness, nonattendance at meetings or any other reason, be deemed unable to satisfactorily perform the designated functions as a director by missing three consecutive board

MO-540-8

IBT/CD DRAFT VERSION #1
5/23/23

NAIC Model Laws, Regulations, Guidelines and Other Resources—April 2009

meetings, the board of directors may declare the office vacant and the member or director shall be replaced in accordance with the provisions of Subsection A.

- F. If the commissioner has reasonable cause to believe that a director failed to disclose a known conflict of interest with his or her duties on the board, failed to take appropriate action based on a known conflict of interest with his or her duties on the board, or has been indicted or charged with a felony, or misdemeanor involving moral turpitude, the commissioner may suspend that director pending the outcome of an investigation or hearing by the commissioner or the conclusion of any criminal proceedings. A company elected to the board may replace a suspended director prior to the completion of an investigation, hearing or criminal proceeding. In the event that the allegations are substantiated at the conclusion of an investigation, hearing or criminal proceeding, the office shall be declared vacant and the member or director shall be replaced in accordance with the provisions of Subsection A.

Section 8. Powers and Duties of the Association

- A. The association shall:

- (1) (a) Be obligated to pay covered claims existing prior to the order of liquidation, arising within thirty (30) days after the order of liquidation, or before the policy expiration date if less than thirty (30) days after the order of liquidation, or before the insured replaces the policy or causes its cancellation, if the insured does so within thirty (30) days of the order of liquidation. The obligation shall be satisfied by paying to the claimant an amount as follows:
- (i) The full amount of a covered claim for benefits under a workers' compensation insurance coverage;
 - (ii) An amount not exceeding \$10,000 per policy for a covered claim for the return of unearned premium;
 - (iii) An amount not exceeding \$500,000 per claimant for all other covered claims.
- (b) In no event shall the association be obligated to pay a claimant an amount in excess of the obligation of the insolvent insurer under the policy or coverage from which the claim arises. Notwithstanding any other provisions of this Act, a covered claim shall not include a claim filed with the guaranty fund after the final date set by the court for the filing of claims against the liquidator or receiver of an insolvent insurer.

For the purpose of filing a claim under this subsection, notice of claims to the liquidator of the insolvent insurer shall be deemed notice to the association or its agent and a list of claims shall be periodically submitted to the association or association similar to the association in another State by the liquidator.

Drafting Note: On the general subject of the relationship of the association to the liquidator, the working group/task force takes the position that since this is a model State bill, it will be able to bind only two parties, the association and the in-State liquidator. Nevertheless, the provisions should be clear enough to outline the requests being made to out-of-State liquidators and the requirements placed on in-State liquidators in relation to out-of-State associations.

Drafting Note: Because of its potential impact on guaranty association coverage, it is recommended that the legislation include an appropriate provision stating that the bar date only applies to claims in liquidation commencing after its effective date. Drafters should insure that the State's insurance liquidation act would permit, upon closure, payments to the guaranty association and any association similar to the association for amounts that are estimated to be incurred after closure for workers compensation claims obligations. The amounts should be payable on these obligations related to losses both known and not known at the point of closure.

- (c) Any obligation of the association to defend an insured shall cease upon the association's payment or tender of an amount equal to the lesser of the association's covered claim obligation limit or the applicable policy limit.

MO-540-9

Property and Casualty Insurance Guaranty Association Model Act

Drafting Note: The obligation of the association is limited to covered claims unpaid prior to insolvency, and to claims arising within thirty days after the insolvency, or until the policy is canceled or replaced by the insured, or it expires, whichever is earlier. The basic principle is to permit policyholders to make an orderly transition to other companies. There appears to be no reason why the association should become in effect an insurer in competition with member insurers by continuing existing policies, possibly for several years. It is also felt that the control of the policies is properly in the hands of the liquidator. Finally, one of the major objections of the public to rapid termination, loss of unearned premiums with no corresponding coverage, is ameliorated by this bill since unearned premiums are permissible claims, up to \$10,000, against the association. The maximums (\$10,000 for the return of unearned premium; \$500,000 for all other covered claims) represent the working group's concept of practical limitations, but each State will wish to evaluate these figures.

- (2) Be deemed the insurer to the extent of its obligation on the covered claims and to that extent, subject to the limitations provided in this Act, shall have all rights, duties and obligations of the insolvent insurer as if the insurer had not become insolvent, including but not limited to, the right to pursue and retain salvage and subrogation recoverable on covered claim obligations to the extent paid by the association. The association shall not be deemed the insolvent insurer for the purpose of conferring jurisdiction.

- (3) ~~[Alternative 1a]~~ Assess insurers amounts necessary to pay the obligations of the association under Subsection A(1) subsequent to an insolvency, the expenses of handling covered claims subsequent to an insolvency, and other expenses authorized by this Act. The assessments of each member insurer shall be in the proportion that the net direct written premiums of the member insurer for the calendar year preceding the assessment bears to the net direct written premiums of all member insurers for the calendar year preceding the assessment. Each member insurer shall be notified of the assessment not later than thirty (30) days before it is due. A member insurer may not be assessed in any year an amount greater than two percent (2%) of that member insurer's net direct written premiums for the calendar year preceding the assessment. If the maximum assessment, together with the other assets of the association, does not provide in any one year an amount sufficient to make all necessary payments, the funds available shall be prorated and the unpaid portion shall be paid as soon as funds become available. The association may exempt or defer, in whole or in part, the assessment of a member insurer, if the assessment would cause the member insurer's financial statement to reflect amounts of capital or surplus less than the minimum amounts required for a certificate of authority by a jurisdiction in which the member insurer is authorized to transact insurance. However, during the period of deferment no dividends shall be paid to shareholders or policyholders. Deferred assessments shall be paid when the payment will not reduce capital or surplus below required minimums. Payments shall be refunded to those companies receiving larger assessments by virtue of the deferment, or at the election of the company, credited against future assessments.

Commented [Staff5]: Drafter Comment: The existing Model has a matrix of four options because there are two independent toggles. We're getting rid of one of them, so we don't need two-level numbering anymore, and it should now be either "1 and 2" or "A and B." Also, the Model seems to have a typo in the second "Alternative" below.

~~[Alternative 2a] Assess insurers amounts necessary to pay the obligations of the association under Subsection A(1) subsequent to an insolvency, the expenses of handling covered claims subsequent to an insolvency, and other expenses authorized by this Act. The assessments of each member insurer shall be in the proportion that the net direct written premiums and any premiums received for an assumed contract after the effective date of an assumed claims transaction with a non-member insurer of the member insurer for the calendar year preceding the assessment bears to the net direct written premiums and any premiums received for an assumed contract after the effective date of an assumed claims transaction with a non-member insurer of all member insurers for the calendar year preceding the assessment. Each member insurer shall be notified of the assessment not later than thirty (30) days before it is due. A member insurer may not be assessed in any year an amount greater than two percent (2%) of that member insurer's net direct written premiums and any premiums received for an assumed contract after the effective date of an assumed claims transaction with a non-member insurer for the calendar year preceding the assessment. The 2% limitation on assessments shall not preclude a full payment for assumption consideration. If the maximum assessment, together with the other assets of the association, does not provide in any one year an amount sufficient to make all necessary payments, the funds available shall be prorated and the unpaid portion shall be paid as soon as funds become available. The association may exempt or defer, in whole or in part, the assessment of a member insurer, if the assessment would cause the member insurer's financial statement to reflect amounts of capital or surplus less than the minimum amounts required for a certificate of authority by a jurisdiction in which the member insurer is authorized to transact insurance. However, during the period of deferment no dividends shall be paid to shareholders or policyholders. Deferred assessments shall be paid when the payment will not reduce capital or surplus below required minimums. Payments shall be refunded to those~~

MO-540-10

IBT/CD DRAFT VERSION #1
5/23/23

NAIC Model Laws, Regulations, Guidelines and Other Resources—April 2009

companies receiving larger assessments by virtue of the deferment, or at the election of the company, credited against future assessments.

(3) ~~[Alternative Section 8A(3)(b)]~~

(3) Allocate claims paid and expenses incurred among the three (3) accounts separately, and assess member insurers separately for each account, amounts necessary to pay the obligations of the association under Subsection 8A(1) subsequent to an insolvency, the expenses of handling covered claims subsequent to an insolvency and other expenses authorized by this Act. The assessments of each member insurer shall be in the proportion that the net direct written premiums of the member insurer for the calendar year preceding the assessment on the kinds of insurance in the account bears to the net direct written premiums of all member insurers for the calendar year preceding the assessment on the kinds of insurance in the account. Each member insurer shall be notified of the assessment not later than thirty (30) days before it is due. A member insurer may not be assessed in any one year on any account an amount greater than two percent (2%) of that member insurer's net direct written premiums for the calendar year preceding the assessment on the kinds of insurance in the account. If the maximum assessment, together with the other assets of the association in any account, does not provide in any one year in any account an amount sufficient to make all necessary payments from that account, the funds available shall be pro-rated and the unpaid portion shall be paid as soon thereafter as funds become available. The association may exempt or defer, in whole or in part, the assessment of a member insurer, if the assessment would cause the member insurer's financial statement to reflect amounts of capital or surplus less than the minimum amounts required for a certificate of authority by a jurisdiction in which the member insurer is authorized to transact insurance. However, during the period of deferment no dividends shall be paid to shareholders or policyholders. Deferred assessments shall be paid when the payment will not reduce capital or surplus below required minimums. Payments shall be refunded to those companies receiving larger assessments by virtue of such deferment, or at the election of the company, credited against future assessments. A member insurer may set off against any assessment, authorized payments made on covered claims and expenses incurred in the payment of claims by the member insurer if they are chargeable to the account for which the assessment is made.]

Commented [Staff6]: Drafter Comment: See Comment to Section 6 Drafting Note

[Optional:

(4) Assess member insurers that have entered into transactions described in Section 5G(3), in addition to the assessment levied under Paragraph (3), an amount reflecting liabilities that may have arisen before the date of the transaction. The assessment under this paragraph is not subject to the annual percentage limitation under Paragraph (3) and shall be the amount that would have been paid by the assuming insurer under Paragraph (3) during the three calendar years preceding the effective date of the transaction if the business had been written directly by the assuming insurer. If the amount of the applicable premiums for the three year period cannot be determined, the assessment shall be 130% of the sum of the unpaid losses, loss adjustment expenses, and incurred but not reported losses, as of the effective date of the assumed claims transaction, multiplied by the applicable guaranty association assessment percentage for the calendar year of the transaction.]

Drafting Note: Optional Paragraph (4) is for states that have adopted Alternative Section 5G(2) and choose to require an additional "assumption consideration" assessment when claim obligations are assumed from an entity other than a member insurer.]

(3) ~~[Alternate 2b] Allocate claims paid and expenses incurred among the three (3) accounts separately, and assess member insurers separately for each account, amounts necessary to pay the obligations of the association under Subsection 8A(1) subsequent to an insolvency, the expenses of handling covered claims subsequent to an insolvency and other expenses authorized by this Act. The assessments of each member insurer shall be in the proportion that the net direct written premiums and any premiums received for an assumed contract after the effective date of an assumed claims transaction with a non-member insurer of the member insurer for the calendar year preceding the assessment on the kinds of insurance in the account bears to the net direct written premiums and any premiums received for an assumed contract after the effective date of an assumed claims transaction with a non-member insurer of all member insurers for the calendar year preceding the assessment on the kinds of insurance in the account. Each member insurer shall be notified of the assessment~~

Commented [Staff7]: Drafter Comment: Note that the bracket was never deleted from the end of 1b and 2b when it was deleted from the beginning as the four-way mix-and-match was adopted.

MO-540-11

Property and Casualty Insurance Guaranty Association Model Act

not later than thirty (30) days before it is due. A member insurer may not be assessed in any one year on any account an amount greater than two percent (2%) of that member insurer's net direct written premiums and any premiums received for an assumed contract after the effective date of an assumed claims transaction with a non-member insurer for the calendar year preceding the assessment on the kinds of insurance in the account. The 2% limitation on assessments shall not preclude a full payment for assumption consideration. If the maximum assessment, together with the other assets of the association in any account, does not provide in any one year in any account an amount sufficient to make all necessary payments from that account, the funds available shall be pro-rated and the unpaid portion shall be paid as soon thereafter as funds become available. The association may exempt or defer, in whole or in part, the assessment of a member insurer, if the assessment would cause the member insurer's financial statement to reflect amounts of capital or surplus less than the minimum amounts required for a certificate of authority by a jurisdiction in which the member insurer is authorized to transact insurance. However, during the period of deferment no dividends shall be paid to shareholders or policyholders. Deferred assessments shall be paid when the payment will not reduce capital or surplus below required minimums. Payments shall be refunded to those companies receiving larger assessments by virtue of such deferment, or at the election of the company, credited against future assessments. A member insurer may set off against any assessment, authorized payments made on covered claims and expenses incurred in the payment of claims by the member insurer if they are chargeable to the account for which the assessment is made.]

- (4) Investigate claims brought against the association and adjust, compromise, settle and pay covered claims to the extent of the association's obligation and deny all other claims. The association shall pay claims in any order that it may deem reasonable, including the payment of claims as they are received from the claimants or in groups or categories of claims. The association shall have the right to appoint and to direct legal counsel retained under liability insurance policies for the defense of covered claims.
- (5) Notify claimants in this State as deemed necessary by the commissioner and upon the commissioner's request, to the extent records are available to the association.

Drafting Note: The intent of this paragraph is to allow, in exceptional circumstances, supplementary notice to that given by the domiciliary receiver.

- (6) (a) Have the right to review and contest as set forth in this subsection settlements, releases, compromises, waivers and judgments to which the insolvent insurer or its insureds were parties prior to the entry of the order of liquidation. In an action to enforce settlements, releases and judgments to which the insolvent insurer or its insureds were parties prior to the entry of the order of liquidation, the Association shall have the right to assert the following defenses, in addition to the defenses available to the insurer:
 - (i) The association is not bound by a settlement, release, compromise or waiver executed by an insured or the insurer, or any judgment entered against an insured or the insurer by consent or through a failure to exhaust all appeals, if the settlement, release, compromise, waiver or judgment was:
 - (I) Executed or entered within 120 days prior to the entry of an order of liquidation, and the insured or the insurer did not use reasonable care in entering into the settlement, release, compromise, waiver or judgment, or did not pursue all reasonable appeals of an adverse judgment; or
 - (II) Executed by or taken against an insured or the insurer based on default, fraud, collusion or the insurer's failure to defend.
 - (ii) If a court of competent jurisdiction finds that the association is not bound by a settlement, release, compromise, waiver or judgment for the reasons described in Subparagraph (a)(i), the settlement, release, compromise, waiver or judgment shall be set aside, and the association shall be permitted to defend any covered

MO-540-12

IBT/CD DRAFT VERSION #1
5/23/23

NAIC Model Laws, Regulations, Guidelines and Other Resources—April 2009

claim on the merits. The settlement, release, compromise, waiver or judgment may not be considered as evidence of liability or damages in connection with any claim brought against the association or any other party under this Act.

- (iii) The association shall have the right to assert any statutory defenses or rights of offset against any settlement, release, compromise or waiver executed by an insured or the insurer, or any judgment taken against the insured or the insurer.
- (b) As to any covered claims arising from a judgment under any decision, verdict or finding based on the default of the insolvent insurer or its failure to defend, the association, either on its own behalf or on behalf of an insured may apply to have the judgment, order, decision, verdict or finding set aside by the same court or administrator that entered the judgment, order, decision, verdict or finding and shall be permitted to defend the claim on the merits.
- (7) Handle claims through its own employees, one or more insurers, or other persons designated as servicing facilities, which may include the receiver for the insolvent insurer. Designation of a servicing facility is subject to the approval of the commissioner, but the designation may be declined by a member insurer.
- (8) Reimburse each servicing facility for obligations of the association paid by the facility and for expenses incurred by the facility while handling claims on behalf of the association and shall pay the other expenses of the association authorized by this Act.
- (9) Submit, not later than 90 days after the end of the association's fiscal year, a financial report for the preceding fiscal year in a form approved by the commissioner.

B. The association may:

- (1) Employ or retain persons as are necessary to handle claims and perform other duties of the association;
- (2) Borrow funds necessary to effect the purposes of this Act in accordance with the plan of operation;
- (3) Sue or be sued;
- (4) Negotiate and become a party to contracts necessary to carry out the purpose of this Act;
- (5) Perform other acts necessary or proper to effectuate the purpose of this Act;
- (6) Refund to the member insurers in proportion to the contribution of each member insurer to the association that amount by which the assets of the association exceed the liabilities, if at the end of any calendar year, the board of directors finds that the assets of the association exceed the liabilities of the association as estimated by the board of directors for the coming year.

[Alternate Section 8B(6)

- (6) *Refund to the member insurers in proportion to the contribution of each member insurer to that account that amount by which the assets of the account exceed the liabilities, if at the end of any calendar year, the board of directors finds that the assets of the association in any account exceed the liabilities of that account as estimated by the board of directors for the coming year.]*

Drafting Note: The working group/task force feels that the board of directors should determine the amount of the refunds to members when the assets of the association exceed its liabilities. However, since this excess may be quite small, the board is given the option of retaining all or part of it to pay expenses and possibly remove the need for a relatively small assessment at a later time.

C. Suits involving the association:

MO-540-13

Property and Casualty Insurance Guaranty Association Model Act

- (1) Except for actions by the receiver, all actions relating to or arising out of this Act against the association shall be brought in the courts in this State. The courts shall have exclusive jurisdiction over all actions relating to or arising out of this Act against the association.
- (2) The exclusive venue in any action by or against the association is in [designate appropriate court]. The association may, at its option, waive this venue as to specific actions.

*[Optional Section 8D**D.*

- (1) *The legislature finds:*
 - (a) *The potential for widespread and massive damage to persons and property caused by natural disasters such as earthquakes, windstorms, or fire in this State can generate insurance claims of such a number as to render numerous insurers operating within this State insolvent and therefore unable to satisfy covered claims;*
 - (b) *The inability of insureds within this State to receive payments of covered claims or to timely receive the payments creates financial and other hardships for insureds and places undue burdens on the State, the affected units of local government, and the community at large;*
 - (c) *The insolvency of a single insurer in a material amount or a catastrophic event may result in the same hardships as those produced by a natural disaster;*
 - (d) *The State has previously taken action to address these problems by adopting the [insert name of guaranty association act], which among other things, provides a mechanism for the payment of covered claims under certain insurance policies to avoid excessive delay in payment and to avoid financial loss to claimants or policyholders because of the insolvency of an insurer; and*
 - (e) *In order for the association to timely pay claims of insolvent insurers in this State and otherwise carry out its duties, the association may require additional financing options. The intent of the Legislature is to make those options available to the association in the event that a natural disaster such as an earthquake, windstorm, fire or material insolvency of any member insurer results in covered claim obligations currently payable by the association in excess of its capacity to pay from current funds and current assessments under Subsection A(3). In cases where the association determines that it is cost effective, the association may issue bonds as provided in this subsection. In determining whether to issue bonds, the association shall consider the transaction costs of issuing the bonds.*
- (2) *In the event a natural disaster such as an earthquake, windstorm, fire or material insolvency of any member insurer results in covered claim obligations currently payable by the association in excess of its capacity to pay from current funds and current assessments under Subsection 8A(3), the association, in its sole discretion, may by resolution request the [insert name of agency] Agency to issue bonds pursuant to [insert statutory authority], in such amounts as the association may determine to provide funds for the payment of covered claims and expenses related thereto. In the event bonds are issued, the association shall have the authority to annually assess member insurers for amounts necessary to pay the principal of, and interest on those bonds. Assessments collected pursuant to this authority shall be collected under the same procedures as provided in Subsection 8A(3) and, notwithstanding the two percent (2%) limit in Subsection 8A(3), shall be limited to an additional [insert percentage] percent of the annual net direct written premium in this State of each member insurer for the calendar year preceding the assessment. The commissioner's approval shall be required for any assessment greater than five percent (5%). Assessments collected pursuant to this authority may only be used for servicing the bond obligations provided for in this subsection and shall be pledged for that purpose.*
- (3) *In addition to the assessments provided for in this subsection, the association in its discretion, and after considering other obligations of the association, may utilize current funds of the association,*

MO-540-14

IBT/CD DRAFT VERSION #1
5/23/23

NAIC Model Laws, Regulations, Guidelines and Other Resources—April 2009

assessments made under Subsection 8A(3) and advances or dividends received from the liquidators of insolvent insurers to pay the principal and interest on any bonds issued at the board's request.

- (4) *Assessments under this subsection shall be payable in twelve (12) monthly installments with the first installment being due and payable at the end of the month after an assessment is levied, and subsequent installments being due not later than the end of each succeeding month.*
- (5) *In order to assure that insurers paying assessments levied under this subsection continue to charge rates that are neither inadequate nor excessive, within ninety (90) days after being notified of the assessments, each insurer that is to be assessed pursuant to this subsection shall make a rate filing for lines of business additionally assessed under this subsection. If the filing reflects a rate change that, as a percentage, is equal to the difference between the rate of the assessment and the rate of the previous year's assessment under this subsection, the filing shall consist of a certification so stating and shall be deemed approved when made. Any rate change of a different percentage shall be subject to the standards and procedures of [cite appropriate statutory authority for provisions on filing and approval of rates].*

Drafting Note: This provision should only be considered by those States that have serious concerns that circumstances could result in a substantial capacity problem resulting in unpaid or pro rata payment of claims. An association intending to consider this provision should first consult with experienced bond counsel in its State to identify an appropriate State agency or bonding authority to act as vehicle for issuing the bonds. That agency or authority's statute may also have to be amended to specifically authorize these types of bonds and to cross-reference this provision in the guaranty association law. It is possible that in some situations a new bonding authority may have to be created for this purpose.

Regardless of the vehicle used, it is important that the decision-making authority on whether bonds are needed and in what amounts be retained by the association's board.

The extent of additional assessment authority under this subsection has not been specified. When considering the amount of additional authority that will be needed, a determination should be made as to the amount of funds needed to service the bonds. More specifically, consideration should be given to the amount of the bonds to be issued, interest rate and the maturity date of the bonds. The association should be able to raise sufficient funds through assessments to pay the interest and retire the bonds after some reasonable period (e.g. ten (10) years). Subsection D(2) requires the Commissioner's approval before the association can impose an additional assessment in excess of 5%. This is to assure that the additional assessment will not result in financial hardship to the member insurers and additional insolvencies.

The intent of Subsection D(4) is to permit recoupment by member insurers of the additional cost of assessments under this subsection without any related regulatory approval. A State enacting this subsection may need to revise Subsection D(4) so that it conforms to the particular State's recoupment provisions, as well as the provisions on filing and approval of rates.]

MO-540-15

Property and Casualty Insurance Guaranty Association Model Act

Section 9. Plan of Operation

- A. (1) The association shall submit to the commissioner a plan of operation and any amendments to the plan of operation necessary or suitable to assure the fair, reasonable and equitable administration of the association. The plan of operation and amendments shall become effective upon approval in writing by the commissioner.
- (2) If the association fails to submit a suitable plan of operation within ninety (90) days following the effective date of this Act, or if at any time thereafter the association fails to submit suitable amendments to the plan, the commissioner shall, after notice and hearing, adopt reasonable rules necessary or advisable to effectuate the provisions of this Act. The rules shall continue in force until modified by the commissioner or superseded by a plan submitted by the association and approved by the commissioner.
- B. All member insurers shall comply with the plan of operation.
- C. The plan of operation shall:
- (1) Establish the procedures under which the powers and duties of the association under Section 8 will be performed;
 - (2) Establish procedures for handling assets of the association;
 - (3) Require that written procedures be established for the disposition of liquidating dividends or other monies received from the estate of the insolvent insurer;
 - (4) Require that written procedures be established to designate the amount and method of reimbursing members of the board of directors under Section 7;
 - (5) Establish procedures by which claims may be filed with the association and establish acceptable forms of proof of covered claims;
 - (6) Establish regular places and times for meetings of the board of directors;
 - (7) Require that written procedures be established for records to be kept of all financial transactions of the association, its agents and the board of directors;
 - (8) Provide that any member insurer aggrieved by any final action or decision of the association may appeal to the commissioner within thirty (30) days after the action or decision;
 - (9) Establish the procedures under which selections for the board of directors will be submitted to the commissioner;
 - (10) Contain additional provisions necessary or proper for the execution of the powers and duties of the association.
- D. The plan of operation may provide that any or all powers and duties of the association, except those under Sections 8A(3) and 8B(2), are delegated to a corporation, association similar to the association or other organization which performs or will perform functions similar to those of this association or its equivalent in two (2) or more States. The corporation, association similar to the association or organization shall be reimbursed as a servicing facility would be reimbursed and shall be paid for its performance of any other functions of the association. A delegation under this subsection shall take effect only with the approval of both the board of directors and the commissioner, and may be made only to a corporation, association or organization which extends protection not substantially less favorable and effective than that provided by this Act.

Section 10. Duties and Powers of the Commissioner

MO-540-16

IBT/CD DRAFT VERSION #1
5/23/23

NAIC Model Laws, Regulations, Guidelines and Other Resources—April 2009

- A. The commissioner shall:
- (1) Notify the association of the existence of an insolvent insurer not later than three (3) days after the commissioner receives notice of the determination of the insolvency. The association shall be entitled to a copy of a complaint seeking an order of liquidation with a finding of insolvency against a member company at the same time that the complaint is filed with a court of competent jurisdiction;
 - (2) Provide the association with a statement of the net direct written premiums of each member insurer upon request of the board of directors.
- B. The commissioner may:
- (1) Suspend or revoke, after notice and hearing, the certificate of authority to transact insurance in this State of a member insurer that fails to pay an assessment when due or fails to comply with the plan of operation. As an alternative, the commissioner may levy a fine on a member insurer that fails to pay an assessment when due. The fine shall not exceed five percent (5%) of the unpaid assessment per month, except that a fine shall not be less than \$100 per month;
 - (2) Revoke the designation of a servicing facility if the commissioner finds claims are being handled unsatisfactorily.
 - (3) Examine, audit, or otherwise regulate the association.

Drafting Note: This section does not require periodic examinations of the guaranty associations but allows the commissioner to conduct examinations as the commissioner deems necessary.

- C. A final action or order of the commissioner under this Act shall be subject to judicial review in a court of competent jurisdiction.

Section 11. Coordination Among Guaranty Associations

- A. The association may join one or more organizations of other State associations of similar purposes, to further the purposes and administer the powers and duties of the association. The association may designate one or more of these organizations to act as a liaison for the association and, to the extent the association authorizes, to bind the association in agreements or settlements with receivers of insolvent insurance companies or their designated representatives.
- B. The association, in cooperation with other obligated or potentially obligated guaranty associations, or their designated representatives, shall make all reasonable efforts to coordinate and cooperate with receivers, or their designated representatives, in the most efficient and uniform manner, including the use of Uniform Data Standards as promulgated or approved by the National Association of Insurance Commissioners.

Section 12. Effect of Paid Claims

- A. Any person recovering under this Act shall be deemed to have assigned any rights under the policy to the association to the extent of his or her recovery from the association. Every insured or claimant seeking the protection of this Act shall cooperate with the association to the same extent as the person would have been required to cooperate with the insolvent insurer. The association shall have no cause of action against the insured of the insolvent insurer for sums it has paid out except any causes of action as the insolvent insurer would have had if the sums had been paid by the insolvent insurer and except as provided in Subsection B and in Section 13. In the case of an insolvent insurer operating on a plan with assessment liability, payments of claims of the association shall not operate to reduce the liability of the insureds to the receiver, liquidator or statutory successor for unpaid assessments.

MO-540-17

Property and Casualty Insurance Guaranty Association Model Act

- B. The association shall have the right to recover from any person who is an affiliate of the insolvent insurer all amounts paid by the association on behalf of that person pursuant to the Act, whether for indemnity, defense or otherwise.
- C. The association and any association similar to the association in another State shall be entitled to file a claim in the liquidation of an insolvent insurer for any amounts paid by them on covered claim obligations as determined under this Act or similar laws in other States and shall receive dividends and other distributions at the priority set forth in [insert reference to State priority of distribution in liquidation act].
- D. The association shall periodically file with the receiver or liquidator of the insolvent insurer statements of the covered claims paid by the association and estimates of anticipated claims on the association which shall preserve the rights of the association against the assets of the insolvent insurer.

Section 13 [Optional] Net Worth Exclusion

Drafting Note: Various alternatives are provided for a net worth limitation in the guaranty association act. States may choose any of the Subsection B alternatives below or may elect to not have any net worth limitation. Subsection A, which defines "high net worth insured," has two alternatives allowing States to choose different net worth limitations for first and third party claims if that State chooses alternatives 1 or 2 to Subsection B. Subsections C, D and E are recommended to accompany any of the Subsection B alternatives. In cases where States elect not to include net worth, States may either omit this section in its entirety or include only Subsection C, which excludes from coverage claims denied by other States' net worth restrictions pursuant to those States' guaranty association laws.

- A. For purposes of this section "high net worth insured" shall mean any insured whose net worth exceeds \$50 million on December 31 of the year prior to the year in which the insurer becomes an insolvent insurer; provided that an insured's net worth on that date shall be deemed to include the aggregate net worth of the insured and all of its subsidiaries and affiliates as calculated on a consolidated basis.

[Alternate Section 13A

- A. (1) *For the purposes of Subsection B(1), "high net worth insured" shall mean any insured whose net worth exceeds \$25 million on December 31 of the year prior to the year in which the insurer becomes an insolvent insurer; provided that an insured's net worth on that date shall be deemed to include the aggregate net worth of the insured and all of its subsidiaries and affiliates as calculated on a consolidated basis.]*
- (2) *For the purpose of Subsection B(2) [and B(4) if Alternative 2 for Subsection B is selected] "high net worth insured" shall mean any insured whose net worth exceeds \$50 million on December 31 of the year prior to the year in which the insurer becomes an insolvent insurer; provided that an insured's net worth on that date shall be deemed to include the aggregate net worth of the insured and all of its subsidiaries and affiliates as calculated on a consolidated basis.*

Drafting Note: Alternate Subsection A language should only be considered in cases where a State is considering Alternative 1 or 2 of Subsection B and would like to set different dollar thresholds for the first party claim exclusion provision and the third party recovery provision.

Drafting Note: States may wish to consider the impact on governmental entities and charitable organizations of the application of the net worth exclusion contained in the definition of "covered claim." The Michigan Supreme Court, in interpreting a "net worth" provision in the Michigan guaranty association statute, held that governmental entities possess a "net worth" for purposes of the provision in the Michigan guaranty association statute that prohibits claims against the guaranty association by a person who has a specified net worth. Oakland County Road Commission vs. Michigan Property & Casualty Guaranty Association, 575 N.W. 2d 751 (Mich. 1998).

[Alternative 1 for Section 13B

- B. (1) The association shall not be obligated to pay any first party claims by a high net worth insured.
- (2) The association shall have the right to recover from a high net worth insured all amounts paid by the association to or on behalf of such insured, whether for indemnity, defense or otherwise.]

[Alternative 2 for Section 13B

- B. (1) The association shall not be obligated to pay any first party claims by a high net worth insured.
- (2) Subject to Paragraph (3), the association shall not be obligated to pay any third party claim relating to a policy of a high net worth insured. This exclusion shall not apply to third party claims against the high net worth insured where:

MO-540-18

IBT/CD DRAFT VERSION #1
5/23/23

NAIC Model Laws, Regulations, Guidelines and Other Resources—April 2009

- (a) The insured has applied for or consented to the appointment of a receiver, trustee or liquidator for all or a substantial part of its assets;
 - (b) The insured has filed a voluntary petition in bankruptcy, filed a petition or an answer seeking a reorganization or arrangement with creditors or to take advantage of any insolvency law; or
 - (c) An order, judgment, or decree is entered by a court of competent jurisdiction, on the application of a creditor, adjudicating the insured bankrupt or insolvent or approving a petition seeking reorganization of the insured or of all or substantial part of its assets.
- (3) Paragraph (2) shall not apply to workers' compensation claims, personal injury protection claims, no-fault claims and any other claims for ongoing medical payments to third parties.
 - (4) The association shall have the right to recover from a high net worth insured all amounts paid by the association to or on behalf of such insured, whether for indemnity, defense or otherwise.]

[Alternative 3 for Section 13B

- B. The association shall not be obligated to pay any first party claims by a high net worth insured.]
- C. The association shall not be obligated to pay any claim that would otherwise be a covered claim that is an obligation to or on behalf of a person who has a net worth greater than that allowed by the insurance guaranty association law of the State of residence of the claimant at the time specified by that State's applicable law, and which association has denied coverage to that claimant on that basis.
- D. The association shall establish reasonable procedures subject to the approval of the commissioner for requesting financial information from insureds on a confidential basis for purposes of applying this section, provided that the financial information may be shared with any other association similar to the association and the liquidator for the insolvent insurer on the same confidential basis. Any request to an insured seeking financial information must advise the insured of the consequences of failing to provide the financial information. If an insured refuses to provide the requested financial information where it is requested and available, the association may, until such time as the information is provided, provisionally deem the insured to be a high net worth insured for the purpose of denying a claim under Subsection B.
- E. In any lawsuit contesting the applicability of this section where the insured has refused to provide financial information under the procedure established pursuant to Subsection D, the insured shall bear the burden of proof concerning its net worth at the relevant time. If the insured fails to prove that its net worth at the relevant time was less than the applicable amount, the court shall award the association its full costs, expenses and reasonable attorneys' fees in contesting the claim.

Section 14. Exhaustion of Other Coverage

- A. (1) Any person having a claim against an insurer, shall be required first to exhaust all coverage provided by any other policy, including the right to a defense under the other policy, if the claim under the other policy arises from the same facts, injury or loss that gave rise to the covered claim against the association. The requirement to exhaust shall apply without regard to whether the other insurance policy is a policy written by a member insurer. However, no person shall be required to exhaust any right under the policy of an insolvent insurer or any right under a life insurance policy.
- (2) Any amount payable on a covered claim under this Act shall be reduced by the full applicable limits stated in the other insurance policy, or by the amount of the recovery under the other insurance policy as provided herein. The association shall receive a full credit for the stated limits, unless the claimant demonstrates that the claimant used reasonable efforts to exhaust all coverage and limits applicable under the other insurance policy. If the claimant demonstrates that the claimant used

MO-540-19

Property and Casualty Insurance Guaranty Association Model Act

reasonable efforts to exhaust all coverage and limits applicable under the other insurance policy, or if there are no applicable stated limits under the policy, the association shall receive a full credit for the total recovery.

[Alternative 1 for Section 14A(2)(a)]

- (a) The credit shall be deducted from the lesser of:
- (i) The association's covered claim limit;
 - (ii) The amount of the judgment or settlement of the claim; or
 - (iii) The policy limits of the policy of the insolvent insurer./

[Alternative 2 for Section 14A(2)(a)]

- The credit shall be deducted from the lesser of:
- (i) The amount of the judgment or settlement of the claim; or
 - (ii) The policy limits of the policy of the insolvent insurer./
- (b) In no case, however, shall the obligation of the association exceed the covered claim limit embodied in Section 8 of this Act.
- (3) Except to the extent that the claimant has a contractual right to claim defense under an insurance policy issued by another insurer, nothing in this section shall relieve the association of the duty to defend under the policy issued by the insolvent insurer. This duty shall, however, be limited by any other limitation on the duty to defend embodied in this Act.
- (4) A claim under a policy providing liability coverage to a person who may be jointly and severally liable as a joint tortfeasor with the person covered under the policy of the insolvent insurer that gives rise to the covered claim shall be considered to be a claim arising from the same facts, injury or loss that gave rise to the covered claim against the association.
- (5) For purposes of this section, a claim under an insurance policy other than a life insurance policy shall include, but is not limited to:
- (a) A claim against a health maintenance organization, a hospital plan corporation, a professional health service corporation or disability insurance policy; and
 - (b) Any amount payable by or on behalf of a self-insurer.
- (6) The person insured by the insolvent insurer's policy may not be pursued by a third-party claimant for any amount paid to the third party by which the association's obligation is reduced by the application of this section.

- B. Any person having a claim which may be recovered under more than one insurance guaranty association or its equivalent shall seek recovery first from the association of the place of residence of the insured, except that if it is a first party claim for damage to property with a permanent location, the person shall seek recovery first from the association of the location of the property. If it is a workers' compensation claim, the person shall seek recovery first from the association of the residence of the claimant. Any recovery under this Act shall be reduced by the amount of recovery from another insurance guaranty association or its equivalent.

Drafting Note: This subsection does not prohibit recovery from more than one association, but it does describe the association to be approached first and then requires that any previous recoveries from like associations must be set off against recoveries from this association.

Section 15. Prevention of Insolvencies

To aid in the detection and prevention of insurer insolvencies:

- A. The board of directors may, upon majority vote, make recommendations to the commissioner on matters generally related to improving or enhancing regulation for solvency.
- B. At the conclusion of any domestic insurer insolvency in which the association was obligated to pay covered

MO-540-20

IBT/CD DRAFT VERSION #1
5/23/23

NAIC Model Laws, Regulations, Guidelines and Other Resources—April 2009

claims, the board of directors may, upon majority vote, prepare a report on the history and causes of the insolvency, based on the information available to the association and submit the report to the commissioner.

- C. Reports and recommendations provided under this section shall not be considered public documents.

Section 16. Tax Exemption

The association shall be exempt from payment of all fees and all taxes levied by this State or any of its subdivisions except taxes levied on real or personal property.

Section 17. Recoupment of Assessments

Drafting Note: States may choose how they wish to allow member insurers to recoup assessments paid by selecting one of three alternatives for Section 17.

[Alternative 1 for Section 17]

- A. Except as provided in Subsection D, each member insurer shall annually recoup assessments it remitted in preceding years under Section 8. The recoupment shall be by means of a policyholder surcharge on premiums charged for all kinds of insurance in the accounts assessed. The surcharge shall be at a uniform percentage rate determined annually by the commissioner that is reasonably calculated to recoup the assessment remitted by the insurer, less any amounts returned to the member insurer by the association. Changes in this rate shall be effective no sooner than 180 days after insurers have received notice of the changed rate.
- B. If a member insurer fails to recoup the entire amount of the assessment in the first year under this section, it shall repeat the surcharge procedure provided for herein in succeeding years until the assessment is fully recouped or a de minimis amount remains uncollected. Any such de minimis amount shall be collected as provided in Subsection D of this section. If a member insurer collects excess surcharges, the insurer shall remit the excess amount to the association, and the excess amount shall be applied to reduce future assessments in the appropriate account.
- C. The amount and nature of any surcharge shall be separately stated on either a billing or policy declaration sent to an insured. The surcharge shall not be considered premium for any purpose, including the [insert all appropriate taxes] or agents' commission.
- D. A member may elect not to collect the surcharge from its insureds only when the expense of collecting the surcharge would exceed the amount of the surcharge. In that case, the member shall recoup the assessment through its rates, provided that:
- (1) The insurer shall be obligated to remit the amount of surcharge not collected by election under this subsection; and
 - (2) The last sentence in Subsection C above shall not apply.
- E. In determining the rate under Subsection A for the first year of recoupment under this section, under rules prescribed by the commissioner, the commissioner shall provide for the recoupment in that year, or in such reasonable period as the commissioner may determine, of any assessments that have not been recouped as of that year. Insurers shall not be required to recoup assessments through surcharges under this section until 180 days after this section takes effect.]

[Alternative 2 for Section 17]

- A. Notwithstanding any provision of [insert citation to relevant tax and insurance codes] to the contrary, a member insurer may offset against its [insert all appropriate taxes] liability the entire amount of the assessment imposed under this Act at a rate of [insert number] percent per year for [insert number of years] successive years following the date of assessment. If the assessment is not fully recovered over the [insert number of years] period, the remaining unrecovered assessment may be claimed for subsequent calendar years until fully recovered.

Drafting Note: States may choose the number of years to allow an insurer to offset an assessment against the insurer's premium tax liability.

MO-540-21

Property and Casualty Insurance Guaranty Association Model Act

- B. Any tax credit under this section shall, for the purposes of Section [insert citation to retaliatory tax statute] be treated as a tax paid both under the tax laws of this State and under the laws of any other State or country.
- C. If a member insurer ceases doing business in this State, any uncredited assessment may be credited against its [insert all appropriate taxes] during the year it ceases doing business in this State.
- D. Any sums that are acquired by refund from the association by member insurers and that have been credited against [insert all appropriate taxes], as provided in this section, shall be paid by member insurers to this State as required by the department. The association shall notify the department that the refunds have been made./

[Alternative 3 for Section 17]

The rates and premiums charged for insurance policies to which this section applies shall include amounts sufficient to recoup a sum equal to the amounts paid to the association by the member insurer less any amounts returned to the member insurer by the association. Rates shall not be deemed excessive because they contain an additional amount reasonably calculated to recoup all assessments paid by the member insurer./

Section 18. Immunity

There shall be no liability on the part of, and no cause of action of any nature shall arise against a member insurer, the association or its agents or employees, the board of directors, or any person serving as an alternate or substitute representative of any director, or the commissioner or the commissioner's representatives for any action taken or any failure to act by them in the performance of their powers and duties under this Act

Section 19. Stay of Proceedings

All proceedings in which the insolvent insurer is a party or is obligated to defend a party in any court in this State shall, subject to waiver by the association in specific cases involving covered claims, be stayed for six (6) months and such additional time as may be determined by the court from the date the insolvency is determined or an ancillary proceeding is instituted in the State, whichever is later, to permit proper defense by the association of all pending causes of action.

The liquidator, receiver or statutory successor of an insolvent insurer covered by this Act shall permit access by the board or its authorized representative to such of the insolvent insurer's records which are necessary for the board in carrying out its functions under this Act with regard to covered claims. In addition, the liquidator, receiver or statutory successor shall provide the board or its representative with copies of those records upon the request by the board and at the expense of the board.

Chronological Summary of Actions (all references are to the Proceedings of the NAIC).

1970 Proc. I 218, 252, 253-262, 298 (adopted).
 1972 Proc. I 15, 16, 443, 477-478, 479-480 (amended).
 1973 Proc. I 9, 11, 140, 154, 155-157 (amended).
 1973 Proc. II 18, 21, 370, 394, 396 (recoupment formula adopted).
 1979 Proc. I 44, 46, 126, 217 (amended).
 1981 Proc. I 47, 50, 175, 225 (amended).
 1984 Proc. I 6, 31, 196, 326, 352 (amended).
 1986 Proc. I 9-10, 22, 149, 294, 296-305 (amended and reprinted).
 1986 Proc. II 410-411 (amendments adopted later printed here).
 1987 Proc. I 11, 18, 161, 421, 422, 429, 450-452 (amended).
 1993 Proc. 2nd Quarter 12, 33, 227, 600, 602, 621 (amended).
 1994 Proc. 4th Quarter 17, 26, 566, 576, 579-589 (amended and reprinted).
 1996 Proc. 1st Quarter 29-30, 123, 564, 570, 570-580 (amended and reprinted).
 2009 Proc. 1st Quarter, Vol I 111, 139, 188, 288-317 (amended).

MO-540-22

MODEL 540 IBT/CD PROPOSED AMENDMENTS

VERSION #1 DESCRIPTION

Currently, a claim can only be a “covered claim” under the Model Act if the claim is made against an “insolvent insurer” and the policy under which the claim was made “was either issued by the insurer or assumed by the insurer in an assumed claims transaction.” Both of these restrictions, in their current form, can extinguish existing guaranty fund coverage after an insurance business transfer (IBT) or corporate division (CD), as well as a wide range of other policy transfers where there is a broad consensus among most regulators and stakeholders that coverage ought to be preserved.

Two specific obstacles are: (1) even though the “assumed claims transaction” provisions of the Model Act might appear at first glance as though they were designed to address policy transfers of all kinds, the primary “Alternative 1” definition does not allow coverage for a transfer without the consent of the policyholder, which is an essential feature of IBTs and CDs; and (2) the definition of “insolvent insurer” requires the insurer to have been licensed “either at the time the policy was issued, when the obligation with respect to the covered claim was assumed under an assumed claims transaction, or when the insured event occurred.” But IBTs and CDs only require approval by the domiciliary state, and an IBT transferee insurer or a CD resulting insurer might not seek or might not qualify for licensure in the state where the claim is presented, or might not obtain licensure until after the applicable date. Furthermore, only a handful of states have adopted the either version of the Model’s “assumed claims” provisions.

Therefore, the drafters of Version 1 approached the problem from a first-principles perspective: what is the clearest and simplest way to ensure that if guaranty fund coverage exists before an IBT, CD, or other policy transfer, it will continue to exist afterward? Proposed § 5(G)(2), which was inspired by language recently adopted in New Hampshire as its starting point, codifies this principle directly, with a limited exception for transactions in which the policyholder knowingly and voluntarily takes the policy out of the admitted market. It can be added to the definition of “covered claim” in the same manner regardless of whether or not the state has chosen to adopt the Model’s assumed-claim provisions. With the addition of this paragraph, claims are covered if either (1) the claim is made against a policy that was issued by a member insurer that was placed in liquidation; or (2) the claim is made against another insurer that took on a member insurer’s claim obligations and then was placed in liquidation.

Because proposed § 5(G)(2) also preserves existing guaranty fund coverage after a merger or assumption-reinsurance transaction, it removes the need for any additional assumed-claims language unless the state chooses to provide guaranty fund coverage for transactions involving the transfer of claim obligations from a self-insurer or a non-member insurer to a member insurer in certain scenarios where the member insurer fails to issue a replacement insurance policy or where some of the “assumed claims” might not otherwise qualify as covered claims against the replacement policy. Because the vast majority of states have not chosen to cover these relatively unusual scenarios, the drafters of Version 1 believe the NAIC should acknowledge the optional nature of such coverage and provide states with a clean version of the Model Act that is readily available for their use. Accordingly, the “baseline” language of Version 1 deletes the following verbiage: both of the alternative definitions of “assumed claims transaction”; the substantive clauses where that term appears; the related definitions of “assumption consideration” and “novation”; and two of the four alternative versions of § 8(A)(3)).

In addition, some optional language was drafted to accommodate states that wish to provide coverage for the full range of nonmember-to-member assumed claims transactions that would be covered under the existing (but not widely-adopted) Model. Version 1's modular approach allows states to add this optional language without replacing any of the other "baseline" language of Version 1. The optional language highlighted in blue is based on Model Act Alternative 1. Model Act Alternative 2 would also add the language highlighted in green. The drafters do not endorse this language and would not object if the Task Force chose to eliminate it as a formal option within the Model Act and treat it instead as state-by-state variation.

The drafters of Version 1 were also asked to prepare a comparison matrix to facilitate discussions within the drafting group. Although the classic IBT/CD scenarios are straightforward, there are some weedy, lower-frequency scenarios where the two versions differ because Version 1 is not expressly limited to IBTs and CDs, and does not rely on interpretations of the assumed claims language in the Model. This is why the drafters included the footnotes below. Please note that the footnotes reflect the Version 1 drafters' analysis of Version 2, and the Version 2 drafter is not always in agreement with that analysis.

	VERSION #1
IBT/CD MEMBER TO MEMBER	Always covered
OTHER MEMBER TO MEMBER(*a)	Always covered
IBT/CD MEMBER TO NONMEMBER(*b)	Always covered
OTHER MEMBER TO NONMEMBER(*b) (*c)	Not Covered
IBT/CD NONMEMBER TO MEMBER(*d)	Not covered
OTHER NONMEMBER TO MEMBER(*d) (*e)	Optional (G3)
NONMEMBER TO NONMEMBER	Not covered

(*a) "Other" member-to-member transactions are only covered under Version #2 if the state has assumed-claims language, which leaves out Alternatives 1 & 2. Other transactions, such as common-law novations, do not qualify as assumed-claims transactions, so coverage could be lacking or could be open to dispute even under the default & Alternative 3. There could also be questions about where exactly to draw the line between "IBT/CD" and "Other" transactions, and we would agree with not making the proposed definition of IBT/CD mandatory because it might raise as many questions as it answers.

(*b) Within Version #2, Alternatives 2 & 3 provide "nonmember transferee coverage" for IBTs and CDs; in other words, claims are covered even if the transferee did not seek or was not granted a license in This State. But the default and Alternative 1 do not have that language, and thus require the transferee to be an "insolvent insurer," which by definition must be or have formerly been a member insurer at the relevant time (which also means Version #2 would require a revision to the "insolvent insurer" definition to add the time of an IBT or CD). And even under Version #2 Alternatives 2 & 3, coverage is not provided for "other" transactions, because it is only triggered by "such a" transaction, *i.e.* an IBT or CD.

(*c) Although Version #1 does not explicitly distinguish between "IBT/CD" and "Other" transactions, the reason it makes "regulatory or judicial approval" the trigger for coverage is to include IBTs/CDs and similar transactions but exclude voluntary transactions, such as a policyholder commuting an admitted policy and transferring the risk to its own captive.

(*d) Under all four variations of Version #2, coverage is provided as long as a revision to the definition of “insolvent insurer” is added to include insurers that were members at the time they picked up the claim in an IBT/CD. However, nonmember-to-member IBTs/CDs seem like a highly unusual transaction, and coverage would seem to be an unintended consequence – I’m picturing something like an insurer that’s admitted in its state of domicile and has written surplus lines in this state, and then transfers business to an insurer that purely by coincidence happens to have a license here. The “nonmember-to-member IBT/CDs” line of Version #1 is “no coverage with an asterisk” because the proposal doesn’t provide any coverage without the original policy being issued by a member insurer unless either (1) the transaction would qualify as an “assumed claims transaction” under at least one of the 2009 versions of the Model, in which case coverage is provided in states that elect “Optional G(3)” or (2) coverage already existed under the Model even before the 2009 amendments (for example, “tail coverage” clauses in claims-made policies and perhaps “take-out policies” issued when a self-insurance program is terminated), and those would not be taken away by either Version when a valid covered claim is made against such a policy. If we read the 2009 Model correctly, there’s a lot of overlap between assumed claims transactions and IBTs/CDs on the member-to-member side but very little on the nonmember-to-member side.

(*e) Finally, because coverage under Version #2’s “other” nonmember-to-member transactions depends on whether they qualify as “assumed claims transactions” under the existing language of the Model, this will in turn depend on which of the two alternate definitions the state chooses. Version #2’s Definition 2 appears, as written, to make coverage optional, on a case-by-case basis, for nonmember-to-member assumed-claims transactions. If the member chooses to buy guaranty fund coverage for the policies it has assumed, it apparently must enter into some sort of agreement to pay “assumption consideration” to all “applicable guaranty associations,” and failure to pay one of them appears as currently written to result in the loss of coverage in all states with substantially similar legislation. Version #1’s optional Paragraph 8(A)(4) takes a simpler approach, making assumption consideration obligatory but providing guaranty fund coverage even if the insurer defaults in whole or part on that obligation (the purpose of guaranty funds, after all, being to protect claimants when insurers default on their obligations). If that’s not the intended outcome, this paragraph would need to be rewritten.

NCIGF Comment on Version #1

Here are some comments on the substance of Bob's draft:

NCIGF supports the standalone g(2) language regarding divisions in the Bob Wake draft. We believe that g(2) reflects the most recent draft best practices being considered by the Restructuring Mechanisms Working Group which indicate that GA coverage should not be changed as a result of an IBT or division transaction.

Regarding g(3), while some may regard this as an option that should be made available to states, we do not support the enactment of g(3). We feel coverage for claims originating from an uncovered entity could create moral hazard. Moreover, it is unfair to charge the cost of such claims to the guaranty fund created for licensed business. If safety net coverage is desired for such claims it can, and has in some jurisdictions, been created. As a practical matter, we sense that non-member to member transactions would be rare.

Regarding the provisions in the Bob Wake draft relating to assessment consideration for cases covered in g(3), such consideration is not a part of the NCIGF policy on restructured business. While we are neutral regarding its enactment, we do observe that the language adds an additional layer of complexity to the amendment package this working group is currently considering.

We understand drafter of Version 1 would be fine with eliminating the Optional Clauses if the Working Group wants to go that route and would also be happy to get rid of the green language if they wanted to simplify it.

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PROPERTY AND CASUALTY INSURANCE GUARANTY ASSOCIATION MODEL ACT

Table of Contents

Section 1.	Title
Section 2.	Purpose
Section 3.	Scope
Section 4.	Construction
Section 5.	Definitions
Section 6.	Creation of the Association
Section 7.	Board of Directors
Section 8.	Powers and Duties of the Association
Section 9.	Plan of Operation
Section 10.	Duties and Powers of the Commissioner
Section 11.	Coordination Among Guaranty Associations
Section 12.	Effect of Paid Claims
Section 13.	[Optional] Net Worth Exclusion
Section 14.	Exhaustion of Other Coverage
Section 15.	Prevention of Insolvencies
Section 16.	Tax Exemption
Section 17.	Recoupment of Assessments
Section 18.	Immunity
Section 19.	Stay of Proceedings

Section 1. Title

This Act shall be known as the [State] Insurance Guaranty Association Act.

Section 2. Purpose

The purpose of this Act is to provide a mechanism for the payment of covered claims under certain insurance policies, to avoid excessive delay in payment and to the extent provided in this Act minimize financial loss to claimants or policyholders because of the insolvency of an insurer, and to provide an association to assess the cost of such protection among insurers.

Section 3. Scope

This Act shall apply to all kinds of direct insurance, but shall not be applicable to the following:

- A. Life, annuity, health or disability insurance;
- B. Mortgage guaranty, financial guaranty or other forms of insurance offering protection against investment risks;
- C. Fidelity or surety bonds, or any other bonding obligations;
- D. Credit insurance, vendors' single interest insurance, or collateral protection insurance or any similar insurance protecting the interests of a creditor arising out of a creditor-debtor transaction;
- E. Insurance of warranties or service contracts including insurance that provides for the repair, replacement or service of goods or property, indemnification for repair, replacement or service for the operational or structural failure of the goods or property due to a defect in materials, workmanship or normal wear and tear, or provides reimbursement for the liability incurred by the issuer of agreements or service contracts that provide such benefits;

MO-540-1

IBT/CD DRAFT VERSION #2
5/23/23

Property and Casualty Insurance Guaranty Association Model Act

- F. Title insurance;
- G. Ocean marine insurance;
- H. Any transaction or combination of transactions between a person (including affiliates of such person) and an insurer (including affiliates of such insurer) which involves the transfer of investment or credit risk unaccompanied by transfer of insurance risk; or
- I. Any insurance provided by or guaranteed by government.

Drafting Note: This Act focuses on property and liability kinds of insurance and therefore exempts those kinds of insurance deemed to present problems quite distinct from those of property and liability insurance. The Act further precludes from its scope certain types of insurance that provide protection for investment and financial risks. Financial guaranty is one of these. The NAIC Life and Health Insurance Guaranty Association Model Act provides for coverage of some, of the lines excluded by this provision.

For purposes of this section, "Financial guaranty insurance" includes any insurance under which loss is payable upon proof of occurrence of any of the following events to the damage of an insured claimant or obligee:

1. Failure of any obligor or obligors on any debt instrument or other monetary obligation, including common or preferred stock, to pay when due the principal, interest, dividend or purchase price of such instrument or obligation, whether failure is the result of a financial default or insolvency and whether or not the obligation is incurred directly or as guarantor by, or on behalf of, another obligor which has also defaulted;
2. Changes in the level of interest rates whether short term or long term, or in the difference between interest rates existing in various markets;
3. Changes in the rate of exchange of currency, or from the inconvertibility of one currency into another for any reason;
4. Changes in the value of specific assets or commodities, or price levels in general.

For purposes of this section, "credit insurance" means insurance on accounts receivable.

The terms "disability insurance" and "accident and health insurance," and "health insurance" are intended to be synonymous. Each State will wish to examine its own statutes to determine which is the appropriate phrase.

A State where the insurance code does not adequately define ocean marine insurance may wish to add the following to Section 5, Definitions: "Ocean marine insurance" means any form of insurance, regardless of the name, label or marketing designation of the insurance policy, which insures against maritime perils or risks and other related perils or risks, which are usually insured against by traditional marine insurance, such as hull and machinery, marine builders risk, and marine protection and indemnity. Perils and risk insured against include without limitation loss, damage, expense or legal liability of the insured for loss, damage or expense arising out of or incident to ownership, operation, chartering, maintenance, use, repair or construction of any vessel, craft or instrumentality in use in ocean or inland waterways for commercial purposes, including liability of the insured for personal injury, illness or death or for loss or damage to the property of the insured or another person.

Section 4. Construction

This Act shall be construed to effect the purpose under Section 2 which will constitute an aid and guide to interpretation.

Section 5. Definitions

As used in this Act:

[Optional:

- A. "Account" means any one of the three accounts created by Section 6.]

Drafting Note: This definition should be used by those States wishing to create separate accounts for assessment purposes. For a note on the use of separate accounts for assessments see the Drafting Note after Section 6. If this definition is used, all subsequent subsections should be renumbered.

- A. "Affiliate" means a person who directly, or indirectly, through one or more intermediaries, controls, is controlled by, or is under common control with another person on December 31 of the year immediately preceding the date the insurer becomes an insolvent insurer.
- B. "Association" means the [State] Insurance Guaranty Association created under Section 6.

MO-540-2

IBT/CD DRAFT VERSION #2

5/23/23

NAIC Model Laws, Regulations, Guidelines and Other Resources—April 2009

- C. “Association similar to the association” means any guaranty association, security fund or other insolvency mechanism that affords protection similar to that of the association. The term shall also include any property and casualty insolvency mechanism that obtains assessments or other contributions from insurers on a pre-insolvency basis.

Drafting Note: There are two options for handling claims assumed by a licensed carrier from an unlicensed carrier or self insurer. Alternative 1 provides that these claims shall be covered by the guaranty association if the licensed insurer becomes insolvent subsequent to the assumption. Alternative 2 provides coverage only if the assuming carrier makes a payment to the guaranty association in an amount equal to that which the assuming carrier would have paid in guaranty association assessments had the insurer written the assumed business itself. If a State wishes to adopt Alternative 1, it must select Alternative 1 in Section 5D and Alternative 1a or 2a in Section 8A(3). If a State wishes to adopt Alternative 2, it must select Alternative 2 in Section 5D and Q and Alternative 1b or 2b in Section 8A(3).

- D. **[Alternative 1]** “Assumed claims transaction” means the following:

- (1) Policy obligations that have been assumed by the insolvent insurer, prior to the entry of a final order of liquidation, through a merger between the insolvent insurer and another entity obligated under the policies; or
- (2) An assumption reinsurance transaction in which all of the following has occurred:
 - (a) The insolvent insurer assumed, prior to the entry of a final order of liquidation, the claim or policy obligations of another insurer or entity obligated under the claims or policies; and
 - (b) The assumption of the claim or policy obligations has been approved, if such approval is required, by the appropriate regulatory authorities; and
 - (c) As a result of the assumption, the claim or policy obligations became the direct obligations of the insolvent insurer through a novation of the claims or policies

- [Alternative 2]** “Assumed claims transaction” means the following:

- (1) Policy obligations that have been assumed by the insolvent insurer, prior to the entry of a final order of liquidation, through a merger between the insolvent insurer and another entity obligated under the policies, and for which Assumption Consideration has been paid to the applicable guaranty associations, if the merged entity is a non-member insurer; or
- (2) Policy obligations that have been assumed by the insolvent insurer, prior to the entry of a final order of liquidation, pursuant to a plan, approved by the domestic commissioner of the assuming insurer, which:
 - (a) Transfers the direct policy obligations and future policy renewals from one insurer to another insurer; and
 - (b) For which Assumption Consideration has been paid to the applicable guaranty associations, if the assumption is from a non-member insurer.
 - (c) For purposes of this section the term non-member insurer also includes a self-insurer, non-admitted insurer and risk retention group; or
- (3) An assumption reinsurance transaction in which all of the following has occurred:
 - (a) The insolvent insurer assumed, prior to the entry of a final order of liquidation, the claim or policy obligations of another insurer or entity obligated under the claims or policies;
 - (b) The assumption of the claim or policy obligations has been approved, if such approval is required, by the appropriate regulatory authorities; and

MO-540-3

IBT/CD DRAFT VERSION #2
5/23/23

Property and Casualty Insurance Guaranty Association Model Act

As a result of the assumption, the claim or policy obligations became the direct obligations of the insolvent insurer through a novation of the claims or policies.

- E. "Claimant" means any person instituting a covered claim, provided that no person who is an affiliate of the insolvent insurer may be a claimant.
- F. "Commissioner" means the Commissioner of Insurance of this State.

Drafting Note: Use the appropriate title for the chief insurance regulatory official wherever the term "commissioner" appears.

- G. "Control" means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or nonmanagement services, or otherwise, unless the power is the result of an official position with or corporate office held by the person. Control shall be presumed to exist if a person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing, ten percent (10%) or more of the voting securities of any other person. This presumption may be rebutted by a showing that control does not exist in fact.

VERSION #2 PROPOSAL

- H. "Covered claim" means the following:

- (1) An unpaid claim, including one for unearned premiums, submitted by a claimant, which arises out of and is within the coverage and is subject to the applicable limits of an insurance policy to which this Act applies, if the insurer becomes an insolvent insurer after the effective date of this Act and: the policy was either issued by the insurer or assumed by, or allocated to, the insurer in an assumed claims transaction; or in an Insurance Business Transfer or Corporate Division transaction that was approved by the chief insurance regulator in the insurer's state of domicile and, if required, by the [Commissioner/Director/Superintendent]; and

Drafting Note: Versions of this language can be adopted whether or not the Assumed Claim language has been adopted. The proposal deliberately doesn't remove the "assumed claims" language. However, a state that wants to adopt this remedial provision without adopting the assumed claims language can do so easily enough just by making this change to the definition:

(1) An unpaid claim, including one for unearned premiums, submitted by a claimant, which arises out of and is within the coverage and is subject to the applicable limits of an insurance policy to which this Act applies, if the insurer becomes an insolvent insurer after the effective date of this Act and the policy was either issued by the insurer or assumed by, or allocated to, the insurer in an assumed claims transaction or in an Insurance Business Transfer or Corporate Division transaction that was approved by the chief insurance regulator in the insurer's state of domicile and, if required, by the [Commissioner/Director/Superintendent]; and ...

- (a) The claimant or insured is a resident of this State at the time of the insured event, provided that for entities other than an individual, the residence of a claimant, insured or policyholder is the State in which its principal place of business is located at the time of the insured event; or
- (b) The claim is a first party claim for damage to property with a permanent location in this State.

OPTIONAL H(c) – TO DEFINE IBT AND CD IF DEEMED NECESSARY

- (c) For purposes of this Act, an Insurance Business Transfer or Corporate Division transaction shall mean a transaction [ALTERNATIVE 1] as described in [INSERT STATE STATUTORY CITATIONS] [OR ALTERNATIVE 2] authorized by the laws of another state authorizing such transactions and as the result of which, apart from other provisions, the insurer assumed all of the obligations under the policy from a transferor which was thereby discharged from such obligations.

Commented [Staff1]: Drafter Explanation:

If IBT and CD are deemed to need further definition the attachment provides suggested optional language. It is not necessary in order to accomplish the goal but might be helpful.

A couple of notes about this proposal:

1) This language lends itself well to amendment of existing state laws. For example, 215 ILCS/534.3 (the Illinois statute, could be amended as follows:

(a) "Covered claim" means an unpaid claim for a loss arising out of and within the coverage of an insurance policy to which this Article applies, including specifically a policy assumed in an Insurance Business Transfer or Corporate Division transaction that was approved by the chief insurance regulator in the insurer's state of domicile and, if required, by the Director, and which is in force at the time of the occurrence giving rise to the unpaid claim, including claims presented during any extended discovery period which was purchased from the company before the entry of a liquidation order or which is purchased or obtained from the liquidator after the entry of a liquidation order, made by a person insured under such policy or by a person suffering injury or damage for which a person insured under such policy is legally liable, and for unearned premium, if:

(2) This approach does not remove any actual or possible coverage from what is currently provided by Model 540; but

(3) This approach does NOT expressly provide GA coverage when the transferor is a member insurer but the transferee insurer is not a member or licensed insurer. However, if the goal of the RLWG includes providing GA coverage in those cases, that could be done by additional language as shown on the attachment.

This last point is important. It arises because the definition of "insolvent insurer" requires that it be licensed (thereby making it a member insurer). In my view, requiring GA coverage when the insolvent insurer was not a member insurer (which effectively means it was not licensed in the state) can be problematic. However, I propose language to accomplish that if the Working Group determines that it is part of their charge. (see Alternatives 2 & 3)

MO-540-4

IBT/CD DRAFT VERSION #2

5/23/23

NAIC Model Laws, Regulations, Guidelines and Other Resources—April 2009

[ALTERNATIVE 1: WITHOUT ASSUMED CLAIMS LANGUAGE AND NON-MEMBER TRANSFEREE COVERAGE]

H. “Covered claim” means the following:

- (1) An unpaid claim, including one for unearned premiums, submitted by a claimant, which arises out of and is within the coverage and is subject to the applicable limits of an insurance policy to which this Act applies, if the insurer becomes an insolvent insurer after the effective date of this Act and the policy was either issued by the insurer or assumed by, or allocated to, the insurer in an Insurance Business Transfer or Corporate Division transaction that was approved by the chief insurance regulator in the insurer’s state of domicile and, if required, by the [Commissioner/Director/Superintendent]; and
 - (a) The claimant or insured is a resident of this State at the time of the insured event, provided that for entities other than an individual, the residence of a claimant, insured or policyholder is the State in which its principal place of business is located at the time of the insured event; or
 - (b) The claim is a first party claim for damage to property with a permanent location in this State.

[ALTERNATIVE 2: WITHOUT ASSUMED CLAIMS LANGUAGE BUT WITH NON-MEMBER TRANSFEREE COVERAGE]

H. “Covered claim” means the following:

- (1) An unpaid claim, including one for unearned premiums, submitted by a claimant, which arises out of and is within the coverage and is subject to the applicable limits of an insurance policy to which this Act applies, if (A) the insurer becomes an insolvent insurer after the effective date of this Act and the policy was either issued by the insurer, or assumed by, or allocated to, the insurer in an Insurance Business Transfer or Corporate Division transaction that was approved by the chief insurance regulator in the insurer’s state of domicile and, if required, by the [Commissioner/Director/Superintendent]; or (B) the policy was issued by a member insurer and, in such a transaction, subsequently assumed by, or allocated to, another insurer (other than a risk retention group) against whom a final order of liquidation has been entered after the effective date of this Act with a finding of insolvency by a court of competent jurisdiction in the insurer’s State of domicile, and
 - (a) The claimant or insured is a resident of this State at the time of the insured event, provided that for entities other than an individual, the residence of a claimant, insured or policyholder is the State in which its principal place of business is located at the time of the insured event; or
 - (b) The claim is a first party claim for damage to property with a permanent location in this State.

[ALTERNATIVE 3: WITH ASSUMED CLAIMS LANGUAGE AND NON-MEMBER TRANSFEREE COVERAGE]

H. “Covered claim” means the following:

- (1) An unpaid claim, including one for unearned premiums, submitted by a claimant, which arises out of and is within the coverage and is subject to the applicable limits of an insurance policy to which this Act applies, if (A) the insurer becomes an insolvent insurer after the effective date of this Act

MO-540-5

IBT/CD DRAFT VERSION #2

5/23/23

Property and Casualty Insurance Guaranty Association Model Act

and the policy was either issued by the insurer, or assumed by, or allocated to, the insurer in an assumed claims transaction or in an Insurance Business Transfer or Corporate Division transaction that was approved by the chief insurance regulator in the insurer's state of domicile and, if required, by the [Commissioner/Director/Superintendent]; or (B) the policy was issued by a member insurer and in such a transaction subsequently assumed by, or allocated to, another insurer (other than a risk retention group) against whom a final order of liquidation has been entered after the effective date of this Act with a finding of insolvency by a court of competent jurisdiction in the insurer's State of domicile, and

- (a) The claimant or insured is a resident of this State at the time of the insured event, provided that for entities other than an individual, the residence of a claimant, insured or policyholder is the State in which its principal place of business is located at the time of the insured event; or
 - (b) The claim is a first party claim for damage to property with a permanent location in this State.
- (2) Except as provided elsewhere in this section, "covered claim" shall not include:
- (a) Any amount awarded as punitive or exemplary damages;
 - (b) Any amount sought as a return of premium under any retrospective rating plan;
 - (c) Any amount due any reinsurer, insurer, insurance pool or underwriting association, health maintenance organization, hospital plan corporation, professional health service corporation or self-insurer as subrogation recoveries, reinsurance recoveries, contribution, indemnification or otherwise. No claim for any amount due any reinsurer, insurer, insurance pool, underwriting association, health maintenance organization, hospital plan corporation, professional health service corporation or self-insurer may be asserted against a person insured under a policy issued by an insolvent insurer other than to the extent the claim exceeds the association obligation limitations set forth in Section 8 of this Act;
 - (d) Any claims excluded pursuant to Section 13 due to the high net worth of an insured;
 - (e) Any first party claims by an insured that is an affiliate of the insolvent insurer;
 - (f) Any fee or other amount relating to goods or services sought by or on behalf of any attorney or other provider of goods or services retained by the insolvent insurer or an insured prior to the date it was determined to be insolvent;
 - (g) Any fee or other amount sought by or on behalf of any attorney or other provider of goods or services retained by any insured or claimant in connection with the assertion or prosecution of any claim, covered or otherwise, against the association;
 - (h) Any claims for interest; or
 - (i) Any claim filed with the association or a liquidator for protection afforded under the insured's policy for incurred-but-not-reported losses.

Drafting note: The language in this provision referring to claims for incurred-but-not-reported losses has been inserted to expressly include the existing intent of this provision and make it clear that "policyholder protection" proofs of claim, while valid to preserve rights against the ~~state~~ of the insolvent insurer under the Insurer Receivership Model Act, are not valid to preserve rights against the association.

- I. "Insolvent insurer" means an insurer that is licensed to transact insurance in this State, either at the time the policy was issued, when the obligation with respect to the covered claim was assumed under an assumed

MO-540-6

IBT/CD DRAFT VERSION #2
5/23/23

NAIC Model Laws, Regulations, Guidelines and Other Resources—April 2009

claims transaction, or when the insured event occurred, and against whom a final order of liquidation has been entered after the effective date of this Act with a finding of insolvency by a court of competent jurisdiction in the insurer's State of domicile.

Drafting Note: "Final order" as used in this section means an order which has not been stayed. States in which the "final order" language does not accurately reflect whether or not the order is subject to a stay should substitute appropriate language consistent with the statutes or rules of the State to convey the intended meaning.

- J. "Insured" means any named insured, any additional insured, any vendor, lessor or any other party identified as an insured under the policy.
- K. (1) "Member insurer" means any person who:
 - (a) Writes any kind of insurance to which this Act applies under Section 3, including the exchange of reciprocal or inter-insurance contracts; and
 - (b) Is licensed to transact insurance in this State (except at the option of the State).
- (2) An insurer shall cease to be a member insurer effective on the day following the termination or expiration of its license to transact the kinds of insurance to which this Act applies, however, the insurer shall remain liable as a member insurer for any and all obligations, including obligations for assessments levied prior to the termination or expiration of the insurer's license and assessments levied after the termination or expiration, which relate to any insurer that became an insolvent insurer prior to the termination or expiration of the insurer's license.
- L. "Net direct written premiums" means direct gross premiums written in this State on insurance policies to which this Act applies, including policy and membership fees, less the following amounts: (1) return premiums, (2) premiums on policies not taken, and (3) dividends paid or credited to policyholders on that direct business. "Net direct written premiums" does not include premiums on contracts between insurers or reinsurers.
- M. "Novation" means that the assumed claim or policy obligations became the direct obligations of the insolvent insurer through consent of the policyholder and that thereafter the ceding insurer or entity initially obligated under the claims or policies is released by the policyholder from performing its claim or policy obligations. Consent may be express or implied based upon the circumstances, notice provided and conduct of the parties.
- N. "Person" means any individual, aggregation of individuals, corporation, partnership or other entity.
- O. "Receiver" means liquidator, rehabilitator, conservator or ancillary receiver, as the context requires.

Drafting Note: Each State should conform the definition of "receiver" to the definition used in the State's insurer receivership act.

- P. "Self-insurer" means a person that covers its liability through a qualified individual or group self-insurance program or any other formal program created for the specific purpose of covering liabilities typically covered by insurance.
- Q. **[Alternative 2b]** "Assumption Consideration" shall mean the consideration received by a guaranty association to extend coverage to the policies assumed by a member insurer from a non-member insurer in any assumed claims transaction including liabilities that may have arisen prior to the date of the transaction. The Assumption Consideration shall be in an amount equal to the amount that would have been paid by the assuming insurer during the three calendar years prior to the effective date of the transaction to the applicable guaranty associations if the business had been written directly by the assuming insurer.

In the event that the amount of the premiums for the three year period cannot be determined, the Assumption Consideration will be determined by multiplying 130% against the sum of the unpaid losses, loss adjustment expenses, and incurred but not reported losses, as of the effective date of the Assumed

MO-540-7

IBT/CD DRAFT VERSION #2
5/23/23

Property and Casualty Insurance Guaranty Association Model Act

claims transaction, and then multiplying such sum times the applicable guaranty association assessment percentage for the calendar year of the transaction.

The funds paid to a guaranty association shall be allocated in the same manner as any assessments made during the three year period. The guaranty association receiving the Assumption Consideration shall not be required to recalculate or adjust any assessments levied during the prior three calendar years as a result of receiving the Assumption Consideration. Assumption Consideration paid by an insurer may be recouped in the same manner as other assessments made by a guaranty association.

Section 6. Creation of the Association

There is created a nonprofit unincorporated legal entity to be known as the [State] Insurance Guaranty Association. All insurers defined as member insurers in Section 5K shall be and remain members of the association as a condition of their authority to transact insurance in this State. The association shall perform its functions under a plan of operation established and approved under Section 9 and shall exercise its powers through a board of directors established under Section 7.

[Alternate Section 6. Creation of the Association

There is created a nonprofit unincorporated legal entity to be known as the [State] Insurance Guaranty Association. All insurers defined as member insurers in Section 5K shall be and remain members of the association as a condition of their authority to transact insurance in this State. The association shall perform its functions under a plan of operation established and approved under Section 9 and shall exercise its powers through a board of directors established under Section 7. For purposes of administration and assessment, the association shall be divided into three separate accounts:

- A. *The workers' compensation insurance account;*
- B. *The automobile insurance account; and*
- C. *The account for all other insurance to which this Act applies.]*

Drafting Note: The alternate Section 6 should be used if a State, after examining its insurance market, determines that separate accounts for various kinds of insurance are necessary and feasible. The major consideration is whether each account will have a base sufficiently large to cover possible insolvencies. Separate accounts will permit assessments to be generally limited to insurers writing the same kind of insurance as the insolvent company. If this approach is adopted the provision of alternate Sections 8A(3) and 8B(6) and optional Section 5A should also be used.

Section 7. Board of Directors

- A. The board of directors of the association shall consist of not less than five (5) nor more than [insert number] persons serving terms as established in the plan of operation. The insurer members of the board shall be selected by member insurers subject to the approval of the commissioner. Vacancies on the board shall be filled for the remaining period of the term by a majority vote of the remaining insurer members subject to the approval of the commissioner. If no members are selected within sixty (60) days after the effective date of this Act, the commissioner may appoint the initial members of the board of directors. Two (2) persons, who must be public representatives, shall be appointed by the commissioner to the board of directors. Vacancies of positions held by public representatives shall be filled by the commissioner. A public representative may not be an officer, director or employee of an insurance company or any person engaged in the business of insurance. For the purposes of this section, the term "director" shall mean an individual serving on behalf of an insurer member of the board of directors or a public representative on the board of directors.

Drafting Note: A State adopting this language should make certain that its insurance code includes a definition of "the business of insurance" similar to that found in the NAIC Insurer Receivership Model Act.

- B. In approving selections to the board, the commissioner shall consider among other things whether all member insurers are fairly represented.
- C. Members of the board of directors may be reimbursed from the assets of the association for reasonable

MO-540-8

IBT/CD DRAFT VERSION #2

5/23/23

NAIC Model Laws, Regulations, Guidelines and Other Resources—April 2009

expenses incurred by them as members of the board of directors.

- D. Any board member who is an insurer in receivership shall be terminated as a board *member*, effective as of the date of the entry of the order of receivership. Any resulting vacancies on the board shall be filled for the remaining period of the term in accordance with the provisions of Subsection A.
- E. In the event that a director shall, because of illness, nonattendance at meetings or any other reason, be deemed unable to satisfactorily perform the designated functions as a director by missing three consecutive board meetings, the board of directors may declare the office vacant and the member or director shall be replaced in accordance with the provisions of Subsection A.
- F. If the commissioner has reasonable cause to believe that a director failed to disclose a known conflict of interest with his or her duties on the board, failed to take appropriate action based on a known conflict of interest with his or her duties on the board, or has been indicted or charged with a felony, or misdemeanor involving moral turpitude, the commissioner may suspend that director pending the outcome of an investigation or hearing by the commissioner or the conclusion of any criminal proceedings. A company elected to the board may replace a suspended director prior to the completion of an investigation, hearing or criminal proceeding. In the event that the allegations are substantiated at the conclusion of an investigation, hearing or criminal proceeding, the office shall be declared vacant and the member or director shall be replaced in accordance with the provisions of Subsection A.

Section 8. Powers and Duties of the Association

A. The association shall:

- (1) (a) Be obligated to pay covered claims existing prior to the order of liquidation, arising within thirty (30) days after the order of liquidation, or before the policy expiration date if less than thirty (30) days after the order of liquidation, or before the insured replaces the policy or causes its cancellation, if the insured does so within thirty (30) days of the order of liquidation. The obligation shall be satisfied by paying to the claimant an amount as follows:
 - (i) The full amount of a covered claim for benefits under a workers' compensation insurance coverage;
 - (ii) An amount not exceeding \$10,000 per policy for a covered claim for the return of unearned premium;
 - (iii) An amount not exceeding \$500,000 per claimant for all other covered claims.
- (b) In no event shall the association be obligated to pay a claimant an amount in excess of the obligation of the insolvent insurer under the policy or coverage from which the claim arises. Notwithstanding any other provisions of this Act, a covered claim shall not include a claim filed with the guaranty fund after the final date set by the court for the filing of claims against the liquidator or receiver of an insolvent insurer.

For the purpose of filing a claim under this subsection, notice of claims to the liquidator of the insolvent insurer shall be deemed notice to the association or its agent and a list of claims shall be periodically submitted to the association or association similar to the association in another State by the liquidator.

Drafting Note: On the general subject of the relationship of the association to the liquidator, the working group/task force takes the position that since this is a model State bill, it will be able to bind only two parties, the association and the in-State liquidator. Nevertheless, the provisions should be clear enough to outline the requests being made to out-of-State liquidators and the requirements placed on in-State liquidators in relation to out-of-State associations.

Drafting Note: Because of its potential impact on guaranty association coverage, it is recommended that the legislation include an appropriate provision stating that the bar date only applies to claims in liquidation commencing after its effective date. Drafters should insure that the State's insurance liquidation act would permit, upon closure, payments to the guaranty association and any association similar to the association for amounts that are estimated to be

IBT/CD DRAFT VERSION #2
5/23/23

Property and Casualty Insurance Guaranty Association Model Act

incurred after closure for workers compensation claims obligations. The amounts should be payable on these obligations related to losses both known and not known at the point of closure.

- (c) Any obligation of the association to defend an insured shall cease upon the association's payment or tender of an amount equal to the lesser of the association's covered claim obligation limit or the applicable policy limit.

Drafting Note: The obligation of the association is limited to covered claims unpaid prior to insolvency, and to claims arising within thirty days after the insolvency, or until the policy is canceled or replaced by the insured, or it expires, whichever is earlier. The basic principle is to permit policyholders to make an orderly transition to other companies. There appears to be no reason why the association should become in effect an insurer in competition with member insurers by continuing existing policies, possibly for several years. It is also felt that the control of the policies is properly in the hands of the liquidator. Finally, one of the major objections of the public to rapid termination, loss of unearned premiums with no corresponding coverage, is ameliorated by this bill since unearned premiums are permissible claims, up to \$10,000, against the association. The maximums (\$10,000 for the return of unearned premium; \$500,000 for all other covered claims) represent the working group's concept of practical limitations, but each State will wish to evaluate these figures.

- (2) Be deemed the insurer to the extent of its obligation on the covered claims and to that extent, subject to the limitations provided in this Act, shall have all rights, duties and obligations of the insolvent insurer as if the insurer had not become insolvent, including but not limited to, the right to pursue and retain salvage and subrogation recoverable on covered claim obligations to the extent paid by the association. The association shall not be deemed the insolvent insurer for the purpose of conferring jurisdiction.
- (3) **[Alternative 1a]** Assess insurers amounts necessary to pay the obligations of the association under Subsection A(1) subsequent to an insolvency, the expenses of handling covered claims subsequent to an insolvency, and other expenses authorized by this Act. The assessments of each member insurer shall be in the proportion that the net direct written premiums of the member insurer for the calendar year preceding the assessment bears to the net direct written premiums of all member insurers for the calendar year preceding the assessment. Each member insurer shall be notified of the assessment not later than thirty (30) days before it is due. A member insurer may not be assessed in any year an amount greater than two percent (2%) of that member insurer's net direct written premiums for the calendar year preceding the assessment. If the maximum assessment, together with the other assets of the association, does not provide in any one year an amount sufficient to make all necessary payments, the funds available shall be prorated and the unpaid portion shall be paid as soon as funds become available. The association may exempt or defer, in whole or in part, the assessment of a member insurer, if the assessment would cause the member insurer's financial statement to reflect amounts of capital or surplus less than the minimum amounts required for a certificate of authority by a jurisdiction in which the member insurer is authorized to transact insurance. However, during the period of deferment no dividends shall be paid to shareholders or policyholders. Deferred assessments shall be paid when the payment will not reduce capital or surplus below required minimums. Payments shall be refunded to those companies receiving larger assessments by virtue of the deferment, or at the election of the company, credited against future assessments.

[Alternative 2a] Assess insurers amounts necessary to pay the obligations of the association under Subsection A(1) subsequent to an insolvency, the expenses of handling covered claims subsequent to an insolvency, and other expenses authorized by this Act. The assessments of each member insurer shall be in the proportion that the net direct written premiums and any premiums received for an assumed contract after the effective date of an assumed claims transaction with a non-member insurer of the member insurer for the calendar year preceding the assessment bears to the net direct written premiums and any premiums received for an assumed contract after the effective date of an assumed claims transaction with a non-member insurer of all member insurers for the calendar year preceding the assessment. Each member insurer shall be notified of the assessment not later than thirty (30) days before it is due. A member insurer may not be assessed in any year an amount greater than two percent (2%) of that member insurer's net direct written premiums and any premiums received for an assumed contract after the effective date of an assumed claims transaction with a non-member insurer for the calendar year preceding the assessment. The 2% limitation on assessments shall not preclude a full payment for assumption consideration. If the

IBT/CD DRAFT VERSION #2
5/23/23

NAIC Model Laws, Regulations, Guidelines and Other Resources—April 2009

- maximum assessment, together with the other assets of the association, does not provide in any one year an amount sufficient to make all necessary payments, the funds available shall be prorated and the unpaid portion shall be paid as soon as funds become available. The association may exempt or defer, in whole or in part, the assessment of a member insurer, if the assessment would cause the member insurer's financial statement to reflect amounts of capital or surplus less than the minimum amounts required for a certificate of authority by a jurisdiction in which the member insurer is authorized to transact insurance. However, during the period of deferment no dividends shall be paid to shareholders or policyholders. Deferred assessments shall be paid when the payment will not reduce capital or surplus below required minimums. Payments shall be refunded to those companies receiving larger assessments by virtue of the deferment, or at the election of the company, credited against future assessments.
- (3) **[Alternate 1b]** Allocate claims paid and expenses incurred among the three (3) accounts separately, and assess member insurers separately for each account, amounts necessary to pay the obligations of the association under Subsection 8A(1) subsequent to an insolvency, the expenses of handling covered claims subsequent to an insolvency and other expenses authorized by this Act. The assessments of each member insurer shall be in the proportion that the net direct written premiums of the member insurer for the calendar year preceding the assessment on the kinds of insurance in the account bears to the net direct written premiums of all member insurers for the calendar year preceding the assessment on the kinds of insurance in the account. Each member insurer shall be notified of the assessment not later than thirty (30) days before it is due. A member insurer may not be assessed in any one year on any account an amount greater than two percent (2%) of that member insurer's net direct written premiums for the calendar year preceding the assessment on the kinds of insurance in the account. If the maximum assessment, together with the other assets of the association in any account, does not provide in any one year in any account an amount sufficient to make all necessary payments from that account, the funds available shall be pro-rated and the unpaid portion shall be paid as soon thereafter as funds become available. The association may exempt or defer, in whole or in part, the assessment of a member insurer, if the assessment would cause the member insurer's financial statement to reflect amounts of capital or surplus less than the minimum amounts required for a certificate of authority by a jurisdiction in which the member insurer is authorized to transact insurance. However, during the period of deferment no dividends shall be paid to shareholders or policyholders. Deferred assessments shall be paid when the payment will not reduce capital or surplus below required minimums. Payments shall be refunded to those companies receiving larger assessments by virtue of such deferment, or at the election of the company, credited against future assessments. A member insurer may set off against any assessment, authorized payments made on covered claims and expenses incurred in the payment of claims by the member insurer if they are chargeable to the account for which the assessment is made.]
- (3) **[Alternate 2b]** Allocate claims paid and expenses incurred among the three (3) accounts separately, and assess member insurers separately for each account, amounts necessary to pay the obligations of the association under Subsection 8A(1) subsequent to an insolvency, the expenses of handling covered claims subsequent to an insolvency and other expenses authorized by this Act. The assessments of each member insurer shall be in the proportion that the net direct written premiums and any premiums received for an assumed contract after the effective date of an assumed claims transaction with a non-member insurer of the member insurer for the calendar year preceding the assessment on the kinds of insurance in the account bears to the net direct written premiums and any premiums received for an assumed contract after the effective date of an assumed claims transaction with a non-member insurer of all member insurers for the calendar year preceding the assessment on the kinds of insurance in the account. Each member insurer shall be notified of the assessment not later than thirty (30) days before it is due. A member insurer may not be assessed in any one year on any account an amount greater than two percent (2%) of that member insurer's net direct written premiums and any premiums received for an assumed contract after the effective date of an assumed claims transaction with a non-member insurer for the calendar year preceding the assessment on the kinds of insurance in the account. The 2% limitation on assessments shall not preclude a full payment for assumption consideration. If the

MO-540-11

IBT/CD DRAFT VERSION #2
5/23/23

Property and Casualty Insurance Guaranty Association Model Act

maximum assessment, together with the other assets of the association in any account, does not provide in any one year in any account an amount sufficient to make all necessary payments from that account, the funds available shall be pro-rated and the unpaid portion shall be paid as soon thereafter as funds become available. The association may exempt or defer, in whole or in part, the assessment of a member insurer, if the assessment would cause the member insurer's financial statement to reflect amounts of capital or surplus less than the minimum amounts required for a certificate of authority by a jurisdiction in which the member insurer is authorized to transact insurance. However, during the period of deferment no dividends shall be paid to shareholders or policyholders. Deferred assessments shall be paid when the payment will not reduce capital or surplus below required minimums. Payments shall be refunded to those companies receiving larger assessments by virtue of such deferment, or at the election of the company, credited against future assessments. A member insurer may set off against any assessment, authorized payments made on covered claims and expenses incurred in the payment of claims by the member insurer if they are chargeable to the account for which the assessment is made.]

- (4) Investigate claims brought against the association and adjust, compromise, settle and pay covered claims to the extent of the association's obligation and deny all other claims. The association shall pay claims in any order that it may deem reasonable, including the payment of claims as they are received from the claimants or in groups or categories of claims. The association shall have the right to appoint and to direct legal counsel retained under liability insurance policies for the defense of covered claims.
- (5) Notify claimants in this State as deemed necessary by the commissioner and upon the commissioner's request, to the extent records are available to the association.

Drafting Note: The intent of this paragraph is to allow, in exceptional circumstances, supplementary notice to that given by the domiciliary receiver.

- (6) (a) Have the right to review and contest as set forth in this subsection settlements, releases, compromises, waivers and judgments to which the insolvent insurer or its insureds were parties prior to the entry of the order of liquidation. In an action to enforce settlements, releases and judgments to which the insolvent insurer or its insureds were parties prior to the entry of the order of liquidation, the Association shall have the right to assert the following defenses, in addition to the defenses available to the insurer:
 - (i) The association is not bound by a settlement, release, compromise or waiver executed by an insured or the insurer, or any judgment entered against an insured or the insurer by consent or through a failure to exhaust all appeals, if the settlement, release, compromise, waiver or judgment was:
 - (I) Executed or entered within 120 days prior to the entry of an order of liquidation, and the insured or the insurer did not use reasonable care in entering into the settlement, release, compromise, waiver or judgment, or did not pursue all reasonable appeals of an adverse judgment; or
 - (II) Executed by or taken against an insured or the insurer based on default, fraud, collusion or the insurer's failure to defend.

MO-540-12

IBT/CD DRAFT VERSION #2

5/23/23

NAIC Model Laws, Regulations, Guidelines and Other Resources—April 2009

- (ii) If a court of competent jurisdiction finds that the association is not bound by a settlement, release, compromise, waiver or judgment for the reasons described in Subparagraph (a)(i), the settlement, release, compromise, waiver or judgment shall be set aside, and the association shall be permitted to defend any covered claim on the merits. The settlement, release, compromise, waiver or judgment may not be considered as evidence of liability or damages in connection with any claim brought against the association or any other party under this Act.
- (iii) The association shall have the right to assert any statutory defenses or rights of offset against any settlement, release, compromise or waiver executed by an insured or the insurer, or any judgment taken against the insured or the insurer.
- (b) As to any covered claims arising from a judgment under any decision, verdict or finding based on the default of the insolvent insurer or its failure to defend, the association, either on its own behalf or on behalf of an insured may apply to have the judgment, order, decision, verdict or finding set aside by the same court or administrator that entered the judgment, order, decision, verdict or finding and shall be permitted to defend the claim on the merits.
- (7) Handle claims through its own employees, one or more insurers, or other persons designated as servicing facilities, which may include the receiver for the insolvent insurer. Designation of a servicing facility is subject to the approval of the commissioner, but the designation may be declined by a member insurer.
- (8) Reimburse each servicing facility for obligations of the association paid by the facility and for expenses incurred by the facility while handling claims on behalf of the association and shall pay the other expenses of the association authorized by this Act.
- (9) Submit, not later than 90 days after the end of the association's fiscal year, a financial report for the preceding fiscal year in a form approved by the commissioner.
- B. The association may:
 - (1) Employ or retain persons as are necessary to handle claims and perform other duties of the association;
 - (2) Borrow funds necessary to effect the purposes of this Act in accordance with the plan of operation;
 - (3) Sue or be sued;
 - (4) Negotiate and become a party to contracts necessary to carry out the purpose of this Act;
 - (5) Perform other acts necessary or proper to effectuate the purpose of this Act;
 - (6) Refund to the member insurers in proportion to the contribution of each member insurer to the association that amount by which the assets of the association exceed the liabilities, if at the end of any calendar year, the board of directors finds that the assets of the association exceed the liabilities of the association as estimated by the board of directors for the coming year.

[Alternate Section 8B(6)

- (6) *Refund to the member insurers in proportion to the contribution of each member insurer to that account that amount by which the assets of the account exceed the liabilities, if at the end of any calendar year, the board of directors finds that the assets of the association in any account exceed the liabilities of that account as estimated by the board of directors for the coming year.]*

MO-540-13

IBT/CD DRAFT VERSION #2
5/23/23

Property and Casualty Insurance Guaranty Association Model Act

Drafting Note: The working group/task force feels that the board of directors should determine the amount of the refunds to members when the assets of the association exceed its liabilities. However, since this excess may be quite small, the board is given the option of retaining all or part of it to pay expenses and possibly remove the need for a relatively small assessment at a later time.

C. Suits involving the association:

- (1) Except for actions by the receiver, all actions relating to or arising out of this Act against the association shall be brought in the courts in this State. The courts shall have exclusive jurisdiction over all actions relating to or arising out of this Act against the association.
- (2) The exclusive venue in any action by or against the association is in [designate appropriate court]. The association may, at its option, waive this venue as to specific actions.

[Optional Section 8D

D. (1)

The legislature finds:

- (a) *The potential for widespread and massive damage to persons and property caused by natural disasters such as earthquakes, windstorms, or fire in this State can generate insurance claims of such a number as to render numerous insurers operating within this State insolvent and therefore unable to satisfy covered claims;*
 - (b) *The inability of insureds within this State to receive payments of covered claims or to timely receive the payments creates financial and other hardships for insureds and places undue burdens on the State, the affected units of local government, and the community at large;*
 - (c) *The insolvency of a single insurer in a material amount or a catastrophic event may result in the same hardships as those produced by a natural disaster;*
 - (d) *The State has previously taken action to address these problems by adopting the [insert name of guaranty association act], which among other things, provides a mechanism for the payment of covered claims under certain insurance policies to avoid excessive delay in payment and to avoid financial loss to claimants or policyholders because of the insolvency of an insurer; and*
 - (e) *In order for the association to timely pay claims of insolvent insurers in this State and otherwise carry out its duties, the association may require additional financing options. The intent of the Legislature is to make those options available to the association in the event that a natural disaster such as an earthquake, windstorm, fire or material insolvency of any member insurer results in covered claim obligations currently payable by the association in excess of its capacity to pay from current funds and current assessments under Subsection A(3). In cases where the association determines that it is cost effective, the association may issue bonds as provided in this subsection. In determining whether to issue bonds, the association shall consider the transaction costs of issuing the bonds.*
- (2) *In the event a natural disaster such as an earthquake, windstorm, fire or material insolvency of any member insurer results in covered claim obligations currently payable by the association in excess of its capacity to pay from current funds and current assessments under Subsection 8A(3), the association, in its sole discretion, may by resolution request the [insert name of agency] Agency to issue bonds pursuant to [insert statutory authority], in such amounts as the association may determine to provide funds for the payment of covered claims and expenses related thereto. In the event bonds are issued, the association shall have the authority to annually assess member insurers for amounts necessary to pay the principal of, and interest on those bonds. Assessments collected pursuant to this authority shall be collected under the same procedures as provided in Subsection 8A(3) and, notwithstanding the two percent (2%) limit in Subsection 8A(3), shall be limited to an additional [insert percentage] percent of the annual net direct written premium in*

MO-540-14

IBT/CD DRAFT VERSION #2

5/23/23

NAIC Model Laws, Regulations, Guidelines and Other Resources—April 2009

this State of each member insurer for the calendar year preceding the assessment. The commissioner's approval shall be required for any assessment greater than five percent (5%). Assessments collected pursuant to this authority may only be used for servicing the bond obligations provided for in this subsection and shall be pledged for that purpose.

- (3) *In addition to the assessments provided for in this subsection, the association in its discretion, and after considering other obligations of the association, may utilize current funds of the association, assessments made under Subsection 8A(3) and advances or dividends received from the liquidators of insolvent insurers to pay the principal and interest on any bonds issued at the board's request.*
- (4) *Assessments under this subsection shall be payable in twelve (12) monthly installments with the first installment being due and payable at the end of the month after an assessment is levied, and subsequent installments being due not later than the end of each succeeding month.*
- (5) *In order to assure that insurers paying assessments levied under this subsection continue to charge rates that are neither inadequate nor excessive, within ninety (90) days after being notified of the assessments, each insurer that is to be assessed pursuant to this subsection shall make a rate filing for lines of business additionally assessed under this subsection. If the filing reflects a rate change that, as a percentage, is equal to the difference between the rate of the assessment and the rate of the previous year's assessment under this subsection, the filing shall consist of a certification so stating and shall be deemed approved when made. Any rate change of a different percentage shall be subject to the standards and procedures of [cite appropriate statutory authority for provisions on filing and approval of rates].*

Drafting Note: This provision should only be considered by those States that have serious concerns that circumstances could result in a substantial capacity problem resulting in unpaid or pro rata payment of claims. An association intending to consider this provision should first consult with experienced bond counsel in its State to identify an appropriate State agency or bonding authority to act as vehicle for issuing the bonds. That agency or authority's statute may also have to be amended to specifically authorize these types of bonds and to cross-reference this provision in the guaranty association law. It is possible that in some situations a new bonding authority may have to be created for this purpose.

Regardless of the vehicle used, it is important that the decision-making authority on whether bonds are needed and in what amounts be retained by the association's board.

The extent of additional assessment authority under this subsection has not been specified. When considering the amount of additional authority that will be needed, a determination should be made as to the amount of funds needed to service the bonds. More specifically, consideration should be given to the amount of the bonds to be issued, interest rate and the maturity date of the bonds. The association should be able to raise sufficient funds through assessments to pay the interest and retire the bonds after some reasonable period (e.g. ten (10) years). Subsection D(2) requires the Commissioner's approval before the association can impose an additional assessment in excess of 5%. This is to assure that the additional assessment will not result in financial hardship to the member insurers and additional insolvencies.

The intent of Subsection D(4) is to permit recoupment by member insurers of the additional cost of assessments under this subsection without any related regulatory approval. A State enacting this subsection may need to revise Subsection D(4) so that it conforms to the particular State's recoupment provisions, as well as the provisions on filing and approval of rates.]

Section 9. Plan of Operation

- A.
 - (1) The association shall submit to the commissioner a plan of operation and any amendments to the plan of operation necessary or suitable to assure the fair, reasonable and equitable administration of the association. The plan of operation and amendments shall become effective upon approval in writing by the commissioner.
 - (2) If the association fails to submit a suitable plan of operation within ninety (90) days following the effective date of this Act, or if at any time thereafter the association fails to submit suitable amendments to the plan, the commissioner shall, after notice and hearing, adopt reasonable rules necessary or advisable to effectuate the provisions of this Act. The rules shall continue in force until modified by the commissioner or superseded by a plan submitted by the association and approved by the commissioner.
- B. All member insurers shall comply with the plan of operation.

MO-540-15

IBT/CD DRAFT VERSION #2
5/23/23

Property and Casualty Insurance Guaranty Association Model Act

- C. The plan of operation shall:
- (1) Establish the procedures under which the powers and duties of the association under Section 8 will be performed;
 - (2) Establish procedures for handling assets of the association;
 - (3) Require that written procedures be established for the disposition of liquidating dividends or other monies received from the estate of the insolvent insurer;
 - (4) Require that written procedures be established to designate the amount and method of reimbursing members of the board of directors under Section 7;
 - (5) Establish procedures by which claims may be filed with the association and establish acceptable forms of proof of covered claims;
 - (6) Establish regular places and times for meetings of the board of directors;
 - (7) Require that written procedures be established for records to be kept of all financial transactions of the association, its agents and the board of directors;
 - (8) Provide that any member insurer aggrieved by any final action or decision of the association may appeal to the commissioner within thirty (30) days after the action or decision;
 - (9) Establish the procedures under which selections for the board of directors will be submitted to the commissioner;
 - (10) Contain additional provisions necessary or proper for the execution of the powers and duties of the association.
- D. The plan of operation may provide that any or all powers and duties of the association, except those under Sections 8A(3) and 8B(2), are delegated to a corporation, association similar to the association or other organization which performs or will perform functions similar to those of this association or its equivalent in two (2) or more States. The corporation, association similar to the association or organization shall be reimbursed as a servicing facility would be reimbursed and shall be paid for its performance of any other functions of the association. A delegation under this subsection shall take effect only with the approval of both the board of directors and the commissioner, and may be made only to a corporation, association or organization which extends protection not substantially less favorable and effective than that provided by this Act.

Section 10. Duties and Powers of the Commissioner

- A. The commissioner shall:
- (1) Notify the association of the existence of an insolvent insurer not later than three (3) days after the commissioner receives notice of the determination of the insolvency. The association shall be entitled to a copy of a complaint seeking an order of liquidation with a finding of insolvency against a member company at the same time that the complaint is filed with a court of competent jurisdiction;
 - (2) Provide the association with a statement of the net direct written premiums of each member insurer upon request of the board of directors.

MO-540-16

IBT/CD DRAFT VERSION #2

5/23/23

NAIC Model Laws, Regulations, Guidelines and Other Resources—April 2009

- B. The commissioner may:
- (1) Suspend or revoke, after notice and hearing, the certificate of authority to transact insurance in this State of a member insurer that fails to pay an assessment when due or fails to comply with the plan of operation. As an alternative, the commissioner may levy a fine on a member insurer that fails to pay an assessment when due. The fine shall not exceed five percent (5%) of the unpaid assessment per month, except that a fine shall not be less than \$100 per month;
 - (2) Revoke the designation of a servicing facility if the commissioner finds claims are being handled unsatisfactorily.
 - (3) Examine, audit, or otherwise regulate the association.

Drafting Note: This section does not require periodic examinations of the guaranty associations but allows the commissioner to conduct examinations as the commissioner deems necessary.

- C. A final action or order of the commissioner under this Act shall be subject to judicial review in a court of competent jurisdiction.

Section 11. Coordination Among Guaranty Associations

- A. The association may join one or more organizations of other State associations of similar purposes, to further the purposes and administer the powers and duties of the association. The association may designate one or more of these organizations to act as a liaison for the association and, to the extent the association authorizes, to bind the association in agreements or settlements with receivers of insolvent insurance companies or their designated representatives.
- B. The association, in cooperation with other obligated or potentially obligated guaranty associations, or their designated representatives, shall make all reasonable efforts to coordinate and cooperate with receivers, or their designated representatives, in the most efficient and uniform manner, including the use of Uniform Data Standards as promulgated or approved by the National Association of Insurance Commissioners.

Section 12. Effect of Paid Claims

- A. Any person recovering under this Act shall be deemed to have assigned any rights under the policy to the association to the extent of his or her recovery from the association. Every insured or claimant seeking the protection of this Act shall cooperate with the association to the same extent as the person would have been required to cooperate with the insolvent insurer. The association shall have no cause of action against the insured of the insolvent insurer for sums it has paid out except any causes of action as the insolvent insurer would have had if the sums had been paid by the insolvent insurer and except as provided in Subsection B and in Section 13. In the case of an insolvent insurer operating on a plan with assessment liability, payments of claims of the association shall not operate to reduce the liability of the insureds to the receiver, liquidator or statutory successor for unpaid assessments.
- B. The association shall have the right to recover from any person who is an affiliate of the insolvent insurer all amounts paid by the association on behalf of that person pursuant to the Act, whether for indemnity, defense or otherwise.
- C. The association and any association similar to the association in another State shall be entitled to file a claim in the liquidation of an insolvent insurer for any amounts paid by them on covered claim obligations as determined under this Act or similar laws in other States and shall receive dividends and other distributions at the priority set forth in [insert reference to State priority of distribution in liquidation act].
- D. The association shall periodically file with the receiver or liquidator of the insolvent insurer statements of the covered claims paid by the association and estimates of anticipated claims on the association which shall preserve the rights of the association against the assets of the insolvent insurer.

MO-540-17

IBT/CD DRAFT VERSION #2
5/23/23

Property and Casualty Insurance Guaranty Association Model Act

Section 13 [Optional] Net Worth Exclusion

Drafting Note: Various alternatives are provided for a net worth limitation in the guaranty association act. States may choose any of the Subsection B alternatives below or may elect to not have any net worth limitation. Subsection A, which defines "high net worth insured," has two alternates allowing States to choose different net worth limitations for first and third party claims if that State chooses alternatives 1 or 2 to Subsection B. Subsections C, D and E are recommended to accompany any of the Subsection B alternatives. In cases where States elect not to include net worth, States may either omit this section in its entirety or include only Subsection C, which excludes from coverage claims denied by other States' net worth restrictions pursuant to those States' guaranty association laws.

- A. For purposes of this section "high net worth insured" shall mean any insured whose net worth exceeds \$50 million on December 31 of the year prior to the year in which the insurer becomes an insolvent insurer; provided that an insured's net worth on that date shall be deemed to include the aggregate net worth of the insured and all of its subsidiaries and affiliates as calculated on a consolidated basis.

[Alternate Section 13A

- A. (1) *For the purposes of Subsection B(1), "high net worth insured" shall mean any insured whose net worth exceeds \$25 million on December 31 of the year prior to the year in which the insurer becomes an insolvent insurer; provided that an insured's net worth on that date shall be deemed to include the aggregate net worth of the insured and all of its subsidiaries and affiliates as calculated on a consolidated basis.]*
- (2) *For the purpose of Subsection B(2) [and B(4) if Alternative 2 for Subsection B is selected] "high net worth insured" shall mean any insured whose net worth exceeds \$50 million on December 31 of the year prior to the year in which the insurer becomes an insolvent insurer; provided that an insured's net worth on that date shall be deemed to include the aggregate net worth of the insured and all of its subsidiaries and affiliates as calculated on a consolidated basis.*

Drafting Note: Alternate Subsection A language should only be considered in cases where a State is considering Alternative 1 or 2 of Subsection B and would like to set different dollar thresholds for the first party claim exclusion provision and the third party recovery provision.

Drafting Note: States may wish to consider the impact on governmental entities and charitable organizations of the application of the net worth exclusion contained in the definition of "covered claim." The Michigan Supreme Court, in interpreting a "net worth" provision in the Michigan guaranty association statute, held that governmental entities possess a "net worth" for purposes of the provision in the Michigan guaranty association statute that prohibits claims against the guaranty association by a person who has a specified net worth. Oakland County Road Commission vs. Michigan Property & Casualty Guaranty Association, 575 N.W. 2d 751 (Mich. 1998).

[Alternative 1 for Section 13B

- B. (1) The association shall not be obligated to pay any first party claims by a high net worth insured.
- (2) The association shall have the right to recover from a high net worth insured all amounts paid by the association to or on behalf of such insured, whether for indemnity, defense or otherwise.]

[Alternative 2 for Section 13B

- B. (1) The association shall not be obligated to pay any first party claims by a high net worth insured.
- (2) Subject to Paragraph (3), the association shall not be obligated to pay any third party claim relating to a policy of a high net worth insured. This exclusion shall not apply to third party claims against the high net worth insured where:
- (a) The insured has applied for or consented to the appointment of a receiver, trustee or liquidator for all or a substantial part of its assets;
 - (b) The insured has filed a voluntary petition in bankruptcy, filed a petition or an answer seeking a reorganization or arrangement with creditors or to take advantage of any insolvency law; or
 - (c) An order, judgment, or decree is entered by a court of competent jurisdiction, on the application of a creditor, adjudicating the insured bankrupt or insolvent or approving a petition seeking reorganization of the insured or of all or substantial part of its assets.

MO-540-18

IBT/CD DRAFT VERSION #2

5/23/23

NAIC Model Laws, Regulations, Guidelines and Other Resources—April 2009

- (3) Paragraph (2) shall not apply to workers' compensation claims, personal injury protection claims, no-fault claims and any other claims for ongoing medical payments to third parties.
- (4) The association shall have the right to recover from a high net worth insured all amounts paid by the association to or on behalf of such insured, whether for indemnity, defense or otherwise.]

[Alternative 3 for Section 13B

- B. The association shall not be obligated to pay any first party claims by a high net worth insured.]
- C. The association shall not be obligated to pay any claim that would otherwise be a covered claim that is an obligation to or on behalf of a person who has a net worth greater than that allowed by the insurance guaranty association law of the State of residence of the claimant at the time specified by that State's applicable law, and which association has denied coverage to that claimant on that basis.
- D. The association shall establish reasonable procedures subject to the approval of the commissioner for requesting financial information from insureds on a confidential basis for purposes of applying this section, provided that the financial information may be shared with any other association similar to the association and the liquidator for the insolvent insurer on the same confidential basis. Any request to an insured seeking financial information must advise the insured of the consequences of failing to provide the financial information. If an insured refuses to provide the requested financial information where it is requested and available, the association may, until such time as the information is provided, provisionally deem the insured to be a high net worth insured for the purpose of denying a claim under Subsection B.
- E. In any lawsuit contesting the applicability of this section where the insured has refused to provide financial information under the procedure established pursuant to Subsection D, the insured shall bear the burden of proof concerning its net worth at the relevant time. If the insured fails to prove that its net worth at the relevant time was less than the applicable amount, the court shall award the association its full costs, expenses and reasonable attorneys' fees in contesting the claim.

Section 14. Exhaustion of Other Coverage

- A. (1) Any person having a claim against an insurer, shall be required first to exhaust all coverage provided by any other policy, including the right to a defense under the other policy, if the claim under the other policy arises from the same facts, injury or loss that gave rise to the covered claim against the association. The requirement to exhaust shall apply without regard to whether the other insurance policy is a policy written by a member insurer. However, no person shall be required to exhaust any right under the policy of an insolvent insurer or any right under a life insurance policy.
- (2) Any amount payable on a covered claim under this Act shall be reduced by the full applicable limits stated in the other insurance policy, or by the amount of the recovery under the other insurance policy as provided herein. The association shall receive a full credit for the stated limits, unless the claimant demonstrates that the claimant used reasonable efforts to exhaust all coverage and limits applicable under the other insurance policy. If the claimant demonstrates that the claimant used reasonable efforts to exhaust all coverage and limits applicable under the other insurance policy, or if there are no applicable stated limits under the policy, the association shall receive a full credit for the total recovery.

[Alternative 1 for Section 14A(2)(a)

- (a) The credit shall be deducted from the lesser of:
 - (i) The association's covered claim limit;
 - (ii) The amount of the judgment or settlement of the claim; or
 - (iii) The policy limits of the policy of the insolvent insurer.]

MO-540-19

IBT/CD DRAFT VERSION #2
5/23/23

Property and Casualty Insurance Guaranty Association Model Act

[Alternative 2 for Section 14A(2)(a)]

The credit shall be deducted from the lesser of:

- (i) The amount of the judgment or settlement of the claim; or
- (ii) The policy limits of the policy of the insolvent insurer./

- (b) In no case, however, shall the obligation of the association exceed the covered claim limit embodied in Section 8 of this Act.
- (3) Except to the extent that the claimant has a contractual right to claim defense under an insurance policy issued by another insurer, nothing in this section shall relieve the association of the duty to defend under the policy issued by the insolvent insurer. This duty shall, however, be limited by any other limitation on the duty to defend embodied in this Act.
- (4) A claim under a policy providing liability coverage to a person who may be jointly and severally liable as a joint tortfeasor with the person covered under the policy of the insolvent insurer that gives rise to the covered claim shall be considered to be a claim arising from the same facts, injury or loss that gave rise to the covered claim against the association.
- (5) For purposes of this section, a claim under an insurance policy other than a life insurance policy shall include, but is not limited to:
 - (a) A claim against a health maintenance organization, a hospital plan corporation, a professional health service corporation or disability insurance policy; and
 - (b) Any amount payable by or on behalf of a self-insurer.
- (6) The person insured by the insolvent insurer's policy may not be pursued by a third-party claimant for any amount paid to the third party by which the association's obligation is reduced by the application of this section.
- B. Any person having a claim which may be recovered under more than one insurance guaranty association or its equivalent shall seek recovery first from the association of the place of residence of the insured, except that if it is a first party claim for damage to property with a permanent location, the person shall seek recovery first from the association of the location of the property. If it is a workers' compensation claim, the person shall seek recovery first from the association of the residence of the claimant. Any recovery under this Act shall be reduced by the amount of recovery from another insurance guaranty association or its equivalent.

Drafting Note: This subsection does not prohibit recovery from more than one association, but it does describe the association to be approached first and then requires that any previous recoveries from like associations must be set off against recoveries from this association.

Section 15. Prevention of Insolvencies

To aid in the detection and prevention of insurer insolvencies:

- A. The board of directors may, upon majority vote, make recommendations to the commissioner on matters generally related to improving or enhancing regulation for solvency.
- B. At the conclusion of any domestic insurer insolvency in which the association was obligated to pay covered claims, the board of directors may, upon majority vote, prepare a report on the history and causes of the insolvency, based on the information available to the association and submit the report to the commissioner.
- C. Reports and recommendations provided under this section shall not be considered public documents.

MO-540-20

IBT/CD DRAFT VERSION #2

5/23/23

NAIC Model Laws, Regulations, Guidelines and Other Resources—April 2009

Section 16. Tax Exemption

The association shall be exempt from payment of all fees and all taxes levied by this State or any of its subdivisions except taxes levied on real or personal property.

Section 17. Recoupment of Assessments

Drafting Note: States may choose how they wish to allow member insurers to recoup assessments paid by selecting one of three alternatives for Section 17.

[Alternative 1 for Section 17]

- A. Except as provided in Subsection D, each member insurer shall annually recoup assessments it remitted in preceding years under Section 8. The recoupment shall be by means of a policyholder surcharge on premiums charged for all kinds of insurance in the accounts assessed. The surcharge shall be at a uniform percentage rate determined annually by the commissioner that is reasonably calculated to recoup the assessment remitted by the insurer, less any amounts returned to the member insurer by the association. Changes in this rate shall be effective no sooner than 180 days after insurers have received notice of the changed rate.
- B. If a member insurer fails to recoup the entire amount of the assessment in the first year under this section, it shall repeat the surcharge procedure provided for herein in succeeding years until the assessment is fully recouped or a de minimis amount remains uncollected. Any such de minimis amount shall be collected as provided in Subsection D of this section. If a member insurer collects excess surcharges, the insurer shall remit the excess amount to the association, and the excess amount shall be applied to reduce future assessments in the appropriate account.
- C. The amount and nature of any surcharge shall be separately stated on either a billing or policy declaration sent to an insured. The surcharge shall not be considered premium for any purpose, including the [insert all appropriate taxes] or agents' commission.
- D. A member may elect not to collect the surcharge from its insureds only when the expense of collecting the surcharge would exceed the amount of the surcharge. In that case, the member shall recoup the assessment through its rates, provided that:
 - (1) The insurer shall be obligated to remit the amount of surcharge not collected by election under this subsection; and
 - (2) The last sentence in Subsection C above shall not apply.
- E. In determining the rate under Subsection A for the first year of recoupment under this section, under rules prescribed by the commissioner, the commissioner shall provide for the recoupment in that year, or in such reasonable period as the commissioner may determine, of any assessments that have not been recouped as of that year. Insurers shall not be required to recoup assessments through surcharges under this section until 180 days after this section takes effect.]

[Alternative 2 for Section 17]

- A. Notwithstanding any provision of [insert citation to relevant tax and insurance codes] to the contrary, a member insurer may offset against its [insert all appropriate taxes] liability the entire amount of the assessment imposed under this Act at a rate of [insert number] percent per year for [insert number of years] successive years following the date of assessment. If the assessment is not fully recovered over the [insert number of years] period, the remaining unrecovered assessment may be claimed for subsequent calendar years until fully recovered.

Drafting Note: States may choose the number of years to allow an insurer to offset an assessment against the insurer's premium tax liability.

- B. Any tax credit under this section shall, for the purposes of Section [insert citation to retaliatory tax statute] be treated as a tax paid both under the tax laws of this State and under the laws of any other State or country.

MO-540-21

IBT/CD DRAFT VERSION #2
5/23/23

Property and Casualty Insurance Guaranty Association Model Act

- C. If a member insurer ceases doing business in this State, any uncredited assessment may be credited against its [insert all appropriate taxes] during the year it ceases doing business in this State.
- D. Any sums that are acquired by refund from the association by member insurers and that have been credited against [insert all appropriate taxes], as provided in this section, shall be paid by member insurers to this State as required by the department. The association shall notify the department that the refunds have been made./

[Alternative 3 for Section 17]

The rates and premiums charged for insurance policies to which this section applies shall include amounts sufficient to recoup a sum equal to the amounts paid to the association by the member insurer less any amounts returned to the member insurer by the association. Rates shall not be deemed excessive because they contain an additional amount reasonably calculated to recoup all assessments paid by the member insurer./

Section 18. Immunity

There shall be no liability on the part of, and no cause of action of any nature shall arise against a member insurer, the association or its agents or employees, the board of directors, or any person serving as an alternate or substitute representative of any director, or the commissioner or the commissioner's representatives for any action taken or any failure to act by them in the performance of their powers and duties under this Act

Section 19. Stay of Proceedings

All proceedings in which the insolvent insurer is a party or is obligated to defend a party in any court in this State shall, subject to waiver by the association in specific cases involving covered claims, be stayed for six (6) months and such additional time as may be determined by the court from the date the insolvency is determined or an ancillary proceeding is instituted in the State, whichever is later, to permit proper defense by the association of all pending causes of action.

The liquidator, receiver or statutory successor of an insolvent insurer covered by this Act shall permit access by the board or its authorized representative to such of the insolvent insurer's records which are necessary for the board in carrying out its functions under this Act with regard to covered claims. In addition, the liquidator, receiver or statutory successor shall provide the board or its representative with copies of those records upon the request by the board and at the expense of the board.

Chronological Summary of Actions (all references are to the Proceedings of the NAIC).

1970 Proc. 1 218, 252, 253-262, 298 (adopted).
 1972 Proc. 1 15, 16, 443, 477-478, 479-480 (amended).
 1973 Proc. 1 9, 11, 140, 154, 155-157 (amended).
 1973 Proc. II 18, 21, 370, 394, 396 (recoupment formula adopted).
 1979 Proc. 1 44, 46, 126, 217 (amended).
 1981 Proc. 1 47, 50, 175, 225 (amended).
 1984 Proc. 1 6, 31, 196, 326, 352 (amended).
 1986 Proc. 1 9-10, 22, 149, 294, 296-305 (amended and reprinted).
 1986 Proc. II 410-411 (amendments adopted later printed here).
 1987 Proc. 1 11, 18, 161, 421, 422, 429, 450-452 (amended).
 1993 Proc. 2nd Quarter 12, 33, 227, 600, 602, 621 (amended).
 1994 Proc. 4th Quarter 17, 26, 366, 376, 579-589 (amended and reprinted).
 1996 Proc. 1st Quarter 29-30, 123, 564, 570, 570-580 (amended and reprinted).
 2009 Proc. 1st Quarter, Vol 1 111, 139, 188, 288-317 (amended).

MO-540-22

MODEL 540 IBT/CD PROPOSED AMENDMENTS**VERSION #2 DESCRIPTION**

	VERSION #2
IBT/CD MEMBER TO MEMBER	Always covered
OTHER MEMBER TO MEMBER	Always covered
IBT/CD MEMBER TO NONMEMBER	Always covered
OTHER MEMBER TO NONMEMBER	Default and Alternative 3
IBT/CD NONMEMBER TO MEMBER	Always covered
OTHER NONMEMBER TO MEMBER	Default and Alternative 3

Overriding observations.

1. Version #2 proposal:
 - a. Is far simpler (in all cases only one section need be edited),
 - b. Accomplishes the goal of preserving IBT and CD GA coverage whether or not the state has adopted the assumed claims provision, and
 - c. Does not take away any coverage currently provided by the Model Act.
2. Where the proposals differ is that (unlike Version #2) Version #1 proposal provides a mechanism for the NAIC to reverse the 2009 inclusion of optional assumed claim coverage. That is to say, one version of their proposal can be adopted by the NAIC to achieve this result. The states already have that option and have exercised it by either adopting or not adopting that language from the 2009 amendments.
3. Version #1 highlights narrow areas in which one might interpret existing law (state or model) as excluding GA coverage, but those instances are unrelated to IBT and CD transactions and, at least in my view, are contrary to current custom and practice or so exotic as to never having arisen.

NCIGF Suggested Amendments Cyber Liability Claims
May 23, 2023

NAIC Model Laws, Regulations, Guidelines and Other Resources—April 2009

PROPERTY AND CASUALTY INSURANCE GUARANTY ASSOCIATION MODEL ACT**Table of Contents**

Section 1.	Title
Section 2.	Purpose Section
Section 3.	Scope
Section 4.	Construction
Section 5.	Definitions
Section 6.	Creation of the Association
Section 7.	Board of Directors
Section 8.	Powers and Duties of the Association
Section 9.	Plan of Operation
Section 10.	Duties and Powers of the Commissioner
Section 11.	Coordination Among Guaranty Associations
Section 12.	Effect of Paid Claims Section 13
Section 13.	[Optional] Net Worth Exclusion
Section 14.	Exhaustion of Other Coverage
Section 15.	Prevention of Insolvencies
Section 16.	Tax Exemption
Section 17.	Recoupment of Assessments
Section 18.	Immunity
Section 19.	Stay of Proceedings

Section 1. Title

This Act shall be known as the [State] Insurance Guaranty Association Act.

Section 2. Purpose

The purpose of this Act is to provide a mechanism for the payment of covered claims under certain insurance policies, to avoid excessive delay in payment and to the extent provided in this Act minimize financial loss to claimants or policyholders because of the insolvency of an insurer, and to provide an association to assess the cost of such protection among insurers.

Section 3. Scope

This Act shall apply to all kinds of direct insurance, but shall not be applicable to the following:

- A. Life, annuity, health or disability insurance;
- B. Mortgage guaranty, financial guaranty or other forms of insurance offering protection against investment risks;
- C. Fidelity or surety bonds, or any other bonding obligations;
- D. Credit insurance, vendors' single interest insurance, or collateral protection insurance or any similar insurance protecting the interests of a creditor arising out of a creditor-debtor transaction;

NCIGF Suggested Amendments Cyber Liability Claims

May 23, 2023

Property and Casualty Insurance Guaranty Association Model Act

- E. Other than coverages that may be set forth in a cybersecurity insurance policy, insurance Insuree—of warranties or service contracts including insurance that provides for the repair, replacement or service of goods or property, indemnification for repair, replacement or service for the operational or structural failure of the goods or property due to a defect in materials, workmanship or normal wear and tear, or provides reimbursement for the liability incurred by the issuer of agreements or service contracts that provide such benefits;
- F. Title insurance;
- G. Ocean marine insurance;
- H. Any transaction or combination of transactions between a person (including affiliates of such person) and an insurer (including affiliates of such insurer) which involves the transfer of investment or credit risk unaccompanied by transfer of insurance risk; or
- I. Any insurance provided by or guaranteed by government.

Drafting Note: This Act focuses on property and liability kinds of insurance and therefore exempts those kinds of insurance deemed to present problems quite distinct from those of property and liability insurance. The Act further precludes from its scope certain types of insurance that provide protection for investment and financial risks. Financial guaranty is one of these. The NAIC Life and Health Insurance Guaranty Association Model Act provides for coverage of some of the lines excluded by this provision.

For purposes of this section, “Financial guaranty insurance” includes any insurance under which loss is payable upon proof of occurrence of any of the following events to the damage of an insured claimant or obligee:

1. Failure of any obligor or obligors on any debt instrument or other monetary obligation, including common or preferred stock, to pay when due the principal, interest, dividend or purchase price of such instrument or obligation, whether failure is the result of a financial default or insolvency and whether or not the obligation is incurred directly or as guarantor by, or on behalf of, another obligor which has also defaulted;
2. Changes in the level of interest rates whether short term or long term, or in the difference between interest rates existing in various markets;
3. Changes in the rate of exchange of currency, or from the inconvertibility of one currency into another for any reason;
4. Changes in the value of specific assets or commodities, or price levels in general.

For purposes of this section, “credit insurance” means insurance on accounts receivable.

The terms “disability insurance” and “accident and health insurance,” and “health insurance” are intended to be synonymous. Each State will wish to examine its own statutes to determine which is the appropriate phrase.

A State where the insurance code does not adequately define ocean marine insurance may wish to add the following to Section 5, Definitions: “Ocean marine insurance” means any form of insurance, regardless of the name, label or marketing designation of the insurance policy, which insures against maritime perils or risks and other related perils or risks, which are usually insured against by traditional marine insurance, such as hull and machinery, marine builders risk, and marine protection and indemnity. Perils and risk insured against include without limitation loss, damage, expense or legal liability of the insured for loss, damage or expense arising out of or incident to ownership, operation, chartering, maintenance, use, repair or construction of any vessel, craft or instrumentality in use in ocean or inland waterways for commercial purposes, including liability of the insured for personal injury, illness or death or for loss or damage to the property of the insured or another person.

Section 4. Construction

This Act shall be construed to effect the purpose under Section 2 which will constitute an aid and guide to interpretation.

NCIGF Suggested Amendments Cyber Liability Claims
May 23, 2023

NAIC Model Laws, Regulations, Guidelines and Other Resources—April 2009

Section 5. Definitions

As used in this Act:

[Optional:

- A. *“Account” means any one of the three accounts created by Section 6.]*

Drafting Note: This definition should be used by those States wishing to create separate accounts for assessment purposes. For a note on the use of separate accounts for assessments see the Drafting Note after Section 6. If this definition is used, all subsequent subsections should be renumbered.

- A. “Affiliate” means a person who directly, or indirectly, through one or more intermediaries, controls, is controlled by, or is under common control with another person on December 31 of the year immediately preceding the date the insurer becomes an insolvent insurer.
- B. “Association” means the [State] Insurance Guaranty Association created under Section 6.
- C. “Association similar to the association” means any guaranty association, security fund or other insolvency mechanism that affords protection similar to that of the association. The term shall also include any property and casualty insolvency mechanism that obtains assessments or other contributions from insurers on a preinsolvency basis.

Drafting Note: There are two options for handling claims assumed by a licensed carrier from an unlicensed carrier or self insurer. Alternative 1 provides that these claims shall be covered by the guaranty association if the licensed insurer becomes insolvent subsequent to the assumption. Alternative 2 provides coverage only if the assuming carrier makes a payment to the guaranty association in an amount equal to that which the assuming carrier would have paid in guaranty association assessments had the insurer written the assumed business itself. If a State wishes to adopt Alternative 1, it must select Alternative 1 in Section 5D and Alternative 1a or 2a in Section 8A(3). If a State wishes to adopt Alternative 2, it must select Alternative 2 in Section 5D and Q and Alternative 1b or 2b in Section 8A(3).

- D. **[Alternative 1]** “Assumed claims transaction” means the following:
- (1) Policy obligations that have been assumed by the insolvent insurer, prior to the entry of a final order of liquidation, through a merger between the insolvent insurer and another entity obligated under the policies; or
 - (2) An assumption reinsurance transaction in which all of the following has occurred:
 - (a) The insolvent insurer assumed, prior to the entry of a final order of liquidation, the claim or policy obligations of another insurer or entity obligated under the claims or policies; and
 - (b) The assumption of the claim or policy obligations has been approved, if such approval is required, by the appropriate regulatory authorities; and
 - (c) As a result of the assumption, the claim or policy obligations became the direct obligations of the insolvent insurer through a novation of the claims or policies

[Alternative 2] “Assumed claims transaction” means the following:

- (1) Policy obligations that have been assumed by the insolvent insurer, prior to the entry of a final order of liquidation, through a merger between the insolvent insurer and another entity obligated under

540-3

NCIGF Suggested Amendments Cyber Liability Claims

May 23, 2023

Property and Casualty Insurance Guaranty Association Model Act

the policies, and for which Assumption Consideration has been paid to the applicable guaranty associations, if the merged entity is a non-member insurer; or

- (2) Policy obligations that have been assumed by the insolvent insurer, prior to the entry of a final order of liquidation, pursuant to a plan, approved by the domestic commissioner of the assuming insurer, which:
- (a) Transfers the direct policy obligations and future policy renewals from one insurer to another insurer; and
 - (b) For which Assumption Consideration has been paid to the applicable guaranty associations, if the assumption is from a non-member insurer.
 - (c) For purposes of this section the term non-member insurer also includes a self-insurer, non-admitted insurer and risk retention group; or
- (3) An assumption reinsurance transaction in which all of the following has occurred:
- (a) The insolvent insurer assumed, prior to the entry of a final order of liquidation, the claim or policy obligations of another insurer or entity obligated under the claims or policies;
 - (b) The assumption of the claim or policy obligations has been approved, if such approval is required, by the appropriate regulatory authorities; and
 - (c) As a result of the assumption, the claim or policy obligations became the direct obligations of the insolvent insurer through a novation of the claims or policies.
- E. “Claimant” means any person instituting a covered claim, provided that no person who is an affiliate of the insolvent insurer may be a claimant.
- F. “Commissioner” means the Commissioner of Insurance of this State.

Drafting Note: Use the appropriate title for the chief insurance regulatory official wherever the term “commissioner” appears.

- G. “Control” means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or nonmanagement services, or otherwise, unless the power is the result of an official position with or corporate office held by the person. Control shall be presumed to exist if a person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing, ten percent (10%) or more of the voting securities of any other person. This presumption may be rebutted by a showing that control does not exist in fact.
- H. “Covered claim” means the following:
- (1) An unpaid claim, including one for unearned premiums, submitted by a claimant, which arises out of and is within the coverage and is subject to the applicable limits of an insurance policy to which this Act applies, if the insurer becomes an insolvent insurer after the effective date of this Act and: the policy was either issued by the insurer or assumed by the insurer in an assumed claims transaction; and

NCIGF Suggested Amendments Cyber Liability Claims
May 23, 2023

NAIC Model Laws, Regulations, Guidelines and Other Resources—April 2009

- (a) The claimant or insured is a resident of this State at the time of the insured event, provided that for entities other than an individual, the residence of a claimant, insured or policyholder is the State in which its principal place of business is located at the time of the insured event; or
 - (b) The claim is a first party claim for damage to property with a permanent location in this State.
- (2) Except as provided elsewhere in this section, “covered claim” shall not include:
- (a) Any amount awarded as punitive or exemplary damages;
 - (b) Any amount sought as a return of premium under any retrospective rating plan;
 - (c) Any amount due any reinsurer, insurer, insurance pool or underwriting association, health maintenance organization, hospital plan corporation, professional health service corporation or self-insurer as subrogation recoveries, reinsurance recoveries, contribution, indemnification or otherwise. No claim for any amount due any reinsurer, insurer, insurance pool, underwriting association, health maintenance organization, hospital plan corporation, professional health service corporation or self-insurer may be asserted against a person insured under a policy issued by an insolvent insurer other than to the extent the claim exceeds the association obligation limitations set forth in Section 8 of this Act;
 - (d) Any claims excluded pursuant to Section 13 due to the high net worth of an insured;
 - (e) Any first party claims by an insured that is an affiliate of the insolvent insurer;
 - (f) Any fee or other amount relating to goods or services sought by or on behalf of any attorney or other provider of goods or services retained by the insolvent insurer or an insured prior to the date it was determined to be insolvent;
 - (g) Any fee or other amount sought by or on behalf of any attorney or other provider of goods or services retained by any insured or claimant in connection with the assertion or prosecution of any claim, covered or otherwise, against the association;
 - (h) Any claims for interest; or
 - (i) Any claim filed with the association or a liquidator for protection afforded under the insured’s policy for incurred-but-not-reported losses.

Drafting note: The language in this provision referring to claims for incurred-but-not-reported losses has been inserted to expressly include the existing intent of this provision and make it clear that “policyholder protection” proofs of claim, while valid to preserve rights against the State of the insolvent insurer under the Insurer Receivership Model Act, are not valid to preserve rights against the association.

I. “Cybersecurity insurance”, for purposes of this Act, includes first and third party coverage, in a policy or endorsement, written on a direct, admitted basis for losses and loss mitigation arising out of or relating to data privacy breaches, unauthorized information network security intrusions, computer viruses, ransomware, cyber extortion, identity theft, and similar exposures.

Note: This definition is optional.

NCIGF Suggested Amendments Cyber Liability Claims

May 23, 2023

Property and Casualty Insurance Guaranty Association Model Act

J. “Insolvent insurer” means an insurer that is licensed to transact insurance in this State, either at the time the policy was issued, when the obligation with respect to the covered claim was assumed under an assumed claims transaction, or when the insured event occurred, and against whom a final order of liquidation has been entered after the effective date of this Act with a finding of insolvency by a court of competent jurisdiction in the insurer’s State of domicile.

Drafting Note: “Final order” as used in this section means an order which has not been stayed. States in which the “final order” language does not accurately reflect whether or not the order is subject to a stay should substitute appropriate language consistent with the statutes or rules of the State to convey the intended meaning.

K. “Insured” means any named insured, any additional insured, any vendor, lessor or any other party identified as an insured under the policy.

L.(1) “Member insurer” means any person who:

- (a) Writes any kind of insurance to which this Act applies under Section 3, including the exchange of reciprocal or inter-insurance contracts; and
- (b) Is licensed to transact insurance in this State (except at the option of the State).

- (2) An insurer shall cease to be a member insurer effective on the day following the termination or expiration of its license to transact the kinds of insurance to which this Act applies, however, the insurer shall remain liable as a member insurer for any and all obligations, including obligations for assessments levied prior to the termination or expiration of the insurer’s license and assessments levied after the termination or expiration, which relate to any insurer that became an insolvent insurer prior to the termination or expiration of the insurer’s license.

M. “Net direct written premiums” means direct gross premiums written in this State on insurance policies to which this Act applies, including policy and membership fees, less the following amounts: (1) return premiums, (2) premiums on policies not taken, and (3) dividends paid or credited to policyholders on that direct business. “Net direct written premiums” does not include premiums on contracts between insurers or reinsurers.

N. “Novation” means that the assumed claim or policy obligations became the direct obligations of the insolvent insurer through consent of the policyholder and that thereafter the ceding insurer or entity initially obligated under the claims or policies is released by the policyholder from performing its claim or policy obligations. Consent may be express or implied based upon the circumstances, notice provided and conduct of the parties.

O. “Person” means any individual, aggregation of individuals, corporation, partnership or other entity.

P. “Receiver” means liquidator, rehabilitator, conservator or ancillary receiver, as the context requires.

Drafting Note: Each State should conform the definition of “receiver” to the definition used in the State’s insurer receivership act.

SeQ. “If-insurer” means a person that covers its liability through a qualified individual or group self-insurance program or any other formal program created for the specific purpose of covering liabilities typically covered by insurance.

NCIGF Suggested Amendments Cyber Liability Claims
May 23, 2023

NAIC Model Laws, Regulations, Guidelines and Other Resources—April 2009

R. [Alternative 2b] “Assumption Consideration” shall mean the consideration received by a guaranty association to extend coverage to the policies assumed by a member insurer from a non-member insurer in any assumed claims transaction including liabilities that may have arisen prior to the date of the transaction. The Assumption Consideration shall be in an amount equal to the amount that would have been paid by the assuming insurer during the three calendar years prior to the effective date of the transaction to the applicable guaranty associations if the business had been written directly by the assuming insurer.

In the event that the amount of the premiums for the three year period cannot be determined, the Assumption Consideration will be determined by multiplying 130% against the sum of the unpaid losses, loss adjustment expenses, and incurred but not reported losses, as of the effective date of the Assumed claims transaction, and then multiplying such sum times the applicable guaranty association assessment percentage for the calendar year of the transaction.

The funds paid to a guaranty association shall be allocated in the same manner as any assessments made during the three year period. The guaranty association receiving the Assumption Consideration shall not be required to recalculate or adjust any assessments levied during the prior three calendar years as a result of receiving the Assumption Consideration. Assumption Consideration paid by an insurer may be recouped in the same manner as other assessments made by a guaranty association.

Section 6. Creation of the Association

There is created a nonprofit unincorporated legal entity to be known as the [State] Insurance Guaranty Association. All insurers defined as member insurers in Section 5K shall be and remain members of the association as a condition of their authority to transact insurance in this State. The association shall perform its functions under a plan of operation established and approved under Section 9 and shall exercise its powers through a board of directors established under Section 7.

[Alternate Section 6. Creation of the Association

There is created a nonprofit unincorporated legal entity to be known as the [State] Insurance Guaranty Association. All insurers defined as member insurers in Section 5K shall be and remain members of the association as a condition of their authority to transact insurance in this State. The association shall perform its functions under a plan of operation established and approved under Section 9 and shall exercise its powers through a board of directors established under Section 7. For purposes of administration and assessment, the association shall be divided into three separate accounts:

- A. *The workers’ compensation insurance account;*
- B. *The automobile insurance account; and*
- C. *The account for all other insurance to which this Act applies.]*

Drafting Note: The alternate Section 6 should be used if a State, after examining its insurance market, determines that separate accounts for various kinds of insurance are necessary and feasible. The major consideration is whether each account will have a base sufficiently large to cover possible insolvencies. Separate accounts will permit assessments to be generally limited to insurers writing the same kind of insurance as the insolvent company. If this approach is adopted the provision of alternate Sections 8A(3) and 8B(6) and optional Section 5A should also be used.

Section 7. Board of Directors

- A. The board of directors of the association shall consist of not less than five (5) nor more than [insert number] persons serving terms as established in the plan of operation. The insurer members of the board shall be selected by member insurers subject to the approval of the commissioner. Vacancies on the board shall be filled for the remaining period of the term by a majority vote of the remaining insurer members subject to the

540-7

NCIGF Suggested Amendments Cyber Liability Claims

May 23, 2023

Property and Casualty Insurance Guaranty Association Model Act

approval of the commissioner. If no members are selected within sixty (60) days after the effective date of this Act, the commissioner may appoint the initial members of the board of directors. Two (2) persons, who must be public representatives, shall be appointed by the commissioner to the board of directors. Vacancies of positions held by public representatives shall be filled by the commissioner. A public representative may not be an officer, director or employee of an insurance company or any person engaged in the business of insurance. For the purposes of this section, the term “director” shall mean an individual serving on behalf of an insurer member of the board of directors or a public representative on the board of directors.

Drafting Note: A State adopting this language should make certain that its insurance code includes a definition of “the business of insurance” similar to that found in the NAIC Insurer Receivership Model Act.

- B. In approving selections to the board, the commissioner shall consider among other things whether all member insurers are fairly represented.
- C. Members of the board of directors may be reimbursed from the assets of the association for reasonable expenses incurred by them as members of the board of directors.
- D. Any board member who is an insurer in receivership shall be terminated as a *board member*, effective as of the date of the entry of the order of receivership. Any resulting vacancies on the board shall be filled for the remaining period of the term in accordance with the provisions of Subsection A.
- E. In the event that a director shall, because of illness, nonattendance at meetings or any other reason, be deemed unable to satisfactorily perform the designated functions as a director by missing three consecutive board meetings, the board of directors may declare the office vacant and the member or director shall be replaced in accordance with the provisions of Subsection A.
- F. If the commissioner has reasonable cause to believe that a director failed to disclose a known conflict of interest with his or her duties on the board, failed to take appropriate action based on a known conflict of interest with his or her duties on the board, or has been indicted or charged with a felony, or misdemeanor involving moral turpitude, the commissioner may suspend that director pending the outcome of an investigation or hearing by the commissioner or the conclusion of any criminal proceedings. A company elected to the board may replace a suspended director prior to the completion of an investigation, hearing or criminal proceeding. In the event that the allegations are substantiated at the conclusion of an investigation, hearing or criminal proceeding, the office shall be declared vacant and the member or director shall be replaced in accordance with the provisions of Subsection A.

Section 8. Powers and Duties of the Association

- A. The association shall:
 - (1) (a) Be obligated to pay covered claims existing prior to the order of liquidation, arising within thirty (30) days after the order of liquidation, or before the policy expiration date if less than thirty (30) days after the order of liquidation, or before the insured replaces the policy or causes its cancellation, if the insured does so within thirty (30) days of the order of liquidation. The obligation shall be satisfied by paying to the claimant an amount as follows:
 - (i) The full amount of a covered claim for benefits under a workers’ compensation insurance coverage;

NCIGF Suggested Amendments Cyber Liability Claims
May 23, 2023

NAIC Model Laws, Regulations, Guidelines and Other Resources—April 2009

(ii) An amount not exceeding \$10,000 per policy for a covered claim for the return of unearned premium;

(iii) An amount not exceeding \$500,000 per claimant for all other covered claims.

(iv) In no event shall the Association be obligated to pay an amount in excess of \$500,000 for all first- and third-party claims under a policy or endorsement providing or that is found to provide cybersecurity -insurance coverage and arising out of or related to a single insured event, regardless of the number of claims made or the number of claimants.

- (b) In no event shall the association be obligated to pay a claimant an amount in excess of the obligation of the insolvent insurer under the policy or coverage from which the claim arises. Notwithstanding any other provisions of this Act, a covered claim shall not include a claim filed with the guaranty fund after the final date set by the court for the filing of claims against the liquidator or receiver of an insolvent insurer.

For the purpose of filing a claim under this subsection, notice of claims to the liquidator of the insolvent insurer shall be deemed notice to the association or its agent and a list of claims shall be periodically submitted to the association or association similar to the association in another State by the liquidator.

Drafting Note: On the general subject of the relationship of the association to the liquidator, the working group/task force takes the position that since this is a model State bill, it will be able to bind only two parties, the association and the in-State liquidator. Nevertheless, the provisions should be clear enough to outline the requests being made to out-of-State liquidators and the requirements placed on in-State liquidators in relation to out-of-State associations.

Drafting Note: Because of its potential impact on guaranty association coverage, it is recommended that the legislation include an appropriate provision stating that the bar date only applies to claims in liquidation commencing after its effective date. Drafters should insure that the State's insurance liquidation act would permit, upon closure, payments to the guaranty association and any association similar to the association for amounts that are estimated to be incurred after closure for workers compensation claims obligations. The amounts should be payable on these obligations related to losses both known and not known at the point of closure.

- (c) Any obligation of the association to defend an insured shall cease upon the association's payment or tender of an amount equal to the lesser of the association's covered claim obligation limit or the applicable policy limit.

Drafting Note: The obligation of the association is limited to covered claims unpaid prior to insolvency, and to claims arising within thirty days after the insolvency, or until the policy is canceled or replaced by the insured, or it expires, whichever is earlier. The basic principle is to permit policyholders to make an orderly transition to other companies. There appears to be no reason why the association should become in effect an insurer in competition with member insurers by continuing existing policies, possibly for several years. It is also felt that the control of the policies is properly in the hands of the liquidator. Finally, one of the major objections of the public to rapid termination, loss of unearned premiums with no corresponding coverage, is ameliorated by this bill since unearned premiums are permissible claims, up to \$10,000, against the association. The maximums (\$10,000 for the return of unearned premium; \$500,000 for all other covered claims) represent the working group's concept of practical limitations, but each State will wish to evaluate these figures.

- (2) Be deemed the insurer to the extent of its obligation on the covered claims and to that extent, subject to the limitations provided in this Act, shall have all rights, duties and obligations of the insolvent insurer as if the insurer had not become insolvent, including but not limited to, the right to pursue and retain salvage and subrogation recoverable on covered claim obligations to the extent paid by the association. The association shall not be deemed the insolvent insurer for the purpose of conferring jurisdiction.
- (3) **[Alternative 1a]** Assess insurers amounts necessary to pay the obligations of the association under Subsection A(1) subsequent to an insolvency, the expenses of handling covered claims subsequent

540-9

NCIGF Suggested Amendments Cyber Liability Claims

May 23, 2023

Property and Casualty Insurance Guaranty Association Model Act

to an insolvency, and other expenses authorized by this Act. The assessments of each member insurer shall be in the proportion that the net direct written premiums of the member insurer for the calendar year preceding the assessment bears to the net direct written premiums of all member insurers for the calendar year preceding the assessment. Each member insurer shall be notified of the assessment not later than thirty (30) days before it is due. A member insurer may not be assessed in any year an amount greater than two percent (2%) of that member insurer's net direct written premiums for the calendar year preceding the assessment. If the maximum assessment, together with the other assets of the association, does not provide in any one year an amount sufficient to make all necessary payments, the funds available shall be prorated and the unpaid portion shall be paid as soon as funds become available. The association may exempt or defer, in whole or in part, the assessment of a member insurer, if the assessment would cause the member insurer's financial statement to reflect amounts of capital or surplus less than the minimum amounts required for a certificate of authority by a jurisdiction in which the member insurer is authorized to transact insurance. However, during the period of deferment no dividends shall be paid to shareholders or policyholders. Deferred assessments shall be paid when the payment will not reduce capital or surplus below required minimums. Payments shall be refunded to those companies receiving larger assessments by virtue of the deferment, or at the election of the company, credited against future assessments.

[Alternative 2a] Assess insurers amounts necessary to pay the obligations of the association under Subsection A(1) subsequent to an insolvency, the expenses of handling covered claims subsequent to an insolvency, and other expenses authorized by this Act. The assessments of each member insurer shall be in the proportion that the net direct written premiums and any premiums received for an assumed contract after the effective date of an assumed claims transaction with a non-member insurer of the member insurer for the calendar year preceding the assessment bears to the net direct written premiums and any premiums received for an assumed contract after the effective date of an assumed claims transaction with a non-member insurer of all member insurers for the calendar year preceding the assessment. Each member insurer shall be notified of the assessment not later than thirty (30) days before it is due. A member insurer may not be assessed in any year an amount greater than two percent (2%) of that member insurer's net direct written premiums and any premiums received for an assumed contract after the effective date of an assumed claims transaction with a non-member insurer for the calendar year preceding the assessment. The 2% limitation on assessments shall not preclude a full payment for assumption consideration. If the maximum assessment, together with the other assets of the association, does not provide in any one year an amount sufficient to make all necessary payments, the funds available shall be prorated and the unpaid portion shall be paid as soon as funds become available. The association may exempt or defer, in whole or in part, the assessment of a member insurer, if the assessment would cause the member insurer's financial statement to reflect amounts of capital or surplus less than the minimum amounts required for a certificate of authority by a jurisdiction in which the member insurer is authorized to transact insurance. However, during the period of deferment no dividends shall be paid to shareholders or policyholders. Deferred assessments shall be paid when the payment will not reduce capital or surplus below required minimums. Payments shall be refunded to those companies receiving larger assessments by virtue of the deferment, or at the election of the company, credited against future assessments.

(3) **[Alternate 1b]** Allocate claims paid and expenses incurred among the three (3) accounts separately, and assess member insurers separately for each account, amounts necessary to pay the obligations of the association under Subsection 8A(1) subsequent to an insolvency, the expenses of handling covered claims subsequent to an insolvency and other expenses authorized by this Act. The assessments of each member insurer shall be in the proportion that the net direct written premiums of the member

NCIGF Suggested Amendments Cyber Liability Claims
May 23, 2023

NAIC Model Laws, Regulations, Guidelines and Other Resources—April 2009

insurer for the calendar year preceding the assessment on the kinds of insurance in the account bears to the net direct written premiums of all member insurers for the calendar year preceding the assessment on the kinds of insurance in the account. Each member insurer shall be notified of the assessment not later than thirty (30) days before it is due. A member insurer may not be assessed in any one year on any account an amount greater than two percent (2%) of that member insurer's net direct written premiums for the calendar year preceding the assessment on the kinds of insurance in the account. If the maximum assessment, together with the other assets of the association in any account, does not provide in any one year in any account an amount sufficient to make all necessary payments from that account, the funds available shall be pro-rated and the unpaid portion shall be paid as soon thereafter as funds become available. The association may exempt or defer, in whole or in part, the assessment of a member insurer, if the assessment would cause the member insurer's financial statement to reflect amounts of capital or surplus less than the minimum amounts required for a certificate of authority by a jurisdiction in which the member insurer is authorized to transact insurance. However, during the period of deferment no dividends shall be paid to shareholders or policyholders. Deferred assessments shall be paid when the payment will not reduce capital or surplus below required minimums. Payments shall be refunded to those companies receiving larger assessments by virtue of such deferment, or at the election of the company, credited against future assessments. A member insurer may set off against any assessment, authorized payments made on covered claims and expenses incurred in the payment of claims by the member insurer if they are chargeable to the account for which the assessment is made.]

- (3) **[Alternate 2b]** Allocate claims paid and expenses incurred among the three (3) accounts separately, and assess member insurers separately for each account, amounts necessary to pay the obligations of the association under Subsection 8A(1) subsequent to an insolvency, the expenses of handling covered claims subsequent to an insolvency and other expenses authorized by this Act. The assessments of each member insurer shall be in the proportion that the net direct written premiums and any premiums received for an assumed contract after the effective date of an assumed claims transaction with a non-member insurer of the member insurer for the calendar year preceding the assessment on the kinds of insurance in the account bears to the net direct written premiums and any premiums received for an assumed contract after the effective date of an assumed claims transaction with a non-member insurer of all member insurers for the calendar year preceding the assessment on the kinds of insurance in the account. Each member insurer shall be notified of the assessment not later than thirty (30) days before it is due. A member insurer may not be assessed in any one year on any account an amount greater than two percent (2%) of that member insurer's net direct written premiums and any premiums received for an assumed contract after the effective date of an assumed claims transaction with a non-member insurer for the calendar year preceding the assessment on the kinds of insurance in the account. The 2% limitation on assessments shall not preclude a full payment for assumption consideration. If the maximum assessment, together with the other assets of the association in any account, does not provide in any one year in any account an amount sufficient to make all necessary payments from that account, the funds available shall be pro-rated and the unpaid portion shall be paid as soon thereafter as funds become available. The association may exempt or defer, in whole or in part, the assessment of a member insurer, if the assessment would cause the member insurer's financial statement to reflect amounts of capital or surplus less than the minimum amounts required for a certificate of authority by a jurisdiction in which the member insurer is authorized to transact insurance. However, during the period of deferment no dividends shall be paid to shareholders or policyholders. Deferred assessments shall be paid when the payment will not reduce capital or surplus below required minimums. Payments shall be refunded to those companies receiving larger assessments by virtue of such deferment, or at the election of the company, credited against future assessments. A member insurer may set off against any assessment, authorized payments made on covered claims and

540-11

NCIGF Suggested Amendments Cyber Liability Claims

May 23, 2023

Property and Casualty Insurance Guaranty Association Model Act

expenses incurred in the payment of claims by the member insurer if they are chargeable to the account for which the assessment is made.]

- (4) Investigate claims brought against the association and adjust, compromise, settle and pay covered claims to the extent of the association's obligation and deny all other claims. The association shall pay claims in any order that it may deem reasonable, including the payment of claims as they are received from the claimants or in groups or categories of claims. The association shall have the right to appoint and to direct legal counsel retained under liability insurance policies for the defense of covered claims- and to appoint and direct other service providers for covered services.
- (5) Notify claimants in this State as deemed necessary by the commissioner and upon the commissioner's request, to the extent records are available to the association.

Drafting Note: The intent of this paragraph is to allow, in exceptional circumstances, supplementary notice to that given by the domiciliary receiver.

- (6) (a) Have the right to review and contest as set forth in this subsection settlements, releases, compromises, waivers and judgments to which the insolvent insurer or its insureds were parties prior to the entry of the order of liquidation. In an action to enforce settlements, releases and judgments to which the insolvent insurer or its insureds were parties prior to the entry of the order of liquidation, the Association shall have the right to assert the following defenses, in addition to the defenses available to the insurer:
- (i) The association is not bound by a settlement, release, compromise or waiver executed by an insured or the insurer, or any judgment entered against an insured or the insurer by consent or through a failure to exhaust all appeals, if the settlement, release, compromise, waiver or judgment was:
- (I) Executed or entered within 120 days prior to the entry of an order of liquidation, and the insured or the insurer did not use reasonable care in entering into the settlement, release, compromise, waiver or judgment, or did not pursue all reasonable appeals of an adverse judgment; or
- (II) Executed by or taken against an insured or the insurer based on default, fraud, collusion or the insurer's failure to defend.
- (ii) If a court of competent jurisdiction finds that the association is not bound by a settlement, release, compromise, waiver or judgment for the reasons described in Subparagraph (a)(i), the settlement, release, compromise, waiver or judgment shall be set aside, and the association shall be permitted to defend any covered claim on the merits. The settlement, release, compromise, waiver or judgment may not be considered as evidence of liability or damages in connection with any claim brought against the association or any other party under this Act.
- (iii) The association shall have the right to assert any statutory defenses or rights of offset against any settlement, release, compromise or waiver executed by an insured or the insurer, or any judgment taken against the insured or the insurer.
- (b) As to any covered claims arising from a judgment under any decision, verdict or finding based on the default of the insolvent insurer or its failure to defend, the association, either on its own behalf or on behalf of an insured may apply to have the judgment, order,

NCIGF Suggested Amendments Cyber Liability Claims
May 23, 2023

NAIC Model Laws, Regulations, Guidelines and Other Resources—April 2009

decision, verdict or finding set aside by the same court or administrator that entered the judgment, order, decision, verdict or finding and shall be permitted to defend the claim on the merits.

- (7) Handle claims through its own employees, one or more insurers, or other persons designated as servicing facilities, which may include the receiver for the insolvent insurer. Designation of a servicing facility is subject to the approval of the commissioner, but the designation may be declined by a member insurer.
- (8) Reimburse each servicing facility for obligations of the association paid by the facility and for expenses incurred by the facility while handling claims on behalf of the association and shall pay the other expenses of the association authorized by this Act.
- (9) Submit, not later than 90 days after the end of the association's fiscal year, a financial report for the preceding fiscal year in a form approved by the commissioner.

B. The association may:

- (1) Employ or retain persons as are necessary to handle claims, provide covered policy benefits and services, and perform other duties of the association;
- (2) Borrow funds necessary to effect the purposes of this Act in accordance with the plan of operation;
- (3) Sue or be sued;
- (4) Negotiate and become a party to contracts necessary to carry out the purpose of this Act;
- (5) Perform other acts necessary or proper to effectuate the purpose of this Act;
- (6) Refund to the member insurers in proportion to the contribution of each member insurer to the association that amount by which the assets of the association exceed the liabilities, if at the end of any calendar year, the board of directors finds that the assets of the association exceed the liabilities of the association as estimated by the board of directors for the coming year.

[Alternate Section 8B(6)

- (6) Refund to the member insurers in proportion to the contribution of each member insurer to that account that amount by which the assets of the account exceed the liabilities, if at the end of any calendar year, the board of directors finds that the assets of the association in any account exceed the liabilities of that account as estimated by the board of directors for the coming year.]*

Drafting Note: The working group/task force feels that the board of directors should determine the amount of the refunds to members when the assets of the association exceed its liabilities. However, since this excess may be quite small, the board is given the option of retaining all or part of it to pay expenses and possibly remove the need for a relatively small assessment at a later time.

C. Suits involving the association:

- (1) Except for actions by the receiver, all actions relating to or arising out of this Act against the association shall be brought in the courts in this State. The courts shall have exclusive jurisdiction over all actions relating to or arising out of this Act against the association.

NCIGF Suggested Amendments Cyber Liability Claims

May 23, 2023

Property and Casualty Insurance Guaranty Association Model Act

- (2) The exclusive venue in any action by or against the association is in [designate appropriate court]. The association may, at its option, waive this venue as to specific actions.

[Optional Section 8D

D. (1) *The legislature finds:*

- (a) *The potential for widespread and massive damage to persons and property caused by natural disasters such as earthquakes, windstorms, or fire in this State can generate insurance claims of such a number as to render numerous insurers operating within this State insolvent and therefore unable to satisfy covered claims;*
- (b) *The inability of insureds within this State to receive payments of covered claims or to timely receive the payments creates financial and other hardships for insureds and places undue burdens on the State, the affected units of local government, and the community at large;*
- (c) *The insolvency of a single insurer in a material amount or a catastrophic event may result in the same hardships as those produced by a natural disaster;*
- (d) *The State has previously taken action to address these problems by adopting the [insert name of guaranty association act], which among other things, provides a mechanism for the payment of covered claims under certain insurance policies to avoid excessive delay in payment and to avoid financial loss to claimants or policyholders because of the insolvency of an insurer; and*
- (e) *In order for the association to timely pay claims of insolvent insurers in this State and otherwise carry out its duties, the association may require additional financing options. The intent of the Legislature is to make those options available to the association in the event that a natural disaster such as an earthquake, windstorm, fire or material insolvency of any member insurer results in covered claim obligations currently payable by the association in excess of its capacity to pay from current funds and current assessments under Subsection A(3). In cases where the association determines that it is cost effective, the association may issue bonds as provided in this subsection. In determining whether to issue bonds, the association shall consider the transaction costs of issuing the bonds.*

- (2) *In the event a natural disaster such as an earthquake, windstorm, fire or material insolvency of any member insurer results in covered claim obligations currently payable by the association in excess of its capacity to pay from current funds and current assessments under Subsection 8A(3), the association, in its sole discretion, may by resolution request the [insert name of agency] Agency to issue bonds pursuant to [insert statutory authority], in such amounts as the association may determine to provide funds for the payment of covered claims and expenses related thereto. In the event bonds are issued, the association shall have the authority to annually assess member insurers for amounts necessary to pay the principal of, and interest on those bonds. Assessments collected pursuant to this authority shall be collected under the same procedures as provided in Subsection 8A(3) and, notwithstanding the two percent (2%) limit in Subsection 8A(3), shall be limited to an additional [insert percentage] percent of the annual net direct written premium in this State of each member insurer for the calendar year preceding the assessment. The commissioner's approval shall be required for any assessment greater than five percent (5%). Assessments collected pursuant to this authority may only be used for servicing the bond obligations provided for in this subsection and shall be pledged for that purpose.*

540-14

NCIGF Suggested Amendments Cyber Liability Claims
May 23, 2023

NAIC Model Laws, Regulations, Guidelines and Other Resources—April 2009

- (3) *In addition to the assessments provided for in this subsection, the association in its discretion, and after considering other obligations of the association, may utilize current funds of the association, assessments made under Subsection 8A(3) and advances or dividends received from the liquidators of insolvent insurers to pay the principal and interest on any bonds issued at the board's request.*
- (4) *Assessments under this subsection shall be payable in twelve (12) monthly installments with the first installment being due and payable at the end of the month after an assessment is levied, and subsequent installments being due not later than the end of each succeeding month.*
- (5) *In order to assure that insurers paying assessments levied under this subsection continue to charge rates that are neither inadequate nor excessive, within ninety (90) days after being notified of the assessments, each insurer that is to be assessed pursuant to this subsection shall make a rate filing for lines of business additionally assessed under this subsection. If the filing reflects a rate change that, as a percentage, is equal to the difference between the rate of the assessment and the rate of the previous year's assessment under this subsection, the filing shall consist of a certification so stating and shall be deemed approved when made. Any rate change of a different percentage shall be subject to the standards and procedures of [cite appropriate statutory authority for provisions on filing and approval of rates].*

Drafting Note: This provision should only be considered by those States that have serious concerns that circumstances could result in a substantial capacity problem resulting in unpaid or pro rata payment of claims. An association intending to consider this provision should first consult with experienced bond counsel in its State to identify an appropriate State agency or bonding authority to act as vehicle for issuing the bonds. That agency or authority's statute may also have to be amended to specifically authorize these types of bonds and to cross-reference this provision in the guaranty association law. It is possible that in some situations a new bonding authority may have to be created for this purpose.

Regardless of the vehicle used, it is important that the decision-making authority on whether bonds are needed and in what amounts be retained by the association's board.

The extent of additional assessment authority under this subsection has not been specified. When considering the amount of additional authority that will be needed, a determination should be made as to the amount of funds needed to service the bonds. More specifically, consideration should be given to the amount of the bonds to be issued, interest rate and the maturity date of the bonds. The association should be able to raise sufficient funds through assessments to pay the interest and retire the bonds after some reasonable period (e.g. ten (10) years). Subsection D(2) requires the Commissioner's approval before the association can impose an additional assessment in excess of 5%. This is to assure that the additional assessment will not result in financial hardship to the member insurers and additional insolvencies.

The intent of Subsection D(4) is to permit recoupment by member insurers of the additional cost of assessments under this subsection without any related regulatory approval. A State enacting this subsection may need to revise Subsection D(4) so that it conforms to the particular State's recoupment provisions, as well as the provisions on filing and approval of rates.]

Section 9. Plan of Operation

- A.
 - (1) The association shall submit to the commissioner a plan of operation and any amendments to the plan of operation necessary or suitable to assure the fair, reasonable and equitable administration of the association. The plan of operation and amendments shall become effective upon approval in writing by the commissioner.
 - (2) If the association fails to submit a suitable plan of operation within ninety (90) days following the effective date of this Act, or if at any time thereafter the association fails to submit suitable amendments to the plan, the commissioner shall, after notice and hearing, adopt reasonable rules necessary or advisable to effectuate the provisions of this Act. The rules shall continue in force until modified by the commissioner or superseded by a plan submitted by the association and approved by the commissioner.

540-15

NCIGF Suggested Amendments Cyber Liability Claims
May 23, 2023

Property and Casualty Insurance Guaranty Association Model Act

- B. All member insurers shall comply with the plan of operation.
- C. The plan of operation shall:
- (1) Establish the procedures under which the powers and duties of the association under Section 8 will be performed;
 - (2) Establish procedures for handling assets of the association;
 - (3) Require that written procedures be established for the disposition of liquidating dividends or other monies received from the estate of the insolvent insurer;
 - (4) Require that written procedures be established to designate the amount and method of reimbursing members of the board of directors under Section 7;
 - (5) Establish procedures by which claims may be filed with the association and establish acceptable forms of proof of covered claims;
 - (6) Establish regular places and times for meetings of the board of directors;
 - (7) Require that written procedures be established for records to be kept of all financial transactions of the association, its agents and the board of directors;
 - (8) Provide that any member insurer aggrieved by any final action or decision of the association may appeal to the commissioner within thirty (30) days after the action or decision;
 - (9) Establish the procedures under which selections for the board of directors will be submitted to the commissioner;
 - (10) Contain additional provisions necessary or proper for the execution of the powers and duties of the association.
- D. The plan of operation may provide that any or all powers and duties of the association, except those under Sections 8A(3) and 8B(2), are delegated to a corporation, association similar to the association or other organization which performs or will perform functions similar to those of this association or its equivalent in two (2) or more States. The corporation, association similar to the association or organization shall be reimbursed as a servicing facility would be reimbursed and shall be paid for its performance of any other functions of the association. A delegation under this subsection shall take effect only with the approval of both the board of directors and the commissioner, and may be made only to a corporation, association or organization which extends protection not substantially less favorable and effective than that provided by this Act.

Section 10. Duties and Powers of the Commissioner

- A. The commissioner shall:
- (1) Notify the association of the existence of an insolvent insurer not later than three (3) days after the commissioner receives notice of the determination of the insolvency. The association shall be entitled to a copy of a complaint seeking an order of liquidation with a finding of insolvency against

NCIGF Suggested Amendments Cyber Liability Claims
May 23, 2023

NAIC Model Laws, Regulations, Guidelines and Other Resources—April 2009

a member company at the same time that the complaint is filed with a court of competent jurisdiction;

- (2) Provide the association with a statement of the net direct written premiums of each member insurer upon request of the board of directors.

B. The commissioner may:

- (1) Suspend or revoke, after notice and hearing, the certificate of authority to transact insurance in this State of a member insurer that fails to pay an assessment when due or fails to comply with the plan of operation. As an alternative, the commissioner may levy a fine on a member insurer that fails to pay an assessment when due. The fine shall not exceed five percent (5%) of the unpaid assessment per month, except that a fine shall not be less than \$100 per month;
- (2) Revoke the designation of a servicing facility if the commissioner finds claims are being handled unsatisfactorily.
- (3) Examine, audit, or otherwise regulate the association.

Drafting Note: This section does not require periodic examinations of the guaranty associations but allows the commissioner to conduct examinations as the commissioner deems necessary.

- C. A final action or order of the commissioner under this Act shall be subject to judicial review in a court of competent jurisdiction.

Section 11. Coordination Among Guaranty Associations

- A. The association may join one or more organizations of other State associations of similar purposes, to further the purposes and administer the powers and duties of the association. The association may designate one or more of these organizations to act as a liaison for the association and, to the extent the association authorizes, to bind the association in agreements or settlements with receivers of insolvent insurance companies or their designated representatives.
- B. The association, in cooperation with other obligated or potentially obligated guaranty associations, or their designated representatives, shall make all reasonable efforts to coordinate and cooperate with receivers, or their designated representatives, in the most efficient and uniform manner, including the use of Uniform Data Standards as promulgated or approved by the National Association of Insurance Commissioners.

Section 12. Effect of Paid Claims

- A. Any person recovering under this Act shall be deemed to have assigned any rights under the policy to the association to the extent of his or her recovery from the association. Every insured or claimant seeking the protection of this Act shall cooperate with the association to the same extent as the person would have been required to cooperate with the insolvent insurer. The association shall have no cause of action against the insured of the insolvent insurer for sums it has paid out except any causes of action as the insolvent insurer would have had if the sums had been paid by the insolvent insurer and except as provided in Subsection B and in Section 13. In the case of an insolvent insurer operating on a plan with assessment liability, payments of claims of the association shall not operate to reduce the liability of the insureds to the receiver, liquidator or statutory successor for unpaid assessments.

NCIGF Suggested Amendments Cyber Liability Claims

May 23, 2023

Property and Casualty Insurance Guaranty Association Model Act

- B. The association shall have the right to recover from any person who is an affiliate of the insolvent insurer all amounts paid by the association on behalf of that person pursuant to the Act, whether for indemnity, defense or otherwise.
- C. The association and any association similar to the association in another State shall be entitled to file a claim in the liquidation of an insolvent insurer for any amounts paid by them on covered claim obligations as determined under this Act or similar laws in other States and shall receive dividends and other distributions at the priority set forth in [insert reference to Statepriority of distribution in liquidation act].
- D. The association shall periodically file with the receiver or liquidator of the insolvent insurer statements of the covered claims paid by the association and estimates of anticipated claims on the association which shall preserve the rights of the association against the assets of the insolvent insurer.

Section 13 [Optional] Net Worth Exclusion

Drafting Note: Various alternatives are provided for a net worth limitation in the guaranty association act. States may choose any of the Subsection B alternatives below or may elect to not have any net worth limitation. Subsection A, which defines “high net worth insured,” has two alternates allowing States to choose different net worth limitations for first and third party claims if that State chooses alternatives 1 or 2 to Subsection B. Subsections C, D and E are recommended to accompany any of the Subsection B alternatives. In cases where States elect not to include net worth, States may either omit this section in its entirety or include only Subsection C, which excludes from coverage claims denied by other States’ net worth restrictions pursuant to those States’ guaranty association laws.

- A. For purposes of this section “high net worth insured” shall mean any insured whose net worth exceeds \$50 million on December 31 of the year prior to the year in which the insurer becomes an insolvent insurer; provided that an insured’s net worth on that date shall be deemed to include the aggregate net worth of the insured and all of its subsidiaries and affiliates as calculated on a consolidated basis.

[Alternate Section 13A

- A. (1) *For the purposes of Subsection B(1), “high net worth insured” shall mean any insured whose net worth exceeds \$25 million on December 31 of the year prior to the year in which the insurer becomes an insolvent insurer; provided that an insured’s net worth on that date shall be deemed to include the aggregate net worth of the insured and all of its subsidiaries and affiliates as calculated on a consolidated basis.]*
- (2) *For the purpose of Subsection B(2) [and B(4) if Alternative 2 for Subsection B is selected] “high net worth insured” shall mean any insured whose net worth exceeds \$50 million on December 31 of the year prior to the year in which the insurer becomes an insolvent insurer; provided that an insured’s net worth on that date shall be deemed to include the aggregate net worth of the insured and all of its subsidiaries and affiliates as calculated on a consolidated basis.*

Drafting Note: Alternate Subsection A language should only be considered in cases where a State is considering Alternative 1 or 2 of Subsection B and would like to set different dollar thresholds for the first party claim exclusion provision and the third party recovery provision.

Drafting Note: States may wish to consider the impact on governmental entities and charitable organizations of the application of the net worth exclusion contained in the definition of “covered claim.” The Michigan Supreme Court, in interpreting a “net worth” provision in the Michigan guaranty association statute, held that governmental entities possess a “net worth” for purposes of the provision in the Michigan guaranty association statute that prohibits claims against the guaranty association by a person who has a specified net worth. Oakland County Road Commission vs. Michigan Property & Casualty Guaranty Association, 575 N.W. 2d 751 (Mich. 1998).

[Alternative 1 for Section 13B

- B. (1) The association shall not be obligated to pay any first party claims by a high net worth insured.

NCIGF Suggested Amendments Cyber Liability Claims
May 23, 2023

NAIC Model Laws, Regulations, Guidelines and Other Resources—April 2009

- ~~(2) The association shall have the right to recover from a high net worth insured all amounts paid by the association to or on behalf of such insured, whether for indemnity, defense or otherwise./~~
- ~~(3) The Association may also, at its sole discretion and without assumption of any ongoing duty to do so, pay any cybersecurity insurance obligations covered by a policy or endorsement of an insolvent company on behalf of a high net worth insured as defined in Section 13A(1). In that case, the Association shall recover from the high net worth insured under this Section all amounts paid on its behalf, all allocated claim adjusted expenses related to such claims, the Association's attorney's fees, and all court costs in any action necessary to collect the full amount to the Association's reimbursement under this Section.]~~

Note: This revision- would only be a consideration in states with a net worth exclusion.

[Alternative 2 for Section 13B

- B. (1) The association shall not be obligated to pay any first party claims by a high net worth insured.
- (2) Subject to Paragraph (3), the association shall not be obligated to pay any third party claim relating to a policy of a high net worth insured. This exclusion shall not apply to third party claims against the high net worth insured where:
- (a) The insured has applied for or consented to the appointment of a receiver, trustee or liquidator for all or a substantial part of its assets;
 - (b) The insured has filed a voluntary petition in bankruptcy, filed a petition or an answer seeking a reorganization or arrangement with creditors or to take advantage of any insolvency law; or
 - (c) An order, judgment, or decree is entered by a court of competent jurisdiction, on the application of a creditor, adjudicating the insured bankrupt or insolvent or approving a petition seeking reorganization of the insured or of all or substantial part of its assets.
- (3) Paragraph (2) shall not apply to workers' compensation claims, personal injury protection claims, no-fault claims and any other claims for ongoing medical payments to third parties.
- ~~(4) The association shall have the right to recover from a high net worth insured all amounts paid by the association to or on behalf of such insured, whether for indemnity, covered policy benefits and services, defense or otherwise./~~
- ~~(5) The Association may also, at its sole discretion and without assumption of any ongoing duty to do so, pay any third-party claims or cybersecurity insurance obligations covered by a policy or endorsement of an insolvent company on behalf of a high net worth insured as defined in Section 13A(2). In that case, the Association shall recover from the high net worth insured under this Section all amounts paid on its behalf, all allocated claim adjusted expenses related to such claims, the Association's attorney's fees, and all court costs in any action necessary to collect the full amount to the Association's reimbursement under this Section.~~

Note: This revision would only be a consideration in states with a net worth exclusion.

NCIGF Suggested Amendments Cyber Liability Claims

May 23, 2023

Property and Casualty Insurance Guaranty Association Model Act

[Alternative 3 for Section 13B]

- B. The association shall not be obligated to pay any first party claims by a high net worth insured.]
- C. The association shall not be obligated to pay any claim that would otherwise be a covered claim that is an obligation to or on behalf of a person who has a net worth greater than that allowed by the insurance guaranty association law of the State of residence of the claimant at the time specified by that State's applicable law, and which association has denied coverage to that claimant on that basis.
- D. The association shall establish reasonable procedures subject to the approval of the commissioner for requesting financial information from insureds on a confidential basis for purposes of applying this section, provided that the financial information may be shared with any other association similar to the association and the liquidator for the insolvent insurer on the same confidential basis. Any request to an insured seeking financial information must advise the insured of the consequences of failing to provide the financial information. If an insured refuses to provide the requested financial information where it is requested and available, the association may, until such time as the information is provided, provisionally deem the insured to be a high net worth insured for the purpose of denying a claim under Subsection B.
- E. In any lawsuit contesting the applicability of this section where the insured has refused to provide financial information under the procedure established pursuant to Subsection D, the insured shall bear the burden of proof concerning its net worth at the relevant time. If the insured fails to prove that its net worth at the relevant time was less than the applicable amount, the court shall award the association its full costs, expenses and reasonable attorneys' fees in contesting the claim.

Section 14. Exhaustion of Other Coverage

- A. (1) Any person having a claim against an insurer,, shall be required first to exhaust all coverage provided by any other policy, including the right to a defense under the other policy, if the claim under the other policy arises from the same facts, injury or loss that gave rise to the covered claim against the association. The requirement to exhaust shall apply without regard to whether the other insurance policy is a policy written by a member insurer. However, no person shall be required to exhaust any right under the policy of an insolvent insurer or any right under a life insurance policy.
- (2) Any amount payable on a covered claim under this Act shall be reduced by the full applicable limits stated in the other insurance policy, or by the amount of the recovery under the other insurance policy as provided herein. The association shall receive a full credit for the stated limits, unless the claimant demonstrates that the claimant used reasonable efforts to exhaust all coverage and limits applicable under the other insurance policy. If the claimant demonstrates that the claimant used reasonable efforts to exhaust all coverage and limits applicable under the other insurance policy, or if there are no applicable stated limits under the policy, the association shall receive a full credit for the total recovery.

[Alternative 1 for Section 14A(2)(a)]

The credit shall be deducted from the lesser of:

- (i) The association's covered claim limit;
- (ii) The amount of the judgment or settlement of the claim; or
- (iii) The policy limits of the policy of the insolvent insurer.]

[Alternative 2 for Section 14A(2)(a)]

The credit shall be deducted from the lesser of:

NCIGF Suggested Amendments Cyber Liability Claims
May 23, 2023

NAIC Model Laws, Regulations, Guidelines and Other Resources—April 2009

- (i) The amount of the judgment or settlement of the claim; or (ii)
The policy limits of the policy of the insolvent insurer.]

(b)_____In no case, however, shall the obligation of the association exceed the covered claim limit embodied in Section 8 of this Act.

- (3) Except to the extent that the claimant has a contractual right to claim defense under an insurance policy issued by another insurer, nothing in this section shall relieve the association of the duty to defend under the policy issued by the insolvent insurer. This duty shall, however, be limited by any other limitation on the duty to defend embodied in this Act.
 - (4) A claim under a policy providing liability coverage to a person who may be jointly and severally liable as a joint tortfeasor with the person covered under the policy of the insolvent insurer that gives rise to the covered claim shall be considered to be a claim arising from the same facts, injury or loss that gave rise to the covered claim against the association.
 - (5) For purposes of this section, a claim under an insurance policy other than a life insurance policy shall include, but is not limited to:
 - (a) A claim against a health maintenance organization, a hospital plan corporation, a professional health service corporation or disability insurance policy; and
 - (b) Any amount payable by or on behalf of a self-insurer.
 - (6) The person insured by the insolvent insurer's policy may not be pursued by a third-party claimant for any amount paid to the third party by which the association's obligation is reduced by the application of this section.
- B. Any person having a claim which may be recovered under more than one insurance guaranty association or its equivalent shall seek recovery first from the association of the place of residence of the insured, except that if it is a first party claim for damage to property with a permanent location, the person shall seek recovery first from the association of the location of the property. If it is a workers' compensation claim, the person shall seek recovery first from the association of the residence of the claimant. Any recovery under this Act shall be reduced by the amount of recovery from another insurance guaranty association or its equivalent.

Drafting Note: This subsection does not prohibit recovery from more than one association, but it does describe the association to be approached first and then requires that any previous recoveries from like associations must be set off against recoveries from this association.

Section 15. Prevention of Insolvencies

To aid in the detection and prevention of insurer insolvencies:

- A. The board of directors may, upon majority vote, make recommendations to the commissioner on matters generally related to improving or enhancing regulation for solvency.
- B. At the conclusion of any domestic insurer insolvency in which the association was obligated to pay covered claims, the board of directors may, upon majority vote, prepare a report on the history and causes of the insolvency, based on the information available to the association and submit the report to the commissioner.
- C. Reports and recommendations provided under this section shall not be considered public documents.

540-21

NCIGF Suggested Amendments Cyber Liability Claims

May 23, 2023

Property and Casualty Insurance Guaranty Association Model Act

Section 16. Tax Exemption

The association shall be exempt from payment of all fees and all taxes levied by this State or any of its subdivisions except taxes levied on real or personal property.

Section 17. Recoupment of Assessments

Drafting Note: States may choose how they wish to allow member insurers to recoup assessments paid by selecting one of three alternatives for Section 17.

[Alternative 1 for Section 17]

- A. Except as provided in Subsection D, each member insurer shall annually recoup assessments it remitted in preceding years under Section 8. The recoupment shall be by means of a policyholder surcharge on premiums charged for all kinds of insurance in the accounts assessed. The surcharge shall be at a uniform percentage rate determined annually by the commissioner that is reasonably calculated to recoup the assessment remitted by the insurer, less any amounts returned to the member insurer by the association. Changes in this rate shall be effective no sooner than 180 days after insurers have received notice of the changed rate.
- B. If a member insurer fails to recoup the entire amount of the assessment in the first year under this section, it shall repeat the surcharge procedure provided for herein in succeeding years until the assessment is fully recouped or a de minimis amount remains uncollected. Any such de minimis amount shall be collected as provided in Subsection D of this section. If a member insurer collects excess surcharges, the insurer shall remit the excess amount to the association, and the excess amount shall be applied to reduce future assessments in the appropriate account.
- C. The amount and nature of any surcharge shall be separately stated on either a billing or policy declaration sent to an insured. The surcharge shall not be considered premium for any purpose, including the [insert all appropriate taxes] or agents' commission.
- D. A member may elect not to collect the surcharge from its insureds only when the expense of collecting the surcharge would exceed the amount of the surcharge. In that case, the member shall recoup the assessment through its rates, provided that:
 - (1) The insurer shall be obligated to remit the amount of surcharge not collected by election under this subsection; and
 - (2) The last sentence in Subsection C above shall not apply.
- E. In determining the rate under Subsection A for the first year of recoupment under this section, under rules prescribed by the commissioner, the commissioner shall provide for the recoupment in that year, or in such reasonable period as the commissioner may determine, of any assessments that have not been recouped as of that year. Insurers shall not be required to recoup assessments through surcharges under this section until 180 days after this section takes effect./

[Alternative 2 for Section 17]

- A. Notwithstanding any provision of [insert citation to relevant tax and insurance codes] to the contrary, a member insurer may offset against its [insert all appropriate taxes] liability the entire amount of the assessment imposed under this Act at a rate of [insert number] percent per year for [insert number of years] successive years following the date of assessment. If the assessment is not fully recovered over the [insert

NCIGF Suggested Amendments Cyber Liability Claims
May 23, 2023

NAIC Model Laws, Regulations, Guidelines and Other Resources—April 2009
number of years] period, the remaining unrecovered assessment may be claimed for subsequent calendar years until fully recovered.

Drafting Note: States may choose the number of years to allow an insurer to offset an assessment against the insurer's premium tax liability.

- B. Any tax credit under this section shall, for the purposes of Section [insert citation to retaliatory tax statute] be treated as a tax paid both under the tax laws of this State and under the laws of any other State or country.
- C. If a member insurer ceases doing business in this State, any uncredited assessment may be credited against its [insert all appropriate taxes] during the year it ceases doing business in this State.
- D. Any sums that are acquired by refund from the association by member insurers and that have been credited against [insert all appropriate taxes], as provided in this section, shall be paid by member insurers to this State as required by the department. The association shall notify the department that the refunds have been made.]

[Alternative 3 for Section 17

The rates and premiums charged for insurance policies to which this section applies shall include amounts sufficient to recoup a sum equal to the amounts paid to the association by the member insurer less any amounts returned to the member insurer by the association. Rates shall not be deemed excessive because they contain an additional amount reasonably calculated to recoup all assessments paid by the member insurer.]

Section 18. Immunity

There shall be no liability on the part of, and no cause of action of any nature shall arise against a member insurer, the association or its agents or employees, the board of directors, or any person serving as an alternate or substitute representative of any director, or the commissioner or the commissioner's representatives for any action taken or any failure to act by them in the performance of their powers and duties under this Act

Section 19. Stay of Proceedings

All proceedings in which the insolvent insurer is a party or is obligated to defend a party in any court in this State shall, subject to waiver by the association in specific cases involving covered claims, be stayed for six (6) months and such additional time as may be determined by the court from the date the insolvency is determined or an ancillary proceeding is instituted in the State, whichever is later, to permit proper defense by the association of all pending causes of action.

The liquidator, receiver or statutory successor of an insolvent insurer covered by this Act shall permit access by the board or its authorized representative to such of the insolvent insurer's records which are necessary for the board in carrying out its functions under this Act with regard to covered claims. In addition, the liquidator, receiver or statutory successor shall provide the board or its representative with copies of those records upon the request by the board and at the expense of the board.

Chronological Summary of Actions (all references are to the Proceedings of the NAIC).

1970 Proc. I 218, 252, 253-262, 298 (adopted).
1972 Proc. I 15, 16, 443, 477-478, 479-480 (amended).
1973 Proc. I 9, 11, 140, 154, 155-157 (amended).
1973 Proc. II 18, 21, 370, 394, 396 (recoupment formula adopted).
1979 Proc. I 44, 46, 126, 217 (amended).
1981 Proc. I 47, 50, 175, 225 (amended).
1984 Proc. I 6, 31, 196, 326, 352 (amended).
1986 Proc. I 9-10, 22, 149, 294, 296-305 (amended and reprinted).
1986 Proc. II 410-411 (amendments adopted later printed here).

540-23

NCIGF Suggested Amendments Cyber Liability Claims
May 23, 2023

Property and Casualty Insurance Guaranty Association Model Act

1987 Proc. 111, 18, 161, 421, 422, 429, 450-452 (amended).
1993 Proc. 2nd Quarter 12, 33, 227, 600, 602, 621 (amended).
1994 Proc. 4th Quarter 17, 26, 566, 576, 579-589 (amended and reprinted).
1996 Proc. 1st Quarter 29-30, 123, 564, 570, 570-580 (amended and reprinted).
2009 Proc. 1st Quarter, Vol 1111, 139, 188, 288-317 (amended).

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NAIC Model Laws, Regulations, Guidelines and Other Resources—3rd Quarter 2016

**PROPERTY AND CASUALTY
INSURANCE GUARANTY ASSOCIATION MODEL ACT**

This chart is intended to provide readers with additional information to more easily access state statutes, regulations, bulletins or administrative rulings related to the NAIC model. Such guidance provides readers with a starting point from which they may review how each state has addressed the model and the topic being covered. The NAIC Legal Division has reviewed each state’s activity in this area and has determined whether the citation most appropriately fits in the Model Adoption column or Related State Activity column based on the definitions listed below. The NAIC’s interpretation may or may not be shared by the individual states or by interested readers.

This chart does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Nor does this state page reflect a determination as to whether a state meets any applicable accreditation standards. Every effort has been made to provide correct and accurate summaries to assist readers in locating useful information. Readers should consult state law for further details and for the most current information.

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ST-540-1

NAIC Model Laws, Regulations, Guidelines and Other Resources—3rd Quarter 2016

**PROPERTY AND CASUALTY
INSURANCE GUARANTY ASSOCIATION MODEL ACT**

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ST-540-2

NAIC Model Laws, Regulations, Guidelines and Other Resources—3rd Quarter 2016

**PROPERTY AND CASUALTY
INSURANCE GUARANTY ASSOCIATION MODEL ACT**

KEY:

MODEL ADOPTION: States that have citations identified in this column adopted the most recent version of the NAIC model in a **substantially similar manner**. This requires states to adopt the model in its entirety but does allow for variations in style and format. States that have adopted portions of the current NAIC model will be included in this column with an explanatory note.

RELATED STATE ACTIVITY: Examples of Related State Activity include but are not limited to: older versions of the NAIC model, statutes or regulations addressing the same subject matter, or other administrative guidance such as bulletins and notices. States that have citations identified in this column **only** (and nothing listed in the Model Adoption column) have **not** adopted the most recent version of the NAIC model in a **substantially similar manner**.

NO CURRENT ACTIVITY: No state activity on the topic as of the date of the most recent update. This includes states that have repealed legislation as well as states that have never adopted legislation.

NAIC MEMBER	MODEL ADOPTION	RELATED STATE ACTIVITY
Alabama	ALA. CODE §§ 27-42-1 to 27-42-20 (1981/2009) (Uses separate account option).	
Alaska		ALASKA STAT. §§ 21.80.010 to 21.80.190 (1970/2004) (uses separate account option) (previous version of model).
American Samoa	NO CURRENT ACTIVITY	
Arizona		ARIZ. REV. STAT. ANN. §§ 20-661 to 20-680 (1977/2014) (previous version of model).
Arkansas		ARK. CODE ANN. §§ 23-90-101 to 23-90-123 (1977/1999).
California		CAL. INS. CODE §§ 1063 to 1063.15 (1969/2013).
Colorado		COLO. REV. STAT. §§ 10-4-501 to 10-4-519 (1963/2002) (uses separate account option) (previous version of model).
Connecticut		CONN. GEN. STAT. §§ 38a-836 to 38a-853 (1971/2011) (uses separate account option) (previous version of model).
Delaware		DEL. CODE ANN. tit.18, §§ 4201 to 4221 (1982/1991) (previous version of model).

ST-540-3

NAIC Model Laws, Regulations, Guidelines and Other Resources—3rd Quarter 2016**PROPERTY AND CASUALTY
INSURANCE GUARANTY ASSOCIATION MODEL ACT**

NAIC MEMBER	MODEL ADOPTION	RELATED STATE ACTIVITY
District of Columbia		D. C. CODE §§ 31-5501 to 31-5515 (1993) (previous version of model).
Florida		FLA. STAT. §§ 631.50 to 631.70 (1982/2010) (previous version of model).
Georgia		GA. CODE ANN. §§ 33-36-1 to 33-36-19 (1970/2005).
Guam	NO CURRENT ACTIVITY	
Hawaii		HAW. REV. STAT. §§ 431:16-101 to 431:16-117 (1988/2003) (previous version of model).
Idaho		IDAHO CODE ANN. §§ 41-3601 to 41-3621 (1970/2014) (previous version of model).
Illinois	215 ILL. COMP. STAT. 5/532 to 5/553 (1977/2013) (Uses separate account option).	
Indiana		IND. CODE §§ 27-6-8-1 to 27-6-8-19 (1973/2013) (uses separate account option) (previous version of model).
Iowa	IOWA CODE §§ 515B.1 to 515B.26 (1970/2010).	IOWA CODE §§ 518C.1 to 518C.19 (2000) (separate fund for state and county mutuals).
Kansas		KAN. STAT. ANN. §§ 40-2901 to 40-2919 (1970/2005) (previous version of model).
Kentucky		KY. REV. STAT. ANN. §§ 304.36-010 to 304.36-170 (1972/1990) (previous version of model).
Louisiana	LA. REV. STAT. ANN. §§ 22:2051 to 22:2070 (1970/2010).	
Maine		ME. REV. STAT. ANN. tit. 24-A, §§ 4431 to 4452 (1969/2009) (uses separate account option) (previous version of model).
Maryland		MD. CODE ANN., INS. §§ 9-301 to 9-316 (1971/1997) (previous version of model); BULLETIN 2012-13 (2012).

ST-540-4

NAIC Model Laws, Regulations, Guidelines and Other Resources—3rd Quarter 2016**PROPERTY AND CASUALTY
INSURANCE GUARANTY ASSOCIATION MODEL ACT**

Massachusetts		MASS. GEN. LAWS ch. 175D, §§ 1 to 16 (1970/2004) (previous version of model).
NAIC MEMBER	MODEL ADOPTION	RELATED STATE ACTIVITY
Michigan		MICH. COMP. LAWS §§ 500.7901 to 500.7949 (1969/1982); BULLETIN 2010-10-INS; BULLETIN 2010-04-INS (2010); BULLETIN 2014-12-INS (2014).
Minnesota		MINN. STAT. §§ 60C.01 to 60C.20 (1971/2003) (uses separate account option) (previous version of model).
Mississippi		MISS. CODE ANN. §§ 83-23-101 to 83-23-137 (1970/1992) (previous version of model).
Missouri		MO. REV. STAT. §§ 375.771 to 375.780 (1971/2013) (uses separate account option) (previous version of model).
Montana		MONT. CODE ANN. §§ 33-10-101 to 33-10-117 (1971/2013) (previous version of model).
Nebraska		NEB. REV. STAT. §§ 44-2401 to 44-2418 (1971/1990) (uses separate account option) (previous version of model).
Nevada		NEV. REV. STAT. §§ 687A.010 to 687A.160 (1971/2005) (previous version of model).
New Hampshire		N.H. REV. STAT. ANN. §§ 404-B:1 to 404-B:18 (1970/2004) (uses separate account option); §§ 404-H:1 to 404-H:20 (2004) (previous version of model).
New Jersey		N.J. STAT. ANN. §§ 17:30A-1 to 17:30A-20 (1974/2003) (previous version of model); N.J. INS. ORDER A12-108 (2012); N.J. INS. ORDER A13-110 (2013); N.J. BANKING & INS. ORDER A16-111 (2016).
New Mexico		N.M. STAT. ANN. §§ 59A-43-1 to 59A-43-18 (1985/1989) (uses separate account option) (previous version of model); §§ 59A-30A-1 to 59A-30A-18 (1999) (Title insurance fund).

ST-540-5

NAIC Model Laws, Regulations, Guidelines and Other Resources—3rd Quarter 2016

**PROPERTY AND CASUALTY
INSURANCE GUARANTY ASSOCIATION MODEL ACT**

New York		N.Y. INS. LAW §§ 7601 to 7614 (1984/2013).
North Carolina		N.C. GEN. STAT. §§ 58-48-1 to 58-48-130 (1971/2009) (uses separate account option) (previous version of model).

NAIC MEMBER	MODEL ADOPTION	RELATED STATE ACTIVITY
North Dakota		N.D. CENT. CODE §§ 26.1-42.1-01 to 26.1-42.1-15 (1999) (previous version of model).
Northern Marianas	NO CURRENT ACTIVITY	
Ohio		OHIO REV. CODE ANN. §§ 3955.01 to 3955.21 (1970/2005) (uses separate account option) (previous version of model).
Oklahoma		OKLA. STAT. tit. 36, §§ 2001 to 2019 (1980/2014) (uses separate account option) (previous version of model).
Oregon		OR. REV. STAT. §§ 734.510 to 734.710 (1971/2003) (previous version of model).
Pennsylvania		40 PA. CONS. STAT. §§ 41-201 to 41-220 (1995) (previous version of model).
Puerto Rico		P.R. LAWS ANN. tit. 26, §§ 3801 to 3819 (1974/1980) (previous version of model).
Rhode Island	R. I. GEN. LAWS §§ 27-34-1 to 27-34-19 (1988/2010) (Uses separate account option).	
South Carolina		S. C. CODE ANN. §§ 38-31-10 to 38-31-180 (1988/2001) (uses separate account option) (previous version of model).
South Dakota		S.D. CODIFIED LAWS §§ 58-29A-54 to 58-29A-109 (2001/2013) (Uses separate account option) (previous version of model).
Tennessee		TENN. CODE ANN. §§ 56-12-101 to 56-12-119 (1971/1999) (previous version of model).
Texas		TEX. INS. CODE ANN. §§ 462.001 to 462.351 (2007) (previous version of model).

ST-540-6

NAIC Model Laws, Regulations, Guidelines and Other Resources—3rd Quarter 2016**PROPERTY AND CASUALTY
INSURANCE GUARANTY ASSOCIATION MODEL ACT**

Utah		UTAH CODE ANN. §§ 31A-28-200 to 31A-28-220 (1986/2002) (uses separate account option) (previous version of model); UTAH ADMIN. CODE r. 71-3 (1971).
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NAIC MEMBER	MODEL ADOPTION	RELATED STATE ACTIVITY
Vermont		VT. STAT. ANN. tit. 8, §§ 3611 to 3633 (1969/1979) (uses separate account option) (previous version of model).
Virgin Islands		V.I. CODE ANN. tit. 22, §§ 231 to 247 (1984/1986) (previous version of model).
Virginia		VA. CODE ANN. §§ 38.2-1600 to 38.2-1623 (1986/2014) (previous version of model).
Washington		WASH. REV. CODE §§ 48.32.010 to 48.32.930 (1971/2005) (uses separate account option) (previous version of model).
West Virginia		W. VA. CODE §§ 33-26-1 to 33-26-19 (1970) (uses separate account option) (previous version of model).
Wisconsin		WIS. STAT. §§ 646.01 to 646.73 (1979/2013) (“Insurance Security Fund”).
Wyoming		WYO. STAT. ANN. §§ 26-31-101 to 26-31-117 (1971/2013) (previous version of model).

ST-540-7

NAIC Model Laws, Regulations, Guidelines and Other Resources—3rd Quarter 2016

**PROPERTY AND CASUALTY
INSURANCE GUARANTY ASSOCIATION MODEL ACT**

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ST-540-8

NAIC Model Laws, Regulations, Guidelines and Other Resources—April 2011

**PROPERTY AND CASUALTY
INSURANCE GUARANTY ASSOCIATION MODEL ACT**

Proceedings Citations

Cited to the Proceedings of the NAIC

A regulator discussed the history of revising this model in relation to the new NAIC model law process. He stated that the draft was re-exposed for new comments. **2008 Proc. 1st Quarter Vol. II 10-440.**

The Financial Condition (E) Committee adopted amendments to this model. The Committee summarized the more significant changes including the Task Force’s recommendation on the assumed business options. **2008 Proc. 4th Quarter Vol. II 10-5.**

The joint Executive Committee/Plenary adopted amendments to this model. A commissioner noted that an interested party provided a comment requesting reconsideration of the optional net worth exclusion provision. The commissioner reiterated that the provision was optional and intended to provide uniform language for states interested in implementing a net worth exclusion. **2009 Proc. 1st Quarter Vol. I 3-5.**

Section 1. Title Section 2. Purpose

In 1969 the NAIC prepared a statement of position on automobile insurance. One part of that study concerned automobile insurer insolvencies. It was stated that the “... position of the NAIC [is] that no innocent person should suffer as a result of the insolvency of an insurer...” and the association vowed to take action to assure that end. They recommended serious consideration be given to the establishment of an industry facility regulated by the states to guarantee solvency and to indemnify the public against the insolvency of any casualty insurer. A federal guaranty corporation was suggested in a congressional bill, but a resolution was adopted by the NAIC in opposition to this proposal. The resolution emphasized the fact that the NAIC was recommending a program in each state to establish a means to guarantee the payment of claims against insolvent insurers. **1969 Proc. II 549-552.**

Every insurance company failure undermines public confidence in, and the value of, the insurance institution whose continued existence is the result of the public’s desire and need to be secure from risk. Like taxes, the over-all cost of the solvency of an individual company and of such industry-wide schemes as guaranty funds ultimately falls upon the consumer. **1970 Proc. I 262.**

An insurer association recommended that Section 2 be deleted because it added no substance to the model. **1994 Proc. 2nd Quarter 510.**

The working group decided instead to retain the section, but decided to replace the word “avoid” with “the extent provided in this act, minimize.” The group also deleted a phrase that said one of the purposes was “the detection and prevention of insurer insolvencies.”

The working group felt that the two changes made the section better reflect the purpose of the guaranty association. **1994 Proc. 3rd Quarter 419.**

The Receivership Model Act Working Group voted to delete this section. A couple of regulators made a motion to restore the original language. The argument was that the clause expanded the coverages provided by the guaranty associations. The Task Force voted to retain the original language. **2008 Proc. 1st Quarter 10-440.**

Section 3. Scope

In a report comparing losses of insurance companies and banks, it was pointed out that the property/casualty insurance industry is quite different from the life insurance industry. **1969 Proc. II 564.** The first priority was drafting legislation implementing the NAIC position on automobile insurance problems. **1970 Proc. I 252.**

PC-540-1

NAIC Model Laws, Regulations, Guidelines and Other Resources—April 2011

**PROPERTY AND CASUALTY
INSURANCE GUARANTY ASSOCIATION MODEL ACT**

Proceedings Citations

Cited to the Proceedings of the NAIC

(cont.)

Basic to drafting a model bill is the determination of its scope. What types of insurance and insurers should be included and excluded? The existing bills range from including only automobile insurance to one embracing both life and property coverages. What contacts must there be with the state before recourse may be had against the fund? **1970 Proc. I 263.**

Section 3

The task force was charged with the task of considering whether the term “direct” needed to be defined. There has been litigation and many questions arising as to the types of coverage considered “direct” by the model act language. Courts have found large self-insured groups who purchase excess and aggregate stop loss coverage to be covered by the guaranty associations since there was no underlying contract of insurance, even though the coverage was more in the nature of reinsurance coverage. **1989 Proc. II 331.**

A. The drafters intended that a state choose the term “health insurance,” “disability insurance,” or “accident and sickness insurance” to conform to the terminology found elsewhere in the insurance code of the state in question. **1973 Proc. I 157.**

Amendments proposed in 1985 were considered a “radical departure” from the original model by the task force chair. The proposed amendments excluded products unless they were specifically listed as included. That meant new products would be excluded unless they fit under a generic term. Some of the items not included under the industry-suggested approach were based on a desire to exclude them, such as financial guarantee insurance. Other exclusions resulted from the belief that, recognizing the extraordinary nature of a guaranty fund, many insured exposures did not represent an extreme hardship to the person involved. Still others may have resulted from drafting difficulties. **1985 Proc. II 473-475.**

By the time the amendments were adopted at the end of 1985, the mechanics of the scope section had changed from the earlier draft. Rather than limiting coverage only to stated types of insurance, the list excluded certain types of coverage. One listed item was removed just before adoption of the model. It had provided an exclusion from the act for errors and omissions insurance for directors and officers of for-profit organizations. **1986 Proc. I 294.**

B. The task force was unanimously in favor of excluding financial guaranty insurance from the coverage of the guaranty fund. **1986 Proc. I 431.**

C. After the insolvencies of two large writers of surety business the federal government urged the NAIC to consider coverage of surety bonds under the guaranty association. It had not been the policy to do so because such bonds were generally associated with commercial ventures. **1986 Proc. I 429.**

D. Clarification of the subsection was made in 1986. Originally the model only said “credit insurance” but the additional language was inserted to make clear other types of collateral protection insurance similar to credit insurance were also originally intended to be excluded. **1987 Proc. I 450.**

E. In 1995 the NAIC considered an amendment to Subsection E to amplify the exclusion of coverage for insurance of warranties or service contracts. This provision was included in the package of amendments adopted in 1996. **1995 Proc. 3rd Quarter 586, 1996 Proc. 1st Quarter 571.**

I. When model amendments were adopted in 1985, consideration was given to adding a subsection to exclude coverage for claims covered under a governmental insurance program. The exclusion was not adopted at that time, but instead Section 12 was amended to add a requirement to exhaust governmental benefits before the guaranty fund would be responsible for the claim. **1986 Proc. I 296, 304.** In 1986 the Section 12 limitation was deleted and the exclusion contained in Subsection I added. **1987 Proc. I 421.**

PC-540-2

NAIC Model Laws, Regulations, Guidelines and Other Resources—April 2011

**PROPERTY AND CASUALTY
INSURANCE GUARANTY ASSOCIATION MODEL ACT**

Proceedings Citations

Cited to the Proceedings of the NAIC

(cont.)

An industry association suggested that the comment at the end of the section be amended to note that the Life and Health Insurance Guaranty Association Model Act addresses some of the lines of coverage excluded by this provision. **1994 Proc. 2nd Quarter 510.**

When considering amendments to the model in the latter part of 1995, the working group agreed to add a comment at the end of Section 3. It contained a definition of ocean marine insurance for states whose codes did not contain a definition, so that there would be no question as to the coverages encompassed by the exclusion of ocean marine insurance. The working group agreed to limit the exclusion to craft used for commercial purposes. The working group also decided not to include within the **Section 3**

definition coverage written pursuant to the Jones Act or the Longshore and Harbor Worker's Compensation Act. It was the opinion of the group that these coverages were properly classified as workers' compensation insurance. **1995 Proc. 3rd Quarter 586.**

Section 4. Construction

An industry association recommended that Section 4 be deleted because it added no substance to the model act. **1994 Proc. 2d Quarter 510.**

The working group recommended that the section be retained to encourage appropriate construction of the Act by the courts and to lessen the likelihood that courts would strain to interpret the Act in a manner inconsistent with the intentions of the drafters. The group did remove one word so that the model no longer said *liberally* construed. **1994 Proc. 3rd Quarter 419.**

The Receivership Model Act Working Group voted to delete this section. A couple of regulators made a motion to restore the original language. The argument was that the clause expanded the coverages provided by the guaranty associations. The Task Force voted to retain the original language. **2008 Proc. 1st Quarter 10-440.**

Section 5. Definitions

F. "Covered claim" was considered for modification in 1985. An industry draft suggested a net worth exclusion under which no protection was extended to wealthy persons. The draft recommended exclusion of coverage for any claim in favor of a person having a net worth of \$50 million or more. It was their belief that an insured with that much net worth ought to buy insurance intelligently enough so that it would not be insured by an unsound insurer. They suggested it was not good public policy to send bills for such wealthy persons' losses or claims to all of the homeowners and small business insureds to pay. **1985 Proc. II 474.**

The net worth exclusion was adopted because of potential capacity problems for guaranty funds. The advisory committee felt the suggested change would provide a more even balance between those who really need the protection of guaranty funds and giant corporations. **1985 Proc. II 510.**

Just before adoption of the model revisions in December 1985, the Guaranty Fund Task Force voted to remove a net worth limit of \$10 million that had been included in the draft. A net worth provision was added instead to Section 11. **1986 Proc. I 294.**

The National Committee on Insurance Guaranty Funds approved a document called "Guiding Principles for Settling Disputes Between Property and Casualty Insurance Guaranty Associations as to Responsibility for Claims" and asked the NAIC's acceptance of the program. The purpose was to answer questions about which state's fund should handle the covered claim. **1986 Proc. I 457-459.**

PC-540-3

NAIC Model Laws, Regulations, Guidelines and Other Resources—April 2011

**PROPERTY AND CASUALTY
INSURANCE GUARANTY ASSOCIATION MODEL ACT**

Proceedings Citations

Cited to the Proceedings of the NAIC

(cont.)

A suggestion made to the working group considering amendments to the model in 1994 was to revise the definition of “covered claim” to make it clear that unearned premium claims are covered by the guaranty fund in the state where the policyholder resided at the time the policy was issued. **1994 Proc. 2nd Quarter 510.**

The working group did not follow the suggestion because of a concern that the proposed revised language would be construed to limit the claims that would be covered. **1994 Proc. 3rd Quarter 419.**

Just before adoption of the amendments by the working group, further discussion was held on the suggestion to assign coverage of an unearned premium claim to the guaranty association in the state where the insured resided at the time of issuance of the policy. One regulator said the proposed amendment would place an additional burden on receivers of insolvent insurers, who often must deal with policy records that are unorganized, inadequate or non-existent. Another

Section 5

regulator agreed the proposal could cause delays in paying claims and increase the workload of both receivers and guaranty associations. The working group agreed to defer action on the suggestion. **1994 Proc. 4th Quarter 575.**

Amendments were considered again later in 1995 and Paragraph (2) was revised. It clarifies which guaranty association is primarily liable for the claim for property damage and does not narrow coverage. **1995 Proc. 3rd Quarter 586.**

At a hearing on the proposed amendments held in early 1996 one regulator objected to this proposed amendment. An interested party responded that the amendment does not restrict guaranty association coverage, but only determines the guaranty association that has primary responsibility for a property damage claim. The purpose of the amendment is to clarify that the guaranty association in the jurisdiction where the property giving rise to the claim is located has primary responsibility for the claim. **1996 Proc. 1st Quarter 569.**

An association of guaranty funds recommended that the exclusion from “covered claim” be expanded to exclude claims for reinsurance recoveries, contribution and indemnification brought by other insurers and to prohibit insurers from pursuing such claims against an insured of an insolvent company up to the guaranty fund limits. **1994 Proc. 2nd Quarter 510.**

Paragraph (3)(d) was added in the 1994 revisions. It contains a net worth exclusion for first party claims by an insured whose net worth exceeds \$25 million. The association of guaranty funds had suggested \$10 million as the appropriate level. **1994 3rd Quarter 419.**

G. “Insolvent insurer” was modified in 1972 to change the definition from an insurer “authorized” to transact to one “licensed” to transact insurance. It was the intent of the NAIC committee which drafted the bill to provide coverage only for carriers licensed in the state. In other words, coverage was not to be included for unauthorized insurers since they were not subject to the state’s regulation for solvency. “Authorized” might have been construed to include eligible surplus lines insurers. **1973 Proc. I 155.**

At the June 1976 meeting the industry advisory committee submitted a recommendation for an amendment to the definition of “insolvent insurer.” They contended the law was designed to apply to companies being liquidated, but the language of the model was not sufficiently precise to accomplish that limited objective. The suggestion to add specific language to clarify this point was not acted upon at that time. **1978 Proc. I 277.** It was, however, adopted in December 1978. **1979 Proc. I 217.**

The definition was revised in 1994 to require a final order of liquidation with a finding of insolvency. A drafting note explaining that “final order” means an order that has not been stayed was also included in the amendments. **1994 Proc. 3rd Quarter 419.**

PC-540-4

NAIC Model Laws, Regulations, Guidelines and Other Resources—April 2011

**PROPERTY AND CASUALTY
INSURANCE GUARANTY ASSOCIATION MODEL ACT**

Proceedings Citations

Cited to the Proceedings of the NAIC

(cont.)

H. Paragraph (2) was added in 1994 to incorporate language concerning termination of membership and liability for assessment in the event of a termination. **1994 Proc. 3rd Quarter 419.**

Section 6. Creation of the Association Section 7. Board of Directors

A. This provision was modified to allow vacancies to be filled by a majority vote of the remaining board members. By the terms of the original model, it would have been necessary to call a meeting of all member insurers, which would have been extremely cumbersome. **1972 Proc. I 480.**

An advisory group was asked to consider the issue of public representation on guaranty association boards in 1992. The committee report recommended against it, but one member proposed that a drafting note be added to include a provision for public representation on the board where the state had a premium tax offset. **1993 Proc. IB 703.**

Section 7

One member of the advisory group submitted a minority report explaining her reasons for recommending public representation on guaranty association boards. The main reasons given by the consumer representative were because the public ultimately bears the cost of guaranty fund assessments, because a different perspective is needed, and because accountability is needed. **1993 Proc. I 707.**

As a follow-up from that minority report, the working group decided to draft amendments to both the Life and Health Insurance Guaranty Association Model Act and the Post-Assessment Property and Liability Insurance Guaranty Association Model Act, which were designed to add two public representatives as members of the board of directors of the guaranty associations without increasing the overall number of members on the boards. The amendments also addressed potential conflicts of interest by requiring that the public representatives not be employed or contracted by any entity regulated by the state insurance department or required to register as a lobbyist in the state, or related to either. **1993 Proc. 2nd Quarter 619.**

A representative from an association of guaranty funds said an earlier suggestion for public representatives failed to gain support because of a perception that the commissioner was the representative of the public. Another association representative said his organization's position was that it was a public policy question for the legislatures to determine. The underlying question related to the individual members themselves: their expertise, accountability and responsibility. **1993 Proc. 2nd Quarter 619.**

The consumer representative who authored the minority report restated her position. She believed that because the public ultimately bears the burden of insolvencies either through increased taxes or policy surcharges, the public was entitled to representation on the boards. Any problem experienced with incentive to attend meetings or structure of the board should be addressed separately from the overall issue of representation and should not result in a denial of representation of the public. **1993 Proc. 2nd Quarter 619.**

In a letter of comment on the exposure draft providing for public representation, one association said it had developed a position opposed to public representation when the model was originally drafted. The association's position was that there were substantial conflicts of interest in having consumers and other public representatives on the board. The state guaranty funds stand in the shoes of the insolvent insurer and must pay claims and decide coverage issues as the insolvent insurer would have done. Had the insolvent insurer remained solvent, it would not have had consumers involved in its internal claims process. **1993 Proc. 2nd Quarter 605.**

The consumer representative said insurers also faced a conflict of interest because their interests were not aligned with those of policyholders either, but rather with the solvent insurers who paid the assessment. **1993 Proc. 2nd Quarter 619.**

PC-540-5

NAIC Model Laws, Regulations, Guidelines and Other Resources—April 2011

**PROPERTY AND CASUALTY
INSURANCE GUARANTY ASSOCIATION MODEL ACT****Proceedings Citations**Cited to the Proceedings of the NAIC

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Another insurer association gave conditional support for the amendment. Its experience had been that qualified public representatives can make a positive contribution to board deliberations. The association expressed some concern about selecting qualified individuals who should be knowledgeable about the insurance industry. It recommended the draft be revised to require only one public member, who should not be eligible to serve as the chair of guaranty fund boards. **1993 Proc. 2nd Quarter 604.**

Before the Executive Committee voted on adoption of the amendment regarding public representatives, further discussion took place. The chair of the Financial Condition Subcommittee said the purpose of the amendment was to improve communication among regulators, the insurance industry and consumers on guaranty fund and insurer insolvency issues. The addition of public representatives to the governing boards would provide consumers with access to the guaranty fund process and a direct means to express concerns. The addition of public representatives also recognizes the impact of insurer insolvencies on the general revenues of states and taxpayers. Another commissioner stated that he occupied a position on the guaranty association boards and acted as a public representative since it was his function to protect the public interest. A third commissioner said that public input into the guaranty fund process would be valuable, and that even though the commissioner's function was protection of the consumers, the issue was one of direct public access. He did not favor inclusion of this provision in the financial regulation standards for accreditation. The chair of the subcommittee responded that this was not being recommended. **1993 2nd Quarter 32.**

Section 7

Before final adoption the NAIC plenary body considered the matter again. Concern was expressed that this amendment would be required for a state to be accredited. After assurance that the amendments were not being considered, indeed were not even related to financial solvency, the model amendment was adopted. **1993 Proc. 2nd Quarter 12.**

In 1994 language was added to Section 7A to allow the commissioner to appoint the initial members of the board of directors if not selected by the member insurers within 60 days. A provision was also added to allow the commissioner to fill any vacancies in position held by public representatives. **1994 Proc. 3rd Quarter 419.**

Late in 1995 the working group reviewing suggestions for change to the model recommended that Subsection A be amended to simplify the qualifications for serving as a public member of the board of directors of a guaranty association. **1995 Proc. 3rd Quarter 586.**

The amendment to Subsection A was adopted in 1996, as well as the drafting note following the subsection. **1996 Proc. 1st Quarter 573.**

Section 8. Powers and Duties of the Association

One of the major areas of concern when initially drafting the model was the manner in which the guaranty function was to be performed. Should the program be administered by the commissioner or through an industry association? What functions should the group perform? Shall they be authorized to delegate functions to a servicing insurer? **1970 Proc. I 263.**

A. The drafters started with the promise that the first draft should be a post-assessment rather than a prefunded plan. Then a number of decisions needed to be made in determining those assessments. Should insurers be assessed by lines of business? What, if any, should the maximum rate of assessment be? Should assessments be recognized in the making of premium rates? **1970 Proc. I 263.**

Paragraph (3) of this subsection was amended in December 1971. As the model existed before, if the amount raised by a maximum assessment was insufficient to pay all covered claims, the association would have to marshal all the claims before it

PC-540-6

NAIC Model Laws, Regulations, Guidelines and Other Resources—April 2011

**PROPERTY AND CASUALTY
INSURANCE GUARANTY ASSOCIATION MODEL ACT****Proceedings Citations**Cited to the Proceedings of the NAIC

(cont.)

could make any payment on any one particular claim. Language was added giving the association the right to pay claims in the order it deemed reasonable, thus avoiding administrative problems and delay. **1972 Proc. I 480.**

A second amendment in December 1971 provided that if a company had deferred payment of an assessment due to its financial condition, that company could not pay any dividends to shareholders or policyholders during the period of deferment, and would have to pay the deferred amount as soon as payment would not reduce capital or surplus below required minimums. **1971 Proc. I 480.**

A December 1978 amendment added a sentence to the last paragraph of Subsection A(1) to eliminate claims filed after the final date set by the court for filing claims against the liquidator. **1979 Proc. I 217.**

The model originally contained a \$100 deductible provision that was deleted in December 1980. At the same time a sentence was added at the end of Subsection A(1) to pay only the amount of unearned premium over \$100. The reasoning for this was that certain consumers bore a disproportionate share of the losses; if there were no deductibles, the losses would be borne more equitably by all insureds. The administrative costs of handling the deductibles were high in relation to the amounts involved, sometimes exceeding what would have been paid out in claims. **1981 Proc. I 225, 228.**

The most notable of the amendments to the model act considered in 1994 included deletion of the \$100 deductible for unearned premium claims. **1994 Proc. 4th Quarter 574.**

The working group was asked to consider deletion of the provision that allows the guaranty fund to pay only that portion of an unearned premium claim in excess of \$100. In support of his proposal, the regulator said his state's receiver spent \$91.18 in costs to adjudicate each policyholder claim for the deductible. He said the substantial number of these claims filed also

NAIC Model Laws, Regulations, Guidelines and Other Resources—April 2011

**PROPERTY AND CASUALTY
INSURANCE GUARANTY ASSOCIATION MODEL ACT**

Proceedings Citations

Cited to the Proceedings of the NAIC

Section 8A (cont.)

creates an administrative burden, as well as depleting assets of the insolvent insurer. An industry spokesperson said the industry favored the deductible because it had the effect of spreading the loss due to insolvency and also reduced the cost of each insolvency to the guaranty association. The working group decided to recommend the deletion of the provision for the deductible. **1994 Proc. 3rd Quarter 419.**

Several industry associations commented on the proposal to delete the \$100 deductible and indicated a desire to retain the provision. A regulator responded that the costs to the estate associated with the deductible were out of proportion to any benefit to policyholders. Another regulator said she received numerous complaints from policyholders about the application of the deductible to their claims. Another regulator said that, although guaranty associations might initially derive some cost savings from the deductible, those savings were offset by the cost to the estate, which ultimately results in less money available for distribution to policyholders, guaranty associations and other creditors. Another added that the necessity of processing claims for the deductible unnecessarily prolongs the administration of estates, which is detrimental to the guaranty association. A guaranty association representative argued that the cost savings related to the deductible was important to guaranty associations. He said in one state it was estimated that the deductible had resulted in savings of more than \$13 million. He suggested other options for addressing the issue, including an exclusion of nominal claims from payment by the receiver and lowering the priority of claims for reimbursement of the deductible. He said costs of the guaranty associations are passed on to the public through rate surcharges and premium tax offsets, and that it was appropriate for policyholders to share some of the costs associated with an insolvency. After much discussion the working group decided to dispense with the deductible for unearned premium claims. **1994 Proc. 4th Quarter 574-575.**

The amendments adopted in December 1985 included a revision of this section, including a limit of \$10,000 per policy for claims on return of unearned premiums. The advisory committee also suggested a limit of \$50,000 on non-economic loss, but this suggestion was not adopted. **1986 Proc. I 300, 344.**

In 1986 an alternative provision was drafted to give the liquidator authority to sell a limited optional reporting period to insureds of an insolvent company that would provide coverage for the time period for filing claims with the liquidator. To prevent inconsistencies the time period was set for 18 months. **1986 Proc. II 409-411.** This provision was adopted six months later. **1987 Proc. I 421.**

Revisions were made to this section in 1994 to eliminate the alternative section that had been included for states with a provision in the liquidation law giving the liquidator authority to sell a limited extended reporting period for claims made policies. **1994 Proc. 3rd Quarter 424-425.**

The last sentence of the subsection originally read “Each member insurer may set off against any assessment authorized payments made on covered claims and expenses incurred in the payment of such claims by the member insurer.” That sentence was deleted as being unnecessary and a potential cause of conflict. **1987 Proc. I 450.**

Section 8A(1) was amended to be consistent with the revised definition in Section 5G by replacing “determination of insolvency” with “order of liquidation.” Language was added at the end of Paragraph (1) that provided that the association’s duty to defend ceased upon payment or tender of an amount equal to the lesser of the association covered claim limit or the applicable policy limit. **1994 Proc. 3rd Quarter 419.**

Late in 1995 a working group considering amendments to the model discussed a proposal from a group suggesting a change to the provision regarding the date at which liability to the guaranty association is cut off and discussed the exclusion from coverage of policyholder protection claims. After lengthy discussion the regulators decided not to recommend the proposed amendments. The group also considered amending Paragraph (1)(b) to provide for an aggregate limit of \$10 million per insured. **1995 Proc. 3rd Quarter 586.**

PC-540-8

NAIC Model Laws, Regulations, Guidelines and Other Resources—April 2011

**PROPERTY AND CASUALTY
INSURANCE GUARANTY ASSOCIATION MODEL ACT****Proceedings Citations**Cited to the Proceedings of the NAIC

Members of the working group expressed their support for the idea of an aggregate limit per insured in general, but raised some specific concerns with the proposal. These concerns included the difficulty of application of the aggregate limit if not adopted uniformly by all states and whether the amendment would create an incentive for a guaranty association to delay **Section 8A** (cont.)

claim payments so that payments by other guaranty associations would satisfy the limit, thereby avoiding its statutory responsibility. Another concern was that guaranty association coverage would be exhausted by those who filed claims early, leaving other claimants without any coverage. **1996 Proc. 1st Quarter 569.**

The working group decided to adopt the proposed package of amendments without including the aggregate limit, but to consider a revised proposal in the future. **1996 Proc. 1st Quarter 570.**

A provision was added to Paragraph (2) authorizing the association to pursue and retain salvage and subrogation as to claims paid by the association. **1994 Proc. 3rd Quarter 419.**

An association of guaranty funds recommended that the guaranty funds have the exclusive right to appoint and direct legal counsel retained to defend liability claims. The working group decided to add a provision to Paragraph (4) giving the association the right to choose legal counsel for the defense of covered claims. **1994 Proc. 3rd Quarter 419. Section 8** (cont.)

B. A suggestion was made by an association of guaranty funds to amend Subsection B(3) to afford guaranty associations the right to intervene in a proceeding involving an insolvent insurer. Some members of the working group expressed concern that this provision would result in the estate incurring unnecessary litigation expenses. Another concern expressed was that other creditors would, by extension, also be granted a right to intervene. One regulator felt that guaranty associations should not have rights superior to those of other creditors. No amendments to this subsection were included in the recommendations adopted in 1996. **1995 Proc. 3rd Quarter 586, 1996 Proc. 1st Quarter.**

C. The working group agreed to create an optional Subsection C providing a method of raising funds in excess of the association's normal assessment capacity to pay claims resulting from a natural disaster. This provision was patterned after legislation already enacted in one state. **1995 Proc. 3rd Quarter 586.**

The amendments adopted in 1996 included an optional Subsection C and a comment on that subsection. **1996 Proc. 1st Quarter 576.**

Section 9. Assessments Section 10. Plan of Operation

To supplement the model bill a separate model plan of operation was also adopted. **1970 Proc. IIB 1092-1096.**

When considering revisions to the model in 1994, a suggestion was made to the working group that provision be made for disposition of dividends and other advances received by a guaranty fund from an estate. **1994 Proc. 2nd Quarter 510.**

Section 11. Duties and Powers of the Commissioner

A. The second sentence was added to Paragraph (1) in December 1972. Receipt of a copy of the commissioner's petition for insolvency upon the filing of such a petition with a court would assist the guaranty funds in beginning to prepare to handle a insolvency once declared by a court of competent jurisdiction. **1973 Proc. I 156.**

B. Subsection B contained a provision requiring the association to notify insureds and other interested parties of the insolvency. This provision was deleted in 1994. **1994 Proc. 3rd Quarter 420.**

PC-540-9

NAIC Model Laws, Regulations, Guidelines and Other Resources—April 2011

**PROPERTY AND CASUALTY
INSURANCE GUARANTY ASSOCIATION MODEL ACT**

Proceedings Citations

Cited to the Proceedings of the NAIC

Section 11. Effect of Paid Claims (Previous version of model)

In 1975 the drafters considered an amendment which would have given guaranty funds immediate access to insolvent company assets, declare the guaranty funds priority creditors, and offer a “rescue” funding mechanism. **1976 Proc. I 296.**

The recommendation was not adopted by the executive committee, but was sent back to the drafting task force. **1975 Proc. I 9.**

B. On a close vote the Guaranty Fund Task Force decided to include an amendment to this section limiting covered claims to claimants whose net worth was under \$50 million. All of Subsection B was new material added in December 1985. **1986 Proc. I 340, 347.**

The task force generally favored the net worth exclusion as long as third-party liability claimants who may not have a sufficient net worth were protected. This approach would serve as an incentive to risk managers for commercial insureds to shop wisely in placing their insurance. **1986 Proc. I 431.**

The footnote in Subsection B was added to clarify the original drafter’s intent that the net worth provision apply to workers’ compensation claims. **1987 Proc. I 451.**

A working group considering amendments in 1995 was asked to lower the net worth exclusion to \$25 million but declined to make that recommendation. **1995 Proc. 3rd Quarter 586.**

C. In 1994 Subsection C was substantially amended to clarify the rights of the association as claimant in the estate of an insolvent insurer and to require receivers to accept settlements of covered claims and determination of covered claim eligibility by guaranty associations. **1994 Proc. 3rd Quarter 420.**

In late 1995 an amendment was proposed to Subsection C to address the concern of some members that guaranty association determination of covered claims not affect the receiver’s adjudication of excess claims. **1995 Proc. 4th Quarter 728.**

A second issue identified by the working group was whether the receiver should be bound to accept the guaranty fund’s determination of a covered claim and the amount paid by the guaranty fund in satisfaction of the claim. The suggested amendments addressed the concerns of regulators. **1995 Proc. 4th Quarter 728.**

Section 12. Exhaustion of Other Coverage (Previous version of model)

Section 12 was titled “Nonduplication of Recovery” from the time the original model was adopted in 1962. The title was changed in 1996 to better reflect the intent of the section. **1996 Proc. 1st Quarter 570.**

A new Subsection B was added in December 1985 requiring a person with any right of recovery under a governmental insurance program to exhaust his right there first before submitting a claim to the guaranty association. **1986 Proc. I 296, 304.** A year later this paragraph was deleted and the model returned to its original language. Instead Section 3 was amended to add an additional subsection excluding any insurance provided by or guaranteed by the government. This would have the effect of excluding flood and crop hail insurance guaranteed by the federal government from covered claims. **1987 Proc. I 421.**

A. In 1994 Subsection A was amended to clarify that “other insurance” was not limited to coverage provided by a member insurer. **1994 Proc. 3rd Quarter 420.**

Section 12. Prevention of Insolvencies

PC-540-10

NAIC Model Laws, Regulations, Guidelines and Other Resources—April 2011

**PROPERTY AND CASUALTY
INSURANCE GUARANTY ASSOCIATION MODEL ACT**

Proceedings Citations

Cited to the Proceedings of the NAIC

Protection against insolvency is one of the paramount objectives of insurance regulation. Two approaches are used to achieve this objective. First, insolvency funds have been created to afford protection when insolvencies actually occur. Second, statutes have armed insurance departments with various regulatory standards, procedures and tools to prevent or reduce the likelihood of insolvencies. The drafters also questioned whether additional insolvency preventive measures should be incorporated in the model bill. **1970 Proc. I 263.**

The section was rewritten in 1983 at the urging of the guaranty funds because they felt the section imposed duties on the guaranty funds boards which were more appropriately carried out by insurance departments. **1983 Proc. I 350.** The recommended changes allowed interaction between the guaranty funds and the insurance commissioners. **1984 Proc. I 326.**

A. The old Subsection A was deleted in 1994 to address antitrust concerns. It had required the board of directors to make recommendations to the commissioner for ways to detect and prevent insolvency and to discuss and make recommendations about the status of any member insurer whose financial condition might be hazardous to its policyholders. This was replaced with a provision authorizing the board of directors to make general recommendations concerning solvency regulation. **1994 Proc. 3rd Quarter 420.**

Section 13. Credits for Assessments Paid (Tax Offsets) – OPTIONAL

A regulator stated that the E Committee requested the Task Force reconsider a solution regarding assumed claims transactions. Another regulator stated that the Working Group considered the topic twice and agreed that something should be covered by the guaranty associations. A regulator suggested optional language to avoid controversy and ensure a timely response. After extensive discussion, the Task Force agreed to further study the issue. **2008 Proc. 2nd Quarter Vol. II 10-490 to 10-492.**

A regulator recommended including two options – one option where assumed business was covered, and a second option where assumed business was not covered. Another regulator explained a third option as having two parts. This alternative would be a way to take care of all assumed claims, not necessarily with guaranty fund coverage but by means of a segregated account. The Task Force discussed comments received on these options and whether drafting notes would resolve the issue. A commissioner summarized the four existing options and the potential fifth option. The Task Force decided to draft a background summary and finalize a decision at the 2008 Fall National Meeting. **2008 Proc. 3rd Quarter Vol. II 10-368 to 10-370.**

A commissioner stated that the Committee requested that the Task Force reconsider the assumed business language by considering optional language. A regulator stated that Option Three appeared to be an interim step for when insolvency takes place before a company issues their own policies. This option would be a way to handle the previous incurred losses before the assumption. The Task Force discussed issues related to this option. **2008 Proc. 4th Quarter Vol. II 10-622.**

A commissioner stated that Option Four followed Virginia Law. An interested party stated that Option Four is the mechanism by which Virginia implemented Option One. A regulator asked for clarification on the options. Another regulator said that Option Five was an attempt to be in the middle ground. The Task Force discussed the various aspects of Option Five. An interested party stated that he had an alternative that achieved Option Five's goal through a different mechanism. Another interested party stated that the option they were most supportive of was Option Three. This option leaves parties as close as possible to the position into which they put themselves while still providing relief on a going forward basis for those people finding themselves with a new insurer, but after the transaction date, their claims would be covered just as if they had been issued by the assuming carrier. The Task Force discussed the pros and cons of Option Three. A regulator polled the members on the different options. Options One and Five, received positive support from the majority. Options Two and Three did not receive support. **2008 Proc. 4th Quarter Vol. II 10-624 to 10-625.**

The Task Force voted to send Option One and Option Five to the Financial Condition (E) Committee as optional language within the model. **2008 Proc. 4th Quarter 10-626.**

PC-540-11

NAIC Model Laws, Regulations, Guidelines and Other Resources—April 2011

**PROPERTY AND CASUALTY
INSURANCE GUARANTY ASSOCIATION MODEL ACT**

Proceedings Citations

Cited to the Proceedings of the NAIC

Section 14. Miscellaneous Provisions Section 15. Examination of the Association; Annual Report Section 16. Tax Exemptions Section 16. Recognition of Assessments in Rates

At the December 1972 meeting of the NAIC Property and Liability Guaranty Fund Subcommittee, it was suggested that a task force consisting of both regulators and industry actuaries and rate-making personnel create a recoupment formula under the model law. **1973 Proc. I 395.**

The task force made the following recommendations: (1) In making rates consideration should be given to past assessments paid. It is the intent of the guaranty fund law that the assessments are to be borne by the policyholders eventually through their premium payments. (2) The language is quite clear on the point that, if assessments have been paid, rates are not to be considered excessive because they contain an amount to recoup the assessments paid. Because rate-making is prospective in nature, the rating law required that due consideration be given to prospective expenses as well as past expenses. (3) The task force recommended numeric formulas considering available information from prior insolvencies covered by guaranty funds. **1973 Proc. II 396-397.**

In 1995 the working group recommended the deletion of the assessment recoupment formula because it appeared that the formula had not been utilized by any state. **1995 Proc. 3rd Quarter 586.**

Section 17. Immunity

An amendment to this section was made in December 1986. The words "... for any action taken *or any failure to act* by them ..." were added to strengthen the immunity and reflect more clearly the intent of the drafters. **1987 Proc. I 451.**

A provision was added in 1994 amendments to extend immunity to those persons substituting for a member of the board of directors. **1994 Proc. 3rd Quarter 420.**

Section 18. Stay of Proceedings

Three years after the model was originally adopted, a change was made allowing a proceeding to be stayed for six months instead of the 60 days in the original model. It was found that the records of an insolvent company were in many cases nonexistent, and it took time to determine what actions were pending. The amendment allowed the association up to six months within which to prepare a proper defense, and such time thereafter as the court may grant in its discretion. **1973 Proc. I 156.**

The liquidator of an insolvent insurance company was reluctant, in some cases, to turn over the insolvent company's claims files to the servicing carrier. Because the association couldn't function without access to the insolvent company's files, the second paragraph of Section 18 was added. **1973 Proc. I 156-157.**

The language in the first sentence of this section was modified to remove the words "up to" which had preceded "six months." It was the view of the committee that the words "up to six months" imposed an unnecessary restriction upon the staying power of the court. **1987 Proc. I 451.**

An association of guaranty funds recommended that the stay be extended to the claim filing deadline to allow the guaranty funds more time to obtain and review claim files and determine what actions need to be taken. **1994 Proc. 2nd Quarter 511.**

The drafting group declined to follow the suggestion and recommended retention of the six-month period. The group did, however, add a provision allowing the association to waive the stay in instances where circumstances justify or require quicker action. **1994 Proc. 4th Quarter 588.**

PC-540-12

NAIC Model Laws, Regulations, Guidelines and Other Resources—April 2011

**PROPERTY AND CASUALTY
INSURANCE GUARANTY ASSOCIATION MODEL ACT****Proceedings Citations**Cited to the Proceedings of the NAIC**Section 18 (cont.)**

A set of general comments had been included after Section 18 with further suggestions for drafters. When amendments were considered in 1994, one suggestion was to omit these comments. An insurer association suggested that many comments in the model were outdated and no longer applicable and should be deleted. **1994 Proc. 2nd Quarter 521.**

Chronological Summary of Actions

June 1969: Model adopted.

December 1971: Amended Section 7 to provide method for filling board vacancies and Section 8 to allow payment of claims in any order deemed reasonable.

December 1972: Amended definition of insolvent insurer and added procedures to assist the guaranty association in its duties.

June 1973: Recoupment formula adopted.

December 1978: Revised definition of insolvent insurer and added sentence to limit covered claims to those timely filed.

December 1980: Eliminated \$100 claims deductible but added sentence to retain \$100 unearned premium deductible.

December 1983: Modified Section 13 to aid in detection and prevention of insolvencies.

December 1985: Extensive amendments adopted to clarify and limit scope of act, to add definitions of "claimant" and "control" and to expand section on limits of payments. The net worth limit in Section 11 was added.

December 1986: Amendments adopted to provide for extended reporting period endorsement of a claims-made policy, to exclude flood and crop hail damage insurance provided or guaranteed by the federal government, and to make technical amendments.

September 1993: Adopted amendment to Section 7 to provide for public representatives on the guaranty fund board.

March 1995: Adopted amendments to clarify and update the model.

June 1996: Adopted amendments to clarify and update the model.

January 2009: Adopted amendments to clarify and update the model.

CANTILO & BENNETT, L.L.P.

ATTORNEYS & COUNSELORS
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Comprised of Professional Corporations*

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June 2, 2023

Ms. Laura Lyon Slaymaker Co-Chair
Mr. Kevin Baldwin, Co-Chair
Receivership Model Law (E) Working Group
C/O Jane Koenigsman
Sr. Manager - Life/Health Financial Analysis
National Association of Insurance Commissioners
1100 Walnut Street
Suite 1500
Kansas City, MO 64106-2197

BY ELECTRONIC MAIL

RE: MODEL 540 COMMENTS

Dear Ms. Lyon Slaymaker and Mr. Baldwin:

Please accept this letter as my comments in response the May 24 Model 540 Exposure Draft. I address only the proposed amendments regarding IBT/CD transactions. I offer no comment on those related to cybersecurity insurance. This letter is not a request that you reverse the May 23 decision of the Receivership Law (E) Working Group (RLWG) to adopt the proposal submitted by Ms. Cox and Messrs. Wake and Snider (Version 1). I understand that the RLWG has already considered my comments and my proposal (Version 2). Instead, I submit this letter so that it may be included when the RLWG forwards its recommendation to the Receivership and Insolvency (E) Task Force (RITF) or the Restructuring Mechanisms (E) Working Group (RMWG).

The charge to the RLWG was to propose amendments to Model 540, the Property and Casualty Insurance Guaranty Association Model Act (the Act), to assure that implementation of Insurance Business Transfers (IBT) and Corporate Division (CD) transactions, will not result in loss by policyholders of guaranty association protection.

After extensive discussion and analysis, I proposed a straightforward amendment as follows:

H. "Covered claim" means the following:

- (1) An unpaid claim, including one for unearned premiums, submitted by a claimant, which arises out of and is within the coverage and is subject to the applicable limits of an*

**Ms. Lyon Slaymaker and Mr. Baldwin
June 2, 2023, page 2**

insurance policy to which this Act applies, if the insurer becomes an insolvent insurer after the effective date of this Act and the policy was either issued by the insurer or assumed by, or allocated to, the insurer in an assumed claims transaction or in an Insurance Business Transfer or Corporate Division transaction that was approved by the chief insurance regulator in the insurer's state of domicile and, if required, by the [Commissioner/Director/Superintendent]; and ...

No other change to the Act would be needed to fulfill the goal of the referral to the RLWG. The NAIC could adopt this simple amendment thereby assuring that IBT and CD transactions would not result in the loss of guaranty association coverage.

Recognizing that some may conclude that a definition of IBT and CD should be included, I proposed the following:

(c) For purposes of this Act, an Insurance Business Transfer or Corporate Division transaction shall mean a transaction [ALTERNATIVE 1] as described in [INSERT STATE STATUTORY CITATIONS] [OR ALTERNATIVE 2] authorized by the laws of another state authorizing such transactions and as the result of which, apart from other provisions, the insurer assumed all of the obligations under the policy from a transferor which was thereby discharged from such obligations.

To be clear, however, this definition is an optional suggestion, not necessary to achieve the stipulated purpose.

During the discussions it emerged that, since many states have not adopted the assumed claims provisions added to the Act in 2009, an alternative should be offered that would accomplish the same goal in those states. That is true because the current Act's assumed claims provisions assure coverage even if the transferee insurer (even in an IBT or CD transaction) is not a member insurer. My initial "Default" provision (quoted above) accomplishes only the goal of assuring that IBT and CD transactions do not eliminate guaranty association coverage under the Act as it exists currently. That was the goal articulated in the referral to the RLWG. Under this provision, transactions (including IBT or CD) would be covered in most cases: member to member and non member to member, but would not be covered in IBT and CD transactions in which the transferee insurer is unlicensed (highly improbable in my view).

Although I would not recommend it, it is possible that some states may want to provide guaranty association coverage even if the transferee insurer is unlicensed. The discussions also resulted in suggestions that some states may not want to provide coverage in all the other cases encompassed within my proposal, for example when the transferee insurer is not a member insurer. While this went beyond the RLWG's charge, to address these permutations, I offered three alternatives (SEE Exhibit 1) included in the exposure draft. They would permit a state to select an option that, both, addresses the goal of the referral, and limits coverage as follows:

ALTERNATIVE 1: Does not provide coverage for assumed claims transactions or transfers to non-member insurers;

Ms. Lyon Slaymaker and Mr. Baldwin
June 2, 2023, page 3

ALTERNATIVE 2: Does not provide coverage for assumed claims transactions but retains it for transfers to non-member insurers; and

ALTERNATIVE 3: Provides coverage for assumed claims transactions and transfers to non-member insurers.

All of the alternatives have the same virtue as the default proposal: they only envision limited edits to Section H(1). Thus, no matter what its preference, under my proposal a state could accomplish the referral's goal of preserving coverage in the case of IBTs or CDs, AND also limit coverage as summarized above.

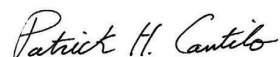
This contrasts with the very extensive and complicated edits of the Act (including extensive deletions of current provisions) required to implement Version 1, the one selected by the RLWG. The simple explanation for the difference is that, unlike my proposal, Version 1 is structured to permit the NAIC to remove now the assumed claims coverage added in 2009. If it were not for that new goal, there would be no reason to prefer Version 1. That new goal, of course, was not part of the charge to this Working Group.

This point merits a bit further explanation. My proposal DOES enable an individual state to provide guaranty association coverage for IBT and CD transactions WITHOUT assumed claims coverage. Where it differs from that adopted by the Working Group is that the latter enables amendment of the Act to ELIMINATE EVEN THE POSSIBILITY of assumed claims coverage. I submit respectfully that there is no public policy justification for this *sotto voce volte-face*.

My purpose here is simply to highlight that my proposal would enable RITF to accomplish the referral's goal with a simple amendment of the Act. I respectfully reserve further explanation as to why I think the new goal served by Version 1 is inappropriate, and other concerns I have articulated already as to Version 1, pending further deliberations following referral of the proposed amendments by the RLWG to RITF.

I thank you for your kindness in adding my comments to your referral.

Very truly yours,



Patrick H. Cantilo

EXHIBIT 1PATRICK CANTILO'S PROPOSED REVISION TO THE DEFINITION OF COVERED CLAIM
IN MODEL 5401-1 SECTION 5.

H. "Covered claim" means the following:

- (1) *An unpaid claim, including one for unearned premiums, submitted by a claimant, which arises out of and is within the coverage and is subject to the applicable limits of an insurance policy to which this Act applies, if the insurer becomes an insolvent insurer after the effective date of this Act and the policy was either issued by the insurer or assumed by, or allocated to, the insurer in an assumed claims transaction or in an Insurance Business Transfer or Corporate Division transaction that was approved by the chief insurance regulator in the insurer's state of domicile and, if required, by the [Commissioner/Director/Superintendent]; and ...*

[OPTIONAL – to define IBT and CD if deemed necessary]

- (c) *For purposes of this Act, an Insurance Business Transfer or Corporate Division transaction shall mean a transaction [ALTERNATIVE 1] as described in [INSERT STATE STATUTORY CITATIONS] [OR ALTERNATIVE 2] authorized by the laws of another state authorizing such transactions and as the result of which, apart from other provisions, the insurer assumed all of the obligations under the policy from a transferor which was thereby discharged from such obligations.*

EXPLANATION

Versions of this language can be adopted whether or not the Assumed Claim language has been adopted. The proposal deliberately doesn't remove the "assumed claims" language. However, a state that wants to adopt this remedial provision without adopting the assumed claims language can do so easily enough just by making this change to the definition:

- (1) *An unpaid claim, including one for unearned premiums, submitted by a claimant, which arises out of and is within the coverage and is subject to the applicable limits of an insurance policy to which this Act applies, if the insurer becomes an insolvent insurer after the effective date of this Act and the policy was either issued by the insurer or assumed by, or allocated to, the insurer in an ~~assumed claims transaction or in an~~ Insurance Business Transfer or Corporate Division transaction that was approved by the chief insurance regulator in the insurer's state of domicile and, if required, by the [Commissioner/Director/Superintendent]; and ...*

Similarly, if a state wants to add coverage when the transferee is a non-member insurer, the following edits accomplish this.

- (1) *An unpaid claim, including one for unearned premiums, submitted by a claimant, which arises out of and is within the coverage and is subject to the applicable limits of an insurance policy to which this Act applies, if (A) the insurer becomes an insolvent insurer after the effective date of this Act, and the policy was either issued by the insurer or assumed by, or allocated to, the insurer in an Insurance Business Transfer or Corporate Division transaction that was approved by the chief insurance regulator in the insurer's state of domicile and, if required, by the [Commissioner/Director/Superintendent]; or (B) the policy*

was issued by a member insurer and, in such a transaction, subsequently assumed by, or allocated to, another insurer (other than a risk retention group) against whom a final order of liquidation has been entered after the effective date of this Act with a finding of insolvency by a court of competent jurisdiction in the insurer's State of domicile, and

Here's how the final would look:

WITH ASSUMED CLAIMS LANGUAGE AND WITHOUT NON-MEMBER TRANSFEREE COVERAGE

H. "Covered claim" means the following:

- (1) An unpaid claim, including one for unearned premiums, submitted by a claimant, which arises out of and is within the coverage and is subject to the applicable limits of an insurance policy to which this Act applies, if the insurer becomes an insolvent insurer after the effective date of this Act and the policy was issued by the insurer or assumed by, or allocated to, the insurer in an assumed claims transaction or in an Insurance Business Transfer or Corporate Division transaction that was approved by the chief insurance regulator in the insurer's state of domicile and, if required, by the [Commissioner/Director/Superintendent]; and

ALTERNATIVE 1: WITHOUT ASSUMED CLAIMS LANGUAGE AND NON-MEMBER TRANSFEREE COVERAGE

H. "Covered claim" means the following:

- (1) An unpaid claim, including one for unearned premiums, submitted by a claimant, which arises out of and is within the coverage and is subject to the applicable limits of an insurance policy to which this Act applies, if the insurer becomes an insolvent insurer after the effective date of this Act and the policy was either issued by the insurer or assumed by, or allocated to, the insurer in an Insurance Business Transfer or Corporate Division transaction that was approved by the chief insurance regulator in the insurer's state of domicile and, if required, by the [Commissioner/Director/Superintendent]; and

ALTERNATIVE 2: WITHOUT ASSUMED CLAIMS LANGUAGE BUT WITH NON-MEMBER TRANSFEREE COVERAGE

H. "Covered claim" means the following:

- (1) An unpaid claim, including one for unearned premiums, submitted by a claimant, which arises out of and is within the coverage and is subject to the applicable limits of an insurance policy to which this Act applies, if (A) the insurer becomes an insolvent insurer after the effective date of this Act and the policy was either issued by the insurer, or assumed by, or allocated to, the insurer in an Insurance Business Transfer or Corporate Division transaction that was approved by the chief insurance regulator in the insurer's state of domicile and, if required, by the [Commissioner/Director/Superintendent]; or (B) the policy was issued by a member insurer and, in such a transaction, subsequently assumed by, or allocated to, another insurer (other than a risk retention group) against whom a final order of liquidation has been entered after the effective date of this Act with a finding of insolvency by a court of competent jurisdiction in the insurer's State of domicile, and

ALTERNATIVE 3: WITH ASSUMED CLAIMS LANGUAGE AND NON-MEMBER TRANSFEREE COVERAGE

H. “Covered claim” means the following:

- (1) *An unpaid claim, including one for unearned premiums, submitted by a claimant, which arises out of and is within the coverage and is subject to the applicable limits of an insurance policy to which this Act applies, if (A) the insurer becomes an insolvent insurer after the effective date of this Act and the policy was either issued by the insurer, or assumed by, or allocated to, the insurer in an assumed claims transaction or in an Insurance Business Transfer or Corporate Division transaction that was approved by the chief insurance regulator in the insurer’s state of domicile and, if required, by the [Commissioner/Director/Superintendent]; or (B) the policy was issued by a member insurer and in such a transaction subsequently assumed by, or allocated to, another insurer (other than a risk retention group) against whom a final order of liquidation has been entered after the effective date of this Act with a finding of insolvency by a court of competent jurisdiction in the insurer’s State of domicile, and*

- (a) *The claimant or insured is a resident of this State at the time of the insured event, provided that for entities other than an individual, the residence of a claimant, insured or policyholder is the State in which its principal place of business is located at the time of the insured event; or*
- (b) *The claim is a first party claim for damage to property with a permanent location in this State.*

OPTIONAL

- (c) *For purposes of this Act, an Insurance Business Transfer or Corporate Division transaction shall mean a transaction [ALTERNATIVE 1] as described in [INSERT STATE STATUTORY CITATIONS] [OR ALTERNATIVE 2] authorized by the laws of another state authorizing such transactions and as the result of which, apart from other provisions, the insurer assumed all of the obligations under the policy from a transferor which was thereby discharged from such obligations.*

2850 LAKE VISTA DRIVE, SUITE 150
LEWISVILLE TX 75067

Kevin Baldwin and Laura Slaymaker
Co- Chairmen, Model Law Working Group

RE: Exposure Draft on Restructuring Transactions and Cyber Security-Comments due June 23

Dear Kevin and Laura:

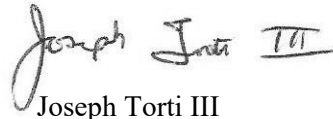
I am writing to offer comments on the aforementioned exposure draft, specifically regarding guaranty fund coverage for restructured business. As you may know, I have been a supporter at the NAIC of the concept of business restructuring. Additionally, I have served as an insurance regulator in Rhode Island for over 30 years and have been active in many NAIC initiatives. Currently I am employed by the Fairfax US Inc. as Vice President – Regulatory Affairs. Coincidentally, I also serve as the Chairman of the NCIGF Board of Directors. In this capacity I have a keen interest in supporting the protection the guaranty fund system affords to covered policyholders.

I offer a few observations that I hope will move the Working Group towards a solution that includes only 5(g)(2) of the exposure draft. First, restructuring transactions, while a useful business tool, were never intended to afford coverage on policy claims that were, before the transaction, not covered by guaranty funds. The current drafts being circulated by the Restructuring Working Group support the idea that guaranty coverage not be “changed” by the transaction. G(2) as a standalone is consistent with this approach. Second, regarding the assumption reinsurance provisions that were adopted by the NAIC in 2009, I understand that the drafting group has determined that, in current form, those provisions would not deal with IBTs and CDs – the most recent iterations of restructured business. Moreover, the 2009 amendments have only been adopted in three states – Rhode Island- the state I regulated - among them. It is appropriate to strike these provisions in the way that the current exposure draft indicates. Third, and probably most important, IBT and CD statutes continue to be enacted in the states and have already been used on several occasions in various jurisdictions. It is important to have a legislative remedy on the books to protect policyholders soon to address situations where the transferee company, despite all efforts to prevent this, becomes insolvent.

I understand that 5(g)(3) provides for an optional remedy for states to cover some transactions that did not originate from guaranty fund covered business. This, in my view, is contrary to the intent of the transactions. Further, as I understand it, there is additional “optional” language throughout the draft to clarify and permit some recoupment of guaranty fund assessments that may have been collected had the business originally been guaranty fund covered, a concept NCIGF has not put forward. This additional language adds a layer of complexity that would not be necessary if g(3) were not enacted and, sadly, has the potential to complicate legislative efforts to protect covered policyholders.

Thank you for your attention to my comments.

Sincerely yours,

A handwritten signature in black ink that reads "Joseph Torti III". The signature is written in a cursive style with a horizontal line under the "III".

Joseph Torti III

Cc: Roger Schmelzer, NCIGF
Rowe Snider, Locke Lord
Barbara Cox, Barbara F. Cox, LLC

June 20, 2023

Kevin Baldwin and Laura Slaymaker
Co-Chairmen of the Receivership Law (E) Working Group

Subject: May 23 Exposure Draft on Guaranty Fund Coverage for Restructured Business

Dear Kevin and Laura:

We appreciate the Receivership Law Working Group's consideration of our proposed guaranty fund model law amendment to address restructuring transactions. As you know, NCIGF's policy is coverage neutrality – that is, if there was guaranty fund coverage before the transaction the coverage should remain in place after the transaction. Conversely, coverage that did not exist prior to the transaction should not be created by the transaction. We believe this position aligns with the charge to the Model Law Working Group and the most recent drafts circulated by the Restructuring Working Group.¹

We feel that the proposed amendment to the covered claim definition at 5G(2), as a standalone revision, is consistent with the NCIGF policy. We would be comfortable recommending it to our members and others who may be involved in addressing restructured business guaranty fund coverage in the various states.

Further, we believe that the strike through of the 2009 amendments (including the adjustment to 5G(1)) intended to address assumption transactions is appropriate given that 1) as adopted in 2009 the language does not address IBTs and CDs and 2) the amendments have only been adopted in three states.

The optional paragraph 5G(3) in the exposure draft goes beyond the NCIGF coverage neutrality position and is not supported by the NCIGF. Likewise, the additional language which we understand is intended to offer options to support G(3) (such as additional definitions and options to provide for a look back to recover guaranty fund assessments that may have been collected had the business originally been covered business) is not necessary without G(3). It also may unduly complicate state efforts to amend their guaranty fund acts because of its complexity.

Note that NCIGF is not commenting on the cyber security amendments included in the exposure draft at this time. However, we do look forward to continued discussion of these amendments.

¹ See the Request for NAIC Model Law Development adopted by the E Committee 7/21/22 – “The scope of the request is limited to addressing the issue of continuity of guaranty fund coverage when a policy is transferred from one insurer to another.” See also Best Practices Procedures for IBT/Corporate Divisions discussion draft dated 4-4-23 – “For corporate divisions involving property and casualty insurance, the applicant's representation that that the laws of each U.S. jurisdiction where any such policies issued by the dividing insurer are allocated address restructuring transactions such that rights to guaranty fund coverage are not reduced, eliminated, or otherwise changed as a result of the transaction. Emphasis added. We are not aware of any objections expressed on this portion of the discussion draft.

Many thanks for considering our comments. Please feel free to contact me or Barbara Cox for additional information.

Very truly yours,



President & CEO
National Conference of Insurance Guaranty Funds

¹ See the Request for NAIC Model Law Development adopted by the E Committee 7/21/22 – “The scope of the request is limited to addressing the issue of continuity of guaranty fund coverage when a policy is transferred from one insurer to another.” See also Best Practices Procedures for IBT/Corporate Divisions discussion draft dated 4-4-23 – “For corporate divisions involving property and casualty insurance, the applicant’s representation that that the laws of each U.S. jurisdiction where any such policies issued by the dividing insurer are allocated address restructuring transactions such that rights to guaranty fund coverage are not reduced, eliminated, or otherwise changed as a result of the transaction. Emphasis added. We are not aware of any objections expressed on this portion of the discussion draft.

7/7/23 DRAFT, with formatting and reference edits (in Yellow)
Amendments: IBT/CD, and CyberSecurity

NAIC Model Laws, Regulations, Guidelines and Other Resources—April 2009

PROPERTY AND CASUALTY INSURANCE GUARANTY ASSOCIATION MODEL ACT

Table of Contents

Section 1.	Title
Section 2.	Purpose
Section 3.	Scope
Section 4.	Construction
Section 5.	Definitions
Section 6.	Creation of the Association
Section 7.	Board of Directors
Section 8.	Powers and Duties of the Association
Section 9.	Plan of Operation
Section 10.	Duties and Powers of the Commissioner
Section 11.	Coordination Among Guaranty Associations
Section 12.	Effect of Paid Claims
Section 13.	[Optional] Net Worth Exclusion
Section 14.	Exhaustion of Other Coverage
Section 15.	Prevention of Insolvencies
Section 16.	Tax Exemption
Section 17.	Recoupment of Assessments
Section 18.	Immunity
Section 19.	Stay of Proceedings

Section 1. Title

This Act shall be known as the [State] Insurance Guaranty Association Act.

Section 2. Purpose

The purpose of this Act is to provide a mechanism for the payment of covered claims under certain insurance policies, to avoid excessive delay in payment and to the extent provided in this Act minimize financial loss to claimants or policyholders because of the insolvency of an insurer, and to provide an association to assess the cost of such protection among insurers.

Section 3. Scope

This Act shall apply to all kinds of direct insurance, but shall not be applicable to the following:

- A. Life, annuity, health or disability insurance;
- B. Mortgage guaranty, financial guaranty or other forms of insurance offering protection against investment risks;
- C. Fidelity or surety bonds, or any other bonding obligations;
- D. Credit insurance, vendors' single interest insurance, or collateral protection insurance or any similar insurance protecting the interests of a creditor arising out of a creditor-debtor transaction;
- E. Other than coverages that may be set forth in a cybersecurity insurance policy, insurance ~~insurance~~ of warranties or service contracts including insurance that provides for the repair, replacement or service of goods or property, indemnification for repair, replacement or service for the operational or structural failure

MO-540-1

7/7/23 DRAFT, with formatting and reference edits (in Yellow)
Amendments: IBT/CD, and CyberSecurity

NAIC Model Laws, Regulations, Guidelines and Other Resources—April 2009
Property and Casualty Insurance Guaranty Association Model Act

of the goods or property due to a defect in materials, workmanship or normal wear and tear, or provides reimbursement for the liability incurred by the issuer of agreements or service contracts that provide such benefits;

- F. Title insurance;
- G. Ocean marine insurance;
- H. Any transaction or combination of transactions between a person (including affiliates of such person) and an insurer (including affiliates of such insurer) which involves the transfer of investment or credit risk unaccompanied by transfer of insurance risk; or
- I. Any insurance provided by or guaranteed by government.

Drafting Note: This Act focuses on property and liability kinds of insurance and therefore exempts those kinds of insurance deemed to present problems quite distinct from those of property and liability insurance. The Act further precludes from its scope certain types of insurance that provide protection for investment and financial risks. Financial guaranty is one of these. The NAIC Life and Health Insurance Guaranty Association Model Act provides for coverage of some, of the lines excluded by this provision.

For purposes of this section, “Financial guaranty insurance” includes any insurance under which loss is payable upon proof of occurrence of any of the following events to the damage of an insured claimant or obligee:

1. Failure of any obligor or obligors on any debt instrument or other monetary obligation, including common or preferred stock, to pay when due the principal, interest, dividend or purchase price of such instrument or obligation, whether failure is the result of a financial default or insolvency and whether or not the obligation is incurred directly or as guarantor by, or on behalf of, another obligor which has also defaulted;
2. Changes in the level of interest rates whether short term or long term, or in the difference between interest rates existing in various markets;
3. Changes in the rate of exchange of currency, or from the inconvertibility of one currency into another for any reason;
4. Changes in the value of specific assets or commodities, or price levels in general.

For purposes of this section, “credit insurance” means insurance on accounts receivable.

The terms “disability insurance” and “accident and health insurance,” and “health insurance” are intended to be synonymous. Each State will wish to examine its own statutes to determine which is the appropriate phrase.

A State where the insurance code does not adequately define ocean marine insurance may wish to add the following to Section 5, Definitions: “Ocean marine insurance” means any form of insurance, regardless of the name, label or marketing designation of the insurance policy, which insures against maritime perils or risks and other related perils or risks, which are usually insured against by traditional marine insurance, such as hull and machinery, marine builders risk, and marine protection and indemnity. Perils and risk insured against include without limitation loss, damage, expense or legal liability of the insured for loss, damage or expense arising out of or incident to ownership, operation, chartering, maintenance, use, repair or construction of any vessel, craft or instrumentality in use in ocean or inland waterways for commercial purposes, including liability of the insured for personal injury, illness or death or for loss or damage to the property of the insured or another person.

Section 4. Construction

MO-540-2

7/7/23 DRAFT, with formatting and reference edits (in Yellow)
Amendments: IBT/CD, and CyberSecurity

NAIC Model Laws, Regulations, Guidelines and Other Resources—April 2009

This Act shall be construed to effect the purpose under Section 2 which will constitute an aid and guide to interpretation.

Section 5. Definitions

As used in this Act:

[Optional:

- A. “Account” means any one of the three accounts created by Section 6.]

Drafting Note: This definition should be used by those States wishing to create separate accounts for assessment purposes. For a note on the use of separate accounts for assessments see the Drafting Note after Section 6. If this definition is used, all subsequent subsections should be renumbered.

- A. “Affiliate” means a person who directly, or indirectly, through one or more intermediaries, controls, is controlled by, or is under common control with another person on December 31 of the year immediately preceding the date the insurer becomes an insolvent insurer.
- B. “Association” means the [State] Insurance Guaranty Association created under Section 6.
- C. “Association similar to the association” means any guaranty association, security fund or other insolvency mechanism that affords protection similar to that of the association. The term shall also include any property and casualty insolvency mechanism that obtains assessments or other contributions from insurers on a pre-insolvency basis.

~~**Drafting Note:** There are two options for handling claims assumed by a licensed carrier from an unlicensed carrier or self insurer. Alternative 1 provides that these claims shall be covered by the guaranty association if the licensed insurer becomes insolvent subsequent to the assumption. Alternative 2 provides coverage only if the assuming carrier makes a payment to the guaranty association in an amount equal to that which the assuming carrier would have paid in guaranty association assessments had the insurer written the assumed business itself. If a State wishes to adopt Alternative 1, it must select Alternative 1 in Section 5D and Alternative 1a or 2a in Section 8A(3). If a State wishes to adopt Alternative 2, it must select Alternative 2 in Section 5D and Q and Alternative 1b or 2b in Section 8A(3).~~

~~D. [Alternative 1] “Assumed claims transaction” means the following:~~

- ~~(1) Policy obligations that have been assumed by the insolvent insurer, prior to the entry of a final order of liquidation, through a merger between the insolvent insurer and another entity obligated under the policies; or~~
- ~~(2) An assumption reinsurance transaction in which all of the following has occurred:~~
- ~~(a) The insolvent insurer assumed, prior to the entry of a final order of liquidation, the claim or policy obligations of another insurer or entity obligated under the claims or policies; and~~
- ~~(b) The assumption of the claim or policy obligations has been approved, if such approval is required, by the appropriate regulatory authorities; and~~
- ~~(c) As a result of the assumption, the claim or policy obligations became the direct obligations of the insolvent insurer through a novation of the claims or policies~~

MO-540-3

7/7/23 DRAFT, with formatting and reference edits (in Yellow)
Amendments: IBT/CD, and CyberSecurityNAIC Model Laws, Regulations, Guidelines and Other Resources—April 2009
Property and Casualty Insurance Guaranty Association Model Act~~—————~~ **[Alternative 2]** “Assumed claims transaction” means the following:

- (1) ~~Policy obligations that have been assumed by the insolvent insurer, prior to the entry of a final order of liquidation, through a merger between the insolvent insurer and another entity obligated under the policies, and for which Assumption Consideration has been paid to the applicable guaranty associations, if the merged entity is a non-member insurer; or~~
- (2) ~~Policy obligations that have been assumed by the insolvent insurer, prior to the entry of a final order of liquidation, pursuant to a plan, approved by the domestic commissioner of the assuming insurer, which:~~
- (a) ~~Transfers the direct policy obligations and future policy renewals from one insurer to another insurer; and~~
- (b) ~~For which Assumption Consideration has been paid to the applicable guaranty associations, if the assumption is from a non-member insurer.~~
- (c) ~~For purposes of this section the term non-member insurer also includes a self-insurer, non-admitted insurer and risk retention group; or~~
- (3) ~~An assumption reinsurance transaction in which all of the following has occurred:~~
- (a) ~~The insolvent insurer assumed, prior to the entry of a final order of liquidation, the claim or policy obligations of another insurer or entity obligated under the claims or policies;~~
- (b) ~~The assumption of the claim or policy obligations has been approved, if such approval is required, by the appropriate regulatory authorities; and As a result of the assumption, the claim or policy obligations became the direct obligations of the insolvent insurer through a novation of the claims or policies.~~
- (c) ~~As a result of the assumption, the claim or policy obligations became the direct obligations of the insolvent insurer through a novation of the claims or policies.~~

DE. “Claimant” means any person instituting a covered claim, provided that no person who is an affiliate of the insolvent insurer may be a claimant.

EF. “Commissioner” means the Commissioner of Insurance of this State.

Drafting Note: Use the appropriate title for the chief insurance regulatory official wherever the term “commissioner” appears.

FG. “Control” means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or nonmanagement services, or otherwise, unless the power is the result of an official position with or corporate office held by the person. Control shall be presumed to exist if a person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing, ten percent (10%) or more of the voting securities of any other person. This presumption may be rebutted by a showing that control does not exist in fact.

GH. “Covered claim” means the following:

MO-540-4

7/7/23 DRAFT, with formatting and reference edits (in Yellow)
Amendments: IBT/CD, and CyberSecurity

NAIC Model Laws, Regulations, Guidelines and Other Resources—April 2009

- (1) An unpaid claim, including one for unearned premiums, submitted by a claimant, which arises out of and is within the coverage and is subject to the applicable limits of an insurance policy to which this Act applies, if the policy was issued by an -insurer that becomes an insolvent insurer after the effective date of this Act and: the policy was either issued by the insurer or assumed by the insurer in an assumed claims transaction; and
- (a) The claimant or insured is a resident of this State at the time of the insured event, provided that for entities other than an individual, the residence of a claimant, insured or policyholder is the State in which its principal place of business is located at the time of the insured event; or
- (b) The claim is a first party claim for damage to property with a permanent location in this State.
- (2) “Covered claim” includes claim obligations that arose through the issuance of an insurance policy by a member insurer, which are later allocated, transferred, merged into, novated, assumed by, or otherwise made the sole responsibility of a member or non-member insurer if:
- (a) The original member insurer has no remaining obligations on the policy after the transfer;
- (b) A final order of liquidation with a finding of insolvency has been entered against the insurer that assumed the member’s coverage obligations by a court of competent jurisdiction in the insurer’s State of domicile;
- (c) The claim would have been a covered claim, as defined in Section Paragraph 5G(1), if the claim had remained the responsibility of the original member insurer and the order of liquidation had been entered against the original member insurer, with the same claim submission date and liquidation date; and
- (d) In cases where the member’s coverage obligations were assumed by a non-member insurer, the transaction received prior regulatory or judicial approval.

[Optional Section 5G(3):

- (3) “Covered claim” includes claim obligations that were originally covered by a non-member insurer, including but not limited to a self-insurer, non-admitted insurer or risk retention group, but subsequently became the sole direct obligation of a member insurer before the entry of a final order of liquidation with a finding of insolvency against the member insurer by a court of competent jurisdiction in its State of domicile, if the claim obligations were assumed by the member insurer in a transaction of one of the following types:
- (a) A merger in which the surviving company was a member insurer immediately after the merger;
- (b) An assumption reinsurance transaction that received any required approvals from the appropriate regulatory authorities; or
- (c) A transaction entered into pursuant to a plan approved by the member insurer’s domiciliary regulator.]

MO-540-5

7/7/23 DRAFT, with formatting and reference edits (in Yellow)
Amendments: IBT/CD, and CyberSecurity

NAIC Model Laws, Regulations, Guidelines and Other Resources—April 2009
Property and Casualty Insurance Guaranty Association Model Act

Drafting Note: Optional –Section 5G(3) provides coverage for certain claims that are not within the scope of Paragraphs Subsections (1) or (2) because the original coverage was not provided by a member insurer. Subsections paragraphs (a) and (b) are based on Alternative 1 of the former definition of “assumed claims transaction,” (below) and Subsection paragraph (c) is based on the additional scenario included in Alternative 2 of the former definition of assumed claims transaction (below).

Former Definition of “Assumed Claims Transaction” for Optional Section 5G(3): There are two options for handling claims assumed by a licensed carrier from an unlicensed carrier or self insurer. Alternative 1 below provides that these claims shall be covered by the guaranty association if the licensed insurer becomes insolvent subsequent to the assumption. Alternative 2 below provides coverage only if the assuming carrier makes a payment to the guaranty association in an amount equal to that which the assuming carrier would have paid in guaranty association assessments had the insurer written the assumed business itself. If a State wishes to adopt Alternative 1 below, it must select Alternative 1 below and Alternative 1 or 1a in Section 8A(3). If a State wishes to adopt Alternative 2, it must select Alternative 2 below, the former definitions of Assumption Consideration and Novation (below) and Alternative 2 or 2a in Section 8A(3).

[Assumed Claims Transaction Definition Alternative 1] “Assumed claims transaction” means the following:

- (1) Policy obligations that have been assumed by the insolvent insurer, prior to the entry of a final order of liquidation, through a merger between the insolvent insurer and another entity obligated under the policies; or
- (2) An assumption reinsurance transaction in which all of the following has occurred:
 - (a) The insolvent insurer assumed, prior to the entry of a final order of liquidation, the claim or policy obligations of another insurer or entity obligated under the claims or policies; and
 - (b) The assumption of the claim or policy obligations has been approved, if such approval is required, by the appropriate regulatory authorities; and
 - (c) As a result of the assumption, the claim or policy obligations became the direct obligations of the insolvent insurer through a novation of the claims or policies

[Assumed Claims Transaction Definition Alternative 2] “Assumed claims transaction” means the following:

- (1) Policy obligations that have been assumed by the insolvent insurer, prior to the entry of a final order of liquidation, through a merger between the insolvent insurer and another entity obligated under the policies, and for which Assumption Consideration has been paid to the applicable guaranty associations, if the merged entity is a non-member insurer; or
- (2) Policy obligations that have been assumed by the insolvent insurer, prior to the entry of a final order of liquidation, pursuant to a plan, approved by the domestic commissioner of the assuming insurer, which:
 - (a) Transfers the direct policy obligations and future policy renewals from one insurer to another insurer; and
 - (b) For which Assumption Consideration has been paid to the applicable guaranty associations, if the assumption is from a non-member insurer.
 - (c) For purposes of this section the term non-member insurer also includes a self-insurer, non-

MO-540-6

7/7/23 DRAFT, with formatting and reference edits (in Yellow)
Amendments: IBT/CD, and CyberSecurity

NAIC Model Laws, Regulations, Guidelines and Other Resources—April 2009

admitted insurer and risk retention group; or

- (3) An assumption reinsurance transaction in which all of the following has occurred:
- (a) The insolvent insurer assumed, prior to the entry of a final order of liquidation, the claim or policy obligations of another insurer or entity obligated under the claims or policies;
 - (b) The assumption of the claim or policy obligations has been approved, if such approval is required, by the appropriate regulatory authorities; and
 - (c) As a result of the assumption, the claim or policy obligations became the direct obligations of the insolvent insurer through a novation of the claims or policies.

Former Definition for Assumption Consideration: “Assumption Consideration” shall mean the consideration received by a guaranty association to extend coverage to the policies assumed by a member insurer from a non-member insurer in any assumed claims transaction including liabilities that may have arisen prior to the date of the transaction. The Assumption Consideration shall be in an amount equal to the amount that would have been paid by the assuming insurer during the three calendar years prior to the effective date of the transaction to the applicable guaranty associations if the business had been written directly by the assuming insurer.

In the event that the amount of the premiums for the three year period cannot be determined, the Assumption Consideration will be determined by multiplying 130% against the sum of the unpaid losses, loss adjustment expenses, and incurred but not reported losses, as of the effective date of the Assumed claims transaction, and then multiplying such sum times the applicable guaranty association assessment percentage for the calendar year of the transaction.

The funds paid to a guaranty association shall be allocated in the same manner as any assessments made during the three year period. The guaranty association receiving the Assumption Consideration shall not be required to recalculate or adjust any assessments levied during the prior three calendar years as a result of receiving the Assumption Consideration. Assumption Consideration paid by an insurer may be recouped in the same manner as other assessments made by a guaranty association.

Former Definition of Novation: “Novation” means that the assumed claim or policy obligations became the direct obligations of the insolvent insurer through consent of the policyholder and that thereafter the ceding insurer or entity initially obligated under the claims or policies is released by the policyholder from performing its claim or policy obligations. Consent may be express or implied based upon the circumstances, notice provided and conduct of the parties.

- (~~3~~) Except as provided elsewhere in this section, “covered claim” shall not include:
- (a) Any amount awarded as punitive or exemplary damages;
 - (b) Any amount sought as a return of premium under any retrospective rating plan;
 - (c) Any amount due any reinsurer, insurer, insurance pool or underwriting association, health maintenance organization, hospital plan corporation, professional health service corporation or self-insurer as subrogation recoveries, reinsurance recoveries, contribution, indemnification or otherwise. No claim for any amount due any reinsurer, insurer, insurance pool, underwriting association, health maintenance organization, hospital plan corporation, professional health service corporation or self-insurer may be asserted against a person insured under a policy issued by an insolvent insurer other than to the extent the claim exceeds the association obligation limitations set forth in Section 8 of this Act;
 - (d) Any claims excluded pursuant to Section 13 due to the high net worth of an insured;

MO-540-7

7/7/23 DRAFT, with formatting and reference edits (in Yellow)
Amendments: IBT/CD, and CyberSecurity

NAIC Model Laws, Regulations, Guidelines and Other Resources—April 2009
Property and Casualty Insurance Guaranty Association Model Act

- (e) Any first party claims by an insured that is an affiliate of the insolvent insurer;
- (f) Any fee or other amount relating to goods or services sought by or on behalf of any attorney or other provider of goods or services retained by the insolvent insurer or an insured prior to the date it was determined to be insolvent;
- (g) Any fee or other amount sought by or on behalf of any attorney or other provider of goods or services retained by any insured or claimant in connection with the assertion or prosecution of any claim, covered or otherwise, against the association;
- (h) Any claims for interest; or
- (i) Any claim filed with the association or a liquidator for protection afforded under the insured’s policy for incurred-but-not-reported losses.

Drafting Note: The language in this provision referring to claims for incurred-but-not-reported losses has been inserted to expressly include the existing intent of this provision and make it clear that “policyholder protection” proofs of claim, while valid to preserve rights against the ~~State estate~~ of the insolvent insurer under the Insurer Receivership Model Act, are not valid to preserve rights against the association.

[Optional Section 5H:

H. *“Cybersecurity insurance”, for purposes of this Act, includes first and third party coverage, in a policy or endorsement, written on a direct, admitted basis for losses and loss mitigation arising out of or relating to data privacy breaches, unauthorized information network security intrusions, computer viruses, ransomware, cyber extortion, identity theft, and similar exposures.]*

HH. “Insolvent insurer” means an insurer that is licensed to transact insurance in this State, either at the time the policy was issued, ~~when the obligation with respect to the covered claim was assumed under an assumed claims transaction,~~ or when the insured event occurred, and against whom a final order of liquidation has been entered after the effective date of this Act with a finding of insolvency by a court of competent jurisdiction in the insurer’s State of domicile.

Drafting Note: “Final order” as used in this section means an order which has not been stayed. States in which the “final order” language does not accurately reflect whether or not the order is subject to a stay should substitute appropriate language consistent with the statutes or rules of the State to convey the intended meaning.

IJ. “Insured” means any named insured, any additional insured, any vendor, lessor or any other party identified as an insured under the policy.

- JK. (1) “Member insurer” means any person who:
- (a) Writes any kind of insurance to which this Act applies under Section 3, including the exchange of reciprocal or inter-insurance contracts; and
 - (b) Is licensed to transact insurance in this State (except at the option of the State).
- (2) An insurer shall cease to be a member insurer effective on the day following the termination or

7/7/23 DRAFT, with formatting and reference edits (in Yellow)
Amendments: IBT/CD, and CyberSecurity

NAIC Model Laws, Regulations, Guidelines and Other Resources—April 2009

expiration of its license to transact the kinds of insurance to which this Act applies, however, the insurer shall remain liable as a member insurer for any and all obligations, including obligations for assessments levied prior to the termination or expiration of the insurer's license and assessments levied after the termination or expiration, which relate to any insurer that became an insolvent insurer prior to the termination or expiration of the insurer's license.

- ~~KL~~. “Net direct written premiums” means direct gross premiums written in this State on insurance policies to which this Act applies, including policy and membership fees, less the following amounts: (1) return premiums, (2) premiums on policies not taken, and (3) dividends paid or credited to policyholders on that direct business. “Net direct written premiums” does not include premiums on contracts between insurers or reinsurers.

[Optional Section 5K:

- K. “Net direct written premiums” means direct gross premiums written in this State on insurance policies to which this Act applies, including policy and membership fees and including all premiums and other compensation collected by a member insurer for obligations assumed under a transaction described in Optional Section 5G(3), less the following amounts: (1) return premiums, (2) premiums on policies not taken, and (3) dividends paid or credited to policyholders on that direct business. “Net direct written premiums” does not include premiums on contracts between insurers or reinsurers, other than compensation received for entering into a transaction described in Optional Section 5G(3).]*

Drafting Note: ~~The~~ Optional Section 5K is for states that have adopted Optional Section 5G(3).

- ~~M.~~ “Novation” means that the assumed claim or policy obligations became the direct obligations of the insolvent insurer through consent of the policyholder and that thereafter the ceding insurer or entity initially obligated under the claims or policies is released by the policyholder from performing its claim or policy obligations. Consent may be express or implied based upon the circumstances, notice provided and conduct of the parties.

- ~~KN~~. “Person” means any individual, aggregation of individuals, corporation, partnership or other entity.

- ~~LO~~. “Receiver” means liquidator, rehabilitator, conservator or ancillary receiver, as the context requires.

Drafting Note: Each State should conform the definition of “receiver” to the definition used in the State’s insurer receivership act.

- ~~MP.~~ “Self-insurer” means a person that covers its liability through a qualified individual or group self-insurance program or any other formal program created for the specific purpose of covering liabilities typically covered by insurance.

- ~~Q.~~ ~~[Alternative 2b]~~ “Assumption Consideration” shall mean the consideration received by a guaranty association to extend coverage to the policies assumed by a member insurer from a non-member insurer in any assumed claims transaction including liabilities that may have arisen prior to the date of the transaction. The Assumption Consideration shall be in an amount equal to the amount that would have been paid by the assuming insurer during the three calendar years prior to the effective date of the transaction to the applicable guaranty associations if the business had been written directly by the assuming insurer.

~~In the event that the amount of the premiums for the three year period cannot be determined, the Assumption Consideration will be determined by multiplying 130% against the sum of the unpaid losses, loss adjustment expenses, and incurred but not reported losses, as of the effective date of the Assumed claims transaction, and then multiplying such sum times the applicable guaranty association assessment percentage for the~~

MO-540-9

7/7/23 DRAFT, with formatting and reference edits (in Yellow)
Amendments: IBT/CD, and CyberSecurity

NAIC Model Laws, Regulations, Guidelines and Other Resources—April 2009
Property and Casualty Insurance Guaranty Association Model Act

~~calendar year of the transaction.~~

~~The funds paid to a guaranty association shall be allocated in the same manner as any assessments made during the three year period. The guaranty association receiving the Assumption Consideration shall not be required to recalculate or adjust any assessments levied during the prior three calendar years as a result of receiving the Assumption Consideration. Assumption Consideration paid by an insurer may be recouped in the same manner as other assessments made by a guaranty association.~~

Section 6. Creation of the Association

There is created a nonprofit unincorporated legal entity to be known as the [State] Insurance Guaranty Association. All insurers defined as member insurers in Section 5K shall be and remain members of the association as a condition of their authority to transact insurance in this State. The association shall perform its functions under a plan of operation established and approved under Section 9 and shall exercise its powers through a board of directors established under Section 7.

[Alternate Section 6. Creation of the Association

There is created a nonprofit unincorporated legal entity to be known as the [State] Insurance Guaranty Association. All insurers defined as member insurers in Section 5K shall be and remain members of the association as a condition of their authority to transact insurance in this State. The association shall perform its functions under a plan of operation established and approved under Section 9 and shall exercise its powers through a board of directors established under Section 7. For purposes of administration and assessment, the association shall be divided into three separate accounts:

- A. The workers' compensation insurance account;*
- B. The automobile insurance account; and*
- C. The account for all other insurance to which this Act applies.]*

Drafting Note: The alternate Section 6 should be used if a State, after examining its insurance market, determines that separate accounts for various kinds of insurance are necessary and feasible. The major consideration is whether each account will have a base sufficiently large to cover possible insolvencies. Separate accounts will permit assessments to be generally limited to insurers writing the same kind of insurance as the insolvent company. If this approach is adopted the provision of alternate Sections 8A(3) and 8B(6) and optional Section 5A should also be used.

Section 7. Board of Directors

- A. The board of directors of the association shall consist of not less than five (5) nor more than [insert number] persons serving terms as established in the plan of operation. The insurer members of the board shall be selected by member insurers subject to the approval of the commissioner. Vacancies on the board shall be filled for the remaining period of the term by a majority vote of the remaining insurer members subject to the approval of the commissioner. If no members are selected within sixty (60) days after the effective date of this Act, the commissioner may appoint the initial members of the board of directors. Two (2) persons, who must be public representatives, shall be appointed by the commissioner to the board of directors. Vacancies of positions held by public representatives shall be filled by the commissioner. A public representative may not be an officer, director or employee of an insurance company or any person engaged in the business of insurance. For the purposes of this section, the term "director" shall mean an individual serving on behalf of an insurer member of the board of directors or a public representative on the board of directors.

MO-540-10

7/7/23 DRAFT, with formatting and reference edits (in Yellow)
Amendments: IBT/CD, and CyberSecurity

NAIC Model Laws, Regulations, Guidelines and Other Resources—April 2009

Drafting Note: A State adopting this language should make certain that its insurance code includes a definition of “the business of insurance” similar to that found in the NAIC Insurer Receivership Model Act.

- B. In approving selections to the board, the commissioner shall consider among other things whether all member insurers are fairly represented.
- C. Members of the board of directors may be reimbursed from the assets of the association for reasonable expenses incurred by them as members of the board of directors.
- D. Any board member who is an insurer in receivership shall be terminated as a board *member*, effective as of the date of the entry of the order of receivership. Any resulting vacancies on the board shall be filled for the remaining period of the term in accordance with the provisions of Subsection A.
- E. In the event that a director shall, because of illness, nonattendance at meetings or any other reason, be deemed unable to satisfactorily perform the designated functions as a director by missing three consecutive board meetings, the board of directors may declare the office vacant and the member or director shall be replaced in accordance with the provisions of Subsection A.
- F. If the commissioner has reasonable cause to believe that a director failed to disclose a known conflict of interest with his or her duties on the board, failed to take appropriate action based on a known conflict of interest with his or her duties on the board, or has been indicted or charged with a felony, or misdemeanor involving moral turpitude, the commissioner may suspend that director pending the outcome of an investigation or hearing by the commissioner or the conclusion of any criminal proceedings. A company elected to the board may replace a suspended director prior to the completion of an investigation, hearing or criminal proceeding. In the event that the allegations are substantiated at the conclusion of an investigation, hearing or criminal proceeding, the office shall be declared vacant and the member or director shall be replaced in accordance with the provisions of Subsection A.

Section 8. Powers and Duties of the Association

- A. The association shall:
 - (1) (a) Be obligated to pay covered claims existing prior to the order of liquidation, arising within thirty (30) days after the order of liquidation, or before the policy expiration date if less than thirty (30) days after the order of liquidation, or before the insured replaces the policy or causes its cancellation, if the insured does so within thirty (30) days of the order of liquidation. The obligation shall be satisfied by paying to the claimant an amount as follows:
 - (i) The full amount of a covered claim for benefits under a workers’ compensation insurance coverage;
 - (ii) An amount not exceeding \$10,000 per policy for a covered claim for the return of unearned premium;
 - (iii) An amount not exceeding \$500,000 per claimant for all other covered claims.
 - (iv) In no event shall the Association be obligated to pay an amount in excess of \$500,000 for all first- and third-party claims under a policy or endorsement providing, or that is found to provide, cybersecurity insurance coverage and arising out of or related to a single insured event, regardless of the number of

MO-540-11

7/7/23 DRAFT, with formatting and reference edits (in Yellow)
Amendments: IBT/CD, and CyberSecurity

NAIC Model Laws, Regulations, Guidelines and Other Resources—April 2009
Property and Casualty Insurance Guaranty Association Model Act

claims made or the number of claimants.

- (b) In no event shall the association be obligated to pay a claimant an amount in excess of the obligation of the insolvent insurer under the policy or coverage from which the claim arises. Notwithstanding any other provisions of this Act, a covered claim shall not include a claim filed with the guaranty fund after the final date set by the court for the filing of claims against the liquidator or receiver of an insolvent insurer.

For the purpose of filing a claim under this subsection, notice of claims to the liquidator of the insolvent insurer shall be deemed notice to the association or its agent and a list of claims shall be periodically submitted to the association or association similar to the association in another State by the liquidator.

Drafting Note: On the general subject of the relationship of the association to the liquidator, the working group/task force takes the position that since this is a model State bill, it will be able to bind only two parties, the association and the in-State liquidator. Nevertheless, the provisions should be clear enough to outline the requests being made to out-of-State liquidators and the requirements placed on in-State liquidators in relation to out-of-State associations.

Drafting Note: Because of its potential impact on guaranty association coverage, it is recommended that the legislation include an appropriate provision stating that the bar date only applies to claims in liquidation commencing after its effective date. Drafters should insure that the State's insurance liquidation act would permit, upon closure, payments to the guaranty association and any association similar to the association for amounts that are estimated to be incurred after closure for workers compensation claims obligations. The amounts should be payable on these obligations related to losses both known and not known at the point of closure.

- (c) Any obligation of the association to defend an insured shall cease upon the association's payment or tender of an amount equal to the lesser of the association's covered claim obligation limit or the applicable policy limit.

Drafting Note: The obligation of the association is limited to covered claims unpaid prior to insolvency, and to claims arising within thirty days after the insolvency, or until the policy is canceled or replaced by the insured, or it expires, whichever is earlier. The basic principle is to permit policyholders to make an orderly transition to other companies. There appears to be no reason why the association should become in effect an insurer in competition with member insurers by continuing existing policies, possibly for several years. It is also felt that the control of the policies is properly in the hands of the liquidator. Finally, one of the major objections of the public to rapid termination, loss of unearned premiums with no corresponding coverage, is ameliorated by this bill since unearned premiums are permissible claims, up to \$10,000, against the association. The maximums (\$10,000 for the return of unearned premium; \$500,000 for all other covered claims) represent the working group's concept of practical limitations, but each State will wish to evaluate these figures.

- (2) Be deemed the insurer to the extent of its obligation on the covered claims and to that extent, subject to the limitations provided in this Act, shall have all rights, duties and obligations of the insolvent insurer as if the insurer had not become insolvent, including but not limited to, the right to pursue and retain salvage and subrogation recoverable on covered claim obligations to the extent paid by the association. The association shall not be deemed the insolvent insurer for the purpose of conferring jurisdiction.
- (3) **[Alternative 1a]** Assess insurers amounts necessary to pay the obligations of the association under Subsection A(1) subsequent to an insolvency, the expenses of handling covered claims subsequent to an insolvency, and other expenses authorized by this Act. The assessments of each member insurer shall be in the proportion that the net direct written premiums of the member insurer for the

MO-540-12

7/7/23 DRAFT, with formatting and reference edits (in Yellow)
Amendments: IBT/CD, and CyberSecurity

NAIC Model Laws, Regulations, Guidelines and Other Resources—April 2009

calendar year preceding the assessment bears to the net direct written premiums of all member insurers for the calendar year preceding the assessment. Each member insurer shall be notified of the assessment not later than thirty (30) days before it is due. A member insurer may not be assessed in any year an amount greater than two percent (2%) of that member insurer's net direct written premiums for the calendar year preceding the assessment. If the maximum assessment, together with the other assets of the association, does not provide in any one year an amount sufficient to make all necessary payments, the funds available shall be prorated and the unpaid portion shall be paid as soon as funds become available. The association may exempt or defer, in whole or in part, the assessment of a member insurer, if the assessment would cause the member insurer's financial statement to reflect amounts of capital or surplus less than the minimum amounts required for a certificate of authority by a jurisdiction in which the member insurer is authorized to transact insurance. However, during the period of deferment no dividends shall be paid to shareholders or policyholders. Deferred assessments shall be paid when the payment will not reduce capital or surplus below required minimums. Payments shall be refunded to those companies receiving larger assessments by virtue of the deferment, or at the election of the company, credited against future assessments.

Drafting Note: -Alternative 1 for Subsection 8A(3) above or the Alternative 1a for Subsection 8A(2)(3) included in this drafting note as follows should be used in conjunction with Assumed Claims Transaction Definition Alternative 1 as described in the drafting note for Optional Section 5G(3).

(3) **[Alternative 1a for Subsection 8A(3)]** Assess insurers amounts necessary to pay the obligations of the association under Subsection A(1) subsequent to an insolvency, the expenses of handling covered claims subsequent to an insolvency, and other expenses authorized by this Act. The assessments of each member insurer shall be in the proportion that the net direct written premiums and any premiums received for an assumed contract after the effective date of an assumed claims transaction with a non-member insurer of the member insurer for the calendar year preceding the assessment bears to the net direct written premiums and any premiums received for an assumed contract after the effective date of an assumed claims transaction with a non-member insurer of all member insurers for the calendar year preceding the assessment. Each member insurer shall be notified of the assessment not later than thirty (30) days before it is due. A member insurer may not be assessed in any year an amount greater than two percent (2%) of that member insurer's net direct written premiums and any premiums received for an assumed contract after the effective date of an assumed claims transaction with a non-member insurer for the calendar year preceding the assessment. The 2% limitation on assessments shall not preclude a full payment for assumption consideration. If the maximum assessment, together with the other assets of the association, does not provide in any one year an amount sufficient to make all necessary payments, the funds available shall be prorated and the unpaid portion shall be paid as soon as funds become available. The association may exempt or defer, in whole or in part, the assessment of a member insurer, if the assessment would cause the member insurer's financial statement to reflect amounts of capital or surplus less than the minimum amounts required for a certificate of authority by a jurisdiction in which the member insurer is authorized to transact insurance. However, during the period of deferment no dividends shall be paid to shareholders or policyholders. Deferred assessments shall be paid when the payment will not reduce capital or surplus below required minimums. Payments shall be refunded to those companies receiving larger assessments by virtue of the deferment, or at the election of the company, credited against future assessments.

[Alternative 2a] Assess insurers amounts necessary to pay the obligations of the association under Subsection A(1) subsequent to an insolvency, the expenses of handling covered claims subsequent to an insolvency, and other expenses authorized by this Act. The assessments of each member insurer

MO-540-13

7/7/23 DRAFT, with formatting and reference edits (in Yellow)
Amendments: IBT/CD, and CyberSecurityNAIC Model Laws, Regulations, Guidelines and Other Resources—April 2009
Property and Casualty Insurance Guaranty Association Model Act

shall be in the proportion that the net direct written premiums and any premiums received for an assumed contract after the effective date of an assumed claims transaction with a non member insurer of the member insurer for the calendar year preceding the assessment bears to the net direct written premiums and any premiums received for an assumed contract after the effective date of an assumed claims transaction with a non member insurer of all member insurers for the calendar year preceding the assessment. Each member insurer shall be notified of the assessment not later than thirty (30) days before it is due. A member insurer may not be assessed in any year an amount greater than two percent (2%) of that member insurer's net direct written premiums and any premiums received for an assumed contract after the effective date of an assumed claims transaction with a non member insurer for the calendar year preceding the assessment. The 2% limitation on assessments shall not preclude a full payment for assumption consideration. If the maximum assessment, together with the other assets of the association, does not provide in any one year an amount sufficient to make all necessary payments, the funds available shall be prorated and the unpaid portion shall be paid as soon as funds become available. The association may exempt or defer, in whole or in part, the assessment of a member insurer, if the assessment would cause the member insurer's financial statement to reflect amounts of capital or surplus less than the minimum amounts required for a certificate of authority by a jurisdiction in which the member insurer is authorized to transact insurance. However, during the period of deferment no dividends shall be paid to shareholders or policyholders. Deferred assessments shall be paid when the payment will not reduce capital or surplus below required minimums. Payments shall be refunded to those companies receiving larger assessments by virtue of the deferment, or at the election of the company, credited against future assessments.

- (3) **[Alternative H2]** Allocate claims paid and expenses incurred among the three (3) accounts separately, and assess member insurers separately for each account, amounts necessary to pay the obligations of the association under Subsection 8A(1) subsequent to an insolvency, the expenses of handling covered claims subsequent to an insolvency and other expenses authorized by this Act. The assessments of each member insurer shall be in the proportion that the net direct written premiums of the member insurer for the calendar year preceding the assessment on the kinds of insurance in the account bears to the net direct written premiums of all member insurers for the calendar year preceding the assessment on the kinds of insurance in the account. Each member insurer shall be notified of the assessment not later than thirty (30) days before it is due. A member insurer may not be assessed in any one year on any account an amount greater than two percent (2%) of that member insurer's net direct written premiums for the calendar year preceding the assessment on the kinds of insurance in the account. If the maximum assessment, together with the other assets of the association in any account, does not provide in any one year in any account an amount sufficient to make all necessary payments from that account, the funds available shall be pro-rated and the unpaid portion shall be paid as soon thereafter as funds become available. The association may exempt or defer, in whole or in part, the assessment of a member insurer, if the assessment would cause the member insurer's financial statement to reflect amounts of capital or surplus less than the minimum amounts required for a certificate of authority by a jurisdiction in which the member insurer is authorized to transact insurance. However, during the period of deferment no dividends shall be paid to shareholders or policyholders. Deferred assessments shall be paid when the payment will not reduce capital or surplus below required minimums. Payments shall be refunded to those companies receiving larger assessments by virtue of such deferment, or at the election of the company, credited against future assessments. A member insurer may set off against any assessment, authorized payments made on covered claims and expenses incurred in the payment of claims by the member insurer if they are chargeable to the account for which the assessment is made.]

7/7/23 DRAFT, with formatting and reference edits (in Yellow)
Amendments: IBT/CD, and CyberSecurity

NAIC Model Laws, Regulations, Guidelines and Other Resources—April 2009

Drafting Note: -Alternative 2 to Subsection 8A(3) above and the Alternative 2a to Section 8A(2)(3) included in this drafting note as follows should be used in conjunction with Assumed Claims Transaction Definition Alternative 2 as described in the drafting note for Optional Section 5G(3).

(3) [Alternative 2a for Section 8A(3)] Allocate claims paid and expenses incurred among the three (3) accounts separately, and assess member insurers separately for each account, amounts necessary to pay the obligations of the association under Subsection 8A(1) subsequent to an insolvency, the expenses of handling covered claims subsequent to an insolvency and other expenses authorized by this Act. The assessments of each member insurer shall be in the proportion that the net direct written premiums and any premiums received for an assumed contract after the effective date of an assumed claims transaction with a non-member insurer of the member insurer for the calendar year preceding the assessment on the kinds of insurance in the account bears to the net direct written premiums and any premiums received for an assumed contract after the effective date of an assumed claims transaction with a non-member insurer of all member insurers for the calendar year preceding the assessment on the kinds of insurance in the account. Each member insurer shall be notified of the assessment not later than thirty (30) days before it is due. A member insurer may not be assessed in any one year on any account an amount greater than two percent (2%) of that member insurer's net direct written premiums and any premiums received for an assumed contract after the effective date of an assumed claims transaction with a non-member insurer for the calendar year preceding the assessment on the kinds of insurance in the account. The 2% limitation on assessments shall not preclude a full payment for assumption consideration. If the maximum assessment, together with the other assets of the association in any account, does not provide in any one year in any account an amount sufficient to make all necessary payments from that account, the funds available shall be pro-rated and the unpaid portion shall be paid as soon thereafter as funds become available. The association may exempt or defer, in whole or in part, the assessment of a member insurer, if the assessment would cause the member insurer's financial statement to reflect amounts of capital or surplus less than the minimum amounts required for a certificate of authority by a jurisdiction in which the member insurer is authorized to transact insurance. However, during the period of deferment no dividends shall be paid to shareholders or policyholders. Deferred assessments shall be paid when the payment will not reduce capital or surplus below required minimums. Payments shall be refunded to those companies receiving larger assessments by virtue of such deferment, or at the election of the company, credited against future assessments. A member insurer may set off against any assessment, authorized payments made on covered claims and expenses incurred in the payment of claims by the member insurer if they are chargeable to the account for which the assessment is made.

~~(3) [Alternate 2b] Allocate claims paid and expenses incurred among the three (3) accounts separately, and assess member insurers separately for each account, amounts necessary to pay the obligations of the association under Subsection 8A(1) subsequent to an insolvency, the expenses of handling covered claims subsequent to an insolvency and other expenses authorized by this Act. The assessments of each member insurer shall be in the proportion that the net direct written premiums and any premiums received for an assumed contract after the effective date of an assumed claims transaction with a non member insurer of the member insurer for the calendar year preceding the assessment on the kinds of insurance in the account bears to the net direct written premiums and any premiums received for an assumed contract after the effective date of an assumed claims transaction with a non member insurer of all member insurers for the calendar year preceding the assessment on the kinds of insurance in the account. Each member insurer shall be notified of the assessment not later than thirty (30) days before it is due. A member insurer may not be assessed in~~

MO-540-15

7/7/23 DRAFT, with formatting and reference edits (in Yellow)
Amendments: IBT/CD, and CyberSecurity

NAIC Model Laws, Regulations, Guidelines and Other Resources—April 2009
Property and Casualty Insurance Guaranty Association Model Act

any one year on any account an amount greater than two percent (2%) of that member insurer's net direct written premiums and any premiums received for an assumed contract after the effective date of an assumed claims transaction with a non member insurer for the calendar year preceding the assessment on the kinds of insurance in the account. The 2% limitation on assessments shall not preclude a full payment for assumption consideration. If the maximum assessment, together with the other assets of the association in any account, does not provide in any one year in any account an amount sufficient to make all necessary payments from that account, the funds available shall be pro rated and the unpaid portion shall be paid as soon thereafter as funds become available. The association may exempt or defer, in whole or in part, the assessment of a member insurer, if the assessment would cause the member insurer's financial statement to reflect amounts of capital or surplus less than the minimum amounts required for a certificate of authority by a jurisdiction in which the member insurer is authorized to transact insurance. However, during the period of deferment no dividends shall be paid to shareholders or policyholders. Deferred assessments shall be paid when the payment will not reduce capital or surplus below required minimums. Payments shall be refunded to those companies receiving larger assessments by virtue of such deferment, or at the election of the company, credited against future assessments. A member insurer may set off against any assessment, authorized payments made on covered claims and expenses incurred in the payment of claims by the member insurer if they are chargeable to the account for which the assessment is made.]

[Optional:

- (4) Assess member insurers that have entered into transactions described in Optional Section 5G(3), in addition to the assessment levied under ~~Paragraph~~Section 8A(3), an amount reflecting liabilities that may have arisen before the date of the transaction. The assessment under this ~~paragraph~~subsection is not subject to the annual percentage limitation under Paragraph (3) and shall be the amount that would have been paid by the assuming insurer under Paragraph (3) during the three calendar years preceding the effective date of the transaction if the business had been written directly by the assuming insurer. If the amount of the applicable premiums for the three year period cannot be determined, the assessment shall be 130% of the sum of the unpaid losses, loss adjustment expenses, and incurred but not reported losses, as of the effective date of the assumed claims transaction, multiplied by the applicable guaranty association assessment percentage for the calendar year of the transaction.]*

Drafting Note: Optional ~~Paragraph~~Section 8A(4) is for states that have adopted Optional Section 5G(3) and choose to require an additional "assumption consideration" assessment when claim obligations are assumed from an entity other than a member insurer.

- (4) Investigate claims brought against the association and adjust, compromise, settle and pay covered claims to the extent of the association's obligation and deny all other claims. The association shall pay claims in any order that it may deem reasonable, including the payment of claims as they are received from the claimants or in groups or categories of claims. The association shall have the right to appoint and to direct legal counsel retained under liability insurance policies for the defense of covered claims and to appoint and direct other service providers for covered services.
- (5) Notify claimants in this State as deemed necessary by the commissioner and upon the commissioner's request, to the extent records are available to the association.

Drafting Note: The intent of this paragraph is to allow, in exceptional circumstances, supplementary notice to that given by
MO-540-16

7/7/23 DRAFT, with formatting and reference edits (in Yellow)
Amendments: IBT/CD, and CyberSecurity

NAIC Model Laws, Regulations, Guidelines and Other Resources—April 2009

the domiciliary receiver.

- (6) (a) Have the right to review and contest as set forth in this subsection settlements, releases, compromises, waivers and judgments to which the insolvent insurer or its insureds were parties prior to the entry of the order of liquidation. In an action to enforce settlements, releases and judgments to which the insolvent insurer or its insureds were parties prior to the entry of the order of liquidation, the Association shall have the right to assert the following defenses, in addition to the defenses available to the insurer:
 - (i) The association is not bound by a settlement, release, compromise or waiver executed by an insured or the insurer, or any judgment entered against an insured or the insurer by consent or through a failure to exhaust all appeals, if the settlement, release, compromise, waiver or judgment was:
 - (I) Executed or entered within 120 days prior to the entry of an order of liquidation, and the insured or the insurer did not use reasonable care in entering into the settlement, release, compromise, waiver or judgment, or did not pursue all reasonable appeals of an adverse judgment; or
 - (II) Executed by or taken against an insured or the insurer based on default, fraud, collusion or the insurer's failure to defend.
 - (ii) If a court of competent jurisdiction finds that the association is not bound by a settlement, release, compromise, waiver or judgment for the reasons described in Subparagraph (a)(i), the settlement, release, compromise, waiver or judgment shall be set aside, and the association shall be permitted to defend any covered claim on the merits. The settlement, release, compromise, waiver or judgment may not be considered as evidence of liability or damages in connection with any claim brought against the association or any other party under this Act.
 - (iii) The association shall have the right to assert any statutory defenses or rights of offset against any settlement, release, compromise or waiver executed by an insured or the insurer, or any judgment taken against the insured or the insurer.
- (b) As to any covered claims arising from a judgment under any decision, verdict or finding based on the default of the insolvent insurer or its failure to defend, the association, either on its own behalf or on behalf of an insured may apply to have the judgment, order, decision, verdict or finding set aside by the same court or administrator that entered the judgment, order, decision, verdict or finding and shall be permitted to defend the claim on the merits.
- (7) Handle claims through its own employees, one or more insurers, or other persons designated as servicing facilities, which may include the receiver for the insolvent insurer. Designation of a servicing facility is subject to the approval of the commissioner, but the designation may be declined by a member insurer.
- (8) Reimburse each servicing facility for obligations of the association paid by the facility and for expenses incurred by the facility while handling claims on behalf of the association and shall pay the other expenses of the association authorized by this Act.
- (9) Submit, not later than 90 days after the end of the association's fiscal year, a financial report for the

MO-540-17

7/7/23 DRAFT, with formatting and reference edits (in Yellow)
Amendments: IBT/CD, and CyberSecurity

NAIC Model Laws, Regulations, Guidelines and Other Resources—April 2009
Property and Casualty Insurance Guaranty Association Model Act

preceding fiscal year in a form approved by the commissioner.

B. The association may:

- (1) Employ or retain persons as are necessary to handle claims, provide covered policy benefits and services, and perform other duties of the association;
- (2) Borrow funds necessary to effect the purposes of this Act in accordance with the plan of operation;
- (3) Sue or be sued;
- (4) Negotiate and become a party to contracts necessary to carry out the purpose of this Act;
- (5) Perform other acts necessary or proper to effectuate the purpose of this Act;
- (6) Refund to the member insurers in proportion to the contribution of each member insurer to the association that amount by which the assets of the association exceed the liabilities, if at the end of any calendar year, the board of directors finds that the assets of the association exceed the liabilities of the association as estimated by the board of directors for the coming year.

[Alternate Section 8B(6)

- (6) *Refund to the member insurers in proportion to the contribution of each member insurer to that account that amount by which the assets of the account exceed the liabilities, if at the end of any calendar year, the board of directors finds that the assets of the association in any account exceed the liabilities of that account as estimated by the board of directors for the coming year.]*

Drafting Note: The working group/task force feels that the board of directors should determine the amount of the refunds to members when the assets of the association exceed its liabilities. However, since this excess may be quite small, the board is given the option of retaining all or part of it to pay expenses and possibly remove the need for a relatively small assessment at a later time.

C. Suits involving the association:

- (1) Except for actions by the receiver, all actions relating to or arising out of this Act against the association shall be brought in the courts in this State. The courts shall have exclusive jurisdiction over all actions relating to or arising out of this Act against the association.
- (2) The exclusive venue in any action by or against the association is in [designate appropriate court]. The association may, at its option, waive this venue as to specific actions.

[Optional: Section 8D

D. (1) *The legislature finds:*

- (a) *The potential for widespread and massive damage to persons and property caused by natural disasters such as earthquakes, windstorms, or fire in this State can generate insurance claims of such a number as to render numerous insurers operating within this State insolvent and therefore unable to satisfy covered claims;*
- (b) *The inability of insureds within this State to receive payments of covered claims or to timely receive the payments creates financial and other hardships for insureds and places undue*

MO-540-18

7/7/23 DRAFT, with formatting and reference edits (in Yellow)
Amendments: IBT/CD, and CyberSecurity

NAIC Model Laws, Regulations, Guidelines and Other Resources—April 2009

burdens on the State, the affected units of local government, and the community at large;

- (c) *The insolvency of a single insurer in a material amount or a catastrophic event may result in the same hardships as those produced by a natural disaster;*
 - (d) *The State has previously taken action to address these problems by adopting the [insert name of guaranty association act], which among other things, provides a mechanism for the payment of covered claims under certain insurance policies to avoid excessive delay in payment and to avoid financial loss to claimants or policyholders because of the insolvency of an insurer; and*
 - (e) *In order for the association to timely pay claims of insolvent insurers in this State and otherwise carry out its duties, the association may require additional financing options. The intent of the Legislature is to make those options available to the association in the event that a natural disaster such as an earthquake, windstorm, fire or material insolvency of any member insurer results in covered claim obligations currently payable by the association in excess of its capacity to pay from current funds and current assessments under Subsection A(3). In cases where the association determines that it is cost effective, the association may issue bonds as provided in this subsection. In determining whether to issue bonds, the association shall consider the transaction costs of issuing the bonds.*
- (2) *In the event a natural disaster such as an earthquake, windstorm, fire or material insolvency of any member insurer results in covered claim obligations currently payable by the association in excess of its capacity to pay from current funds and current assessments under Subsection 8A(3), the association, in its sole discretion, may by resolution request the [insert name of agency] Agency to issue bonds pursuant to [insert statutory authority], in such amounts as the association may determine to provide funds for the payment of covered claims and expenses related thereto. In the event bonds are issued, the association shall have the authority to annually assess member insurers for amounts necessary to pay the principal of, and interest on those bonds. Assessments collected pursuant to this authority shall be collected under the same procedures as provided in Subsection 8A(3) and, notwithstanding the two percent (2%) limit in Subsection 8A(3), shall be limited to an additional [insert percentage] percent of the annual net direct written premium in this State of each member insurer for the calendar year preceding the assessment. The commissioner's approval shall be required for any assessment greater than five percent (5%). Assessments collected pursuant to this authority may only be used for servicing the bond obligations provided for in this subsection and shall be pledged for that purpose.*
 - (3) *In addition to the assessments provided for in this subsection, the association in its discretion, and after considering other obligations of the association, may utilize current funds of the association, assessments made under Subsection 8A(3) and advances or dividends received from the liquidators of insolvent insurers to pay the principal and interest on any bonds issued at the board's request.*
 - (4) *Assessments under this subsection shall be payable in twelve (12) monthly installments with the first installment being due and payable at the end of the month after an assessment is levied, and subsequent installments being due not later than the end of each succeeding month.*
 - (5) *In order to assure that insurers paying assessments levied under this subsection continue to charge rates that are neither inadequate nor excessive, within ninety (90) days after being notified of the assessments, each insurer that is to be assessed pursuant to this subsection shall make a rate filing for lines of business additionally assessed under this subsection. If the filing reflects a rate change that, as a percentage, is equal to the difference between the rate of the assessment and the rate of*

MO-540-19

7/7/23 DRAFT, with formatting and reference edits (in Yellow)
Amendments: IBT/CD, and CyberSecurity

NAIC Model Laws, Regulations, Guidelines and Other Resources—April 2009
Property and Casualty Insurance Guaranty Association Model Act

the previous year's assessment under this subsection, the filing shall consist of a certification so stating and shall be deemed approved when made. Any rate change of a different percentage shall be subject to the standards and procedures of [cite appropriate statutory authority for provisions on filing and approval of rates].

Drafting Note: This provision should only be considered by those States that have serious concerns that circumstances could result in a substantial capacity problem resulting in unpaid or pro rata payment of claims. An association intending to consider this provision should first consult with experienced bond counsel in its State to identify an appropriate State agency or bonding authority to act as vehicle for issuing the bonds. That agency or authority's statute may also have to be amended to specifically authorize these types of bonds and to cross-reference this provision in the guaranty association law. It is possible that in some situations a new bonding authority may have to be created for this purpose.

Regardless of the vehicle used, it is important that the decision-making authority on whether bonds are needed and in what amounts be retained by the association's board.

The extent of additional assessment authority under this subsection has not been specified. When considering the amount of additional authority that will be needed, a determination should be made as to the amount of funds needed to service the bonds. More specifically, consideration should be given to the amount of the bonds to be issued, interest rate and the maturity date of the bonds. The association should be able to raise sufficient funds through assessments to pay the interest and retire the bonds after some reasonable period (e.g. ten (10) years). Subsection D(2) requires the Commissioner's approval before the association can impose an additional assessment in excess of 5%. This is to assure that the additional assessment will not result in financial hardship to the member insurers and additional insolvencies.

The intent of Subsection D(4) is to permit recoupment by member insurers of the additional cost of assessments under this subsection without any related regulatory approval. A State enacting this subsection may need to revise Subsection D(4) so that it conforms to the particular State's recoupment provisions, as well as the provisions on filing and approval of rates.]

Section 9. Plan of Operation

- A. (1) The association shall submit to the commissioner a plan of operation and any amendments to the plan of operation necessary or suitable to assure the fair, reasonable and equitable administration of the association. The plan of operation and amendments shall become effective upon approval in writing by the commissioner.
- (2) If the association fails to submit a suitable plan of operation within ninety (90) days following the effective date of this Act, or if at any time thereafter the association fails to submit suitable amendments to the plan, the commissioner shall, after notice and hearing, adopt reasonable rules necessary or advisable to effectuate the provisions of this Act. The rules shall continue in force until modified by the commissioner or superseded by a plan submitted by the association and approved by the commissioner.
- B. All member insurers shall comply with the plan of operation.
- C. The plan of operation shall:
 - (1) Establish the procedures under which the powers and duties of the association under Section 8 will be performed;
 - (2) Establish procedures for handling assets of the association;

MO-540-20

7/7/23 DRAFT, with formatting and reference edits (in Yellow)
Amendments: IBT/CD, and CyberSecurity

NAIC Model Laws, Regulations, Guidelines and Other Resources—April 2009

- (3) Require that written procedures be established for the disposition of liquidating dividends or other monies received from the estate of the insolvent insurer;
 - (4) Require that written procedures be established to designate the amount and method of reimbursing members of the board of directors under Section 7;
 - (5) Establish procedures by which claims may be filed with the association and establish acceptable forms of proof of covered claims;
 - (6) Establish regular places and times for meetings of the board of directors;
 - (7) Require that written procedures be established for records to be kept of all financial transactions of the association, its agents and the board of directors;
 - (8) Provide that any member insurer aggrieved by any final action or decision of the association may appeal to the commissioner within thirty (30) days after the action or decision;
 - (9) Establish the procedures under which selections for the board of directors will be submitted to the commissioner;
 - (10) Contain additional provisions necessary or proper for the execution of the powers and duties of the association.
- D. The plan of operation may provide that any or all powers and duties of the association, except those under Sections 8A(3) and 8B(2), are delegated to a corporation, association similar to the association or other organization which performs or will perform functions similar to those of this association or its equivalent in two (2) or more States. The corporation, association similar to the association or organization shall be reimbursed as a servicing facility would be reimbursed and shall be paid for its performance of any other functions of the association. A delegation under this subsection shall take effect only with the approval of both the board of directors and the commissioner, and may be made only to a corporation, association or organization which extends protection not substantially less favorable and effective than that provided by this Act.

Section 10. Duties and Powers of the Commissioner

A. The commissioner shall:

- (1) Notify the association of the existence of an insolvent insurer not later than three (3) days after the commissioner receives notice of the determination of the insolvency. The association shall be entitled to a copy of a complaint seeking an order of liquidation with a finding of insolvency against a member company at the same time that the complaint is filed with a court of competent jurisdiction;
- (2) Provide the association with a statement of the net direct written premiums of each member insurer upon request of the board of directors.

B. The commissioner may:

- (1) Suspend or revoke, after notice and hearing, the certificate of authority to transact insurance in this State of a member insurer that fails to pay an assessment when due or fails to comply with the plan of operation. As an alternative, the commissioner may levy a fine on a member insurer that fails to

MO-540-21

7/7/23 DRAFT, with formatting and reference edits (in Yellow)
Amendments: IBT/CD, and CyberSecurity

NAIC Model Laws, Regulations, Guidelines and Other Resources—April 2009
Property and Casualty Insurance Guaranty Association Model Act

pay an assessment when due. The fine shall not exceed five percent (5%) of the unpaid assessment per month, except that a fine shall not be less than \$100 per month;

- (2) Revoke the designation of a servicing facility if the commissioner finds claims are being handled unsatisfactorily.
- (3) Examine, audit, or otherwise regulate the association.

Drafting Note: This section does not require periodic examinations of the guaranty associations but allows the commissioner to conduct examinations as the commissioner deems necessary.

- C. A final action or order of the commissioner under this Act shall be subject to judicial review in a court of competent jurisdiction.

Section 11. Coordination Among Guaranty Associations

- A. The association may join one or more organizations of other State associations of similar purposes, to further the purposes and administer the powers and duties of the association. The association may designate one or more of these organizations to act as a liaison for the association and, to the extent the association authorizes, to bind the association in agreements or settlements with receivers of insolvent insurance companies or their designated representatives.
- B. The association, in cooperation with other obligated or potentially obligated guaranty associations, or their designated representatives, shall make all reasonable efforts to coordinate and cooperate with receivers, or their designated representatives, in the most efficient and uniform manner, including the use of Uniform Data Standards as promulgated or approved by the National Association of Insurance Commissioners.

Section 12. Effect of Paid Claims

- A. Any person recovering under this Act shall be deemed to have assigned any rights under the policy to the association to the extent of his or her recovery from the association. Every insured or claimant seeking the protection of this Act shall cooperate with the association to the same extent as the person would have been required to cooperate with the insolvent insurer. The association shall have no cause of action against the insured of the insolvent insurer for sums it has paid out except any causes of action as the insolvent insurer would have had if the sums had been paid by the insolvent insurer and except as provided in Subsection B and in Section 13. In the case of an insolvent insurer operating on a plan with assessment liability, payments of claims of the association shall not operate to reduce the liability of the insureds to the receiver, liquidator or statutory successor for unpaid assessments.
- B. The association shall have the right to recover from any person who is an affiliate of the insolvent insurer all amounts paid by the association on behalf of that person pursuant to the Act, whether for indemnity, defense or otherwise.
- C. The association and any association similar to the association in another State shall be entitled to file a claim in the liquidation of an insolvent insurer for any amounts paid by them on covered claim obligations as determined under this Act or similar laws in other States and shall receive dividends and other distributions at the priority set forth in [insert reference to State priority of distribution in liquidation act].
- D. The association shall periodically file with the receiver or liquidator of the insolvent insurer statements of the covered claims paid by the association and estimates of anticipated claims on the association which shall

7/7/23 DRAFT, with formatting and reference edits (in Yellow)
Amendments: IBT/CD, and CyberSecurity

NAIC Model Laws, Regulations, Guidelines and Other Resources—April 2009

preserve the rights of the association against the assets of the insolvent insurer.

Section 13 [Optional] Net Worth Exclusion

Drafting Note: Various alternatives are provided for a net worth limitation in the guaranty association act. States may choose any of the Subsection B alternatives below or may elect to not have any net worth limitation. Subsection A, which defines “high net worth insured,” has two alternates allowing States to choose different net worth limitations for first and third party claims if that State chooses alternatives 1 or 2 to Subsection B. Subsections C, D and E are recommended to accompany any of the Subsection B alternatives. In cases where States elect not to include net worth, States may either omit this section in its entirety or include only Subsection C, which excludes from coverage claims denied by other States’ net worth restrictions pursuant to those States’ guaranty association laws.

- A. For purposes of this section “high net worth insured” shall mean any insured whose net worth exceeds \$50 million on December 31 of the year prior to the year in which the insurer becomes an insolvent insurer; provided that an insured’s net worth on that date shall be deemed to include the aggregate net worth of the insured and all of its subsidiaries and affiliates as calculated on a consolidated basis.

[Alternate Section 13A

- A. (1) *For the purposes of Subsection B(1), “high net worth insured” shall mean any insured whose net worth exceeds \$25 million on December 31 of the year prior to the year in which the insurer becomes an insolvent insurer; provided that an insured’s net worth on that date shall be deemed to include the aggregate net worth of the insured and all of its subsidiaries and affiliates as calculated on a consolidated basis.]*
- (2) *For the purpose of Subsection B(2) [and B(4) if Alternative 2 for Subsection B is selected] “high net worth insured” shall mean any insured whose net worth exceeds \$50 million on December 31 of the year prior to the year in which the insurer becomes an insolvent insurer; provided that an insured’s net worth on that date shall be deemed to include the aggregate net worth of the insured and all of its subsidiaries and affiliates as calculated on a consolidated basis.*

Drafting Note: Alternate Subsection A language should only be considered in cases where a State is considering Alternative 1 or 2 of Subsection B and would like to set different dollar thresholds for the first party claim exclusion provision and the third party recovery provision.

Drafting Note: States may wish to consider the impact on governmental entities and charitable organizations of the application of the net worth exclusion contained in the definition of “covered claim.” The Michigan Supreme Court, in interpreting a “net worth” provision in the Michigan guaranty association statute, held that governmental entities possess a “net worth” for purposes of the provision in the Michigan guaranty association statute that prohibits claims against the guaranty association by a person who has a specified net worth. Oakland County Road Commission vs. Michigan Property & Casualty Guaranty Association, 575 N.W. 2d 751 (Mich. 1998).

[Alternative 1 for Section 13B

- B. (1) The association shall not be obligated to pay any first party claims by a high net worth insured.
- (2) The association shall have the right to recover from a high net worth insured all amounts paid by the association to or on behalf of such insured, whether for indemnity, defense or otherwise.^f
- i. The Association may also, at its sole discretion and without assumption of any ongoing duty to do so, pay any cybersecurity insurance obligations covered by a policy or endorsement of an insolvent company on behalf of a high net worth insured as defined in Section 13A(1). In that case, the Association shall recover from the high net worth insured under this sSection all amounts paid on its behalf, all

MO-540-23

7/7/23 DRAFT, with formatting and reference edits (in Yellow)
Amendments: IBT/CD, and CyberSecurity

NAIC Model Laws, Regulations, Guidelines and Other Resources—April 2009
Property and Casualty Insurance Guaranty Association Model Act

allocated claim adjusted expenses related to such claims, the Association's attorney's fees, and all court costs in any action necessary to collect the full amount to the Association's reimbursement under this sSection.]

Drafting Note: -Alternative 1 for Section 13B-~~paragraph~~(3), would only be a consideration in states with a net worth exclusion.

[Alternative 2 for Section 13B

- B. (1) The association shall not be obligated to pay any first party claims by a high net worth insured.
- (2) Subject to Paragraph (3), the association shall not be obligated to pay any third party claim relating to a policy of a high net worth insured. This exclusion shall not apply to third party claims against the high net worth insured where:
- (a) The insured has applied for or consented to the appointment of a receiver, trustee or liquidator for all or a substantial part of its assets;
- (b) The insured has filed a voluntary petition in bankruptcy, filed a petition or an answer seeking a reorganization or arrangement with creditors or to take advantage of any insolvency law; or
- (c) An order, judgment, or decree is entered by a court of competent jurisdiction, on the application of a creditor, adjudicating the insured bankrupt or insolvent or approving a petition seeking reorganization of the insured or of all or substantial part of its assets.
- (3) Paragraph (2) shall not apply to workers' compensation claims, personal injury protection claims, no-fault claims and any other claims for ongoing medical payments to third parties.
- (4) The association shall have the right to recover from a high net worth insured all amounts paid by the association to or on behalf of such insured, whether for indemnity, covered policy benefits and services, defense or otherwise.
- ~~(5) The Association may also, at its sole discretion and without assumption of any ongoing duty to do so, pay any third-party claims or cybersecurity insurance obligations covered by a policy or endorsement of an insolvent company on behalf of a high net worth insured as defined in Section 13A(2). In that case, the Association shall recover from the high net worth insured under this sSection all amounts paid on its behalf, all allocated claim adjusted expenses related to such claims, the Association's attorney's fees, and all court costs in any action necessary to collect the full amount to the Association's reimbursement under this sSection.]~~

Drafting Note: Alternative 2 to Section 13B-~~paragraph~~(5) would only be a consideration in states with a net worth exclusion.

[Alternative 3 for Section 13B

- B. The association shall not be obligated to pay any first party claims by a high net worth insured./
- C. The association shall not be obligated to pay any claim that would otherwise be a covered claim that is an obligation to or on behalf of a person who has a net worth greater than that allowed by the insurance guaranty association law of the State of residence of the claimant at the time specified by that State's applicable law, and which association has denied coverage to that claimant on that basis.

7/7/23 DRAFT, with formatting and reference edits (in Yellow)
Amendments: IBT/CD, and CyberSecurity

NAIC Model Laws, Regulations, Guidelines and Other Resources—April 2009

- D. The association shall establish reasonable procedures subject to the approval of the commissioner for requesting financial information from insureds on a confidential basis for purposes of applying this section, provided that the financial information may be shared with any other association similar to the association and the liquidator for the insolvent insurer on the same confidential basis. Any request to an insured seeking financial information must advise the insured of the consequences of failing to provide the financial information. If an insured refuses to provide the requested financial information where it is requested and available, the association may, until such time as the information is provided, provisionally deem the insured to be a high net worth insured for the purpose of denying a claim under Subsection B.
- E. In any lawsuit contesting the applicability of this section where the insured has refused to provide financial information under the procedure established pursuant to Subsection D, the insured shall bear the burden of proof concerning its net worth at the relevant time. If the insured fails to prove that its net worth at the relevant time was less than the applicable amount, the court shall award the association its full costs, expenses and reasonable attorneys' fees in contesting the claim.

Section 14. Exhaustion of Other Coverage

- A. (1) Any person having a claim against an insurer, shall be required first to exhaust all coverage provided by any other policy, including the right to a defense under the other policy, if the claim under the other policy arises from the same facts, injury or loss that gave rise to the covered claim against the association. The requirement to exhaust shall apply without regard to whether the other insurance policy is a policy written by a member insurer. However, no person shall be required to exhaust any right under the policy of an insolvent insurer or any right under a life insurance policy.
- (2) Any amount payable on a covered claim under this Act shall be reduced by the full applicable limits stated in the other insurance policy, or by the amount of the recovery under the other insurance policy as provided herein. The association shall receive a full credit for the stated limits, unless the claimant demonstrates that the claimant used reasonable efforts to exhaust all coverage and limits applicable under the other insurance policy. If the claimant demonstrates that the claimant used reasonable efforts to exhaust all coverage and limits applicable under the other insurance policy, or if there are no applicable stated limits under the policy, the association shall receive a full credit for the total recovery.

[Alternative 1 for Section 14A(2)(a)]

- (a) The credit shall be deducted from the lesser of:
- (i) The association's covered claim limit;
 - (ii) The amount of the judgment or settlement of the claim; or
 - (iii) The policy limits of the policy of the insolvent insurer.]

[Alternative 2 for Section 14A(2)(a)]

- The credit shall be deducted from the lesser of:
- (i) The amount of the judgment or settlement of the claim; or
 - (ii) The policy limits of the policy of the insolvent insurer.]
- (b) In no case, however, shall the obligation of the association exceed the covered claim limit embodied in Section 8 of this Act.
- (3) Except to the extent that the claimant has a contractual right to claim defense under an insurance policy issued by another insurer, nothing in this section shall relieve the association of the duty to

MO-540-25

7/7/23 DRAFT, with formatting and reference edits (in Yellow)
Amendments: IBT/CD, and CyberSecurity

NAIC Model Laws, Regulations, Guidelines and Other Resources—April 2009
Property and Casualty Insurance Guaranty Association Model Act

defend under the policy issued by the insolvent insurer. This duty shall, however, be limited by any other limitation on the duty to defend embodied in this Act.

- (4) A claim under a policy providing liability coverage to a person who may be jointly and severally liable as a joint tortfeasor with the person covered under the policy of the insolvent insurer that gives rise to the covered claim shall be considered to be a claim arising from the same facts, injury or loss that gave rise to the covered claim against the association.
 - (5) For purposes of this section, a claim under an insurance policy other than a life insurance policy shall include, but is not limited to:
 - (a) A claim against a health maintenance organization, a hospital plan corporation, a professional health service corporation or disability insurance policy; and
 - (b) Any amount payable by or on behalf of a self-insurer.
 - (6) The person insured by the insolvent insurer's policy may not be pursued by a third-party claimant for any amount paid to the third party by which the association's obligation is reduced by the application of this section.
- B. Any person having a claim which may be recovered under more than one insurance guaranty association or its equivalent shall seek recovery first from the association of the place of residence of the insured, except that if it is a first party claim for damage to property with a permanent location, the person shall seek recovery first from the association of the location of the property. If it is a workers' compensation claim, the person shall seek recovery first from the association of the residence of the claimant. Any recovery under this Act shall be reduced by the amount of recovery from another insurance guaranty association or its equivalent.

Drafting Note: This subsection does not prohibit recovery from more than one association, but it does describe the association to be approached first and then requires that any previous recoveries from like associations must be set off against recoveries from this association.

Section 15. Prevention of Insolvencies

To aid in the detection and prevention of insurer insolvencies:

- A. The board of directors may, upon majority vote, make recommendations to the commissioner on matters generally related to improving or enhancing regulation for solvency.
- B. At the conclusion of any domestic insurer insolvency in which the association was obligated to pay covered claims, the board of directors may, upon majority vote, prepare a report on the history and causes of the insolvency, based on the information available to the association and submit the report to the commissioner.
- C. Reports and recommendations provided under this section shall not be considered public documents.

-Section 16. Tax Exemption

The association shall be exempt from payment of all fees and all taxes levied by this State or any of its subdivisions except taxes levied on real or personal property.

Section 17. Recoupment of Assessments

MO-540-26

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Amendments: IBT/CD, and CyberSecurity

NAIC Model Laws, Regulations, Guidelines and Other Resources—April 2009

Drafting Note: States may choose how they wish to allow member insurers to recoup assessments paid by selecting one of three alternatives for Section 17.

[Alternative 1 for Section 17]

- A. Except as provided in Subsection D, each member insurer shall annually recoup assessments it remitted in preceding years under Section 8. The recoupment shall be by means of a policyholder surcharge on premiums charged for all kinds of insurance in the accounts assessed. The surcharge shall be at a uniform percentage rate determined annually by the commissioner that is reasonably calculated to recoup the assessment remitted by the insurer, less any amounts returned to the member insurer by the association. Changes in this rate shall be effective no sooner than 180 days after insurers have received notice of the changed rate.
- B. If a member insurer fails to recoup the entire amount of the assessment in the first year under this section, it shall repeat the surcharge procedure provided for herein in succeeding years until the assessment is fully recouped or a de minimis amount remains uncollected. Any such de minimis amount shall be collected as provided in Subsection D of this section. If a member insurer collects excess surcharges, the insurer shall remit the excess amount to the association, and the excess amount shall be applied to reduce future assessments in the appropriate account.
- C. The amount and nature of any surcharge shall be separately stated on either a billing or policy declaration sent to an insured. The surcharge shall not be considered premium for any purpose, including the [insert all appropriate taxes] or agents' commission.
- D. A member may elect not to collect the surcharge from its insureds only when the expense of collecting the surcharge would exceed the amount of the surcharge. In that case, the member shall recoup the assessment through its rates, provided that:
 - (1) The insurer shall be obligated to remit the amount of surcharge not collected by election under this subsection; and
 - (2) The last sentence in Subsection C above shall not apply.
- E. In determining the rate under Subsection A for the first year of recoupment under this section, under rules prescribed by the commissioner, the commissioner shall provide for the recoupment in that year, or in such reasonable period as the commissioner may determine, of any assessments that have not been recouped as of that year. Insurers shall not be required to recoup assessments through surcharges under this section until 180 days after this section takes effect./

[Alternative 2 for Section 17]

- A. Notwithstanding any provision of [insert citation to relevant tax and insurance codes] to the contrary, a member insurer may offset against its [insert all appropriate taxes] liability the entire amount of the assessment imposed under this Act at a rate of [insert number] percent per year for [insert number of years] successive years following the date of assessment. If the assessment is not fully recovered over the [insert number of years] period, the remaining unrecovered assessment may be claimed for subsequent calendar years until fully recovered.

Drafting Note: States may choose the number of years to allow an insurer to offset an assessment against the insurer's premium tax liability.

- B. Any tax credit under this section shall, for the purposes of Section [insert citation to retaliatory tax statute] be treated as a tax paid both under the tax laws of this State and under the laws of any other State or country.

MO-540-27

7/7/23 DRAFT, with formatting and reference edits (in Yellow)
Amendments: IBT/CD, and CyberSecurity

NAIC Model Laws, Regulations, Guidelines and Other Resources—April 2009
Property and Casualty Insurance Guaranty Association Model Act

- C. If a member insurer ceases doing business in this State, any uncredited assessment may be credited against its [insert all appropriate taxes] during the year it ceases doing business in this State.
- D. Any sums that are acquired by refund from the association by member insurers and that have been credited against [insert all appropriate taxes], as provided in this section, shall be paid by member insurers to this State as required by the department. The association shall notify the department that the refunds have been made.]

[Alternative 3 for Section 17

The rates and premiums charged for insurance policies to which this section applies shall include amounts sufficient to recoup a sum equal to the amounts paid to the association by the member insurer less any amounts returned to the member insurer by the association. Rates shall not be deemed excessive because they contain an additional amount reasonably calculated to recoup all assessments paid by the member insurer.]

Section 18. Immunity

There shall be no liability on the part of, and no cause of action of any nature shall arise against a member insurer, the association or its agents or employees, the board of directors, or any person serving as an alternate or substitute representative of any director, or the commissioner or the commissioner's representatives for any action taken or any failure to act by them in the performance of their powers and duties under this Act

Section 19. Stay of Proceedings

All proceedings in which the insolvent insurer is a party or is obligated to defend a party in any court in this State shall, subject to waiver by the association in specific cases involving covered claims, be stayed for six (6) months and such additional time as may be determined by the court from the date the insolvency is determined or an ancillary proceeding is instituted in the State, whichever is later, to permit proper defense by the association of all pending causes of action.

The liquidator, receiver or statutory successor of an insolvent insurer covered by this Act shall permit access by the board or its authorized representative to such of the insolvent insurer's records which are necessary for the board in carrying out its functions under this Act with regard to covered claims. In addition, the liquidator, receiver or statutory successor shall provide the board or its representative with copies of those records upon the request by the board and at the expense of the board.

Chronological Summary of Actions (all references are to the Proceedings of the NAIC).

1970 Proc. I 218, 252, 253-262, 298 (adopted).
 1972 Proc. I 15, 16, 443, 477-478, 479-480 (amended).
 1973 Proc. I 9, 11, 140, 154, 155-157 (amended).
 1973 Proc. II 18, 21, 370, 394, 396 (recoupment formula adopted).
 1979 Proc. I 44, 46, 126, 217 (amended).
 1981 Proc. I 47, 50, 175, 225 (amended).
 1984 Proc. I 6, 31, 196, 326, 352 (amended).
 1986 Proc. I 9-10, 22, 149, 294, 296-305 (amended and reprinted).
 1986 Proc. II 410-411 (amendments adopted later printed here).
 1987 Proc. I 11, 18, 161, 421, 422, 429, 450-452 (amended).
 1993 Proc. 2nd Quarter 12, 33, 227, 600, 602, 621 (amended).
 1994 Proc. 4th Quarter 17, 26, 566, 576, 579-589 (amended and reprinted).

MO-540-28


7/7/23 DRAFT, with formatting and reference edits (in Yellow)
Amendments: IBT/CD, and CyberSecurity

NAIC Model Laws, Regulations, Guidelines and Other Resources—April 2009


1996 Proc. 1st Quarter 29-30, 123, 564, 570, 570-580 (amended and reprinted).
2009 Proc. 1st Quarter, Vol I 111, 139, 188, 288-317 (amended).

Preservation of Records Post-Closure of Insolvent Estate


July 24, 2023



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Next Steps

- ▶ Stop the Destruction of Any Estate Records that are nearing Closure
- ▶ Determine documents within Estate Records to retain for Public Purpose
- ▶ Determine Authority and Duties bestowed on Libraries
- ▶ Determine if evidentiary standard for Estate Records must be changed
- ▶ Determine ability to restore any recently destroyed Estate Records

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REINSURANCE (E) TASK FORCE

Reinsurance (E) Task Force July 24, 2023, Minutes..... 9-1051
Reinsurance (E) Task Force 2024 Proposed Charges (Attachment One) 9-1054
Implementation of *Term and Universal Life Insurance Reserve Financing Model Regulation (#787)*;
Status as of June 27, 2023 (Attachment Two)..... 9-1056

Draft: 8/1/23

Reinsurance (E) Task Force
Virtual Meeting (*in lieu of meeting at the 2023 Summer National Meeting*)
July 24, 2023

The Reinsurance (E) Task Force met July 24, 2023. The following Task Force members participated: Chlora Lindley-Myers, Chair, represented by John Rehagen (MO); Adrienne A. Harris, Vice Chair, represented by John Finston (NY); Lori K. Wing-Heier represented by David Phifer (AK); Mark Fowler represented by Sheila Travis (AL); Alan McClain represented by Leo Liu (AR); Ricardo Lara represented by Monica Macaluso (CA); Michael Conway represented by Rolf Kaumann (CO); Andrew N. Mais represented by Wanchin Chou (CT); Michael Yaworsky represented by Jane Nelson (FL); John F. King represented by Martin Sullivan (GA); Doug Ommen represented by Kim Cross (IA); Vicki Schmidt represented by Chut Tee (KS); Sharon P. Clark represented by Vicki Lloyd (KY); James J. Donelon represented by Tom Travis (LA); Gary D. Anderson represented by Christopher Joyce (MA); Kathleen A. Birrane represented by Lynn Beckner (MD); Timothy N. Schott represented by Robert Wake (ME); Grace Arnold represented by Ben Slutsker (MN); Troy Downing represented by Kari Leonard (MT); Mike Causey represented by Jackie Obusek (NC); Jon Godfread represented by Matt Fischer (ND); Eric Dunning represented by Lindsay Crawford (NE); D.J. Bettencourt represented by Pat Gosselin (NH); Justin Zimmerman represented by David Wolf (NJ); Alice T. Kane represented by Patrick Zeller (NM); Judith L. French represented by Dale Bruggeman (OH); Glen Mulready represented by Eli Snowbarger (OK); Elizabeth Kelleher Dwyer represented by Liz Ammerman (RI); Michael Wise represented by Ryan Basnett (SC); Cassie Brown represented by Jamie Walker (TX); Jon Pike represented by Jake Garn (UT); Scott A. White represented by David Smith and Doug Stolte (VA); and Nathan Houdek (WI).

1. Adopted its Spring National Meeting Minutes

Finston made a motion, seconded by Macaluso, to adopt the Task Force's March 6 minutes (*see NAIC Proceedings – Spring 2023, Reinsurance (E) Task Force*). The motion passed unanimously.

2. Adopted its 2024 Proposed Charges

Rehagen noted that the Task Force's 2024 proposed charges included minor revisions from 2023 to reflect the current duties of the Task Force and the Reinsurance Financial Analysis (E) Working Group.

Obusek made a motion, seconded by Finston, to adopt the 2024 proposed charges of the Task Force and the Reinsurance Financial Analysis (E) Working Group (Attachment One). The motion passed unanimously.

3. Adopted the Report of the Reinsurance Financial Analysis (E) Working Group

Kaumann stated that the Working Group meets in regulator-to-regulator session pursuant to paragraph 3 (specific companies, entities, or individuals) of the NAIC Policy Statement on Open Meetings. He stated that the Working Group met July 19 and May 2 to approve several certified and reciprocal jurisdiction reinsurers for passporting. He noted that the Working Group will meet several more times during 2023.

Kaumann stated that the Working Group has now approved 61 reciprocal jurisdiction reinsurers and 41 certified reinsurers for passporting, and that 41 states have passported a reciprocal jurisdiction reinsurer. He noted that the list of passported reinsurers can be found on the Certified and Reciprocal Jurisdiction Reinsurer web page.

Kaumann made a motion, seconded by Gosselin, to adopt the Working Group's report. The motion passed unanimously.

4. Received a Status Report on the Reinsurance Activities of the Mutual Recognition of Jurisdictions (E) Working Group

Wake stated that the Working Group last met on Nov. 7, 2022, to reapprove the status of Bermuda, France, Germany, Ireland, Japan, Switzerland, and the United Kingdom (UK) as qualified jurisdictions and to reapprove Bermuda, Japan, and Switzerland as reciprocal jurisdictions. He noted that this process will be completed again this fall.

Wake stated that on Feb. 24, the Bermuda Monetary Authority (BMA) issued a consultation paper on planned enhancements to its regulatory process. He added that the BMA will issue another draft later in August or September, with expected changes to its regulatory regime to be adopted in 2024. Wake noted that the UK is working on regulatory regime changes; it will move from Solvency II to a new Solvency UK, which is expected to be adopted by the UK Parliament by the end of 2024. Wake stated that Japan will also issue changes to its solvency regime, which is effective April 1, 2025. He stated that any changes to Bermuda, Japan, or the UK's regulatory practices will be evaluated during the annual re-review of their status as qualified and reciprocal jurisdictions.

5. Discussed Ongoing Projects at the NAIC that Affect Reinsurance

Jake Stultz (NAIC) stated that there are five ongoing projects at the NAIC that affect reinsurance. He noted that the Macroprudential (E) Working Group had created a new reinsurance worksheet, which is an optional tool for regulators to get a better understanding of reinsurance transactions at the companies that they regulate. He noted that the worksheet will allow for more consistent and thorough reviews of reinsurance, can be used for any type of reinsurance, is not intended to otherwise affect the Task Force's policies or procedures, and will not be required in the *Financial Analysis Handbook* or the *Financial Examiner's Handbook*. He said that the work completed using the reinsurance worksheet will remain confidential. He stated that the Macroprudential (E) Working Group adopted the reinsurance worksheet during its June 20 meeting and that the Financial Condition (E) Committee will consider it for adoption at the Summer National Meeting.

Stultz stated that the Valuation Analysis (E) Working Group is currently completing its first year of reviews of *Actuarial Guideline LIII—Application of the Valuation Manual for Testing the Adequacy of Life Insurer Reserves* (AG 53). He noted that AG 53 is broad and covers asset adequacy testing (AAT) for life insurers, but he noted that the Task Force's primary focus in the process has been on the work involved with reinsurance, primarily focused on where this may affect the "Bilateral Agreement Between the United States of America and the European Union on Prudential Measures Regarding Insurance and Reinsurance" (EU Covered Agreement) or the "Bilateral Agreement Between the United States of America and the United Kingdom on Prudential Measures Regarding Insurance and Reinsurance" (UK Covered Agreement). He noted that a wide range of people are working on this project, including actuaries from the NAIC and regulators from several states, which include actuaries, investment experts, and financial staff. Stultz said that other subject matter experts (SMEs) from the NAIC are brought in when needed and that the work being performed is regulator-only.

Stultz stated that the Life Risk-Based Capital (E) Working Group had received a request to potentially modify the risk-based capital (RBC) instructions to allow comfort trusts or a similar form to be allowed as collateral for reinsurance, but only for RBC treatment purposes and for credit for reinsurance purposes. He stated that comfort trusts and custody control accounts are a design of trust that are common at financial institutions but do not meet the rigorous standards set in the *Credit for Reinsurance Model Law* (#785). He said that currently, the rules for trusts for RBC mirror the trust provisions of Model #785. Stultz noted that this proposal would then lower the standard for a trust that can be used for RBC purposes. He noted that NAIC staff from the Task Force have been in contact with staff support from the Life Risk-Based Capital (E) Working Group but that there had not been any formal communication. He stated that during the Life Risk-Based Capital (E) Working Group's June 22 meeting,

this topic was discussed. However, it was put on hold pending further discussions and additional information to address Working Group concerns.

Stultz stated that a new project had been started by NAIC staff to get better information on catastrophe reinsurance programs of property/casualty (P/C) insurers. He stated that this project began because of the recent catastrophe-related insolvencies and the increasing cost of catastrophe reinsurance coverage, where state insurance regulators have identified a need to collect additional detail from insurers on the structure of their catastrophe reinsurance programs on an annual basis. This project is intended to enhance the disclosures for catastrophe reinsurance programs and will include several new interrogatories that will be added to the P/C RBC Instructions. He noted that the reason this is planned to be done through RBC is that the reinsurance program structure relates to the existing RCAT charge in RBC. This is based on modeled probable maximum loss amounts that take reinsurance program structure into account, recognizing that some insurers view detailed information about their reinsurance program structure as proprietary. Including it in the RBC filing provides confidentiality protections. He noted that no formal referrals or discussions have been held and that the details of the process to get these revisions adopted have not yet been finalized.

Stultz stated that earlier this year, several banks had failed, which affected reinsurance since these were approved on the *List of Qualified U.S. Financial Institutions* (QUSFI). He noted that Model #785, Section 3 allows a letter of credit (LOC) to be used as collateral if the issuing bank meets the criteria of Section 4, which details the process for a bank to be reviewed and approved to be added to the QUSFI list and added that a drafting note in Model #785 clarifies situations when a financial institution loses its status as a QUSFI. Stultz stated that the Valuation of Securities (E) Task Force adopted a revision to the *Purposes and Procedures Manual* (P&P Manual) that will help it streamline the process of removing troubled financial institutions from the QUSFI list in the future.

6. Received a Status Report on the States' Implementation of Model #787

Stultz stated that the *Term and Universal Life Insurance Reserve Financing Model Regulation* (#787) became an accreditation standard on Sept. 1, 2022, with enforcement beginning on Jan. 1, 2023. He noted that as of June 27, 34 jurisdictions have adopted Model #787. He noted that Model #787 mirrors *Actuarial Guideline XLVIII—Actuarial Opinion and Memorandum Requirements for the Reinsurance of Policies Required to be Valued under Sections 6 and 7 of the NAIC Valuation of Life Insurance Policies Model Regulation* (AG 48) and that under the accreditation standards, a state may meet the requirements through an administrative practice, such as an actuarial guideline. Stultz stated that 12 states have advised NAIC staff that they will rely on AG 48, either through an insurance bulletin or through simple adoption of the NAIC's *Accounting Practices and Procedures Manual* (AP&P Manual). He added that if a state adopts Model #787, it also will need to adopt Section 5B(4) of Model #785. He stated that the map showing the current adoption status for Model #787 was included in the meeting materials (Attachment Two).

Having no further business, the Reinsurance (E) Task Force adjourned.

NAICSupportStaffHub/Member Meetings/E CMTE/RTF/2023SummerNM/Meeting/Minutes/0 ReinsuranceTFmin 07.24.2023.docx

Reinsurance (E) Task Force 2024 Proposed Charges

The mission of the Reinsurance (E) Task Force is to monitor and coordinate activities and areas of interest that overlap to some extent the charges of other NAIC groups—specifically, the International Insurance Relations (G) Committee.

The **Reinsurance (E) Task Force** will:

1. Provide a forum for the consideration of reinsurance-related issues of public policy.
2. Oversee the activities of the Reinsurance Financial Analysis (E) Working Group.
- ~~3.~~ ~~Monitor the implementation of the 2011, 2016, and 2019 revisions to the Credit for Reinsurance Model Law (#785); and the 2011 and 2019 revisions to the Credit for Reinsurance Model Regulation (#786) and the Term and Universal Life Insurance Reserve Financing Model Regulation (#787).~~
- ~~4.~~ ~~3.~~ Communicate and coordinate with the Federal Insurance Office (FIO), other federal authorities, and international regulators and authorities on matters pertaining to reinsurance.
- ~~5.~~ ~~4.~~ Consider any other issues related to the revised Model #785, Model #786, and Model #787.
- ~~6.~~ ~~5.~~ Monitor the development of international principles, standards, and guidance with respect to reinsurance. This includes, but is not limited to, monitoring the activities of various groups within the International Association of Insurance Supervisors (IAIS), including the Reinsurance and Other Forms of Risk Transfer Subcommittee, the Reinsurance Mutual Recognition Subgroup, and the Reinsurance Transparency Group.
- ~~7.~~ ~~6.~~ Consider the impact of reinsurance-related federal legislation, including, but not limited to, the federal Nonadmitted and Reinsurance Reform Act (NRRRA) and the Federal Insurance Office Act, and coordinate any appropriate NAIC action.
- ~~8.~~ ~~7.~~ Continue to monitor the impact of reinsurance-related international agreements, including the “Bilateral Agreement Between the United States of America and the European Union on Prudential Measures Regarding Insurance and Reinsurance” (EU Covered Agreement) and the “Bilateral Agreement Between the United States of America and the United Kingdom on Prudential Measures Regarding Insurance and Reinsurance” (UK Covered Agreement).

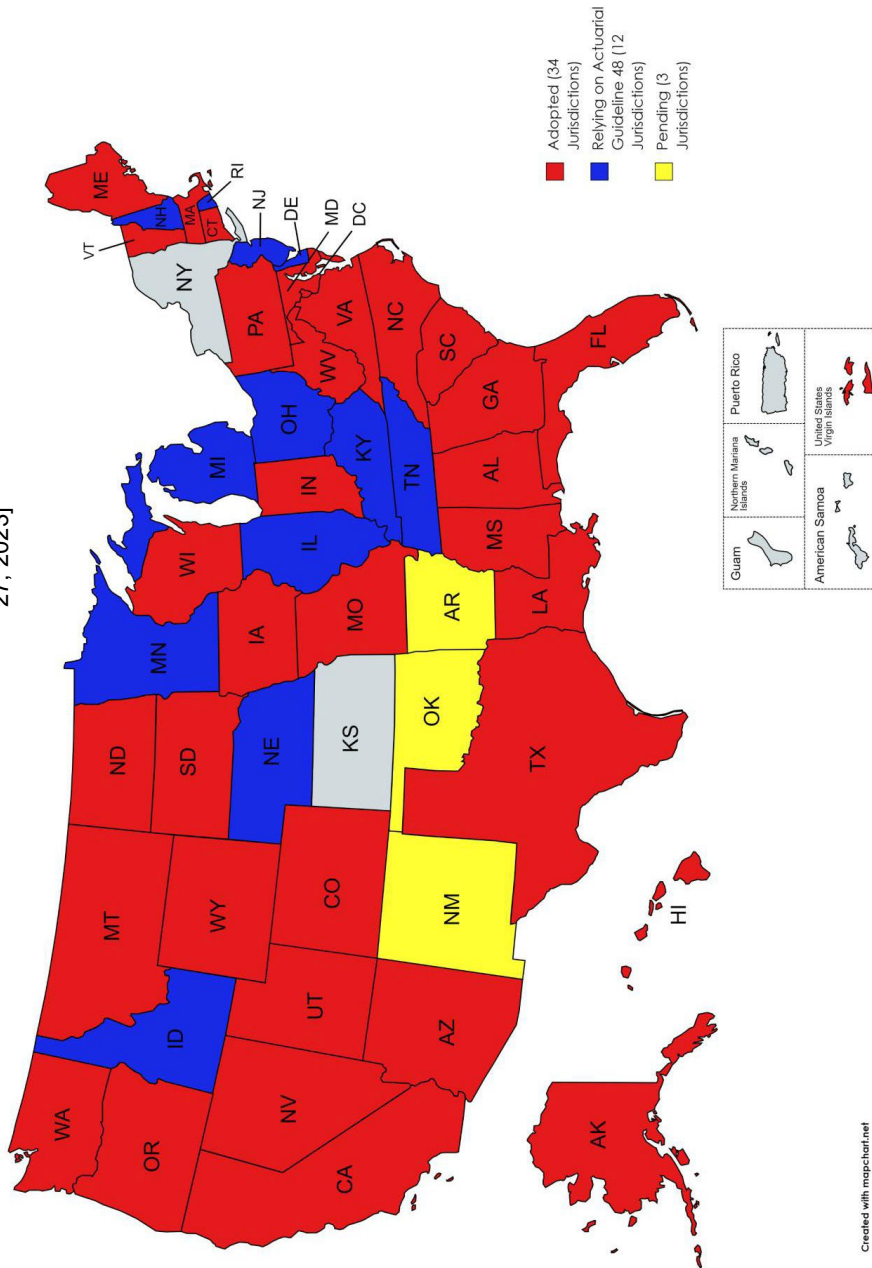
The **Reinsurance Financial Analysis (E) Working Group** will:

1. Operate in regulator-to-regulator session pursuant to paragraph 3 (specific companies, entities or individuals) of the NAIC Policy Statement on Open Meetings and operate in open session when discussing certified reinsurance topics and policy issues, such as amendments to the Uniform Application for ~~C~~Certified or reciprocal Reinsurers.
2. Provide advisory support and assistance to states in the review of reinsurance collateral reduction applications. Such a process with respect to the review of applications for reinsurance collateral reduction and qualified jurisdictions should strengthen state regulation and prevent regulatory arbitrage.
3. Provide a forum for discussion among NAIC jurisdictions of reinsurance issues related to specific companies, entities or individuals.
4. Support, encourage, promote and coordinate multistate efforts in addressing issues related to certified reinsurers, including, but not limited to, multistate recognition of certified reinsurers.
5. Provide analytical expertise and support to the states with respect to certified or reciprocal reinsurers and applicants ~~for certification~~.
6. Provide advisory support with respect to issues related to the determination of qualified jurisdictions.
7. Ensure the public passporting website remains current.

~~8. For reinsurers domiciled in Reciprocal Jurisdictions, determine the best and most effective approaches for the financial solvency surveillance to assist the states in their work to protect the interests of policyholders.~~

https://naiconline.sharepoint.com/sites/naicsupportstaffhub/member_meetings/e_cmte/rtf/2023summernm/meeting/minutes/1_2024_proposed_charges_with_updates.docx

Implementation of Model #787 (XXXI/XXXX)
Term and Universal Life Insurance Reserve Financing Model Regulation [status as of June
27, 2023]



Disclaimer: This map represents state action or pending state action regarding NAIC amendments to the model(s). This map does not reflect a determination as to whether the pending or enacted legislation contains all elements of NAIC amendments to the model(s) or whether a state meets any applicable accreditation standards.

RISK RETENTION GROUP (E) TASK FORCE

The Risk Retention Group (E) Task Force did not meet at the Summer National Meeting.

VALUATION OF SECURITIES (E) TASK FORCE

Valuation of Securities (E) Task Force Aug. 14, 2023, Minutes	9-1059
Valuation of Securities (E) Task Force July 13, 2023, Minutes (Attachment One)	9-1074
Memorandum Dated April 28, 2023, to Carrie Mears, Chair of the Valuation of Securities (E) Task Force, from Charles A. Therriault, Director of the NAIC Securities Valuation Office, and Marc Perlman, Managing Investment Counsel of the NAIC Securities Valuation Office, Regarding Clarifying the Meaning of Repurchase Agreement in the Derivatives Transaction Definition for Funds in Part Three of the <i>Purposes and Procedures Manual of the NAIC Investment Analysis Office</i> (P&P Manual) (Attachment One-A)	9-1081
Valuation of Securities (E) Task Force May 15, 2023, Minutes (Attachment Two)	9-1085
Valuation of Securities (E) Task Force 2024 Proposed Charges (Attachment Three)	9-1093

Draft: 8/28/23

Valuation of Securities (E) Task Force
Seattle, Washington
August 14, 2023

The Valuation of Securities (E) Task Force met in Seattle, WA, Aug. 14, 2023. The following Task Force members participated: Doug Ommen, Chair, represented by Carrie Mears (IA); Eric Dunning, Vice Chair, represented by Lindsay Crawford and Nolan Beal (NE); Lori K. Wing-Heier represented by David Phifer (AK); Mark Fowler represented by Sheila Travis (AL); Ricardo Lara represented by Laura Clements (CA); Andrew N. Mais represented by Kenneth Cotrone and Wanchin Chou (CT); Michael Yaworsky represented by Carolyn Morgan and Bradley Trim (FL); Dean L. Cameron represented by Eric Fletcher (ID); Dana Popish Severinghaus represented by Vincent Tsang (IL); Vicki Schmidt represented by Tish Becker (KS); James J. Donelon represented by Stewart Guerin (LA); Gary D. Anderson represented by John Turchi (MA); Kathleen A. Birrane represented by Matt Kozak and Lynn Beckner (MD); Grace Arnold represented by Fred Andersen (MN); Chlora Lindley-Myers represented by Debbie Doggett (MO); Jon Godfread represented by Matt Fischer (ND); D.J. Bettencourt represented by Jennifer Li (NH); Justin Zimmerman represented by John Sirovets (NJ); Adrienne A. Harris represented by Bob Kasinow and Jim Everett (NY); Glen Mulready represented by Diane Carter and Ryan Rowe (OK); Carter Lawrence represented by Trey Hancock (TN); Cassie Brown represented by Amy Garcia and Jamie Walker (TX); Jon Pike represented by Jake Garn (UT); Scott A. White represented by Doug Stolte and Greg Chew (VA); and Nathan Houdek represented by Amy Malm (WI). Also participating was: Elizabeth Kelleher Dwyer (RI).

1. Adopted its July 13, May 15, and Spring National Meeting Minutes

Mears said the first item is to consider adoption of the Task Force's July 13, May 15, and Spring National Meeting minutes. There were a couple of non-substantive editorial items identified that will be corrected. Mears asked for a motion to adopt the minutes from the Task Force's July 13, May 15, and Spring National Meeting.

Crawford made a motion, seconded by Clements, to adopt the Task Force's July 13 (Attachment One), May 15 (Attachment Two), and March 23 (see *NAIC Proceedings – Spring 2023, Valuation of Securities (E) Task Force*) minutes. The motion passed unanimously.

2. Adopted its 2024 Proposed Charges

Mears said next item is to consider the Task Force's 2024 proposed charges, which are unchanged from 2023.

Doggett made a motion, seconded by Malm, to adopt the Task Force's 2024 proposed charges (Attachment Three). The motion passed unanimously.

3. Received a Report on the Projects of the Statutory Accounting Principles (E) Working Group

Mears said the next item is to hear a report on projects before the Statutory Accounting Principles (E) Working Group.

Jake Stultz (NAIC) said the Working Group adopted several items and briefly discussed several items interest to the Task Force. First, the Working Group adopted the majority of the items from the Principles-Based Bond Project, including revisions to the *Statement of Statutory Accounting Principles (SSAP) No. 26R—Bonds, SSAP No. 43R—Loan-Backed and Structured Securities*, and several other SSAPs that were affected by the changes. This effectively changes the Principles-Based Bond Definition for bonds, which includes issuer credit obligations and asset-backed securities (ABS). The changes are effective Jan. 1, 2025. Stultz explained that as part of the same

project, the Working Group exposed revisions to *SSAP No. 21R—Other Admitted Assets* to provide guidance for accounting for debt securities that do not qualify as bonds and provide proposed measurement guidance for residuals. The exposure also includes the updated issue paper that details the discussions and development of this guidance. The Working Group would also sponsor a Blanks proposal to revise Schedule BA, and it will send a formal notice to the Task Force and the Capital Adequacy (E) Task Force on the proposal to allow life reporting entities the ability to use existing Schedule BA reporting provisions for Securities Valuation Office (SVO)-assigned designations in determining risk-based capital (RBC) for debt securities that do not qualify as bonds.

Stultz mentioned an item that he explained is less investment-related but has been a major focus within the NAIC over the previous year. The Working Group adopted *Interpretation (INT) 23-01: Net Negative (Disallowed) Interest Maintenance Reserve*, which provides optional limited-time guidance that allows the admittance of net negative disallowed interest maintenance reserve (IMR) up to 10% of adjusted capital and surplus. INT 23-01 will be effective until Dec. 31, 2025, and it will automatically be nullified on Jan 1, 2026, but the effective date can be adjusted. In addition, the Working Group directed the formation of an ad hoc subgroup to work on a long-term solution to the issue.

The Working Group also re-exposed agenda item 2023-11-EP: AP&P Manual Editorial Updates, which provides for revisions to clarify the scope and reporting of investment structures and residual interest, primarily limited partnerships, joint ventures, and other equity fund investments. The agenda item is primarily focused on *SSAP No. 48—Joint Ventures, Partnerships and Limited Liability Companies investments*. There were two additional items adopted by the Working Group: 1) revisions to *SSAP No. 34—Investment Income Due and Accrued*, which clarifies and incorporates a practical expedient to the paid-in-kind interest aggregate disclosure in *SSAP No. 34 and Annual Statement Instructions*; and 2) revisions to *SSAP No. 43R* to incorporate changes to add collateralized loan obligations (CLOs) to the financial modeling guidance and clarify that CLOs are not captured as legacy securities.

Stultz noted that the Working Group will have a shortened comment deadline for four items that were exposed: 1) *INT 23-02: Third Quarter 2023 Corporate Alternative Minimum Tax*; 2) *INT 23-03: Corporate Alternative Minimum Tax Guidance*; 3) agenda item 2022-11: Collateral for Loans; and 4) agenda item 2023-11-EP.

4. Discussed Comments on a Proposed P&P Manual Amendment to Update the Definition of an NAIC Designation

Mears said the next agenda item is to continue the discussion on the comments received on the proposed amendment to update the definition of an NAIC designation. As mentioned during the Task Force's July 13 meeting, the amendment was referred to the Capital Adequacy (E) Task Force, the RBC Investment Risk and Evaluation (E) Working Group, and the Statutory Accounting Principles (E) Working Group requesting comments. Those groups did not have any comments. During the July 13 meeting, the Valuation of Securities (E) Task Force directed the SVO to work with industry on creating a brief, straightforward statement as to the objective of an NAIC designation and why it is different than a rating agency rating and make additional updates to further simplify the definition. The SVO was also asked to consider different ways it could communicate to state insurance regulators the issues encapsulated in the current Subscript S descriptions and examples.

Marc Perlman (NAIC) said NAIC designations are explained and defined in both Parts One and Two of the *Purposes and Procedures Manual of the NAIC Investment Analysis Office* (P&P Manual). The SVO proposed consolidating the explanations and definitions into Part One, because an NAIC designation is a fundamental policy of the Task Force. The amendment tried to clarify the meaning of an NAIC designation, including a designation's use, purpose, and risks addressed. Given the comments received, additional refinements to the amendment are necessary, such as adding a summary of the overall regulatory objective of an NAIC designation. The SVO met with industry on July 28 to begin discussions on additional definition simplifications and clarifications that can be brought back to the Task Force for consideration at a future date. Perlman said there appears to be some unfortunate general confusion about the proposed definition amendment, as most of the text would be unchanged. Nothing in the

update changes the scope of responsibility for the SVO. An NAIC designation should reflect the likelihood of timely and full payment of principal and scheduled periodic interest, as appropriate, as well as the probability of principal and interest payment default.

There were several references made in the comments to the work conducted by the Risk Subgroup of the Invested Assets (E) Working Group, the predecessor to the RBC Investment Risk and Evaluation (E) Working Group. The Subgroup identified eight different risk attributes of a fixed income investment: credit, deferral, event, liquidity, call, extension, currency, and leverage. The Subgroup noted, “the impact of deferral was already explicitly incorporated into rating agency credit ratings.” Given that it is explicitly incorporated into ratings, any deferral of payment is a risk that should therefore be considered as part of credit risk in the definition of an NAIC designation. The other risk attributes mentioned—events, liquidity, call, extension, currency, and leverage—and another risk referenced in the comment letters, portfolio risk, are not part of the current designation definition or contemplated as part of the proposed amended definition.

Perlman explained that a long-standing core objective of the Task Force and its work product, the NAIC designation, which is relied upon for many regulatory functions in the NAIC’s Financial Regulation Standards, is to “assess the financial ability of an insurer to pay claims, meaning the regulatory assumption is that a fixed income instrument called debt by its originator or issuer requires that the issuer make scheduled payments of interest and fully repay the principal amount to the insurer on a date certain. A contractual modification that is inconsistent with this assumption . . . may result in the insurer not being paid in accordance with the regulatory assumption.” This existing regulatory assumption that an insurer should be repaid in a timely, periodic manner is a core characteristic of an NAIC designation and credit risk, and it should be incorporated into the definition. Likewise, the statement that NAIC designations are, “standards identified in the NAIC Policy Statement and Financial Regulation Standards (SFRS) that have been incorporated into state law by States as participants in the Accreditation Programs administered by the Financial Regulation Standards and Accreditation (F) Committee,” is a factual statement in the current definition that must remain in the updated definition. Commenters suggested that loss given default (LGD) should also be considered when assigning an NAIC designation. Perlman said the SVO agrees, and including LGD would be a similar consideration to including tail risk in that it is appropriate for certain asset classes, structures, or rating levels. Consideration of LGD and tail risk could be used to adjust an NAIC designation up or down, as appropriate. Perlman said if the Task Force agrees, the SVO can include these considerations in the definition.

Perlman said inclusion of separate instructions related to the assignment of the NAIC Designation Subscript S and its related illustrations also caused unintended confusion. The SVO would be happy to work on creating another means to broadly communicate privately to state insurance regulators that an investment may have unusual risk characteristics. It could take time to implement technology enhancements to deactivate Subscript S and create a new communications channel, such as specialized Jumpstart reports to share with the affected state insurance regulators through NAIC systems. However, Perlman explained that the SVO would be able to continue to communicate any issues or concerns it sees to state insurance regulators through things such as regulator-only educational meetings, informal calls, or new proposals to the Task Force, as needed.

Three comment letters were received: 1) a joint letter from the American Council of Life Insurers (ACLI), the Private Placement Investors Association (PPIA), North American Securities Valuation Association (NASVA), and Structured Finance Association (SFA) that included additional NAIC proceedings from 2008 of the Risk Subgroup of the Invested Asset (E) Working Group; 2) a letter from Athene; and 3) a letter from Anderson Insights LLC. The SVO plans to work on making these updates and bringing a minimally revised version of this amendment back to the Task Force for consideration.

Michael Reis (Northwestern Mutual), representing the ACLI, the PPIA, the NASVA, and the SFA, discussed some of the broad parameters of what may happen with the amendment. He said LGD should be part of the NAIC

designation, but there was still confusion about whether tail risk should be in the definition. He said the members of the groups he is representing had varying opinions and need to fully vet it. He asked regarding Subscript S whether there would be a broad statement of what nonpayment risk is within the NAIC designation definition. Charles Therriault (NAIC) said Reis is correct. The concept would remain within the definition, but the separate reporting would be eliminated. Reis said Perlman mentioned a lot. He said the devil is in the details, and he needs to answer to his trade groups' constituents.

Sasha Kamper (Apollo and PPIA) said the PPIA has worked with the ACLI, others in the trade groups, and the SVO on the exposures. She explained that when industry drafted its responses regarding tail risk, the PPIA did not understand how tail risk would be used. In subsequent discussions, she said she understands that the concept of tail risk within a designation definition is to be a principles-based approach. She said she agrees that it is something to look at and figure out the details of how it is used later. She cautioned that if tail risk is included, it is important to be careful that various asset classes are treated fairly and tail risk is applied in a consistent way across asset classes. As she socializes the amendment with her constituents, she will probably have more to say both on tail risk and LGD. She said she is appreciative that it might be appropriate to look at LGD in certain situations.

Mears, with the permission of the Task Force, directed the SVO to: 1) continue to work with industry on the proposed amendment and draft language regarding the consistent treatment among asset classes; 2) include a brief summary of the overall regulatory objective or meaning, which would reflect the likelihood of the timely and full payment of principal and scheduled periodic interest, noting that the risk of payment deferrals will be included; 3) maintain the existing references to the NAIC's financial regulation standards; 4) include consideration of tail risk and LGD when appropriate for the asset class, structure, and rating levels; and 5) within its responsibilities to the Task Force, communicate with the Task Force as it finds different investment characteristics or other areas it believes the Task Force should know and potentially take action on. The SVO may also develop a means to communicate that information privately through internal systems that would not be public documents like Schedule D, and that process may take some time.

Chris Anderson (Anderson Insights LLC) said the topic calls for a very clear, concise definition in simple language that everybody can understand of what is in and what is out of a designation. He stressed that coordination between the other NAIC entities is paramount. As an example, he said if one looks at how RBC C1 and R1 factors were computed, both the frequency of probability of default and the severity were considered. LGD may or may not be in the RBC factors to the extent that it is appropriate. Chris Anderson said it is a matter that should be considered by the other NAIC entities as well, and having a clear and concise definition to share with them could be very beneficial.

5. Discussed Comments on a Proposed P&P Manual Amendment Authorizing the Procedures for the SVO's Discretion Over NAIC Designations Assigned Through the FE Process

Mears said the next agenda item is to discuss the comments received on a proposed amendment authorizing the procedures for SVO discretion over NAIC designations assigned through the filing exemption (FE) process. The topic was introduced during the May 15 meeting, and it stems from the Financial Condition (E) Committee's charge to the Task Force to: "Establish criteria to permit staff discretion over the assignment of NAIC Designations for securities subject to the FE process (the use of credit rating provider [CRP] ratings to determine an NAIC Designation) to ensure greater consistency, uniformity, and appropriateness to achieve the NAIC's financial solvency objectives." Mears reminded various interested parties of the evolution of the topic. Several years back, the process began of receiving private letter rating rationales to get more transparency into the growing use of private ratings. At that time, there was discussion of the possibility of implementing discretion over those ratings to adjust the designation, should it be warranted, with the expectation that the rating change would be instantaneous and automatic. State insurance regulators at that time decided against that route, acknowledging insurer concerns of feeling whipsawed from waking up one day to a new designation it would need to utilize.

Instead, the Task Force provided guidance to the SVO to bring thematic issues back to the Task Force to address, so the Task Force could look at the FE status of those asset classes. Mears said this approach worked well for a while. For example, principal protected securities (PPS) were removed from the FE process. However, the Task Force came across roadblocks as it observed more opaque structures. For example, earlier this year the Task Force deferred action on the proposed amendment related to removing structured equity and funds from FE following criticism from industry that the proposal was too broad. SVO staff recognized some issues with specific securities, and the common feature was the use of what was called structured equity and funds, or a feeder fund. However, there would have been several assets that would have been in scope that were not problematic. It was difficult to provide a scope that would be complete but also efficient in the number of assets that it captured. Industry asked if only the specific problematic securities could be addressed without removing whole swaths of assets from the FE process.

The Task Force was responsive to the industry request and directed SVO staff to draft the current proposal, which is meant to be limited in scope and target specific material risk assessment differences. Mears said the proposal was meant to have a distinct challenge process to provide insurers ample notice, as well as due process, by which an insurer can appeal any potential change well before an FE-produced NAIC designation is affected. The amendment would also address the charge assigned to the Task Force by the Financial Condition (E) Committee. It is incredibly important to note that designations ultimately fall under the purview of state insurance regulators. While the definition is still being worked on, it is necessary to clearly highlight this authority of state insurance regulators and reiterate that designations are solely for use within the insurance regulatory framework, and they are not ratings themselves. The FE process is just that; i.e., exemption from filing that would otherwise be required to be filed with the SVO to receive a designation.

Mears noted rating agencies, or CRPs, provide an invaluable service, and the NAIC benefits by being able to use these ratings in the designation process, when appropriate. Given the number of securities and efficiencies gained by the NAIC in using rating agency ratings to assign NAIC designations, there is no intention of displacing or competing with them. However, because of how the NAIC uses CRP ratings in its processes, this is not an unconditional usage. There is a need and desire to build out a more robust framework for utilizing CRP ratings in the process, and that remains underway. However, Mears explained that even if this is implemented, there could still be instances where a rating is not aligned with NAIC expectations for a designation. The misalignment may even be unrelated to the CRP or methodology. A structure could theoretically have a rating that is fully appropriate outside the insurance regulatory system, but based on whatever policies or procedures the NAIC has in place at that time, the NAIC may need to make an adjustment within its framework.

In exposing this proposal, Mears explained that the Task Force and the SVO recognize that the proposed process is not the final version, and she asked for comments to be as constructive as possible. She thanked the comment letter writers, as many of the letters provided constructive comments. She said there were many good suggestions made by interested parties in the comment letters, and the Task Force and the SVO will be working through many of those suggestions for a modified proposal. Mears commented on some broad themes. First, there is no intent to displace or compete with CRPs. The process was written to be focused on particular assets rather than to subject a broad asset class to removal from FE. The FE status of most assets would be unchallenged. Mears clarified that insurers may continue to use whatever nationally recognized statistical rating organization (NRSRO) opinions they deem appropriate for their decision-making process. The proposal is specific to how NAIC state insurance regulators, as consumers of rating agency ratings for regulatory purposes, choose to use them in the regulatory process. Mears said the SVO will continue to provide a centralized source of investing expertise to support any state insurance regulators in this responsibility. She said while the involvement of an independent, third party to validate individual rating challenges would be costly, inefficient, and not aligned with the NAIC regulatory process, the Task Force should consider how to conduct additional oversight of the SVO in conjunction with the proposal, and that may involve engaging an independent third party to perform a periodic assessment of the reasonability of the SVO's analysis, its operational processes, and supporting systems. She said other themes in the comment

letters included additional transparency during the challenge process, more regulatory oversight, and possibly a look-back or review of the process after implementation. She noted that the Task Force and the SVO will look at each of the suggestions and consider carefully how it can enhance the process, whether as suggested or with a minor adjustment.

Therriault said the SVO has reported to the Task Force on several occasions that it has observed growing and often material discrepancies between the ratings provided by competing NRSROs for the same security. The SVO also reviewed with the Task Force specific examples of the significant differences it has observed with some CRP ratings versus the security's issuance spread relative to similarly rated investments, risk assessment differences when applying other CRP methodologies, and comparing the investment to other CRP rated peers. Therriault explained that the examples were all privately issued and privately rated securities, meaning the SVO cannot publicly discuss the specifics of the security, the rating, the rating methodology, or the rating agency. Other than a generic summary of the issue, the SVO is precluded from being transparent about the issues because it must maintain the confidentiality required by non-public investments. Commenters mentioned transparency repeatedly. Much of what the SVO sees are privately issued and privately rated transactions. By their very nature, there is no transparency of these privately issued investments, and the SVO is restricted from sharing all but the most generic information about them. Prior to 2018, when private letter rated securities first needed to be reported to state insurance regulators through the SVO, no one knew anything about these investments or that they were being privately rated. Additional transparency into these securities was only revealed to the Task Force through the SVO beginning in 2022, when the rationale reports first needed to be submitted. The rating exceptions identified by the SVO to the Task Force only came about because of the requirement for increased regulatory transparency into these non-public transactions. Otherwise, the Task Force would continue to be completely blind to these issues. Therriault cautioned that the SVO cannot be put into a position of being required to disclose highly confidential private information to anyone other than an NAIC state insurance regulator who has a regulatory need for this information or if compelled by a court order. Regarding SVO methodology, as the SVO stated on numerous occasions, it frequently uses large NRSRO methodologies, primarily Moody's Investors Service (Moody's) and Standard & Poor's (S&P), when it reviews securities because the SVO general finds those methodologies to be clear, reasonable, and widely accepted across financial markets. Additionally, Moody's methodology served as the basis for the current RBC factors. However, the SVO could provide a highly generic summary without breaching confidentiality, provided it does not identify the security or issuer directly or indirectly, or the rating agency, if privately rated. An example of such a generic summary for a recent filing would be something like the following:

An insurer submitted a security to the SVO for review in which the insurer applied a Moody's methodology, one of the primary CRP methodologies the SVO often uses to review securities. The insurer's application of the methodology scored the entity's brand strength at the 'AAA' level, while the top brands in this sector that were rated publicly by Moody's only received a 'Baa' for this factor, a substantial seven notches lower. Other financial measures used by the insurer when applying this methodology made adjustments to debt that lowered the amount of debt outstanding, adjustments that improved the financial ratios and are not used in this methodology. The resulting SVO credit assessment differed from the insurer's assessment by three notches.

Therriault said publishing information about the transaction in any greater detail, including the issuer sector and specific methodology, would probably violate the confidentiality the SVO must maintain. The SVO would be willing to discuss privately with those insurers that had invested in the security. If industry finds that level of transparency useful, the SVO could look into publishing that type of information on the SVO web page. As just demonstrated, there can still be significant differences of interpretation when applying a methodology, even from a large rating agency.

Perlman said many of the comment letters point to a rating agency's NRSRO status as a sort of seal of approval by the U.S. Securities and Exchange Commission (SEC), from which the NAIC should derive comfort as to the quality

and reliability of an NRSRO's ratings. He said it has been previously explained at Task Force meetings, but which bears repeating, that the purpose of the Credit Rating Agency Reform Act of 2006 (CRARA), pursuant to which the SEC grants NRSRO status, was to foster accountability, transparency, and competition in the credit ratings industry. The CRARA requires NRSROs to make public certain information to help users of ratings, like the NAIC, assess the NRSRO's credibility and compare the NRSRO with other NRSROs. As with other federal approaches to securities regulation, the focus of NRSRO regulation is on disclosure. While the SEC closely monitors the internal controls of NRSROs, governing conflicts of interest and adherence to their own methodologies, under the CRARA, the SEC is prohibited from regulating the substance of credit ratings or the procedures or methodologies by which an NRSRO determines credit ratings. The SEC does not and cannot validate or approve any rating agency methodology. The SEC does not and cannot endorse or certify that there is any equivalency between any NRSRO ratings. Ratings are opinions of risk, and the CRARA leaves it up to the consumers of ratings, like the NAIC, to decide how they will use those rating opinions for their own use, including not using them at all.

Perlman explains that under the current proposal, the NAIC, as a user of ratings, would neither be regulating nor publicly challenging any of the NAIC's methodologies. Additionally, several comment letters proposed oversight processes for the SVO, which appeared to be excessive and intentionally burdensome, given that no such process exists for NRSRO ratings. If a ratings consumer disagrees with an NRSRO rating or the reasonableness of some aspect of its methodology, the consumer cannot appeal to the SEC or an independent third party to overrule or modify the methodology or rating. The consumer can instead use or rely on NRSROs with methodologies that meet its needs. As mentioned in prior meetings and by some of the commenters, there is no provision in any NAIC guidance, such as the P&P Manual, that permits any state insurance regulator or the SVO to overrule or disallow a CRP rating. Perlman said that is precisely the purpose of the amendment, to create a means by which the NAIC can decide, through the efforts and experience of the SVO, how it will use those rating opinions or not use them at all when regulatorily appropriate. The premise that CRP ratings should be untouchable, unquestionable, and unchallenged by the NAIC was implied in many of the comment letters. However, such treatment is in direct contradiction to the policies of the Task Force and the mandate from the Financial Condition (E) Committee. It is also inconsistent with the objective of the CRARA of allowing the consumer of ratings to decide how and if they will use those rating opinions. The NAIC does not avail itself of that right.

Therriault said it would be helpful to step through the proposed process envisioned by the amendment. Step one is the establishment of the materiality threshold required to flag a CRP rating as in a review. To limit the NAIC's use of this process to only that which would be considered truly material differences of opinion, the SVO would only be able to put a security or CRP rating on notice if it determines, based on the available information, that the CRP rating used in the FE process is three or more notches different than the SVO's assessment. The SVO proposed criteria that it has successfully used to identify such exceptions for the Task Force, which is the comparison to peers rated by other CRPs, the securities yield at issuance or current market yield compared to other securities at that NAIC Designation Category level, or the SVO applying methodologies from another CRP. The SVO frequently uses methodologies from very large NRSROs because it finds them to be clear, reasonable, and widely accepted across the financial markets. However, there can still be differences in the application of the methodologies, which can be discussed with a specific insurer.

Therriault said step two is a means to notify insurers that the SVO is looking at the FE-based designation. Nothing changes at that point; it is just a notification. It is anticipated that insurers will provide additional information to the SVO during this notification period to support why the CRP rating should be maintained. What information will be needed depends on the specific types of securities; there is not a standardized list. It is subject to the asset class that is being reviewed and the information available to the SVO. The proposal provides a sufficient notice period to allow an insurer to decide whether it wants to appeal and provide additional information before any action is taken. Insurers would have up to 120 days to appeal the SVO's assessment notification by introducing additional information and data, as necessary. The 120-day appeal period is similar and consistent with the existing appeal period for an SVO-assigned designation. If an insurer appeals, that review process could take an

additional 90 days or longer. During the SVO review, applicable state insurance regulators would also have the opportunity to be consulted on the deliberation if they request. If, after the SVO review, it determines that the CRP rating should be excluded for that security, the insurer would have another 120 days to either submit the security for review by the SVO or acquire an alternate CRP rating, thereby permitting continuation of the FE eligibility.

Therriault explained that it may take nearly a year or more from the initial notification until any action is taken on an investment, providing insurers ample time to respond and participate. There will not be any abrupt changes. The discretion process could take two to three years to implement and could be designed to permit multiple insurers that own the security, as reflected in the statutory schedules, to join in the appeal. The connection to the statutory schedules is necessary to allow SVO staff to know which insurers are permitted to have access to the confidential information related to the security and who they can share their observations with given that these may likely be privately rated securities. It would be up to the insurers to decide whether they wish to participate.

Therriault said the SVO assessments of investment risk have been compared to insurers' own investments' assessment of risk, and they have been found to be reasonable. He noted the Society of Actuaries (SOA) study titled, "2003 to 2015 Credit Loss Experience Study: Private Placement bonds," for the topic of "Rating Consistencies: The main quality rating used in the study, the internal rating supplied by the contributors, [i.e. the insurance companies] for each CUSIP for all years, was found to be consistent across two dimensions. Based on comparisons of commonly held CUSIPS, [internal] ratings were very consistent between contributors. They were also reasonably consistent in comparison to NAIC ratings [i.e. designations]."

Therriault then listed actionable recommendations from interested parties that should be incorporated into the proposed amendment:

1. The SVO publishes a generic summary of the reason for its action; i.e., that it maintain the confidentiality of the issuer, rating agency, and rating.
2. Include in the SVO's annual report to the Task Force at the Spring National Meeting information on several ratings challenged, the outcome of the challenges, and the average number of notches of the change.
3. Separately, submit a request to the Executive (EX) Committee authorizing the NAIC to engage an independent third party to perform a periodic review and assessment of the reasonability of the analysis, its operational processes, and supporting systems, and provide the Committee with a private and public assessment and recommendations. It would be up to the Committee as to how frequently such a report should be submitted.

Therriault said credit analysis is both an art and a science; differences of professional opinion are unavoidable. The SVO has proposed materiality thresholds to ensure that it is only focusing on material differences of opinion. The SVO agrees that CRPs have areas of strength and expertise, but they also recognize that there are eight different sources of credit rating opinions today, and those opinions can be significantly divergent. NAIC Designations are specifically intended for state insurance regulators, and they do not have a choice as to the opinions used in their regulatory framework. The proposal gives the state insurance regulators, through the SVO, over which the Task Force has oversight, the ability to align opinions to their risk tolerance. The checks and balances in the proposal, with the modifications that were mentioned, will provide the Task Force and industry comfort that the investment risk assessments are reasonable. The SVO recommends that the Task Force continue its overall assessment of CRP ratings, a project it initiated last year.

Walker said she understood the process, and the direction to SVO staff to draft the process, was about strengthening Task Force reliance upon the CRP ratings, but also allowing a relief valve whenever staff or state insurance regulators notice significant outliers in what is being produced through the process. Therefore, Mears' opening comments, that this process is not intended to replace CRPs aligns with Texas's view. Garcia said it should

create certainty for industry going forward that new and emerging asset classes are developed; this process can be used as opposed to creating uncertainty with an insurer not wanting to get into the new asset classes because it does not know whether the new asset class will be FE or not. She said the process is painful at this at this time, but it is a great base and foundation to build on going forward, as there is more innovation in the investment markets, and it will prevent retreading the same ground repeatedly. She said she was excited to hear what Therriault explained about the process. She said it is not perfect now, but we will take all the feedback and work through an iterative process to get something that everybody knows, understands, and is comfortable with.

Cotrone asked Therriault to confirm that no action will be taken on an NAIC Designation until after the insurer is notified and can go through the full appeal process. Therriault confirmed and explained that first there would be notification that the SVO is looking at something that it thinks is off the mark. The insurer could provide information to discuss that with the SVO. At that point, the SVO will know, if it is a private rating, that it has the ability to breach that confidentiality shield. Then, the SVO can discuss that with the insurer and decide if it wants to appeal. When the SVO decides that it should be removed from FE, there is still the option to go to an alternate rating agency to get a different answer or file the security with the SVO for review. Therriault said the process could take nearly a year before security moves from FE to out of FE or to another CRP.

Mears said several comment letters were received on the proposal, and she wants to ensure that everyone has a chance to speak to their comments. She listed the comment letters: a joint letter from the ACLI, the PPIA, the NASVA, the SFA, the Mortgage Bankers Association (MBA), and the Commercial Real Estate Financial Council (CREFC); the Lease-Backed Securities Working Group; Chris Anderson; Michelle Delaney; the National Association of Mutual Insurance Companies (NAMIC); the Bank of Montreal (BMO); Genworth; Teachers Insurance and Annuity Association of America (TIAA) Financial Services; Piper Sandler Companies; Group 1001; and Marty Carus (Martin Carus Consulting LLC).

Reis said he would briefly summarize the letter from the ACLI and the joint trades with the most basic concern being related to transparency. The first issue is that the designation challenge rests with the SVO and one state insurance regulator, yet other insurers may hold that same security, perhaps in other states, potentially resulting in extraterritorial regulatory approval. Also, the SVO would be making its objection or determination of a material discrepancy based on incomplete information. Then, on appeal, the insurer would be allowed to provide additional information. Reis said that seems more like an initial filing rather than an appeal. He said this was concerning to many members of his constituency. He said his constituency also thought there should be additional checks and balances on "appeals." He said there should maybe be a third party so the SVO is not judge, jury, and executioner, a term discussed by his constituents. He explained that there should be transparency to all partners affected and transparency about what is affected, whether it is just the security; a whole asset class; a subset of an asset class; something broader than the asset class, such as a methodology; or one or more rating agencies. There should be transparency as to the rationale and what was inappropriate with the rating rationale. Reis explained that the reason for the transparency request is if there is a problem with a security and that rating gets changed, industry will be left wondering whether the problem is with the whole asset class or a subset of that asset class. Industry is concerned that the private market, of which industry holds substantial assets, could freeze. Reis said there have been instances where certain segments of that market have been frozen due to challenged ratings or similar things. He said industry is ready to assist in addressing specific problems that are identified, but there are problems with transparency. He said Therriault had mentioned that the SVO uses large rating agency methodologies, but industry has heard that those rating methodologies can be misapplied. He explained that a rating methodology applies to apple pie, but it might inappropriately be applied to pumpkin pie. He said there are specific instances where that has happened, and he said he could share the details later. He then addressed materiality. He said it is predicated on a material discrepancy in ratings, and the SVO would be making its objection to a rating with incomplete information. He then addressed the appeal, which he said is not really an appeal but rather a security filing so the SVO has complete information. He reiterated his belief that there is not a real appeals process where there is recourse other than to the SVO.

Mears asked Reis to describe his concern about the providing of incomplete information. She asked if it is that he would want to see that happen in a different order. She explained that by its nature, the SVO would not receive complete information. She asked Reis what he believes the process should be.

Reis said he would answer in two ways. One, the process as outlined would be that the SVO thinks the rating is X, which is three notches higher or lower than the rating that is assigned; therefore, your insurer can file an appeal. Otherwise, the SVO rating stands. Reis explained that the SVO assessment was made with incomplete information, which seems like a backwards approach and is not really an appeal. He said if there were a process, and he clarified that his group has not talked about what the solution is, and the SVO would like to get additional information, it could be shared. He said that is a different process; i.e., the SVO saying it has the answer based on incomplete information.

Therriault said the process envisioned was for the SVO to give notice of what it is thinking and, at that point, to ask industry, through the notification, for additional information. If industry believes the SVO is off the mark, that would be the means by which the SVO would get the information Reis described. Therriault explained that if the SVO does not have a means to communicate to all parties that may be invested in the security in an efficient way, the SVO will not know who to reach out to, how it is going to get the information, and how it is going to be transmitted through NAIC systems. He explained that even if the SVO received the information, it would not be an automatic change in the designation. The only thing it would do is remove it from the population of FE, which then means it is a status change, then the insurer has other options to avail itself, such as another CRP rating if they want to request an alternate review, or a traditional full SVO filing, if the SVO had not received sufficient information already.

Reis said much of the process outlined by Therriault presumes that the rating is wrong based on the SVO assessment, which is based on incomplete information.

Therriault said that is correct, but he referred to the comments made by Perlman; i.e., there is no challenge process for a rating that exists anywhere. One cannot tell the SEC that rating agency X's rating is incorrect and ask the SEC to overrule it or make the rating agency change the answer. Therriault explained that this is a way for the state insurance regulators to avail themselves of a professional group that supports them to provide that function.

Mears said maybe there is another notification process where additional information is needed or something along those lines. She said we can take back that concern and think through what the enhancements would be.

Reis said there is a strong conceptual concern, but there are broad implications. If there is a hundred X types of securities in the market, one of those securities gets picked, and that rating gets notched down three notches, it is going to spread like wildfire through industry that the SVO has a problem with X security. Reis explained that industry would not know what the problem with the security is, and questions would arise, such as whether the whole population of 100 securities is at risk; whether it is a sub-population of those 100 securities that has certain characteristics; or whether it is the rating agency methodology that may rate 40 of those, but the other 60 are not at risk. He explained that if there is fear in the market, that whole population of securities could freeze up because certainty of capital is lacking.

Kamper talked regarding incomplete information. She said what industry envisioned that the information that the SVO would have on the security is the private ratings letter and whatever information is available on Schedule D. The SVO would not have had access to the financials, a private placement memorandum, the legal docs, etc. When this proposal is put into action and those securities would be flagged, that is then when the SVO would come and talk to the insurer; the insurer would provide that information; the SVO would do a more thorough due diligence; and there would be a discussion most likely between the insurers that own the security, the CRP that rated the

security, and the SVO. Kamper said her constituents view that dialog as similar to an initial filing, as if the SVO would have designated and assigned a designation absent a CRP rating. She said one of the concerns is that in the rare chance that after going through that process, the insurer and the SVO cannot come to a meeting of the minds and the insurer still feels strongly that there are fundamental reasons why the rating is appropriate and there is information the insurer wants to present, there needs to be a second place to have that dialog again. She said it is important that in the rare situations—most likely a methodology challenge—where there is something fundamental about the asset class that would affect a broad number of securities, not just any individual security, insurers would like to be able to bring its concern to the Task Force, or some subset thereof with expertise in these issues to bring the concern to. She said she would not envision that happening frequently, but she believes it is important to have an additional place of appeal because her constituents view the 120 days in the exposure as more like an initial filing. With respect to confidentiality language, she said she understands it is a big challenge, but she knows the SVO has provided some examples in the past where it has masked which rating agency assigned the rating and just speak in terms of NAIC equivalent ratings, and it has masked the name of the issuer and watered down the information enough that people can understand what the nature of the underlying transaction is, but it does not necessarily give away who the rating agency is or who the issuer on the deal was. She said the SVO has been able to overcome that challenge in the past and share with the small group, and that is the type of disclosure that industry is looking for here, mainly to avoid what Reis was referring to, meaning the situation where if many insurers have similar securities and the SVO is concerned about a very specific issue that affects the security or a certain methodology, that it does not cause unnecessary disruption to a broader range of securities than just that the SVO is concerned about and wants to challenge and talk about. She said from her constituents' perspective, transparency is key and would appreciate to the extent that the SVO can accommodate, as well as adequate due process, meaning a place to have concerns heard, be able to have a good dialog, and hopefully get to a decision that makes sense for everyone.

John Garrison (Lease-Backed Securities Working Group) said the Lease-Backed Securities Working Group believes the investment community and the state insurance regulators share the same desire for efficient, well-regulated markets that benefit everyone. It goes without saying that markets hate uncertainty. Any policy that allows the NAIC to question and potentially overturn individual CRP ratings after a bond has been purchased by the investor will inevitably create uncertainty in the markets and have a harmful effect on insurance companies, and they will be the only market participants subject to this added uncertainty. Garrison said even the mere discussion of the issue has already started to freeze markets for many securities where insurance investors have simply said they are not going to consider it because there is too much uncertainty involved with making that step. That being the case, the Task Force should strive, wherever possible, to minimize the negative impacts of the policy while preserving the ability to effectively regulate. This could be done, Garrison suggests, by limiting the scrutiny to only those companies where state insurance regulators feel the problem rises to a level where it could have a material impact on an individual company's capital ratios, or by making it clear that only certain classes of securities would be subject to this additional level of scrutiny. Responding to the comments of Reis and Kamper regarding incomplete information, Garrison said the fear is that the SVO will always be operating to some extent on incomplete information. To the extent that NRSROs can talk to management, they can do many things that the SVO is unable to do and that the Lease-Backed Securities Working Group believes the NRSROs will always have a bigger, fuller picture of a credit. Garrison said any analysis by the Investment Analysis Office (IAO) that questions the work of an approved CRP should be justified to the investor in the form of a full ratings rationale report equivalent to the fulsome reports published by the NRSROs and already provided to the SVO, which provide a detailed explanation of the analysis by the CRP, the credit issues, the legal issues, and any mitigants. Regarding the phrase of blind reliance on ratings, he said he understands that the state insurance regulators want to preserve the ability to question ratings in some instances, but it is hardly blind. The report prepared by the SVO or the IAO should highlight specific errors and omissions in the CRP analysis and the specific reasons the IAO reached a different conclusion. Garrison said the sample paragraph Therriault read as an example is insufficient. He said the SVO cannot just say it looked at all the same information, but it just came out with a different opinion. He also agreed that many of the proposed steps put forward by the Financial Condition (E) Committee framework to

modernize the SVO, including the establishment of a broad investment working group under the Committee to act as an adviser and hopefully to harmonize the various different investment-related projects that are underway, including this one, and also with the hiring of an external consultant to advise the Working Group and provide guidance on any policy-related issues. He said the Lease-Backed Securities Working Group believes that these recommendations, as well as the other steps contained in the Committee framework, should be brought into this discussion before any specific policies are implemented by the Task Force.

Chris Anderson said his comments are in the context of the Bond Project, which had just been adopted and should give state insurance regulators confidence that some of the problems that existed or may have existed will be dealt with. Turning to his letter, he said his conclusion was that it would be terrific to have a fresh look at how state insurance regulators can benefit from the resources of the NAIC with respect to their responsibilities to assess the credit quality of the assets of insurers. He referenced a study 25 years ago from an outside consultant and another more recent one saying those kinds of recommendations are appropriate now because the discretion proposal is a sweeping change in the responsibility of the SVO. He said years ago, the SVO was responsible for coming up with securities valuations, and now it comes up with some measure of risk, which in his opinion is essentially credit risk. He said it may well be time to look more fundamentally at how you can be served the best, and hopefully that can be addressed.

Chris Anderson said with respect to this proposal, there is tremendous new power that the SVO will have, and the idea that a security or a class of securities can be put under a cloud for even a brief period of time is market making and market moving and should not be ignored. The notion that it can be done for a year is inconceivable to market participants who are looking at securities on a moment-to-moment basis. The idea that one insurer may have information that other insurers may lack about the status of security and the reasons it is under a cloud can influence the fairness of trading. It could even prohibit the insurer from selling a security because of fear of trading on material nonpublic information. Chris Anderson said a proposal this sweeping needs to be accompanied by better governance, which is the theme of his letter. Regarding better governance, he said he outlined specific steps state insurance regulators can take to oversee the processes. The most fundamental step is something that existed before namely one, but probably more than one, working groups specifically dedicated to these questions. He clarified that a working group is a group that would actually do work. He said there cannot be 26 task force members all responsible for what goes on at the SVO; although, ultimately, they are. However, the Task Force needs arms and legs; i.e., people who are focused on it. Chris Anderson said in his letter that he outlined specific steps that can be taken for the Task Force to have visibility as to what goes on in the process.

The model is essentially what the SEC did when it wanted to have visibility and transparency to the work of rating agencies. Chris Anderson said it has been called burdensome, and he said it would take a significant period of time. He said he understands that that it would be a burden for the SVO because it has never done many of these things. He explained that the SVO has never produced the kinds of documents outlined in his letter, not the least of which is a ratings transition matrix, in other words the SVO's report card. With those documents, the Task Force will be able to assess the work that is being done by the IAO. Chris Anderson asserted that the idea that, as in the proposal, once a year the Task Force may request information about what the IAO has done in this regard is indicative of the notion that the proposal contemplates no disclosure. He said he is advocating for a group that digs into the operations of the SVO and demands accountability.

Chris Anderson said a second group that would be useful is something that existed many years ago, called the Rating Agency Working Group. The Working Group worked closely with the SEC. Chris Anderson said a web search will show interaction between the SEC and the NAIC concerning what kinds of information the NAIC would want. There are many things the Task Force could do, as state insurance regulators, if it had a working group to review the capabilities and performance of the NRSROs. Chris Anderson said Form NRSRO has incredible detail about the performance of rating agencies, and it is a model for the IAO. The SEC reports annually on infractions or

performance of rating agencies in a generic form, but there are several things the Task Force can do if it wants to focus on and improve state insurance regulator visibility on the performance of the NRSROs.

Chris Anderson is afraid that aside from the clouds it will cast over various securities and classes of securities, there are problems with this proposal. He asserted that the notion that one can come up with a three notch difference by using peer review, yield analysis, market yield, and other tools is flawed. He said by peer review specifically, the example of 43 securities was an apples-to-oranges comparison, and that was referred to an ad hoc group. He said he understands that that approach was never validated. Furthermore, if this is not intended to be used to an apples-to-apples review, in other words, two rating agencies rating the same asset, then for private placements, the SVO has noted that only 15% of private placements are rated by more than one rating agency. That means 85% of the private placements the SVO would be looking at would not be able to do an apples-to-apples review. Chris Anderson summarized that the proposal needs a lot of work, and hopefully there will be an opportunity for outside consultants to look at it.

Mears summarized Delany's comments stating that Delany noted that the NRSROs are regulated by the SEC and described the application process. Delany goes on to note that the NRSROs focus on collateral, along with the credit worthiness of the borrower. She highlights that she relies upon NRSROs for making credit decisions in a former role at a large regional bank. She suggests that the SVO should also be subject to an independent review in its provision of designations, as well as highlighting the suggestion that a third-party provider could assist with the request for proposal (RFP) for the review of the NRSROs.

Colleen Scheele (NAMIC) said NAMIC agrees with all other interested parties as it relates to transparency, and it looks forward to continuing the conversation with state insurance regulators and NAIC staff.

Mears summarized BMO's comments stating that BMO provided some considerations based on its observations. BMO noted that the rating agencies have been approved as NRSROs by the SEC due to comfort with their rating methodology and track record over time. They would like rating certainty, as there could be impacts to deal flow. They also note that adoption of this proposal could set a precedent for future negative amendments, increasing the riskiness of investing in private placements.

Michael Shepherd (Genworth) said he believes Genworth's concerns had been addressed by the ACLI and others.

Mears summarized the TIAA's comments stating that the TIAA has specific concerns with Sections 81 and 170 of the proposal. The TIAA does not believe the proposal demonstrates a requirement for the SVO to provide its own analysis or explanation as to why the CRP provided rating was challenged. The TIAA also makes a reference to an assumption that we have gone through this process before with 43 securities, and the Task Force did not approve a method to override the ratings at that time. The TIAA recommends that a clear methodology be outlined, and it noted that the SEC closely regulates all the NRSROs.

Mears summarized Sandler's comments stating that Sandler indicated that the current NAIC proposals have already caused major market disruption as word of the pending proposals permeated all levels of the insurance industry. They said some number of insurance companies have instituted a moratorium on certain rated transactions in the markets, and prior to buying a particular transaction, insurance companies should know what the NAIC Designation will be in order to monitor the regulatory capital charges. They talk about some of the rating agencies that are in the market, and they have seen some potential drop off in the total number of deals and respective transaction sizes. An increasing number of insurance company investors learned of the proposed NAIC/SVO's intent to provide the credit risk designations to FE securities, and they noted that the market has come to a virtual halt denying many strong and viable companies the ability to raise capital. They give some statistics regarding some of the ratings that have been in place. They note that the NAIC/SVO does not have the required resources, analytical capability, or regulatory status; i.e., not an SEC-regulated NRSRO to implement

unexpectedly high credit risk designations. They say insurance clients always carry out intense due diligence and all corporate credits that have come to the market. They note that this could impede the ability of smaller corporations to raise capital and provide strong value added investments for the insurance industry.

Bob Turner (Group 1001) said Group 1001's letter echoed many of the other themes from the other letters. He said he wants to discuss the impact of the Bond Project. He said many of the examples brought forth to industry in previous meetings would be addressed by the Bond Project and the new definition. Consideration should be given not just in the scope of securities that could be affected, but the timing of having to implement the Bond Project at the same time. The total scope of this proposal seems to be unlimited and could affect any number of securities, so there should be some consideration given to certain attributes of securities. Previously, there was the bespoke security letter that talked about red flags. Likewise, there should be attributes to some securities where insurers can have confidence that there will not be any expectation of a challenge based on certain attributes of those assets within the marketplace. Turner also said he echoed what other people said about transparency, and more insight into specific concerns would allow industry to come to the table with some alternative solutions, as well as the SVO's methodologies so people can better understand any appeal process and what the SVO's rating methodology would look like.

Mears summarized Carus's comments stating that he notes his experience as a state insurance regulator for 43 years and participation in NAIC activities during that tenure. He is now a consultant, but he offers his comments as a consumer policyholder of various insurance products and investor in insurance companies and as a taxpayer. He notes this proposal, like most NAIC proposals, does not define the associated costs that are ultimately borne by policyholders or investors. The proposal also does not estimate quantification of the benefits associated with it. As a taxpayer, Carus finds this problematic. He views this proposal as an attempt to overturn the existing FE process. He notes that no major market participant has encountered a severe adverse market event in decades. He lists several questions, including why the proposal is being made at this time, why there is no materiality threshold, what specific conditions have arisen, whether the insurance industry has experienced a financial strength decline due to its investment operations outside of the normal cyclical economic conditions, whether there are examples of companies abusing the fee process to the extent that its RBC calculations were materially misstated, and whether the current solvency regulatory regime is good enough as it is. He then goes on to note concerns with the fact that the timing of the challenge would occur after the investment is made.

Steve Broadie (American Property Casualty Insurance Association—APCIA) said the APCIA did not file comments, but it wants to associate itself with comments made by the ACLI and the other trade associate associations that joined in that letter.

Mears said the next steps are for the Task Force to provide direction back to SVO staff. The direction is to work through the actionable comments in the comment letters and incorporate, as needed. Mears said she would look to Task Force members if there are any specific areas that should be highlighted and further discussed.

Crawford said from the Nebraska standpoint, as heard from several commenters, there is a need to look back at the appeal process and the process of bringing the concerns to an insurer. The ultimate authority needs to rest with the states, and there should be a solution where the authority lies with the states. It could be through a committee, because of the issue of when a company in one state of domicile affects multiple. Crawford mentioned overall transparency and heard the concerns that were brought before the Task Force. The Task Force needs to take those seriously and provide as much transparency as it can, understanding the legal implications of that.

Cotrone said Connecticut agreed with Nebraska's comments. He said there is a need to take into consideration interested parties' comments, such as how to improve the process. He said the comments have provided some very valuable insight.

Mears said most Task Force members would be in agreement that increasing transparency would be a priority. It can be looked into in accordance with the confidentiality issues. There should be an annual report on the number of ratings challenges, outcome of challenges, average number of notches, and possibly some interim reporting, particularly at the initial onset of such a process. Mears said the Task Force should request the engagement of an independent third party to periodically review the operations, analysis, and systems of the IAO. It would require Executive (EX) Committee authorization, but there is the Financial Condition (E) Committee framework that contemplates the usage of such a resource for a purpose like this. Every suggestion that was made will be reviewed in good faith to determine whether it can be incorporated into the process. Mears asked Task Force members to read through the comments and think about this so further guidance can be provided to the SVO as this proposal is updated. She noted the related pending Financial Condition € Committee exposure stating that it is much broader than this Task Force proposal. As comments are received on the Committee proposal that may have implications for the Task Force initiative, that will need to be considered.

6. Heard a Staff Report on the Proposed CLO Modeling Methodology and the Ad Hoc Working Group

Eric Kolchinsky (NAIC) said the collateralized loan obligation (CLO) ad hoc group has continued to set the assumptions for CLO modeling. The assumptions for prepay and purchase pricing were recently finalized. The next step is to look at scenarios and probabilities. There will be a suggested set of scenarios, and based on those, the CLO ad hoc group will seek to set probabilities such that the risk of the underlying loan is approximately equal to the risk of the sum of the tranches. Kolchinsky said the next meeting of the CLO ad hoc group would be after Labor Day.

7. Received Final CRP Questions

Mears said the next agenda item is to note that the SVO received feedback on the initial list of questions to CRPs. She said the responses were private because some of them came from the CRPs themselves, and the Task Force was not going to publish those comments. The responses helped to create a final list of questions, which are published on the Task Force website. The submissions will be formalized to the CRPs, which starts the timeline of scheduling meetings with them as the responses are received over the coming months.

8. Discussed Other Matters

Mears had one additional matter. Fitch Ratings downgraded the U.S. government to AA+ from AAA. Along with S&P, that makes two rating agencies that no longer maintain an AAA rating on the U.S. Currently, the NAIC Designation of U.S. government obligations is fixed in the P&P Manual at NAIC 1.A. Therefore, any upgrades or downgrades do not change the NAIC Designation as they would with the FE process. If the NAIC Designations were governed by the FE process, U.S. government obligations would be at NAIC 1.B. Mears said the Task Force will need to talk about this issue. She said there is no recommendation, but she wants to ensure that the Task Force understands the implications and how that flows through the system, and if there is anything the Task Force needs to address, either within the Task Force or even with some of the groups the Task Force coordinates with, including the Statutory Accounting Principles (E) Working Group and the RBC Investment Risk and Evaluation (E) Working Group.

Having no further business, the Valuation of Securities (E) Task Force adjourned.

Draft: 8/1/23

Valuation of Securities (E) Task Force
Virtual Meeting
July 13, 2023

The Valuation of Securities (E) Task Force met July 13, 2023. The following Task Force members participated: Doug Ommen, Chair, represented by Carrie Mears (IA); Eric Dunning, Vice Chair, represented by Lindsay Crawford (NE); Ricardo Lara represented by Laura Clements (CA); Andrew N. Mais represented by Kenneth Cotrone (CT); Michael Yaworsky represented by Ray Spudeck (FL); Dana Popish Severinghaus represented by Vincent Tsang (IL); Vicki Schmidt represented by Tish Becker (KS); James J. Donelon represented by Bill Warner (LA); Kathleen A. Birrane represented by Matt Kozak (MD); Gary D. Anderson represented by Jim McCarthy (MA); Grace Arnold represented by Fred Andersen (MN); Chlora Lindley-Myers represented by Debbie Doggett (MO); Justin Zimmerman represented by John Sirovets (NJ); Adrienne A. Harris represented by Jim Everett (NY); Carter Lawrence represented by Trey Hancock (TN); Cassie Brown represented by Amy Garcia (TX); Scott A. White represented by Doug Stolte (VA); Mike Kreidler represented by Tim Hays (WA); and Nathan Houdek represented by Amy Malm (WI).

1. Adopted a P&P Manual Amendment to Clarify the Meaning of Repurchase Agreements in the Derivatives Transaction Definition for Funds in Part Three

Mears said the first item on the agenda is to discuss and consider adoption of a proposed technical *Purposes and Procedures Manual of the NAIC Investment Analysis Office* (P&P Manual) amendment to clarify the meaning of repurchase agreements, or repos, in the derivatives transaction definition for funds in Part Three of the P&P Manual.

Marc Perlman (NAIC) said in 2021, the Task Force adopted amendments to the NAIC Fund Lists section of the P&P Manual to provide greater clarity and predictability regarding the applicable use of derivatives in funds and permit funds greater flexibility in their use of derivatives while maintaining limits on funds' use of leverage. The Securities Valuation Office (SVO) proposed a new amendment to clarify which side of a repurchase agreement constitutes a derivative transaction for the purposes of the definition. The original amendment was intended to limit the use of leverage by funds; therefore, the derivative transactions definition encompasses instruments pursuant to which a fund may be required to make a future payment of cash or other assets. Likewise, the inclusion of reverse repurchase agreements, as based on the U.S. Securities and Exchange Commission (SEC) definition in Rule 18f-4, was intended to capture arrangements by which the fund would allow a future cash payment to the counterparty. However, to maintain consistency between the P&P Manual and the Statement of Statutory Accounting Principles (SSAPs) and eliminate any misconception that a fund cannot be the purchaser of securities/lender of cash, the SVO proposes changing reverse repurchase agreement to repurchase agreement in the derivatives transaction definition. To be clear, the SVO is not intending to change the meaning. Rather, the same side of the transaction was named differently by the SEC and the SSAPs, and the SVO wants to be consistent with the SSAPs. The proposed amendment was exposed for a 45-day public comment period that ended June 30, and the Task Force did not receive any comments.

Everett said the SEC definition is written from the broker-dealer perspective. He asked if it makes a difference that the Task Force is now dealing with the issue from a broker-dealer perspective rather than a counterparty perspective.

Perlman said regardless of the perspective, the SEC defined it in reverse. The SEC was looking at it from the fund perspective. It just defined it in reverse. Not only was it the opposite of what is in the SSAPs, but it was also the opposite of the general market convention. The SVO wants to align it with the SSAPs.

Michael Reis (Northwestern Mutual), representing the American Council of Life Insurers (ACLI), said the ACLI supports adoption.

Spudeck made a motion, seconded by Andersen, to adopt the P&P Manual amendment to clarify the meaning of repurchase agreements in the derivatives transaction definition for funds in Part Three (Attachment One-A). The motion passed unanimously.

2. Receive Comments on a P&P Manual Amendment to Update the Definition of an NAIC Designation

Mears said agenda item number two is to receive comments on a proposed P&P Manual amendment to update the definition of an NAIC designation. Once comments are received, direction will then be given to the Task Force. Mears noted that because referrals were mentioned in the letters, the amendment was referred to the Capital Adequacy (E) Task Force, the Risk-Based Capital (RBC) Investment Risk and Evaluation (E) Working Group, and the Statutory Accounting Principles (E) Working Group. The Valuation of Securities (E) Task Force requested that these groups let the Task Force know if the definition meets their needs. If the definition meets their needs, no response needs to be submitted; if the definition does not meet their needs, these groups should notify SVO staff. The Task Force gave a date of June 29 for each group to notify that it may be proposing a modification to the definition of an NAIC designation or request additional time. The Capital Adequacy (E) Task Force distributed the referral to its members and requested comments or recommendations on the definition of an NAIC designation by June 19, and no comments were received. The RBC Investment Risk and Evaluation (E) Working Group and the Statutory Accounting Principles (E) Working Group also distributed the referral to their members and requested comments and recommendations on the definition by July 7, and no comments were received. As no comments have been received nor indications that comments are forthcoming, the Task Force can presume that there will be no further comments, but it certainly will listen to any issues or anything that may arise from these groups if they still were to arise. Mears noted that a joint comment letter was received from the ACLI, the Private Placement Investors Association (PPIA), the North American Securities Valuation Association (NASVA), and the Structured Finance Association (SFA), as well as letters from Athene and Anderson Insights.

Therriault said, as mentioned in the last Task Force meeting, NAIC designations are explained and defined in both Parts One and Two of the P&P Manual. In this amendment, the SVO proposed consolidating the explanation and definitions to make a single uniform definition in Part One that captures all policies and concerns of the Task Force in one place. The amendment added clarifications as to the meaning of an NAIC designation, including their use, purpose, and the risks they address, as these attributes should also be policies of the Task Force, and it explains why NAIC designations are different from credit rating provider (CRP) ratings. The consolidation included the incorporation of the “NAIC Designation Subscript S” illustrations in Part Two into the “NAIC Designation Subscript S” subsection, of “NAIC Designations” in Part One because the description of other nonpayment risk is also a policy of the Task Force. Most of the updates in the amendment involve existing language that was either moved, consolidated, or eliminated if there was redundancy. The new text primarily clarifies the regulatory meaning and objectives of an NAIC designation and expands on the existing guidance. These changes were highlighted in yellow.

Reis, representing the ACLI, the PPIA, NASVA, and the SFA, said there are two related issues, which he will take separately: 1) the changes to an NAIC designation; and 2) Subscript S. He acknowledges that these are somewhat the same and interrelated, but he believes it is easier to address them separately. The three proposed changes to the NAIC designation are: 1) an NAIC designation should reflect the probability of default; 2) it should reflect tail risk; and 3) to a lesser extent, it should be in the context of the NAIC Policy Statement on Financial Regulation

Standards (SFRS) and other NAIC guidance. Part of the challenge for constituents is there was no reason given for the changes. Therefore, the impact, if any, is not understood. For example, if a rating agency used loss given default (LGD) in its methodology, there is the question of whether that means it does not comply with the probability of default and is therefore void. Reis noted that the RBC factors were determined using LGD. If nothing changed, then there is nothing to object to. However, if something changed, that should be understood.

The Capital Adequacy (E) Task Force did not comment about whether the proposed definition changes met their needs. The Task Force was asked to weigh in if anything in the proposed definition changes what an NAIC designation represents (e.g., the LGD versus probability of default or the tail risk), how that would be assessed, whether it would be similar, and whether that would be assessed similarly for a credit issuance bond or the same for asset-backed securities (ABS). If the proposed definition changes anything, another referral can be requested of the Capital Adequacy (E) Task Force or some acknowledgment that nothing changed and why.

Related to Subscript S nonpayment risk, included was a letter that was previously submitted. It is unclear if those questions were answered. This is a big change from what the P&P Manual says, and it is a big change in practice, or at least it could potentially be. It is also a big change from a comprehensive study with conclusions reached by the Valuation of Securities (E) Task Force back in 2008.

The comments distinguish between individual credit risk and portfolio risk. For example, interest deferral may be of interest to state insurance regulators if there are a lot of interest deferral securities. If it is being reflected in asset adequacy testing (AAT), that would be very different from a security with nonpayment risk (e.g., perpetual bonds), where it could miss payments and there are no repercussions. There is an agreement that would be nonpayment risk, and it should possibly be notched, but it is unclear if there is appropriate distinguishment, especially if this proposal means that all interest deferral bonds, all 40-year bonds, and all things that are listed as Subscript S would have to be filed with the SVO. The intent is not really understood, and the ask is twofold: 1) work collaboratively with the Task Force and the SVO on this; and 2) make sure everything is transparent and understood. This begs the question of whether that means 40-year bonds are filed or if that is portfolio risk versus individual credit risk. That is the summary of the letters, and the groups want to be constructive and work with the Task Force and the SVO to address the concerns.

John Golden (Athene) said Athene is right where the joint trades are in terms of the overarching concerns regarding Subscript S. The only thing to add on top of that are the concerns at the higher level above that, which is how to ensure a consistent framework across asset classes that are properly interpreted in the principle of equal capital for equal risk. Looking at a feature like Subscript S, it effectively has a notching right, that presumes that there is a consistent framework where rating agencies have a clear role, as defined, and state insurance regulators, the SVO, and everybody knows how they operate. For that reason, it is premature to have the proposal with a notching right when the basics of who does what under what methodology and how that interrelates with capital charges but also the broader RBC framework. It is hard to really understand how a notching right can be presented at a point where some of these basic foundational issues remain. A larger workstream is proposed that will oversee all the changes that are going on that are parallel across multiple different groups and ideas and functions to bring all of these workstreams together into an overarching look at the framework in its entirety. The rating agencies have a very significant role to play in this framework and the capabilities to perform the primary credit risk assessment across all asset classes effectively that are able to be rated at all. As a structural matter, the state insurance regulators and the SVO, in concert, should have better tools and more governance to oversee rating agencies, interact with them, and make sure they are meeting the credit risk and regulatory assumptions and principles that are set out by the NAIC. When there are bifurcations in how credit risk is determined, by whom or under what methods, or what tools apply to some asset classes or others, those are large concerns.

Mears said Athene's comments focused on the Subscript S component of the proposal, and she asked if Athene had any comments related to the NAIC designation definition itself. Golden said when thinking about how capital is ultimately set in the insurance industry, there are three things needed: 1) who is doing the assessment, because who is doing it matters; 2) under what method: a) intrinsic price; b) Moody's Investors Service (Moody's) methodology; c) Standard & Poor's (S&P) methodology; or d) something else; and 3) how that ultimately relates to the capital charges that were set up. All three of those things are now being proposed to effectively float relative to each other in some way. That is a very big problem in the long run. It is not a regime where there is a clear demarcation of lines and separation of duties and oversight. Sometimes there are people doing certain things depending on what asset class that is. When you think about what an NAIC designation is, it starts with basically what is a rating and then where the NAIC designation needs to be different than a rating. The question that should be asked in a very broad way is what it is that is trying to be solved with that rating versus an NAIC designation. If there is something about the rating agencies that they are doing that does not meet the regulatory objectives of an NAIC designation, a conversation should be had about that.

Chris Anderson (Anderson Insights) said the first thing to note is that there should be a clear definition of what is meant by an NAIC designation. Thinking about the charges of the Task Force, it has the ability to consider all kinds of metrics for assets under charge 4. Under charge 7, of which it is charged with coordinating with other working groups, such as the Capital Adequacy (E) Task Force, the Statutory Accounting Principles (E) Working Group, etc., it is also charged with ensuring that the objectives of its guidance is incorporated into the P&P Manual. It seems that the P&P Manual is looked at first before coordinating on a simple definition of what is meant by an NAIC designation. The principal user of NAIC designations is the Capital Adequacy (E) Task Force because it is used for the R1 and C1 factors. Therefore, when the Valuation of Securities (E) Task Force had that discussion with the Capital Adequacy (E) Task Force, the question was what does the Valuation of Securities (E) Task Force expect the Capital Adequacy (E) Task Force will say it wants in a simple definition. Because the rating agency ratings were used as a basis for R1 and C1 factors, even as it was recently revised, the Capital Adequacy (E) Task Force used essentially ratings of corporates, so the question is whether that is all the Task Force might want to have and is it adequate for the Task Force. That is the Task Force's call. The Task Force should be deciding what the basis for NAIC designations should be in the definition for NAIC designations. It has been said several times that NAIC designations are part of RBC, but RBC is a blunt instrument, so it is not necessarily precise. Additionally, because the Capital Adequacy (E) Task Force is such an important constituent, the definition should probably be tailored to its needs rather than the needs of someone who is developing this.

When thinking about credit, credit is risk of nonpayment. It is whether the investor is going to get paid. An analyst starts with the term sheet and moves on to the prospectus looking at all the terms and conditions in the transaction, not just maturity but every element. Those are all considered. They are considered by the analyst, the analyst supervisor, and the credit committee, and they all decide what the risk of nonpayment is from 1 to 10. The NAIC has had some differences and has acted through the Statutory Accounting Principles (E) Working Group to redefine bonds. Therefore, there are things rating agencies may have rated, and now thanks to the efforts of the Capital Adequacy (E) Task Force and the Statutory Accounting Principles (E) Working Group, those are going to be knocked out. However, the risk of nonpayment is credit risk, and there is not much more to it. When it comes to other risks of investing, and this is something that Reis referred to, there was a study of risks of individual investments, and credit risk is certainly one of those. The Capital Adequacy (E) Task Force will probably tell the Valuation of Securities (E) Task Force that is at the heart of what they would need. There is also call risk, and call risk could be identified. This could be very significant in the future. Coming off a high interest rate environment, it would be a negative thing for insurers to have their bonds called away as rates go down. Perhaps Subscript S could be used to indicate call risk. It is not credit risk, but it could be material. Currency risk is another way Subscript S could be used. If it could be identified that Subscript S one or Subscript S two indicates that there is currency risks, an examiner looking through a statement could see that there is a risk of currency. Something that may be more difficult is liquidity risk. Liquidity risk would be very interesting on a bond-by-bond basis. If an

examiner were looking at the overall liquidity needs of an insurer, and if they had great liquidity needs, then their assets should match that. The issue with a Subscript S for liquidity is the problem of coming up with a measure of liquidity. The SVO, according to its budget, looks at about 12,000 to 13,000 bonds, but for the rest of the universe, it might be hard to find liquidity. The other measures—extension risk, leverage, and event risk—are relatively hard to come up with a Subscript S, but there needs to be a consensus as to what the core of a definition is. If the Capital Adequacy (E) Task Force is looking at a simple definition instead of complicated P&P Manul language, it would probably come close to credit, but that is the Task Force's call. As for Subscript S, there is a use for it; it is not credit, but perhaps it can be used for other purposes such as call, currency, and maybe liquidity.

Mears said following the lead of the ACLI and the various trade groups included on their letter, and talking separately about Subscript S versus the broader NAIC designation definitions, she has been a big proponent of the type of information that Subscript S has to offer for some time, and she has used deferred interest or payments in kind as an example of that. It is an example of the type of information that the SVO has the tools to identify via the multitude of filings that come its way—i.e., private letter ratings and things like that—where it can really be that type of investment characteristic. That is an example, but it broadly refers to a whole host of investment characteristics that are included under Subscript S, as it was written in this proposal and probably ones beyond that as well. State insurance regulators have an interest in this information. Many recognize that it is not always going to result in the need to change the NAIC designation. For example, as Reis noted, if a company has a concentration in assets that can defer payments beyond what would be a normal expected schedule for cash flows, that certainly has implications for cash flow testing. That is the kind of information state insurance regulators would expect to come out of this Task Force with guidance from the SVO and its teams to define where to go from there. For example, a formal letter from the Life Actuarial (A) Task Force of how to incorporate these risks when materiality or exposure is growing is something that could be addressed. The ACLI, the PPIA, NASVA, and the SFA noted in their letter that it may be more of a portfolio risk than an individual investment; regardless, it is certainly imperative that state insurance regulators have a way of receiving this information.

There have been a multitude of comments around the specificity of the Subscript S and what it is supposed to intend, what it actually intends, and what actions or policies are associated with it, and it is a source of confusion. It is understood that if it were in place, it would not be complete because it would be something that would be manually applied by the SVO and then would not necessarily be applicable to all the filing exempt (FE) securities. If state insurance regulators are getting a Schedule D and looking for Subscript S, they would realize that that is not really a representation of the population that has such characteristics as a whole within that insurer. Also, it being a singular letter, it is difficult to say which one of these characteristics it is applicable to. Mears asked for Task Force members' thoughts on the value of having this information shared with state insurance regulators via the Subscript S or to think through more holistic ways of getting this information that fall into normal information sharing that occurs between the SVO and the Task Force and how the Task Force can disseminate to other working groups. For example, payment in kind is something the Life Actuarial (A) Task Force is starting to look at now based on conversations that have occurred within the Valuation of Securities (E) Task Force over the last year or so. Mears said she appreciates the concerns around the Subscript S, and she is not sure it is necessarily fully needed to give the value that the Task Force hoped to get from other directions, including guidance from the SVO of observations that it is making and things the Task Force can discuss internally and then escalate as needed. She asked if Task Force members had any related thoughts to ultimately provide direction back to the SVO.

Andersen said as a reviewer of cash flow testing, that information would be helpful. He said he does not fully understand the pros and cons of this exact approach, but it seems like it is the information that is needed. Mears said it was her sense that that really was not debatable and did not get the sense from interested parties that that is something they had an issue with.

Reis said transparency is not the issue. The issue is the transparency of Subscript S, and that gets further complicated if they all need to be filed and they are going to be notched. That is different than what Mears and Andersen talked about.

Mears agreed and said the Task Force can provide direction to the SVO to consider that and see what kind of revisions could be made to ensure that there are mechanisms for Task Force members and beyond to receive information from an education standpoint, identify emerging characteristics that could pose risk to the regulatory framework as the SVO team sees them, and escalate them to the Task Force or more broadly and put together mechanisms internally to help aggregate them, recognizing that this particular mechanism is not necessarily the most efficient way to do that. Task Force members should consider this and bring any thoughts on the direction they would want back to the Task Force before exposing a different proposal. Second, the definition of a designation itself is an area that is incredibly important and underlies a lot of the discussions that have been had to date as the Task Force talks about working with CRPs, talking about how NAIC designations are different than ratings in what their ultimate purpose is. A rating is created as a measure of credit risk, and it is delivered into the NAIC insurance framework, and in many cases, it is fully appropriate for the NAIC's needs to pass through the NAIC designation process, ultimately to be used for RBC, state investment code restrictions, assumptions, and AAT. However, it is important to realize that the uses of those NAIC designations are different than what a pension plan would use a rating for in terms of measuring asset allocation and from a quality perspective. One of the intents of these definitions is to create that ground level understanding, and that was the feedback that came through some of the comment letters, particularly from Anderson Insights, saying it should start with something very straightforward that really drives what the designation is. Mears said that is the intent. In terms of some of the comments from the ACLI, the PPIA, NASVA, and the SFA of including LGDs, that is a reasonable suggestion. It would be from a consideration standpoint the same way that the tail risk component was because it is talking at a base level and noting that an NAIC designation, when appropriate, would consider the use of an LGD metric versus just the probability of default. It would not necessarily spell out the technical provisions of how the SVO would implement that; that would have to be a separate process. That goes back to the point that this is an underlying foundational definition. Mears encouraged Therriault and the SVO to put together some language that would address that and work with the ACLI, the PPIA, NASVA, and the SFA to see if that aligns with what their expectations would be. Similarly, there were questions on the inclusion of the tail risk component, which was also meant to be a consideration. There were some questions of how that type of attribute would work on a practical basis, and that was not the intent of these designation definitions because it was more based on an understanding of the types of components that would be in an NAIC designation. It was not intended that the Task Force would answer these questions to have a definition in place, but further feedback would be welcomed, as it is reviewed in that context. Lastly, once that is complete, the definition can be brought back to the Capital Adequacy (E) Task Force, and it can be asked informally if the definition is aligned with its expectations and that it fully understands what this definition entails. That addresses to some extent what is in the letters, and it provides some direction back to the SVO to clean up those definitions. That should not result in many major changes to that section, but the SVO can work directly with interested parties to get to some verbiage that makes sense. Catrone agreed with the direction.

Reis said the ACLI, the PPIA, NASVA, and the SFA are happy to work with the SVO. First, there was a lot of debate amongst the constituents about whether there was even a problem. One could argue that probability of default is sort of a subset of LGD, but not the other way around, so it may not change. However, there is a meaningful constituent group that wants to understand if this changes things. As Mears suggested, this is foundational, and change may come later, but the two-step process is a little worrisome to some.

Mears said the Task Force is trying to take a step back and say any future actions, not ones that are already contemplated and not there yet, should be able to look back to a baseline definition of an NAIC designation to understand why those actions would take place. It is not necessarily that this is starting here because there are

already steps two, three, and four in terms of policies that are forthcoming. This is trying to take that step back and say here is that foundational basis, and for future actions, whenever they happen, the Task Force would be able to point to this to say where it fits in.

Anderson said he believes that direction is fine. One of the reasons it is important to go to the Capital Adequacy (E) Task Force because that is part of the R1/C1 calculation; first, they look at probability of default, and then there is a charge or a valuation of the LGD. The Task Force might find that that is already baked into how RBC is done. Double counting is not necessarily a problem; it is conservative.

3. Heard a Staff Report on Updates on the Proposed CLO Modeling Methodology and Ad Hoc Working Group

Mears said agenda item number three is to hear updates on the proposed collateralized loan obligation (CLO) modeling methodology and updates from the CLO Ad Hoc Group.

Eric Kolchinsky (NAIC) said there was a meeting of the CLO Ad Hoc Group that morning. NAIC staff suggested adopting a no prepayment and no discount purchase approach. That is memorialized in a memo on the CLO website. Feedback was also requested from interested parties on a setup of scenarios, as well as the probabilities, which is going to be the next step in the process. The process so far has been great, and there has been really good feedback and a good relationship with working parties.

Mears said she has one additional point since that was seemingly still a source of confusion, given the different workstreams in place. She said for this modeling process, the focus is more on the rated notes of the CLO, which would be ultimately assigned an NAIC designation by the process that comes out of this Task Force. However, the Valuation of Securities (E) Task Force is not responsible for setting RBC factors. There were some questions about another hot topic, the residuals of CLOs, or more broadly of other securitizations, which was discussed within the RBC Investment Risk and Evaluation (E) Working Group and how that would be incorporated into this CLO Ad Hoc Group. There is a back-and-forth working with the Working Group, but it is not the Task Force's responsibility to set capital factors. The way residuals are held without an NAIC designation, without a credit assessment associated with those, means that the Task Force would not be setting factors now or in the future. If there is information that comes out of this process, or the American Academy of Actuaries (Academy), which is working with the Working Group, it could feasibly utilize that for informational purposes while going back through findings. It should be very clear that that is not an anticipated output from this process from the Task Force perspective.

Having no further business, the Valuation of Securities (E) Task Force adjourned.

SVO


NAIC
 NATIONAL ASSOCIATION OF
 INSURANCE COMMISSIONERS

TO: Carrie Mears, Chair, Valuation of Securities (E) Task Force
Members of the Valuation of Securities (E) Task Force

FROM: Charles A. Therriault, Director, NAIC Securities Valuation Office (SVO)
Marc Perlman, Managing Investment Counsel, NAIC Securities Valuation Office (SVO)

CC: Eric Kolchinsky, Director, NAIC Structured Securities Group (SSG) and Capital Markets Bureau

RE: Clarify the meaning of Repurchase Agreement in the Derivatives Transaction Definition for Funds in Part Three of the *Purposes and Procedures Manual of the NAIC Investment Analysis Office*

DATE: April 28, 2023

Summary: In 2021 the Task Force adopted amendments to the NAIC Fund Lists section of the Purposes and Procedures Manual of the NAIC Investment Analysis Office (the “Purposes and Procedures Manual”) to provide greater clarity and predictability regarding the acceptable use of derivatives in funds and permit funds greater flexibility in their use of derivatives while maintaining limits on funds’ use of leverage. The SVO now proposes a new amendment to clarify which side of a repurchase agreement constitutes a derivative transaction for purposes of the section.

The definition “Derivatives Transaction” in the Purposes and Procedures Manual was modeled after the SEC definition in Rule 18f-4 under the Investment Company Act of 1940. The Purposes and Procedures Manual definition reads:

Derivatives Transaction – means: (1) any swap, security-based swap, futures contract, forward contract, option, any combination of the foregoing, or any similar instrument (“*derivatives instrument*”), under which a fund is or may be required to make any payment or delivery of cash or other assets during the life of the instrument or at maturity or early termination, whether as margin or settlement payment or otherwise; (2) any short sale borrowing; and (3) *any reverse repurchase agreement or similar financing transaction* [Italics added for emphasis].

One purpose of the original amendment was to limit the use of leverage by funds and, therefore, “Derivative Transactions” encompasses instruments pursuant to which a fund may be required to make a future payment of cash or other assets. Likewise, the inclusion of “reverse repurchase agreements” was intended to capture arrangements by which the fund would owe a future cash payment to the counterparty.

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According to the SEC definition in the Rule 18f-4 adopting release, “In a reverse repurchase agreement, a fund transfers a security to another party in return for a percentage of the value of the security. At an agreed-upon future date, the fund repurchases the transferred security by paying an amount equal to the proceeds of the initial sale transaction plus interest.” However, according to SSAP No. 103R - Transfers and Servicing of Financial Assets and Extinguishments of Liabilities, “Reverse repurchase agreements are defined as agreements under which a reporting entity purchases securities and simultaneously agrees to resell the same or substantially the same securities at a stated price on a specified date.” The SSAP No. 103R reverse repurchase agreement definition is the opposite of the SEC definition. According to SSAP No. 103, “Repurchase agreements are defined as agreements under which a reporting entity sells securities and simultaneously agrees to repurchase the same or substantially the same securities at a stated price on a specified date.” The SAPP No. 103R definition of repurchase agreement matches the SEC definition of reverse repurchase agreement, in which the fund is obligated to make a repurchase payment at a later date.

Recommendation: To maintain consistency between the Purposes and Procedures Manual and SSAP No. 103R and eliminate any misconception that a fund cannot be the purchaser of securities/lender of cash, the SVO proposes the following changes to the NAIC Fund Lists section of the Purposes and Procedures Manual. The proposed text changes to P&P Manual are shown below with additions in red underline, deletions in ~~red strikethrough~~ as it would appear in the 2023 P&P Manual format.



PART THREE
SVO PROCEDURES AND METHODOLOGY FOR PRODUCTION
OF NAIC DESIGNATIONS



NAIC FUND LISTS

...

REQUIRED DOCUMENTATION, ANALYTICAL PROCEDURES AND ELIGIBILITY CRITERIA

...

Definitions

...

293. **Derivatives Transaction** – means: (1) any swap, security-based swap, futures contract, forward contract, option, any combination of the foregoing, or any similar instrument (“derivatives instrument”), under which a fund is or may be required to make any payment or delivery of cash or other assets during the life of the instrument or at maturity or early termination, whether as margin or settlement payment or otherwise; (2) any short sale borrowing; and (3) any ~~reverse~~ repurchase agreement under which the fund sells securities and simultaneously agrees to repurchase the same or substantially the same securities at a stated price on a specified date, or similar financing transaction, irrespective of accounting treatment.

https://naiconline.sharepoint.com/teams/SVOVOSTaskForce/Shared Documents/Meetings/2023/2023-08 Summer NM/Minutes/Attachment Two-A 2023-006-01 PP Manual Amend - Funds_Repos_v2.docx

Draft: 6/12/23

Valuation of Securities (E) Task Force
Virtual Meeting
May 15, 2023

The Valuation of Securities (E) Task Force met May 15, 2023. The following Task Force members participated: Doug Ommen, Chair, represented by Carrie Mears (IA); Eric Dunning, Vice Chair, represented by Lindsay Crawford (NE); Lori K. Wing-Heier represented by Jeffery Bethel (AK); Mark Fowler represented by Sheila Travis (AL); Ricardo Lara represented by Laura Clements (CA); Andrew N. Mais represented by Kenneth Cotrone (CT); Michael Yaworsky represented by Ray Spudeck (FL); Dana Popish Severinghaus represented by Vincent Tsang (IL); James J. Donelon represented by Stewart Guerin (LA); Kathleen A. Birrane represented by Matt Kozak (MD); Grace Arnold represented by Fred Andersen (MN); Chlora Lindley-Myers represented by Debbie Doggett (MO); Jon Godfread represented by Matt Fischer (ND); Marlene Caride represented by John Sirovetz (NJ); Adrienne A. Harris represented by Jim Everett (NY); Glen Mulready represented by Diane Carter (OK); Carter Lawrence represented by Trey Hancock (TN); Cassie Brown represented by Amy Garcia (TX); Jon Pike represented by Jake Garn (UT); Scott A. White represented by Doug Stolte (VA); Mike Kreidler represented by Tim Hays (WA); and Nathan Houdek represented by Amy Malm (WI).

1. Discussed and Exposed a Proposed P&P Manual Amendment to Update the Definition of an NAIC Designation

Mears said the first item on the agenda is to discuss and consider for exposure a proposed *Purposes and Procedures Manual of the NAIC Investment Analysis Office* (P&P Manual) amendment to update the definition of an NAIC designation.

Charles Therriault (NAIC) said NAIC designations are explained and defined in Part One and Part Two of the P&P Manual. The drafted amendment proposes consolidating the explanation and definition into Part One of the P&P Manual because they are policies of the Task Force. The amendment includes clarifying the meaning of NAIC designations, including their use, their purpose, and the risks they address.

When the new format of the P&P Manual was adopted on Nov. 16, 2018, and published on April 7, 2019, there were several changes made to simplify the P&P Manual. It has since become apparent that some of those changes have led to the interpretation that there are really two meanings of an NAIC designation. One meaning, found in Part One, is applicable to all securities whether assigned an NAIC designation pursuant to the filing exemption (FE) process or by the Securities Valuation Office (SVO). A second meaning, found in Part Two, is applicable only to securities assigned NAIC designations by the SVO.

It is the SVO staff's view that there is only one definition of an NAIC designation, and that is applicable to whatever manner the NAIC designation is assigned. The revisions proposed in the amendment consolidate the instructions defining an NAIC designation creating a single, uniform definition which includes updates that address questions and concerns raised over the years as to the purpose of an NAIC designation versus credit rating provider (CRP) ratings.

Additionally, the SVO recommends consolidating the current NAIC designation subscript "s" definition for other nonpayment risks in Part Two into the consolidated NAIC Designation section in Part One because the application of the subscript "s" to assign an NAIC designation for other nonpayment risks signifies a change in the meaning of the designation, but it is also the policy of the Task Force. Most of the updates in the amendment involve existing language that was either moved, consolidated, or eliminated due to redundancy.

The new text clarifying the regulatory meaning and objectives of an NAIC designation and expansions of existing guidance are highlighted in yellow to try to make that distinction. A clean version is included at the end of the amendment, which removes all the language that has changed location and highlights only the new text in yellow. The SVO recommends exposing the amendment for a public comment period. As the Task Force continues its communication efforts with the Statutory Accounting Principles (E) Working Group and the Capital Adequacy (E) Task Force, the SVO also recommends referrals to those groups.

Chris Anderson (Anderson Insights LLC) said he had some comments and submitted a letter on this topic on Dec. 5, 2022. He said he agreed with staff that an NAIC designation would benefit from clarification, and there should be a single meaning for NAIC designations. He said he also agreed on the need for consolidation. He said he agrees on key points, and simplification is a valid and achievable goal, which was proposed in his letter. He said the appendix of the letter identified numerous examples in the present P&P Manual that referred to NAIC designations as measures of credit risk or credit quality, and the language in that letter was completely consistent with those concepts that are already in the P&P Manual.

What the proposed language does not reflect is that there are such things as other risks of nonpayment. This completely illogical concept found its way into the P&P Manual some years ago. Credit ratings reflect the risk of nonpayment regardless of the reason. That is what credit ratings are: opinions of the risk of nonpayment. Credit analysts are responsible for assessing the likelihood of any possible reason for nonpayment. There are huge numbers of these factors, and they are security specific. Further, they are all incorporated into credit ratings, as that is what credit ratings are. In the past, there may have been valid concerns about whether a payment was promised, but these are being addressed by the Statutory Accounting Principles (E) Working Group, which is devising tighter standards for what constitutes the debt obligation. The proposed P&P Manual language and the Dec. 5, 2022, letter clarify and simplify it by retaining clear definitions. This should be a welcome relief because it proposes deleting redundant and unnecessary language. Anderson requested that the Task Force expose both versions of the proposed language, meaning the staff version and the version in the Dec. 5, 2022, letter.

Mears confirmed that the Dec. 5, 2022, letter was included in the packet, and she said the letter will be part of the exposure.

Malm made a motion, seconded by Clements, to expose the proposed amendment to update the definition of an NAIC designation in the P&P Manual for a 45-day public comment period ending June 30. The motion passed unanimously.

2. Discussed and Exposed a Proposed P&P Manual Amendment Authorizing the Procedures for the SVO's Discretion Over NAIC Designations Assigned Through the FE Process

Mears said the next item on the agenda is to discuss and consider for exposure a proposed P&P Manual amendment authorizing the procedures for the SVO's discretion over NAIC designations assigned through the FE process. This proposal stems from the Financial Condition (E) Committee's new charge that was given to the Task Force to establish the criteria to permit staff discretion over the assignment of NAIC designations. The new charge also aligns with the current Task Force policy applicable to the FE process, which is found in the P&P Manual, Part One, paragraph 80. It states:

The VOS/TF is resolved that the benefit obtained from the use credit rating in state regulation of insurance must be balanced against the risk blind reliance on credit ratings. To ensure the Task Force properly understands the composition and risk of the filing exempt securities population; promote uniformity in the

production of NAIC Designations, reduce reporting exceptions for filing exempt securities and increase the efficiency of this NAIC process, the SVO and SSG (hereafter, the IAO) is charged with administration of the filing exempt process defined in Part Three of this Manual.”

In keeping with these policies and to provide a little bit more history on how the Task Force effectively got here, during the Spring National Meeting, there was a discussion on a proposed amendment for Structured Equity and Funds. That proposed amendment was based on a type of investment the SVO had identified through its review of private letter rating rationale reports, and as the Task Force directed as part of that process, when the SVO finds a significant potential issue, the SVO should bring that issue to the Task Force, along with a proposed solution. The proposal was to remove Structured Equity and Funds from FE.

The response from industry was that scoping was very difficult to do because it was effectively identifying a structure rather than the potential underlying risk that could be embedded underneath. One of the examples given was putting collateralized loan obligation (CLO) combination notes into this type of structure, which subverts the type of regulation that those are already subject to as being non-FE. It was acknowledged that these structures are clearly utilized broadly for many investments that, upon review, would be a valid use of the FE process. The Task Force heard those comments and understood and recognized that scoping can continue to be an issue as the Task Force looks at things that are more embedded in different types of structures, and it is difficult to draw lines around where those need to be without pulling in other types of investments and making that scope much too large. The Task Force directed the SVO staff to draft a distinct process on how it would recommend challenging an NAIC designation that was assigned from a CRP rating in the FE process on more of a case-by-case basis. The request was that the SVO define this in a way that is easily followable; is a well-understood process; acknowledges that, in many cases, there may just be more information needed; and allows a dialog between the insurer and the SVO.

Mark Perlman (NAIC) said to address the current blind reliance on credit ratings, the proposed amendment outlines the process by which a state insurance regulator or SVO staff member can contest an NAIC designation assigned through the FE process that it believes is not a reasonable assessment of the risk of the security for regulatory purposes. Following a notice period and optional appeal by the insurer security owner, the Eligible NAIC CRP Credit Rating or the security's FE eligibility could be maintained or revoked by the SVO in consultation with the appropriate state insurance regulator, if requested. If the final decision is to revoke FE eligibility, the insurer would then have the option of filing the security with the SVO for an assignment of an NAIC designation. An insurer can appeal revocation in a subsequent filing year. In order to limit the SVO's use of this process to only what would be considered truly material differences of opinion, the SVO would only be able to put a security or CRP rating on notice if it determines, based on the information at hand, that the CRP rating used in the FE process is three or more notches different than the SVO's assessment. Additionally, insurers would be allowed to appeal the SVO's initial assessment to ensure due process. Once notice is given to insurers that a security is under review, the insurer would have up to 120 days to appeal the SVO's assessment by introducing additional information and data, as necessary. This 120-day appeal period is similar to the existing one for SVO-assigned NAIC designations. At the request of the Task Force chair, the SVO would provide a report in a regulator-to-regulator meeting of the Task Force, summarizing the Eligible NAIC CRP Credit Ratings and securities removed from FE eligibility over the prior calendar year and the reason for the removal.

Mears said she would add some additional comments based on some preliminary feedback that has been received. When the idea of this concept was introduced at the Spring National Meeting, it was based on discussions of private investments and private letter ratings. One of the initial questions was if this was a broader proposal and would be inclusive of public ratings. If there is going to be an overarching process, which this proposal is introducing and as was discussed at the Spring National Meeting, then it should be consistent across the board to include all of FE. There is currently a red light response with everything removed from FE, or there is a green

light response for everything that is allowed for FE. This proposal would be somewhat of a middle ground or yellow light. The use of private letter ratings, or certain types of private structures, may more likely make up some of the transparency questions that have arisen, and there is a reason to dig into those more. However, if something was found that should be challenged, and that challenge was upheld, then that same concept exists in public securities and should be treated consistently. Private letter ratings may be the start of many reviews, but in the end, the Task Force should be agnostic of whether it is a public or private investment.

Second, as this is put out for exposure and interested parties review and provide feedback, that feedback should provide alternatives, where necessary. There may be instances where the process itself makes sense, but perhaps there may be different components, such as the timing, the type of information, or how that due process works, that need changes. If there are specific concerns with any of those steps, please provide alternatives that would address those concerns. Similarly, the Task Force has been talking for some time about how to address some of the securities out there without taking perhaps too expansive of a view by removing investments from FE. This proposal is to address that concern. If there is a better way to achieve that objective and this proposal is not quite there, comments are welcome; however, it is asked that potential alternatives offered are actionable so they can be reviewed. If one agrees or disagrees with this entirely, that could be in the comment letter as well. It is very helpful when actionable feedback is received. Given the importance of this topic, this will be exposed for a 60-day public comment period and discussed again at the Summer National Meeting in August.

Martin Carus (Martin Carus Consulting LLC) said he is a policyholder, an investor in insurance companies, and a taxpayer. He noted that there is a proposal on the table but no indication of its cost. He asked what this is going to cost and how policyholders are going to benefit. He said there is no cost laid out, and there are no benefits there. It was indicated that this was a very important matter. Carus said he did not see this as a very important matter because he did not see any benefit coming from it. He wondered why this proposal needed to be made at all. FE has been around for a couple of decades, and it has not been a problem. Carus said he has not heard of any company, in any way of its investments, going broke or having its risk-based capital (RBC) materially or even slightly overstated by using the FE process.

Mears said this is something the Task Force has been talking about for quite a bit of time. It is more expansive than just the Task Force. More broadly, there has been a fairly sizeable strategic shift in investments, probably in reaction to a lot of things that the investment managers can speak to, that have driven insurers to more private assets, with the benefit of taking on some more liquidity risk or potential complexity risk, to garner additional returns for insurers that then get passed on to policyholders. That is ultimately beneficial. On the other side, the NAIC's framework, across the board, was not designed for the complexity of these investments or the magnitude at which they are being held. One example is structured securities, which is being addressed elsewhere outside of this proposal. Speaking to some of the broader initiatives that are in place, regulations, as a standard, are always very reactionary. State insurance regulators are not innovators, and they are not going to be proactive. The role is to observe shifts within the market where different materiality increases and then address those issues.

Carus asked how this is going to affect the market if the investor cannot be sure of what they are going to get because the SVO comes in and says that this is now going to be taken out of FE. He asked what that is going to do to the investment marketplace. He also asked whom he is supposed to trust if he is dealing with an insurance company - the SVO's judgment as to whether something is too complicated or not evaluated as to its risk appropriately or the industry and the rating agencies that employ a hundred times or a thousand times as many investment analysts that are credentialed to do that. Carus said this is a way for the SVO to gum up the works in the investment marketplace, and he does not see anything wrong with the FE. If investments come along that are so complicated, there is always a dialogue between the industry and the investment community, and the SVO lays it out for them.

Mears said she would welcome a comment letter from Carus. She said this proposal is a reaction to those same concerns, and there is a dialogue in place as each of these is identified. Currently, when the Task Force tries to do it at a higher level, it creates scoping concerns. Due to the Task Force's efforts, this works as a middle ground to help state insurance regulators further understand where potential issues may arise. It is appreciated that many investors and insurance companies are doing a fantastic job in trying to find returns for their policyholders in a way that is measured, but there are instances where that is not the case. There was an example of a liquidation that occurred due to a lack of transparency in their private investments and how those were designated.

Carus asked if that was a single case, and he added that, from a market perspective, that single case had absolutely zero impact on the marketplace. Mears said it did have an impact on those policyholders, and she would welcome the comment letter.

Spudeck asked Therriault if commercial mortgage-backed securities (CMBS) were at one point FE. Therriault confirmed that they were, and he said residential mortgage-backed securities (RMBS) were also once FE. Spudeck asked Therriault if he believes there might have been a capital hit on the broader industry as a result of the financial crises in 2008, 2009, and 2010. Therriault said it was quite substantial at the time. Spudeck asked if this could have been addressed through this proposed framework. Therriault said yes.

Mears said, as noted and observed here, it is expected that there will be a variety of comments on this proposal, and she would appreciate alternatives provided when feasible.

Andersen said he had a few specific points on the question of whether this should be exposed for comment in its present form, and they relate to the objectives, practicality, and environmental, social, and governance (ESG) concerns. The proposal makes references to reasonable assessments of the risk of a security for "regulatory purposes." The meaning of credit ratings is clear and well-defined, whereas the risk for regulatory purposes is definitely not well-defined or well-understood. It is inappropriate to use that as the standard to "challenge" the ratings of nationally recognized statistical rating organizations (NRSROs), which is being proposed here. Credit ratings indicate what staff have been calling the risk of nonpayment; i.e., nonpayment for any reason. That is a regulatory concern when it comes to bonds' nonpayment. A credit rating should be assessed based on what it is: an opinion of relative creditworthiness. Further, NAIC designations are what FE ratings become. The ratings are intended to be used as measures of nonpayment risk, and they are uniform with C1 and R1 RBC factors. The R1 and C1 RBC factors are based on credit history, so it is unreasonable to attempt to use standards other than credit risk to determine NAIC designations.

Andersen's said that he questions the practicality of what is being proposed here. Specifically, the NAIC's Investment Analysis Office (IAO) has proposed three methods for implementing this proposal. There has been no demonstration that any of them will be able to indicate whether the assessments of the NRSROs are accurate.

Andersen (MN) made a motion, seconded by Stolte, to expose this proposed amendment authorizing the procedures for the SVO's discretion over NAIC designations assigned through the FE process for a 60-day public comment period ending July 14. The motion passed unanimously.

3. Discussed a Proposed Amendment to Clarify the Meaning of Repurchase Agreements in the Derivates Transaction Definition for Funds in Part Three of the P&P Manual

Mears said the next item on the agenda for exposure is the proposed amendment to clarify the meaning of Repurchase Agreements and the Derivate Transaction definition for funds in Part Three.

Perlman said in 2021, the Task Force adopted amendments to the NAIC Fund Lists section of the P&P Manual to provide greater clarity and predictability regarding the acceptable use of derivatives in funds and permit funds greater flexibility in their use of derivatives while maintaining limits on funds' use of leverage. The SVO now proposes a new amendment to clarify which side of a repurchase agreement constitutes a derivative transaction for the purposes of the section.

The definition of Derivatives Transaction in the P&P Manual was modeled after the U.S. Securities and Exchange Commission (SEC) definition in Rule 18f-4 under the Investment Company Act of 1940. The P&P Manual definition reads:

Derivatives Transaction – means: (1) any swap, security-based swap, futures contract, forward contract, option, any combination of the foregoing, or any similar instrument (“derivatives instrument”), under which a fund is or may be required to make any payment or delivery of cash or other assets during the life of the instrument or at maturity or early termination, whether as margin or settlement payment or otherwise; (2) any short sale borrowing; and (3) any reverse repurchase agreement or similar financing transaction.

The original amendment was intended to limit the use of leverage by funds; therefore, Derivative Transactions encompass instruments pursuant to which a fund may be required to make a future payment of cash or other assets. Likewise, the inclusion of reverse repurchase agreements was intended to capture arrangements by which the fund would owe a future cash payment to the counterparty.

According to the SEC definition in Rule 18f-4 adopting release, “In a reverse repurchase agreement, a fund transfers a security to another party in return for a percentage of the value of the security. At an agreed-upon future date, the fund repurchases the transferred security by paying an amount equal to the proceeds of the initial sale transaction plus interest.” However, according to *Statement of Statutory Accounting Principles (SSAP) No. 103R—Transfers and Servicing of Financial Assets and Extinguishments of Liabilities*, “Reverse repurchase agreements are defined as agreements under which a reporting entity purchases securities and simultaneously agrees to resell the same or substantially the same securities at a stated price on a specified date.” The SSAP No. 103R reverse repurchase agreement definition is the opposite of the SEC reverse repurchase agreement definition. According to SSAP No. 103R, “Repurchase agreements, not reverse repurchase agreements, are defined as agreements under which a reporting entity sells securities and simultaneously agrees to repurchase the same or substantially the same securities at a stated price on a specified date.” The SAPP No. 103R definition of a repurchase agreement, therefore, matches the SEC definition of a reverse repurchase agreement, in which the fund is obligated to make a repurchase payment at a later date.

To maintain consistency between the P&P Manual and SSAPs, and to eliminate any misconception that a fund cannot be the purchaser of securities/lender of cash, the SVO proposes changing “reverse repurchase agreement” to “repurchase agreement” in the derivatives transaction definition.

To be clear, it is not intended to change the meaning. It is just that the same side of the transaction was named differently by the SEC and SSAPs, and the SVO wants to be consistent with the SSAPs. Subsequent to posting this amendment, Julie Gann (NAIC) explained that pursuant to both statutory accounting and U.S. generally accepted accounting principles (GAAP), many repurchase agreements are treated as secured borrowings rather than derivatives. To eliminate any confusion that the definition of derivative transaction in the P&P Manual Funds List section might be driven by accounting treatment, the SVO also recommends inserting a clause at the end of the posted proposed definition so that it reads: “(3) any repurchase agreement under which the fund sells securities

and simultaneously agrees to repurchase the same or substantially the same securities at a stated price on a specified date, or similar financing transaction, irrespective of accounting treatment.”

Mears said this is primarily a technical type of change, but it was done in consultation with the Statutory Accounting Principles (E) Working Group staff to ensure that the definitions were aligned.

Kozak made a motion, seconded by Doggett, to expose the proposed amendment to the P&P Manual to clarify the meaning of repurchase agreements in the derivatives transaction definition for funds with the additional language proposed for a 45-day public comment period ending June 30. The motion passed unanimously.

4. Received Updates on the Proposed CLO Modeling Methodology and Ad Hoc Working Group

Mears said the next agenda item is to receive an update on the proposed CLO modeling methodology and any actions and discussions from the CLO ad hoc group.

Eric Kolchinsky (NAIC) said there have already been two meetings of the ad hoc group, and cash flows were shared and discussed for six transactions. Tie-out calls were also held on calls and via numerous email exchanges with several parties that have been involved and which were very helpful.

The next meeting is scheduled for Wednesday, May 17, to discuss some of the issues raised during the tie-out and present cash flows with prepay and discount purchase assumptions. More details will be added to the previously released cashflows, which will help the parties to tie out.

5. Discussed Other Matters

Mears said there was one other matter, and she asked Therriault to provide that update.

Therriault said he wanted to alert the Task Force that the SVO is looking at making a change to how its fees are determined. This is something that has been worked on for at least seven years. Currently, there is a fee for the insurers to file a security with the SVO and then an additional fee to access the NAIC designations assigned by the SVO and the FE process in Automated Valuation Service Plus (AVS+). This can be unfair to insurers that frequently file securities with the SVO. The insurers that do not file with the SVO get the benefit while not sharing the cost. This is an attempt to make it a fairer and more equitable process, as well as more operationally efficient. The concept would be a fee structure based on the book/adjusted carrying value (BACV) of the insurer's Schedule D assets. The fee would cover both the filing of securities with the SVO in Vision and access to the resulting NAIC designation in AVS+. The operational efficiency would be accomplished by the NAIC and insurers not having to process the many invoices produced as the SVO bills for the roughly 12,000 transactions reviewed each year. This is in the preliminary stages, but it can hopefully be included in the 2024 budget and be effective for 2025.

The Executive (EX) Committee must formally consider the proposal and approve any changes, as it and the commissioners as part of the Plenary, are responsible for approving the NAIC budget, which helps the NAIC to better support the nation's chief insurance regulators, as well as the fees charged and the services and functions provided. This is mentioned so the Task Force is aware of this possible change just in case any questions come up about any SVO fee change during the 2024 budget discussions that will begin in the next couple of months. Overall, this change is expected to be revenue neutral from an NAIC budgeting perspective, but the impact on individual insurers could vary, as some insurers may pay no SVO filing fees today but directly benefit from those insurers that frequently file with the SVO and pay the associated fees. Again, a formal proposal will need to be submitted to the Committee and go through its review and approval process before changes can be made.

Mears asked if this would remove any sort of variable cost to an insurer based on the number of filings. Therriault said the proposal would replace the vast majority of filing fees, but some fees would still persist, such as the Qualified U.S. Financial Institution List, regulatory treatment analysis service, appeals, and other similar fees. The majority of the SVO fees would be covered by this overall fee that gives access to AVS+ and filing with the SVO.

Mears said to clarify, the Task Force has no oversight over the fee structure whatsoever, but this was meant to provide information to those states that are involved in other processes.

Having no further business, the Valuation of Securities (E) Task Force adjourned.

[https://naiconline.sharepoint.com/teams/svovostaskforce/shared documents/meetings/2023/2023-05-15 interim meeting/minutes/vostf 5.15.23 interim meeting minutes v8 \(final\).docx](https://naiconline.sharepoint.com/teams/svovostaskforce/shared%20documents/meetings/2023/2023-05-15%20interim%20meeting/minutes/vostf%205.15.23%20interim%20meeting%20minutes%20v8%20(final).docx)

Draft: 7/25/23

2024 Proposed Charges

VALUATION OF SECURITIES (E) TASK FORCE

The mission of the Valuation of Securities (E) Task Force is to provide regulatory leadership and expertise to establish and maintain all aspects of the NAIC's credit assessment process for insurer-owned securities, as well as produce insightful and actionable research and analysis regarding insurer investments.

Ongoing Support of NAIC Programs, Products or Services

1. The Valuation of Securities (E) Task Force will:

- A. Review and monitor the operations of the NAIC Securities Valuation Office (SVO) and the NAIC Structured Securities Group (SSG) to ensure they continue to reflect regulatory objectives.
- B. Maintain and revise the *Purposes and Procedures Manual of the NAIC Investment Analysis Office* (P&P Manual) to provide solutions to investment-related regulatory issues for existing or anticipated investments.
- C. Monitor changes in accounting and reporting requirements resulting from the continuing maintenance of the *Accounting Practices and Procedures Manual*, as well as financial statement blanks and instructions, to ensure that the P&P Manual continues to reflect regulatory needs and objectives.
- D. Consider whether improvements should be suggested to the measurement, reporting and evaluation of invested assets by the NAIC as the result of: 1) newly identified types of invested assets; 2) newly identified investment risks within existing invested asset types; or 3) elevated concerns regarding previously identified investment risks.
- E. Identify potential improvements to the credit filing process, including formats and electronic system enhancements.
- F. Provide effective direction to the NAIC's mortgage-backed securities modeling firms and consultants.
- G. Coordinate with other NAIC working groups and task forces—including, but not limited to, the Capital Adequacy (E) Task Force, the Statutory Accounting Principles (E) Working Group, and the Blanks (E) Working Group and Risk-based Capital Investment Risk & Evaluation (E) Working Group—to formulate recommendations and to make referrals to such other NAIC regulator groups to ensure expertise relative to investments, or the purpose and objective of guidance in the P&P Manual, is reflective in the guidance of such other groups and that the expertise of such other NAIC regulatory groups and the objectives of their guidance is reflected in the P&P Manual.
- H. Identify potential improvements to the filing exempt process (the use of credit rating provider ratings to determine an NAIC designation) to ensure greater consistency, uniformity and appropriateness to achieve the NAIC's financial solvency objectives.

- I. Implement policies to oversee the NAIC's staff administration of rating agency ratings used in NAIC processes, including staff's discretion over the applicability of their use in its administration of filing exemption.
- J. Establish criteria to permit staff's discretion over the assignment of NAIC designations for securities subject to the filing exempt process (the use of credit rating provider ratings to determine an NAIC designation) to ensure greater consistency, uniformity and appropriateness to achieve the NAIC's financial solvency objectives.
- K. Implement additional and alternative ways to measure and report investment risk.

NAIC Support Staff: Charles Therriault, Marc Perlman

https://naiconline.sharepoint.com/teams/SVOVOSTaskForce/Shared Documents/Meetings/2023/2023-08 Summer NM/Minutes/Attachment Three 2023-007.01 VOSTF_Proposed_2024_Charges.docx

FINANCIAL REGULATION STANDARDS AND ACCREDITATION (F) COMMITTEE

Financial Regulation Standards and Accreditation (F) Committee Aug. 13, 2023, Minutes..... 10-2
2024 Proposed Charges (Attachment One)..... 10-4

Draft: 8/17/23

Financial Regulation Standards and Accreditation (F) Committee
Seattle, Washington
August 13, 2023

The Financial Regulation Standards and Accreditation (F) Committee met Aug. 13, 2023. The following Committee members participated: Lori K. Wing-Heier, Chair (AK); Vicki Schmidt, Co-Vice Chair, represented by Tish Becker (KS); Sharon P. Clark, Co-Vice Chair (KY); Alan McClain (AR); Andrew N. Mais (CT); Mike Causey, represented by Jacqueline R. Obusek (NC); Jon Godfread, represented by Matt Fischer (ND); Eric Dunning represented by Lindsay Crawford (NE); Andrew R. Stolfi (OR); Elizabeth Kelleher Dwyer represented by Ted Hurley (RI); Larry D. Deiter (SD); Scott A. White (VA); and Jeff Rude (WY).

1. Adopted its Spring National Meeting Minutes

Commissioner Clark made a motion, seconded by Commissioner Mais, to adopt the Committee's March 22 minutes (*see NAIC Proceedings – Spring 2023, Financial Regulation Standards and Accreditation (F) Committee*). The motion passed unanimously.

Director Wing-Heier said the Committee met Aug. 12 in regulator-to-regulator session, pursuant to paragraph 7 (consideration of individual state insurance department's compliance with NAIC financial regulation standards) of the NAIC Policy Statement of Open Meetings, to vote to award continued accreditation to Missouri, New Hampshire, South Dakota, and Texas.

2. Adopted Proposed Revisions to the Part A Insurance Holding Company Systems Accreditation Standard

Director Wing-Heier stated that in December 2020, the NAIC adopted revisions to the *Insurance Holding Company System Regulatory Act* (#440) and the *Insurance Holding Company System Model Regulation* (#450). These revisions implement a group capital calculation (GCC) for the purpose of group solvency supervision and a liquidity stress test (LST) for macroprudential surveillance. The revisions to these models have been through the formal process for consideration of adoption as an accreditation standard. This process included a 30-day initial exposure period in 2021 and a one-year exposure period that ended Dec. 31, 2022. The exposure included a recommendation by the Committee for a revised approach to the GCC significant elements, allowing the commissioner to grant exemptions to qualifying groups meeting the standards set forth in Model #450, Section 21A and Section 21B, without the requirement to file at least once.

At the Spring National Meeting, Committee members discussed the comment letters received, which affirmed the importance of allowing the commissioner to exempt qualifying groups from the GCC requirements, when appropriate, to avoid placing an unnecessary burden on groups where such a filing would not provide added benefit. In accordance with the procedures for adopting amendments to existing models already included in the standards, if adopted, the recommendation will go to the Plenary at the Fall National Meeting for approval. Once adopted by the Plenary, the revised standard will become effective Jan. 1, 2026.

Dan Schelp (NAIC) stated that with respect to Section 21A and Section 21B of Model #450, a state may still adopt the language of those two sections and require that the insurance holding company system file a GCC at least once in order to grant an exemption with respect to future filings. He said the accreditation standards are minimum standards for solvency requirements, and states can choose to take a more conservative approach in their own requirements. The amended accreditation standard simply permits states to remove the requirement to file at least once at their discretion. Schelp also said that states may contact the NAIC's Legal Division if they would like assistance with drafting language that is consistent with the new accreditation standard.

Acting Superintendent Schott made a motion, seconded by Commissioner Clark, to adopt the significant elements of the 2020 revisions to Model #440 and Model #450, which implement a GCC, allowing for commissioner exemption for qualifying groups without having to file at least once and an LST, as an accreditation standard effective for all states Jan. 1, 2026. The motion passed unanimously.

3. Adopted its 2024 Proposed Charges

Director Wing-Heier discussed a memorandum that includes the Committee's 2024 proposed charges, noting the proposed charges are unchanged from the Committee's 2023 charges.

Acting Superintendent Schott made a motion, seconded by Commissioner Mais, to adopt the Committee's 2024 proposed charges (Attachment One). The motion passed unanimously.

Having no further business, the Financial Regulation Standards and Accreditation (F) Committee adjourned.

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MEMORANDUM

TO: Members of the Financial Regulation Standards and Accreditation (F) Committee

FROM: Bailey Henning, Senior Manager – Accreditation & Financial Examinations

DATE: July 31, 2023

RE: 2024 Proposed Charges

Below are the Financial Regulation Standards and Accreditation (F) Committee's 2024 proposed charges. There have been no substantive changes from the Committee's 2023 charges.

The mission of the Financial Regulation Standards and Accreditation (F) Committee is both administrative and substantive, as it relates to the administration and enforcement of the NAIC Financial Regulation Standards and Accreditation Program. This includes, without limitation: 1) the consideration of standards and revisions of standards for accreditation; 2) the interpretation of standards; 3) the evaluation and interpretation of the states' laws and regulations, as well as departments' practices, procedures, and organizations as they relate to compliance with standards; 4) the examination of members for compliance with standards; 5) the development and oversight of procedures for the examination of members for compliance with standards; 6) the selection of qualified individuals to examine members for compliance with standards; and 7) the determination of whether to accredit members.

Ongoing Support of NAIC Programs, Products or Services

1. The **Financial Regulation Standards and Accreditation (F) Committee** will:
 - A. Maintain and strengthen the NAIC Financial Regulation Standards and Accreditation Program.
 - B. Assist the states, as requested and as appropriate, in implementing laws, practices, and procedures and obtaining personnel required for compliance with the standards.
 - C. Conduct a yearly review of accredited jurisdictions.
 - D. Consider new model laws; new practices and procedures; and amendments to existing model laws, practices, and procedures required for accreditation. Determine the timing and appropriateness of the addition of new model laws, practices, procedures, and amendments.
 - E. Render advisory opinions and interpretations of model laws required for accreditation and on substantial similarity of state laws.
 - F. Review existing standards for effectiveness and relevancy, and make recommendations for change, if appropriate.
 - G. Produce, maintain, and update the NAIC *Accreditation Program Manual* to provide guidance to state insurance regulators regarding the official standards, policies, and procedures of the program.
 - H. Maintain and update the "Financial Regulation Standards and Accreditation Program" pamphlet.
 - I. Perform enhanced pre-accreditation review services, including, but not limited to, additional staff support, increased participation, enhanced report recommendations, and informal feedback.

INTERNATIONAL INSURANCE RELATIONS (G) COMMITTEE

International Insurance Relations (G) Committee Aug. 13, 2023, Minutes.....	11-2
International Insurance Relations (G) Committee April 13, 2023, Minutes (Attachment One).....	11-7
Draft NAIC Comments on Questions for Consultation on Issues Paper on Roles and Functioning of Policyholder Protection Schemes (PPSs) (Attachment One-A)	11-8
Draft Provisional Aggregation Method (AM) for Use in the Comparability Assessment (Attachment Two)	11-21

Draft: 8/22/23

International Insurance Relations (G) Committee
Seattle, Washington
August 13, 2023

The International Insurance Relations (G) Committee met in Seattle, WA, Aug. 13, 2023. The following Committee members participated: Gary D. Anderson, Chair (MA); Eric Dunning, Vice Chair (NE); Lori K. Wing-Heier (AK); Ricardo Lara (CA); Andrew N. Mais (CT); Gordon I. Ito (HI); Doug Ommen (IA); Dean L. Cameron (ID); Dana Popish Severinghaus (IL); Vicki Schmidt represented by Chut Tee (KS); James J. Donelon represented by Adam Patrick (LA); Kathleen A. Birrane (MD); Anita G. Fox (MI); and Justin Zimmerman (NJ).

1. Adopted its April 13 and Spring National Meeting Minutes

The Committee met April 13 and discussed NAIC comments on the International Association of Insurance Supervisors (IAIS) public consultation on the issues paper on the roles and functioning of policyholder protection schemes (PPSs).

Commissioner Mais made a motion, seconded by Director Popish Severinghaus, to adopt the Committee's April 13 (Attachment One) and March 22 (*see NAIC Proceedings – Spring 2023, International Insurance Relations (G) Committee*) minutes. The motion passed unanimously.

2. Heard an Update on International Insurance Developments and Activities in Canada

Commissioner Anderson spotlighted international cooperation on insurance-related matters between the U.S. and Canada. He noted Canadian insurance regulators as strong partners with the NAIC at the IAIS and assisting in advancing North American interests on the global stage.

Jacqueline Friedland (Government of Canada's Office of the Superintendent of Financial Institutions—OSFI) gave an update on international insurance developments and activities in Canada. She explained her role at the OSFI in frontline supervision and her actuarial background, noting that she is in charge of 250 supervisors that have oversight responsibilities of banks, insurers, and private pension plans.

Friedland spoke on the recent implementation of International Financial Reporting Standard (IFRS) 17, which is paramount to the OSFI's 2023 initiatives. While the implementation was not perfect and took longer for some to produce and analyze the results, she noted that only a few of the reporting insurers missed the deadline. She also noted that there were no significant surprises thus far, and not all Canadian insurers operate under federal regulation.

Friedland outlined shared priorities between Canada and the U.S., including looking into analyzing market volatility, and she provided the example of new mandatory stress testing for all Canadian insurers that is focused on inflation. On climate risk, she emphasized a focus on differing risks for each line of insurance and the implications on reinsurance, including availability and affordability.

On the topic of the OSFI's mandate, Friedland spoke to new changes, including expanding powers and enhancements to the broad oversight of banks and securities. Banks and insurers will need to have and adhere to policies and procedures that bring integrity to their security. The OSFI's examination of these results will be directly reported to the Canadian Minister of Finance.

Lastly, Friedland noted that investments are being made in the area of flood insurance coverage as part of a large budget bill that passed earlier this year. On auto rate freezes in Ottawa, she noted her strong opinion for adequate insurance rates and highlighted the OSFI's prudential mandate of ensuring consumer protection.

Commissioner Anderson highlighted the ongoing bilateral partnership between the NAIC and the OSFI, and he complimented their ongoing work at the global level on insurance matters.

3. Heard an Update on Activities of the IAIS

Commissioner Anderson gave an update on IAIS activities and its key 2023 projects and priorities. He began with a review of the IAIS committee meetings and Global Seminar that was hosted by the NAIC and took place in June in Seattle, WA. He began by thanking commissioners and state insurance regulators from the following states that participated: Alaska, California, Connecticut, Idaho, Illinois, Iowa, Nebraska, North Dakota, Maryland, Massachusetts, Michigan, Missouri, Oregon, Rhode Island, South Dakota, Virginia, and Washington.

Commissioner Anderson provided an update on the implementation and assessment activities at the IAIS. On the Targeted Jurisdictional Assessment (TJA) progress monitoring, he noted that this project is underway and will culminate in a report at the end of the year that will be delivered to the Financial Stability Board (FSB). He extended a thank you to New York, New Jersey, and Connecticut for their continued contribution to the project.

Next, Commissioner Anderson gave a brief update on the Common Framework for the Supervision of Internationally Active Insurance Groups (ComFrame), saying work is underway to develop the scope and thematic focus of a forthcoming implementation assessment. This assessment is scheduled to launch later this year.

On the Peer Review Process (PRP) of Insurance Core Principle (ICP) 16 Enterprise Risk Management for Solvency Purposes, Commissioner Anderson noted that this voluntary assessment will begin this fall, which is open to all IAIS members and gives member jurisdictions an opportunity to see how they are observing particular standards. He thanked Susan Berry (IL) for serving on the ICP 16 PRP expert team.

Commissioner Anderson highlighted some of the ongoing work being undertaken by forums and other groups within the IAIS, including:

- The FinTech Forum (FTF) that is continuing its discussions on its artificial intelligence (AI)/machine learning (ML) model risk management thematic review and supervisory responses to the use of ChatGPT and the different approaches adopted to monitor and address such FinTech developments in member jurisdictions. Commissioner Anderson highlighted a recent seminar in June in Basel, Switzerland on the use of innovative technology in financial supervision and thanked the NAIC's FTF member, Rachel Davison (MA), for participating on a panel on Suptech use cases in insurance supervision.
- The Climate Risk Steering Group's public consultation that covers the addition of new text to the IAIS ICPs introduction, work related to climate risk and governance, and the IAIS's plans to address climate more broadly. The group continues to discuss initial observations on the public consultation feedback and draft application paper material on climate-related market conduct considerations and climate scenario analysis, which are scheduled for public consultation by year-end 2023.

On the ICS, Commissioner Anderson said the IAIS has released a public consultation on a “candidate” version of the ICS ahead of its adoption as a Prescribed Capital Requirement for Internationally Active Insurance Groups in late 2024. This consultation also solicits input from stakeholders to support an economic impact assessment of the ICS. He mentioned that the IAIS is entering the fourth year of the five-year monitoring period for the ICS, and specifications for both the ICS and Aggregation Method (AM) data collections will be released at the end of April, with data due to the IAIS by Aug. 31.

To help provide more detailed information about the AM beyond what is already available, the U.S. IAIS members committed to producing a document describing the Provisional AM that is being used in the comparability assessment before the process begins (Attachment Two). Ned Tyrrell (NAIC) gave an overview of the draft document, explaining how it gathers existing AM documentation and communications into one authoritative spot and includes additional narrative context on how the AM will be used in the comparability assessment. He provided a summary of each of the sections of the document, including AM Principles, the Provisional AM, Scalars, and Finalization. Stakeholders were invited to provide any feedback by Sept. 1 for consideration for a final version of the document that will be provided to the IAIS in September.

Tom Finnell (American Property Casualty Insurance Association—APCIA) inquired about the deadline to produce comments on the AM document, noting IAIS public consultations with similar deadlines. Tyrrell responded that an extension would be difficult, given the need to have this document available within the IAIS timeline for the comparability assessment, and he reiterated that much of the document is based on existing material on the AM rather than being brand new. He cited the material on scalars and financial instruments as areas that may be of particular interest to stakeholders.

4. Heard an Update on International Activities

A. International Activities

Director Dunning reported on recent regional supervisory cooperation activities, starting with the European Union (EU)-U.S. Insurance Dialogue Project's public stakeholder event on June 16 in Seattle, WA. He noted that the project has been working within three working groups this year:

- Climate risk financial oversight, including climate risk disclosures, supervisory reporting, and other financial surveillance.
- Climate risk and resilience, including innovative technology, pre-disaster mitigation, adaptation efforts, and modeling.
- Innovation and technology, including big data, AI, and supervisory technology as a regulatory tool.

Next, Director Dunning spotlighted NAIC participation in recent international events, including:

- The Asociación de Supervisores de Seguros de América Latina (ASSAL) Annual Conference in San Jose, Costa Rica in early May, where Director Lindley-Myers, Commissioner Lara, and Commissioner Vega participated on a variety of panels, including ones addressing cybersecurity and climate. The NAIC held a bilateral meeting on the sidelines of the ASSAL Annual Conference, providing updates on a variety of its initiatives, including data privacy; climate resiliency; and diversity, equity, and inclusion (DE&I). The NAIC also discussed continuing opportunities for cooperation and collaboration with the ASSAL and its members.

- A joint Organisation for Economic Co-operation and Development (OECD) and Asian Development Bank Institute (ADBI) Roundtable on Insurance and Retirement Savings in Asia, where Superintendent Dwyer participated on two panels on insurance in a changing climate.
- The Bermuda Climate Summit 2023 held in June, where Commissioner Lara and Director Lindley-Myers addressed the future of the NAIC's Climate and Resiliency (EX) Task Force and highlighted consumer protection issues associated with the National Flood Insurance Program (NFIP) in a discussion panel.
- Keynote remarks by Director Lindley-Myers delivered virtually to the Taiwan Insurance Institute's (TII's) East Asia Pacific Insurance Forum 2023. She spoke on the NAIC and state insurance supervisors' work on embracing and incorporating new technology into regulation to encourage and improve the economic resiliency of the insurance industry and highlighted the NAIC's *State Ahead* strategic work plan.

Director Dunning then spoke to bilateral meetings that have taken place recently, including on the sidelines of the IAIS meetings in Seattle, WA, in June, where the NAIC held 11 bilateral meetings, the primary focus of which was on relationship building, especially among some individual EU member states. He said during these bilateral meetings, the NAIC addressed current strategic priorities and activities, including consumer protection, technology, and climate, and it touched on general macroeconomic issues, such as inflation.

Patrick Reeder (American Council of Life Insurers—ACLI) commented that the ACLI was encouraged by reports on recent bilateral engagements and said the NAIC is a great partner with other countries in developing their insurance frameworks. He noted that members are hearing from host regulators in many countries about their willingness to work with the NAIC, and there is a space to assist U.S. companies in their interactions with regulators overseas. He concluded his remarks by emphasizing how industry can be a resource when discussing prudential issues, and he welcomes the opportunity to participate as a resource and facilitator.

Karalee Morell (Reinsurance Association of America—RAA) agreed with Reeder's comments and emphasized that regulator-to-regulator dialogues are important for creating a level playing field, and she encouraged more engagement by state insurance regulators.

Dave Snyder (APCIA) added that some dialogues in the past involved trade negotiators, regulators, and industry, noting that having the key players at the table can help address regulatory issues on both sides and tackle regulatory issues that serve as barriers to international trade. He requested that these types of meetings be reestablished in critical markets, such as India.

Snyder then complimented the NAIC for its OECD participation, highlighting Director Dunning's remarks at the June meeting. He concluded by saying that a prioritization of how best to address fundamental regulatory conditions, and to do so in a coordinated manner, would be a strong way of combatting challenges coming from technology, macroeconomic conditions, the war in Ukraine, and supply chain disruptions.

Commissioner Anderson thanked Reeder, Morell, and Snyder for their constructive comments on the NAIC's bilateral relationships and activities, noting that industry's feedback on work such as this gives state insurance regulators some perspective as to where we should put our bilateral efforts.

B. OECD

Director Dunning reported on a variety of topics at the OECD that have progressed since the Spring National Meeting, including enhancing the contribution of insurance climate adaption, as well as digitalization to encourage policyholder risk reduction. He highlighted a roundtable discussion on June 26–27 in Paris, France, where he spoke on the NAIC's work overseeing and regulating insurer's use of AI and ML. He reported that during the Insurance and Private Pensions Committee portion of the meeting, members discussed several OECD

documents and reports, which are expected to be released soon, including a revised recommendation on disaster risk financing.

Having no further business, the International Insurance Relations (G) Committee adjourned.

SharePoint/NAIC Support Staff Hub/Member Meetings/G CMTE/National Meetings/2023/Seattle-Summer National Meeting

Draft: 4/28/23

International Insurance Relations (G) Committee
Virtual Meeting
April 13, 2023

The International Insurance Relations (G) Committee met April 13, 2023. The following Committee members participated: Gary D. Anderson, Chair (MA); Eric Dunning, Vice Chair, represented by Lindsay Crawford (NE); Lori K. Wing-Heier (AK); Ricardo Lara represented by Ope Oyewole (CA); Andrew N. Mais (CT); Gordon I. Ito (HI); Doug Ommen (IA); Dean L. Cameron (ID); Dana Popish Severinghaus and Susan Berry (IL); Vicki Schmidt (KS); James J. Donelon (LA); Kathleen A. Birrane (MD); Anita G. Fox (MI); Troy Downing (MT); and Marlene Caride (NJ). Also participating was: Robert Wake (ME).

1. Discussed NAIC Comments on the IAIS Public Consultation on the Issues Paper on the Roles and Functioning of PPSs

Commissioner Anderson explained that the International Association of Insurance Supervisors (IAIS) is conducting a public consultation on the issues paper on the roles and functioning of policyholder protection schemes (PPSs). He noted that the paper was drafted by the IAIS's Resolution Working Group, and it provides an updated overview of global practices regarding PPSs and their roles in insurance resolution and a variety of related activities. He said the NAIC's initial draft comments are based on an internal review of the issues paper and a review completed by members of the NAIC's Receivership and Insolvency (E) Task Force. Those initial comments, as well as input that was received from Maine, were circulated in advance of the call.

Ryan Workman (NAIC) gave an overview of the NAIC's comments on the public consultation, which are mostly editorial to address grammatical changes or ensure that the issues paper follows a style consistent with other IAIS papers. Other comments included enhancing language to clarify which examples apply to certain jurisdictions, removing speculative wording, and ensuring that examples used are relevant to the rest of the topics in the issues paper.

Wake provided a review of the edits he suggested for the NAIC's comments on the issues paper. Berry suggested that an NAIC comment around using alternative language for an example from the United Kingdom (UK) be reworded to enhance clarity. Workman responded that the NAIC comments would be revised to ensure that the intended point is clear prior to submission. As a member of the Working Group, Wake noted that he would work to ensure that the NAIC's comments are addressed and properly understood.

Director Popish Severinghaus made a motion, seconded by Director Cameron, to approve the submission of the NAIC comments, including the discussed revision, on the issues paper on the roles and functioning of PPSs (Attachment One-A). The motion passed unanimously.

Having no further business, the International Insurance Relations (G) Committee adjourned.

G Cmte Minutes 041323



DRAFT NAIC Comments – April 12, 2023

Questions for Consultation on Issues Paper on roles and functioning of Policyholder Protection Schemes (PPSs)

Thank you for your interest in the public consultation on the Issues Paper on roles and functioning of Policyholder Protection Schemes (PPSs). The Consultation Tool is available on the IAIS website.

Please do not submit this document to the IAIS. All responses to the Consultation Document must be made via the [Consultation Tool](#) to enable those responses to be considered.



DRAFT NAIC Comments – April 12, 2023

Consultation questions

1	<p>General comments on the Issues Paper</p> <p>Global Comment: Throughout the paper, “PPS” and “PPSs” are used to refer to “Policyholder Protection Scheme” and “Policyholder Protection Schemes” respectively. This reads a bit awkwardly. To streamline these references, on the acronym page (pg. 5) include one definition that covers the singular and plural and use “PPS” throughout the paper.</p> <p>Pg. 5: PPS – Policyholder Protection Scheme(s)</p> <p>Global Comment: We understand IAIS convention does not use the oxford comma for lists, but in some cases in this paper the oxford comma is used for lists. Please review for consistency with IAIS formatting.</p> <p>Global Comment: For some of the example boxes throughout the document there are awkward breaks and spaces between the jurisdiction and example. Please review and clean up formatting.</p> <p>Global Comment: need to review the use and formatting of em-dashes for consistency; see for example, paras 37, 40, 53, 110 and the blue box after 124.</p>
2	General comments on Section 1 Introduction
3	General comments on Section 1.1 Objectives and background
4	Comments on Paragraph 1
5	Comments on Paragraph 2
6	Comments on Paragraph 3
7	Comments on Paragraph 4
8	Comments on Paragraph 5
9	Comments on Paragraph 6
10	General comments on Section 1.2 Terminology
11	<p>Comments on Paragraph 7</p> <p>2nd sentence, use of “best practices” may not be consistent with how previous IAIS papers review to examples – as these are self-reported and not verified, perhaps prefer to them as “examples of practices within those jurisdictions.”</p>
12	Comments on Paragraph 8
13	Comments on Paragraph 9

Public

Public Consultation on Issues Paper on roles and functioning of PPSs –
13 February 2023 – 14 April 2023



DRAFT NAIC Comments – April 12, 2023

14	Comments on Paragraph 10
15	Comments on Paragraph 11
16	General comments on Section 1.3 Inputs
17	Comments on Paragraph 12
18	General comments on Section 1.4 Structure
19	Comments on Paragraph 13 Fix typo in the first sentence – “reminder” should be “remainder”
20	Comments on Paragraph 14
21	General comments on Section 2
22	General comments on Section 2.1 Overview
23	Comments on Paragraph 15
24	Comments on Paragraph 16
25	Comments on Paragraph 17
26	Comments on Paragraph 18
27	Comments on Paragraph 19
28	General comments on Section 2.2 Functions of PPSs
29	Comments on Paragraph 20 Not all frameworks are necessarily national; suggest: Depending on national jurisdictional frameworks, PPSs could fulfil various functions in different stages of recovery and resolution.
30	Comments on Paragraph 21
31	Comments on Paragraph 22
32	Comments on Paragraph 23
33	Comments on Paragraph 24
34	General comments on Section 2.3 Intervention by PPSs
35	General comments on Section 2.3.1 Recovery phase
36	Comments on Paragraph 25

Public
Public Consultation on Issues Paper on roles and functioning of PPSs –
13 February 2023 – 14 April 2023



DRAFT NAIC Comments – April 12, 2023

37	<p>Comments on Paragraph 26</p> <p>In the blue box, for the UK example, while the first sentence may be true, it does not seem necessarily relevant for what this example is illustrating – suggest deleting. In the last sentence, rather than say “currently” which will lose meaning as the paper ages, suggest noting the year this legislation is proposed, or alternatively revise to:</p> <p>Currently, the UK has no statutory resolution regime for insurers. As proposed, the Financial Services Compensation Scheme (FSCS) would make the following tools available to a firm in recovery: ... In addition, proposed legislation currently in Parliament (as of [insert publication date of paper, or substitute with a reference to the adoption date if and when legislation is adopted]) would provide the option for write-down with a top-up by the Financial Services Compensation Scheme (FSCS).</p>
38	Comments on Paragraph 27
39	Comments on Paragraph 28
40	General comments on Section 2.3.2 Resolution phase
41	<p>Comments on Paragraph 29</p> <p>Given how other parts of the paper note how the scope, role, functions, etc. of a PPS can vary, it seems a bit odd to say a “PPS could intervene in all situations, albeit in different ways.” Is it really <i>all</i> situations? Suggest considering clarifying the intended point here.</p>
42	Comments on Paragraph 30
43	<p>Comments on Paragraph 31</p> <p>Suggested revisions to the 2nd sentence:</p> <p>Alternatively, under open firm bail-in (see Paragraph 24), the insurance contracts will be continued with the same insurer which has been allowed to restart its operations.</p>
44	<p>Comments on Paragraph 32</p> <p>Suggested revisions to the 1st sentence, replace the comma with a semi-colon:</p> <p>The nature of a PPS intervention would also differ depending on the products being offered by the insurer; these can be either products with long term protections (typically life policies) or products with short term protection (typically non-life policies).</p> <p>Suggested revisions to the 2nd sentence, replace the comma with a semi-colon and fix grammar and capitalization:</p> <p>For life products, claims payments likely need to be continueing over longer periods; Ffor non-life products, payments might be necessary for only a short period (eg 30 or 60 days) so that the policyholder has sufficient time to find another insurer.</p>



DRAFT NAIC Comments – April 12, 2023

45	Comments on Paragraph 33
46	<p>Comments on Paragraph 34</p> <p>The 1st sentence is awkwardly written and its intent is unclear; consider revising.</p> <p>Last sentence, for consistency with usual IAIS phrasing, suggest:</p> <p>It should be noted that not necessarily all jurisdictions have resolution frameworks that fully observe comply with ICP 12, and given their resolution frameworks or have comprehensive PPSs in place.</p>
47	General comments on Section 3
48	<p>Comments on Paragraph 35</p> <p>Typo: “The This 2013 Issues Paper...”</p>
49	Comments on Paragraph 36
50	Comments on Paragraph 37
51	General comments on Section 3.1 Scope of coverage
52	Comments on Paragraph 38
53	Comments on Paragraph 39
54	<p>Comments on Paragraph 40</p> <p>Footnote 17 appears to have an unnecessary paragraph break after the first sentence.</p>
55	Comments on Paragraph 41
56	Comments on Paragraph 42
57	General comments on Section 3.2 Limits on compensation
58	Comments on Paragraph 43
59	Comments on Paragraph 44
60	<p>Comments on Paragraph 45</p> <p>Second sentence, if the practice is done in multiple jurisdictions, singling out one jurisdiction seems odd, so would suggest deleting “(eg in Canada)”. If this is unique to Canada, then suggest using a sentence structure more common to other IAIS material:</p> <p>In Canada, the It may also happen (eg in Canada) that a PPS has some form of a “circuit breaker” where the level of protection may depend on the level of difficulty the provided protection would cause to the other industry players.</p>



DRAFT NAIC Comments – April 12, 2023

61	Comments on Paragraph 46
62	Comments on Paragraph 47 Consider capitalizing the first word of each bullet.
63	Comments on Paragraph 48 Third sentence, if the practice is done in multiple jurisdictions, singling out one jurisdiction seems odd, so would suggest deleting “(eg in Canada)”. If this is unique to Canada, then suggest using a sentence structure more common to other IAIS material: In Canada, it may also happen (eg in Canada) that the PPS is allowed to provide higher compensation than the pre-set limit, in cases where it appreciates that observing the pre-set limit would constitute a hardship case.
64	Comments on Paragraph 49
65	Comments on Paragraph 50
66	General comments on Section 3.3 Method of compensation
67	Comments on Paragraph 51
68	Comments on Paragraph 52
69	Comments on Paragraph 53
70	Comments on Paragraph 54
71	Comments on Paragraph 55
72	General comments on Section 3.4 Eligible policyholders and claimants
73	Comments on Paragraph 56 In the blue box, suggest the text could be streamlined as follows: In connection with the issue indicated in the preceding paragraph, In the United States takes a related, but different approach under which most non-life PPSs have “high net worth” exclusions. These exclude a small number of wealthy individuals who are deemed to be sophisticated purchasers, but operate primarily to exclude larger commercial policyholders. A common threshold is \$50 million, but some states draw the line as low as \$10 million.
74	Comments on Paragraph 57
75	Comments on Paragraph 58 In the 3rd sentence the use of the word “devastated” is a bit loaded. Consider changing to something more neutral, such as “unduly impacted.”

Public

Public Consultation on Issues Paper on roles and functioning of PPSs –
13 February 2023 – 14 April 2023



DRAFT NAIC Comments – April 12, 2023

76	Comments on Paragraph 59
77	General comments on Section 3.5 Treatment of unearned premiums
78	Comments on Paragraph 60
79	<p>Comments on Paragraph 61</p> <p>Similar to the comment for paragraph 47, consider capitalizing the first word of each bullet.</p> <p>Following the bullets, suggest it would read better as:</p> <p>In this case, unearned premiums amount to 50 million CUs 50; outstanding claims amount to 80 million CUs 80</p> <p>OR</p> <p>In this case, unearned premiums amount to million CUs 50 million; outstanding claims amount to million CUs 80 million</p>
80	<p>General comments on Section 3.6 Cross-border issues of coverage: home- and host-jurisdiction principles</p> <p>Graph on pgs. 25-26, consider numbering or naming the graph. In the first diagram, add a bit more space to the depiction of “Policyholders of Insurer A domiciled in B.”</p>
81	Comments on Paragraph 62
82	Comments on Paragraph 63
83	<p>Comments on Paragraph 64</p> <p>Suggested revisions to the 3rd sentence:</p> <p>Recent examples of failures in the EU suggest, however, that even with a host-jurisdiction principle, the treatment of policyholders of a failed insurer may still be highly dependent on the jurisdiction where the failed insured was headquartered (the “home” jurisdiction), notably because the liquidation laws that will apply are those of the home jurisdiction, and liquidation laws sometimes very vary markedly diverge across jurisdictions.</p>
84	Comments on Paragraph 65
85	Comments on Paragraph 66
86	Comments on Paragraph 67
87	Comments on Paragraph 68
88	Comments on Paragraph 69



DRAFT NAIC Comments – April 12, 2023

89	Comments on Paragraph 70
90	Comments on Paragraph 71
91	General comments on Section 4
92	Comments on Paragraph 72
93	General comments on Section 4.1 Sources for PPS funding
94	Comments on Paragraph 73
95	Comments on Paragraph 74
96	Comments on Paragraph 75
97	Comments on Paragraph 76
98	Comments on Paragraph 77
99	Comments on Paragraph 78
100	General comments on Section 4.2 Ex-ante, ex-post and hybrid funding
101	Comments on Paragraph 79
102	Comments on Paragraph 80
103	General comments on Section 4.3 Determining the levy level for insurers
104	Comments on Paragraph 81
105	Comments on Paragraph 82
106	Comments on Paragraph 83
107	<p>Comments on Paragraph 84</p> <p><i>As written, the 1st sentence is a bit speculative, suggest the following revisions:</i></p> <p>As price is one of the most important factors in choosing an insurer, competition may creates incentives for insurers to price their products aggressively, potentially assuming risks that threaten the firm's financial soundness.</p>
108	<p>Comments on Paragraph 85</p> <p><i>In the blue box, UK example, FSCS is already spelled out on page 13 so can just use the acronym here.</i></p>
109	General comments on Section 4.4 Differences between resolution funds and PPSs
110	Comments on Paragraph 86



DRAFT NAIC Comments – April 12, 2023

111	Comments on Paragraph 87
112	Comments on Paragraph 88
113	Comments on Paragraph 89
114	General comments on Section 5
115	Comments on Paragraph 90 Second sentence, not clear what “prescriptions” means in this context – suggest considering a better word choice. Perhaps “conditions of coverage”?
116	General comments on Section 5.1 ICPs and PPS disclosure
117	Comments on Paragraph 91
118	Comments on Paragraph 92
119	General comments on Section 5.2 Disclosure considerations relevant to PPS
120	Comments on Paragraph 93
121	Comments on Paragraph 94
122	Comments on Paragraph 95
123	Comments on Paragraph 96
124	Comments on Paragraph 97
125	Comments on Paragraph 98
126	Comments on Paragraph 99 Suggested revisions to the 1 st and 2 nd sentences: The PPS should, through its public disclosure programme, build credibility with policyholders and stakeholders through an active communication process that is effective at different levels of stakeholders, eg insurers, consumers and intermediaries. The public disclosure programme may consider a tailored approach for the various classes of stakeholders.
127	Comments on Paragraph 100
128	Comments on Paragraph 101
129	Comments on Paragraph 102 Suggested revision to the 2 nd sentence to eliminate redundancy:



DRAFT NAIC Comments – April 12, 2023

	In the event of an insurer failure the PPS or an empowered authority, liquidator or court appointee should notify policyholders as expeditiously and appropriately as possible of the role of the PPS and how protection will be provided, via media such as press releases, print advertising, websites and other media outlets.
130	General comments on Section 6
131	Comments on Paragraph 103
132	Comments on Paragraph 104
133	General comments on Section 6.1 Cooperation and coordination between PPSs
134	<p>Comments on Paragraph 105</p> <p>As not all PPSs are necessarily national, suggest:</p> <p>Where this activity is material, cooperation and coordination between national PPSs across jurisdictions are essential,</p>
135	Comments on Paragraph 106
136	Comments on Paragraph 107
137	<p>Comments on Paragraph 108</p> <p>As not all insurance is necessarily issued at national level, suggest:</p> <p>ie where the domestic PPS covers policies issued by domestic insurers both at national level within the jurisdiction and abroad</p>
138	Comments on Paragraph 109
139	<p>Comments on Paragraph 110</p> <p>In the blue box, while the European Union example has interesting information, it does not seem particularly relevant given the focus is on coordination and cooperation. Suggest considering whether there is a more relevant place for this example.</p>
140	General comments on Section 6.2 Cooperation and coordination between a PPS and a supervisor/resolution authority
141	Comments on Paragraph 111
142	Comments on Paragraph 112
143	Comments on Paragraph 113
144	Comments on Paragraph 114
145	Comments on Paragraph 115
146	Comments on Paragraph 116

Public

Public Consultation on Issues Paper on roles and functioning of PPSs –
13 February 2023 – 14 April 2023



DRAFT NAIC Comments – April 12, 2023

147	Comments on Paragraph 117
148	Comments on Paragraph 118
149	Comments on Paragraph 119
150	Comments on Paragraph 120
151	Comments on Paragraph 121
152	<p>Comments on Paragraph 122</p> <p>Typically Issues Papers avoid wording that suggests setting requirements – suggest revising the wording, in particular to avoid the use of “must”:</p> <p>Supervisors and The sharing of confidential information is important to enable supervisors, resolution authorities need to share confidential information with and PPSs for any of them to fulfil their respective responsibilities effectively, and Therefore, jurisdictions should consider whether the governing laws must clearly delineate when and how confidential information can be shared, and what obligations must be assumed by the recipient of the information.</p>
153	<p>Comments on Paragraph 123</p> <p>Typically Issues Papers avoid wording that suggests setting requirements – suggest revising the wording, in particular to avoid the use of “must”.</p> <p>In particular, it could be useful for there must to be explicit legal authority for the supervisor and/or resolution authority to have the discretion to share confidential information about insolvent and impaired insurers with a PPS, but only on and to make this discretion explicitly subject to the condition that the PPS is bound by the same obligations of professional secrecy that apply to the supervisor and/or resolution authority. Confidentiality protocols may also be embedded in the internal operating documents of the PPS.</p>
154	<p>Comments on Paragraph 124</p> <p>In the blue box, while the Canada example has interesting information, only the end of the second paragraph seems particularly relevant to the topic of coordination and cooperation. Suggest moving the remainder to a more appropriate place such as Section 2.3, where the powers of a PPS and the timing of intervention are discussed.</p>
155	General comments on Section 7
156	General comments on Section 7.1 Other mechanisms aimed at protecting policyholders in the event of an insurer failure
157	Comments on Paragraph 125
158	Comments on Paragraph 126
159	General comments on Section 7.1.1 Preferred claims



DRAFT NAIC Comments – April 12, 2023

160	Comments on Paragraph 127
161	General comments on Section 7.1.2 Tied assets
162	Comments on Paragraph 128
163	Comments on Paragraph 129 Referring to tied assets as an “institution” seems a bit odd; suggest considering different wording to make the intended point clearer.
164	General comments on Section 7.1.3 Segregated assets
165	Comments on Paragraph 130
166	Comments on Paragraph 131
167	Comments on Paragraph 132
168	General comments on Section 7.2 Other protection mechanisms outside of insurers’ failure
169	Comments on Paragraph 133
170	General comments on Section 7.2.1 Mechanisms that indemnify the victim when the responsible person is unknown or uninsured
171	Comments on Paragraph 134
172	Comments on Paragraph 135 The example jurisdictions are mentioned in an odd place; suggest this could read better as: Not infrequently (eg France, Italy, Switzerland), the bodies compensating the victims when there is no identified insurer, are the same as those compensating policyholders when an insurer is insolvent (eg in France, Italy, Switzerland). This —which can make sense since, in both cases, it is about compensating victims in the absence of an insurer capable of doing so.
173	General comments on Section 7.2.2 Mechanisms covering catastrophe risks
174	Comments on Paragraph 136
175	General comments on Annex
176	Comments on Section 1 Moral hazard Suggest revision to the 2 nd sentence of the 2 nd paragraph:



DRAFT NAIC Comments – April 12, 2023

	<p>The problem of moral hazard, particularly for larger and more systemic institutions, was illustrated by the behaviour of some market participants in the years preceding the great financial crisis of 2007–09.</p> <p>Page 46, second paragraph, can remove the period in the quote before footnote 62: ““is not an effective tool ... as it can inflict losses without instilling discipline and may trigger bank runs-.””</p> <p>Page 47, second paragraph, second sentence, the phrase “lay policyholder” is a bit odd; suggest using “average policyholder” or simply “policyholders” in this context. Last sentence, to help improve readability:</p> <p>This is all the more true in multi-jurisdictional single markets such as the EU or the USA, where a policyholder based in one place (eg in Portugal or in California) is not expected to exert vigilance on the soundness of an insurer headquartered in another place (eg in Finland or in Maine).</p>
177	Comments on Section 2 Safeguards to mitigate moral hazard

Provisional AM for Use in the Comparability Assessment

*****DRAFT FOR STAKEHOLDER FEEDBACK*****

*Please send any feedback to Ned Tyrrell
(ntyrell@naic.org) by Friday, September 1, 2023.*

Table of Contents

1	Introduction	4
1.1	Purpose	4
1.2	History/Background	4
1.3	AM Development	5
1.4	AM Data Collection	5
2	Design Principles	5
3	Provisional Aggregation Method	6
3.1	Inventory & Group Financials	7
3.1.1	Scope	7
3.1.2	Use of Local Valuation, Capital Resources and Capital Requirements	8
3.2	Adjustments	10
3.3	Capital Requirements	10
3.3.1	Exposures	10
3.3.2	Diversification/Fungibility	11
3.3.3	Scalar Methodology	11
3.4	Capital Resources	11
3.4.1	General Considerations	11
3.4.2	Recognition of Financial Instruments	11
3.4.3	Application of Limits to Recognition of Debt	12
3.5	Aggregation	12
4	Scalars	13
4.1	Purpose of Scalars	13
4.1.1	Identifying a Point of Comparison	14
4.1.2	Total Balance Sheet Perspective on Calibration	14
4.2	Criteria for Evaluating Scalar Methodologies	14
4.3	Methodologies Under Consideration	15
4.3.1	Provisional AM	15
4.3.2	Pure Relative Ratio Approach (Pure RRA)	15
4.3.3	Excess Relative Ratio Approach	15
4.3.4	99.5% Value at Risk	16
4.3.5	Supervisory Assessment Approach	16

4.4	Methodologies No Longer Under Consideration	16
5	Finalizing the AM.....	17
5.1	Selecting Final Methodology.....	17
5.2	AM Implementation.....	17
5.3	Ongoing evolution of the AM.....	17
6	Appendix 1: Correlation Analysis on US Entities.....	19
6.1	Life RBC vs P&C RBC.....	19
6.2	Correlation of P&C RBC with ICS.....	20
7	Appendix 2: Calculation of Excess Relative Ratio Approach.....	21
8	Appendix 3: Comparability Data for US Entities	26
8.1	Comparison of Life Risks	26
8.2	Comparison of Property/Casualty Risks.....	27
8.3	Comparison of Capital Resources	28

DRAFT

1 Introduction

1.1 Purpose

1. This document describes the Aggregation Method (AM) for use in the IAIS' assessment of whether it provides comparable outcomes to the Insurance Capital Standard (ICS). This builds on the Level 1 document that was released in 2020 and the AM Data Collection package which is released annually by the IAIS. This document describes (i) principles for the AM approach (ii) a provisional AM which will serve as the basis for comparison to the candidate ICS during the IAIS' comparability assessment and (iii) steps planned for the finalization of the AM, including further analysis on scalars and decision on a final methodology that delivers comparable outcomes to the ICS.
2. Further documentation will be provided as the AM is finalized after the results of the comparability assessment.

1.2 History/Background

3. The AM was introduced as an alternative group capital approach for interested jurisdictions to apply to Internationally Active Insurance Groups (IAIGs).¹ The goal of the AM is to leverage legal entity reported available and required capital to produce a measure of group capital adequacy.
4. At the November 2017 IAIS Meeting, the IAIS agreed to collect data from US-based IAIGs and any other willing jurisdiction/volunteer at the option of the group-wide supervisor to assist the US and other interested jurisdictions in the development of the AM, through an annual AM Data Collection. In so doing, the IAIS aims to be in a position by the end of the monitoring period to assess whether the AM provides comparable, i.e. substantially the same, outcomes to the ICS and if so, it will be considered an outcome-equivalent approach for implementation of the ICS as a PCR².
5. At the November 2019 IAIS Meeting, the IAIS agreed on the definition of comparable outcomes and an overarching approach to guide the development of high-level principles (HLPs) and criteria³. The IAIS also agreed at this meeting to move forward into a five-year monitoring period from 2020 through 2024, during which optional reporting of the AM would be permitted, at the discretion of group-wide supervisors. As stated in the resulting workplan: "in support of the work on the comparability assessment, there will be an annual AM data collection" with timing that will be "similar to that for the ICS confidential reporting"⁴.
6. In March 2023, the IAIS released the final HLPs and criteria for use in the comparability assessment. These were developed through a deliberate process, including two rounds of consultation to ensure that "the AM is neither precluded at the outset as an outcome equivalent approach to the ICS for measuring group capital, nor given a free pass". The 2023 AM Data

¹ During the monitoring period, other interested Volunteer Groups that do not meet the definition of an IAIG may choose to participate in the annual AM Data Collection exercise, at the option of their group-wide supervisor.

² [Implementation of ICS Version 2.0, IAIS 2 November 2017](#)

³ [Explanatory Note on the ICS and Comparability Assessment, IAIS 14 November 2019](#)

⁴ [Work Plan and Timeline 2020-24, IAIS 14 November 2019](#)

Collection package included updated schedules for reporting data relevant to the comparability assessment. The results of the comparability assessment will be released in 2024.

1.3 AM Development

7. A useful group capital approach provides supervisors with meaningful and reliable information about the solvency risks presented by and to IAIGs. The AM is adaptable to the diverse business models, product designs, and risk management approaches employed by insurance groups around the world that create resilience within the insurance sector. Because the AM relies on a fully transparent methodology and is built on existing legal entity requirements, it helps contribute to the overall stability of the insurance sector as a ready and sound capital framework for detecting a need for appropriate supervisory intervention at the group level.

1.4 AM Data Collection

8. The annual AM Data Collection has a template, specifications and questionnaire that are released annually. The template can calculate the provisional AM as well as other possible versions of the final AM and also includes data to assist with the comparability assessment. If the final version of the AM has different parameters than the provisional AM, the results from prior years can be recalculated retrospectively via data already collected.
9. Since its beginning in 2018, the AM Data Collection has expanded to include 21 groups from 5 countries and includes jurisdictional level data from every major insurance market. This data was used to develop the provisional AM (see Section 3) and to analyze the full range of scaling options that are being considered for use in the final AM (see Section 4).
10. In addition to use in development of the AM, the 2023 AM Data Collection will be used in the comparability assessment. This includes the application of scenarios for the AM and ICS, data on local capital regimes, and ICS results. There is 100% participation from US life IAIGs in the ICS and AM Data Collections. All US non-life IAIG's are participating in the AM Data Collection and an approximation tool was developed and will be used to calculate their ICS results. For US RBC filing legal entities, there is additional data obtained through filings that can be used for an analysis of correlation over the business cycle (see Appendix 1). Lastly, the IAIS is requesting that supervisors provide information about the treatment of risks and capital in their local regime for use in the comparability assessment. See Appendix 3 for examples of completed data collection tables for the US RBC framework. *[Note: this version contains placeholders; the final version will have populated tables.]*

2 Design Principles

11. Based on legal entity building blocks, the AM provides a lens into group capital adequacy that allows supervisors to analyze, identify and address capital deficiencies at the group level as well as where they may reside at the local legal entity level. The AM builds on existing capital regimes. Group capital resources and requirements are derived from the aggregation of legal entity-level reporting.

12. Guiding principles of the AM concept:

- Indifferent to Corporate Structure: Location of an entity within the group and/or intragroup transactions do not impact group-level results.
- Reflective of Appropriate Capital Regimes: Differentiated treatment for insurance/financial entities under existing capital regimes and application of appropriate alternatives for non-insurance entities. This leverages existing solvency frameworks and jurisdictional-tailored approaches to risk.
- Transparency: Clear line of sight to where risks reside and capital is held. Provides supervisors with information for assessing risks at the legal entity level within the group.
- Comparability: Group level results reflect comparable levels of risk through scaling of entity results.

13. The AM calculation has five components. These components are described further in the 'Provisional AM' section of this document. The final version of the AM will include these same components:

- Inventory & Group Financials
- Adjustments
- Capital Requirements
- Capital Resources
- Aggregation

14. Using these principles and information from the AM Data Collection, the US and other interested jurisdictions have developed a provisional AM to serve as the basis for comparison to the Candidate ICS in the IAIS comparability assessment. While the final version of the AM will follow the same design as the provisional AM, ultimately some parameters (particularly scalars) may be subject to change based on further analysis on the annual data collection and the results of the comparability assessment. There is an ability to back-test the AM, applying a variety of parameters with the data collected.

15. When introduced in ComFrame, IAIG capital reporting to group-wide supervisors and public disclosure requirements, including their content, granularity, and frequency, will also apply to the final version of the AM. Results of the implemented capital standard – including but not limited to the template, available capital and required capital – would be reported to the group-wide supervisor. Documentation of the capital standard – specifications, template, scalars, etc. – would be publicly disclosed and updated as required under ComFrame.

3 Provisional Aggregation Method

16. The following section describes the five components of the provisional AM.

3.1 Inventory & Group Financials

3.1.1 Scope

17. The starting point for the AM is the Consolidated Holding Company or Controlling Insurer in the case of a mutual insurer structure. All entities within the defined insurance (or financial) group are included. This is consistent with the perimeter of the calculation of the Candidate ICS and consistent with IAIS Insurance Core Principle (ICP) 23, Group-wide Supervision.
18. The AM is based on regulatory reporting at the legal (or local) entity level. This reporting is used to populate a schedule that separately lists the legal entities within the group and includes their available and required capital plus other relevant financial information. All figures are converted to a common reporting currency using exchange rates provided in the technical specifications.
19. Most legal entities are reported separately, however for simplification purposes, certain legal entities can be grouped or ‘stacked’ together. When the capital ratio is the same, regardless of whether a legal entity is stacked or de-stacked, then only the parent entity may be reported. Examples would include immaterial legal entities and non-insurance/non-financial entities that are not directly subject to a regulatory regime.
20. Legal entities that have material exposure to the total available capital are not grouped with a parent, including specifically legal entities that are subject to consolidated group capital requirements and foreign branches of an IAIG.
21. Each reported entity is mapped by the IAIG to an entity category. Entity categories are used to group entities prior to aggregation. Each entity within an entity category has its AM required capital determined in the same manner. There are entity categories for unregulated and regulated entities (“regulated”, in this context, means that an entity is subject to a capital requirement). For regulated entities, the entity category corresponds to a specific capital regime (e.g. RBC Filing US Life Insurer). Unregulated entities are mapped to categories including “Non-Insurer Holding Company,” “Asset Management,” “Other Non-Insurance/Non-Financial” or “Other Financial” and follow the AM specifications to calculate their required capital.
22. Entities in the provisional AM are mapped to the following categories:

Type	Entity Category	Type	Entity Category
Non-US Ins	Argentina	Non-US Ins	Solvency II (UK) – Life
Non-US Ins	Australia - All	Non-US Ins	Solvency II (UK) - Non-Life
Non-US Ins	Barbados	Non-US Ins	South Africa - Composite
Non-US Ins	Bermuda – Comm Insurers	Non-US Ins	South Africa – Life
Non-US Ins	Bermuda - Other	Non-US Ins	South Africa - Non-Life
Non-US Ins	Brazil	Non-US Ins	Switzerland – Life
Non-US Ins	Canada - Life	Non-US Ins	Switzerland - Non-Life
Non-US Ins	Canadian - P&C	Non-US Ins	Thailand
Non-US Ins	Chile	US Ins	RBC Filing U.S. Insurer (Life)
Non-US Ins	China	US Ins	RBC Filing U.S. Insurer (P&C)
Non-US Ins	Chinese Taipei - All	US Ins	RBC Filing U.S. Insurer (Health)
Non-US Ins	Colombia	US Ins	RBC Filing U.S. Insurer (Other)

Non-US Ins	Hong Kong - Life	US Ins	Non RBC filing U.S. Insurer
Non-US Ins	Hong Kong - Non-Life	Non-US Ins	Regime A
Non-US Ins	India	Non-US Ins	Regime B
Non-US Ins	Indonesia	Non-US Ins	Regime C
Non-US Ins	Japan - Life	Non-US Ins	Regime D
Non-US Ins	Japan - Health	Non-US Ins	Regime E
Non-US Ins	Japan - Non-Life	HoldCo	Non-Insurer Holding Company
Non-US Ins	South Korea	Fin	Bank (Basel III)
Non-US Ins	Malaysia	Fin	Bank (Other)
Non-US Ins	Mexico	Fin	Asset Manager/Registered Inv Advisor
Non-US Ins	New Zealand	Fin	Other Regulated Financial Entity
Non-US Ins	Philippines	Fin	Other Unregulated Financial Entity
Non-US Ins	Singapore - All	Other	Other Non-Ins/Non-Fin with Material Risk
Non-US Ins	Solvency II (EU) - Life	Other	Other Non-Ins/Non-Fin w/o Material Risk
Non-US Ins	Solvency II (EU) - Non-Life		

3.1.2 Use of Local Valuation, Capital Resources and Capital Requirements

23. Available capital is reported for each entity based on either local GAAP or the local capital regime depending on the type of entity. There is no group or consolidated balance sheet reported under the AM.
24. For unregulated entities, available capital is based on local GAAP reporting.
25. For regulated entities, unadjusted available capital and unadjusted required capital refer to reported amounts based on the relevant local capital regime. The local unadjusted available capital reflects all exclusions and adjustments as required by the local capital regime. The local unadjusted required capital is at the prescribed capital requirement (PCR)⁵ intervention level or the closest equivalent.
 - a. For Australian subsidiaries, the PCR is the target capital as set by the insurer/group in accordance with APRA requirements. Effectively, this would be "Target capital under ICAAP". PCR is not a set multiple of MCR.
 - b. For Bermudian subsidiaries, the Legal Entity PCR in Bermuda for medium and large commercial insurers is called the "Enhanced Capital Requirement" (ECR) and is calibrated to Tail-VaR at 99% confidence level over a one-year time horizon.
 - c. For Brazilian subsidiaries, the PCR is reported as the Brazilian MCR (in Portuguese, CMR – Capital Mínimo Requerido).
 - d. For Canadian life entities, the baseline PCR is "100% of the LICAT Base Solvency Buffer". The carrying value should include surplus allowances and eligible deposits on a net of

⁵ A PCR is defined in ICP 17.4 as "a solvency control level above which the supervisor does not intervene on capital adequacy grounds". (<https://www.iaisweb.org/icp-online-tool/13528-icp-17-capital-adequacy/>)

reinsurance basis. For property/casualty entities, the PCR should be the MCT capital requirement at the target level.

- e. For Chilean subsidiaries, the PCR is 100% of the total capital requirement which is the maximum between minimum capital, maximum debt ratios and a solvency margin.
- f. For Chinese subsidiaries, the PCR is 100% of the C-ROSS total capital.
- g. For Chinese Taipei subsidiaries, the PCR is 200% of the RBC ratio.
- h. For European Union member-based subsidiaries, the PCR is the Solvency II Solo SCR (Solvency Capital Requirement).
- i. For Hong Kong subsidiaries, under the current rule-based capital regime, if applied similar to the concept of PCR, the regime's PCR would be 150% of MCR for life insurers and 200% of MCR for non-life insurers.
- j. For Indian subsidiaries, the PCR is a factor-based solvency approach, based on a Solvency I type model, to maintain an excess of the value of assets over the amount of liabilities of not less than 50% of the amount of minimum capital subject to the control level of a solvency ratio of 150%.
- k. For Japanese subsidiaries, the PCR is the solvency margin ratio of 200%.
- l. For Korean subsidiaries, the PCR is 100% of risk-based solvency margin ratio.
- m. For Malaysian subsidiaries, the PCR is the individual target capital level calculated by individual entities based on policy requirements set by the Bank Negara Malaysia. It reflects the individual insurer's/Takaful Operator's own risk profile and risk management practices and includes additional capacity to absorb unexpected losses beyond those covered in the Risk-Based Capital Frameworks for Insurance and Takaful Operators.
- n. For Mexican subsidiaries, the PCR is the solvency capital requirement (SCR) based on a Solvency II type model, using both Value at Risk (VaR) methodologies, considering the time horizon of one year at a confidence level of 99.5%, and Probable Maximum Loss (PML) methodologies for catastrophic risks.
- o. For Singaporean subsidiaries, the PCR at the legal entity level under the enhanced valuation and capital framework for insurers (RBC 2) is calibrated at the 99.5% VaR over a one-year period.
- p. For South African subsidiaries, the PCR is 100% of the SAM SCR.
- q. For Swiss subsidiaries, the legal entity PCR under the "Swiss Solvency Test" (SST) is 100% of the target capital, which is calibrated to Tail-VaR at 99% confidence level over a one-year time horizon.
- r. For US subsidiaries, the RBC Company Action Level of each insurer should be recalibrated to the point at which regulatory action can be taken in any state based on RBC alone, i.e., the point at which the trend test begins, which is one and a half times company action level.

3.2 Adjustments

26. Before entities are aggregated, the reported available and required capital figures are adjusted to remove any double-counting. After adjustment, an entity's available and required capital reflects solely its own capital and risks and not that of its subsidiaries.
27. To ensure that the IAIG has properly eliminated any double-counting, details on each adjustment are provided in the AM template and questionnaire.

3.3 Capital Requirements

28. The AM capital requirement reflects risk aggregated at the group level. The AM also provides the capital requirement contribution from each entity within the scope of the group that provides another level of granularity for jurisdictional analysis. Group-level breakdowns of risk is by type of entity (e.g. entity category, entities by region). Given this approach, reporting at the individual risk level is not necessary nor would it be possible due to differing risk categories and definitions under the local capital regimes.

3.3.1 Exposures

29. The contribution of each legal entity to the total capital requirement is equal to a factor multiplied by a specified exposure measure. An exposure measure is specified for each entity category. All entities within their respective categories use the same factor and exposure measure. For regulated financial entities (including banking and insurance), the exposure measure is the local required capital (after adjustments for double-counting and at a specified PCR-equivalent intervention level). For these regulated entities, the factor will be referred to as a "scalar".
30. The exposure measures used in the provisional AM are provided in the table below. In the event an exposure is negative, the required capital is floored at zero.

Reg/Non-Reg	Category	Exposure Measure
Entities with Regulatory Capital Requirements	Insurance Entities	Adjusted Required Capital
	Banking Entities	Adjusted Required Capital
	Asset Mgmt	Adjusted Required Capital
Entities without Regulatory Capital Requirements	Non-Insurer Holding Company	Adjusted Available Capital
	Asset Mgmt / Other Financial	Average 3-year Gross Revenue

	Non-Insurance / Non-Financial	Adjusted Available Capital
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3.3.2 Diversification/Fungibility

31. The AM reflects the diversification that is already included in local capital requirements. The AM does not allow for further diversification between different legal entities and thereby recognizes the limitations on capital fungibility within a group.

3.3.3 Scalar Methodology

32. The provisional AM uses an unscaled methodology: local capital requirements at a PCR (or equivalent) level without any further adjustment other than for double-counting (i.e. all scalars are 100%).
33. Different scalar methodologies can produce similar indications. For example, results from the AM Data Collection for the provisional AM are similar to those from the '99.5% Value at Risk' scalar methodology. A number of additional scalar methodology options are being analyzed (see Section 4, 'Scalars', for more information.) The scalar methodology to be implemented in the finalized AM will either be one of the tested methodologies or some combination/variation that falls within the range of options under consideration.

3.4 Capital Resources

3.4.1 General Considerations

34. Capital resources have one tier with two components: financial instruments and adjusted available capital. Qualifying financial instruments are determined using a common set of criteria at the group-level. These instruments are issued at the holding company level and treated as liabilities in the holding company's balance sheet. They are classified as 'Senior Debt', 'Hybrid', 'Surplus Notes (or Similar)' and 'Other'. Available capital is determined at the legal entity level and becomes an input to the aggregated amount. Any capital element (other than a financial instrument) that is not recognized as available capital in the local statutory regime will also be excluded from capital resources in the AM.

3.4.2 Recognition of Financial Instruments

35. The AM recognition of a financial instrument as a qualifying capital resource is based on consideration of criteria developed based on five key principles:
- loss absorbing capacity (on a going concern basis and/or in winding-up);
 - subordination;
 - availability to absorb losses;
 - permanence; and
 - absence of both encumbrances and mandatory servicing costs.
36. Based on these principles, the following criteria are applied to financial instruments. These criteria are consistent with those used to determine financial instruments that qualify as capital resources in the ICS while also reflecting the economic circumstances and existing legal protections under a structural subordination environment. Analysis as part of the AM Data

Collection has shown there are no material differences in the amount of these financial instruments recognized in the AM and the ICS.

- The instrument must have a maturity date and initial maturity must be at least five years;
- Instruments must be subordinated to policyholders. For structurally subordinated instruments, supervisory approval of ordinary dividends can be met if the supervisor has in place supervisory controls over distributions, including the ability for the supervisor to limit, defer and/or disallow the payment of any distributions should it find that the insurer is presently, or may potentially become, financially distressed;
- Distributions cannot be linked to the credit standing or financial condition of the insurance group;
- The issuer has full discretion at all times to cancel distribution or payments;
- The instrument is not secured or covered by a guarantee given by the issuer or a related entity of the issuer;
- The debt instrument has been issued by a clean holding company, which is defined as a holding company that does not have policyholder liabilities on its stand-alone balance sheet;
- Amounts from the instrument issuance have been down-streamed into an insurance subsidiary of the holding company and the insurance subsidiary is located in a jurisdiction whose regulatory regime proactively enforces structural subordination;
- The IAIG and its group-wide supervisor have determined that the proceeds of the instruments, which have been down-streamed into insurance subsidiaries, are being tracked and reported appropriately; and
- The instrument must be fully paid up.

3.4.3 Application of Limits to Recognition of Debt

37. The amount of qualifying financial instruments recognized is subject to a limit of 75% of the aggregated available capital (before the addition of instruments). This is equivalent to a limit of 43% of group capital resources including financial instruments. This was reviewed as part of the AM Data Collection to ensure there was no material difference between the impact of this limit and the impact of limits on the same financial instruments in the ICS. The AM template has the functionality to test a range of approaches to applying limits.

3.5 Aggregation

38. After application of adjustments and scaling, the IAIG's available and required capital are aggregated by entity category.
39. Group capital resources are the sum of the adjusted available capital for the underlying entities plus any qualifying financial instruments subject to limits described above.
40. Group required capital is the sum of the scaled adjusted required capital for the underlying entities.

4 Scalars

41. The AM Data Collection includes analysis to identify, estimate and assess reasonable scaling methodologies. This analysis has been informed by a 2021 paper by American Academy of Actuaries on scalars: “Aggregating Regulatory Capital Requirements Across Jurisdictions: Theoretical and Practical Considerations” ([Academy paper](#)). The purpose of the Academy paper is to assist group-wide supervisors that are creating an aggregation-based group capital approach. The Academy paper does not make a recommendation as to which scalar(s) should be used nor does it discuss comparability of the AM and ICS. Rather it provides a framework for classifying and evaluating different methodologies.
42. The goal is to select a scaling methodology for the final AM that is meaningful from a prudential point of view, relevant for the monitoring of financial soundness and that provides for comparable outcomes to the ICS.

4.1 Purpose of Scalars

43. Scalars adjust local capital requirements to comparable levels. The AM will have one scalar for each entity category. The AM currently has 45 insurance entity categories and 3 non-insurance entity categories. This includes 5 placeholders (Regime A, Regime B, Regime C, Regime D and Regime E) to be used if/when further categories are needed. Given that these categories encompass the largest insurance markets, it is expected this list will be generally stable over time.
44. The provisional AM’s scalar methodology is unscaled (i.e. each scalar is 100%) for every regulated entity category. For alternative scalar methodologies, a scalar would be assigned to each of these entity categories; the assigned scalars may be different than 100% but would not necessarily be. Different methodologies may produce similar results. Scalars are jurisdiction-specific and not IAIG specific. For a given type of entity, every IAIG will use the exact same scalar.
45. A ‘scalar methodology’ is a means of using data, statistical analysis and/or judgment to calculate a set of scalars. A methodology is a verbal description of how scalars are determined for each entity category. Once selected, a methodology does not change.
46. A scalar can adjust for differences in the level of calibration between different types of capital requirements and also potentially differences in valuation.
47. Scalars can be “pure” or “excess”. Pure scalars are only applied to the underlying capital requirement. Excess scalars also make an adjustment to available capital to preserve the amount of excess assets (the amount by which the available capital exceeds the required capital). For a pure scalar, the calibration level depends on the intervention level of the underlying capital requirement and the scalar itself. For example, applying a scalar of 1.5 to US RBC at 200% of the Authorized Control Level is equivalent to applying a scalar of 1.0 to US RBC at 300% of the Authorized Control Level. For excess scalars, the calibration level only depends on the choice of intervention level. Further information on these types of scalar methodologies can be found in section 4.3 below.

4.1.1 Identifying a Point of Comparison

48. The Academy paper recommends using a practical approach to scaling by identifying some characteristic of the entities within each jurisdiction as a point of comparison – a common “yardstick”. This contrasts with the more abstract “ideal” of scalars that produce the same capital ratio for the foreign entity as that entity would have exhibited had it operated in exactly the same way in the home jurisdiction. This ideal is unachievable and undesirable. Differences between entities (risks, products, regulatory practices, etc.) limit the effectiveness of a capital framework outside the business model to which it was designed to apply. As the Academy paper notes, for a bank to recalculate its available and required capital using rules governing insurance entities “may not only not be ideal, it may not be useful at all”. Even within the insurance industry, using the “ideal” scalar would remove the adjustments that have been contemplated by the local supervisor to address these differences. The Academy paper recommends selecting a “yardstick” that can be measured for the full range of business models and industries in which an insurance group may operate. The Academy paper considers many variations, but the two basic examples of this are probability of default and average level of capital adequacy.

4.1.2 Total Balance Sheet Perspective on Calibration

49. Scalars can adjust for differences in: (1) the overall level of conservatism of different capital frameworks (i.e. their calibration); and/or (2) the extent to which that conservatism is reflected in the valuation of liabilities versus the capital requirement itself.
50. Adjustments for differences in calibration are made by adjusting the amount of required capital. Analysis on individual regimes would determine the individual level of solvency protection. Examples of such analysis include empirical study of probability of default, comparison to known benchmarks that are calibrated to known levels, or reference to existing equivalence agreements between regimes. Required capital can be scaled up (or down) to any level to achieve the target calibration of the aggregation method as a whole. Note that, mathematically, this is equivalent to using a higher (or lower) intervention level as the starting point of the AM calculation.
51. Adjustments for differing levels can be made by adjusting available capital in a way that preserves the amount by which it exceeds the required capital. An example of a method that does this is the Excess Relative Ratio approach. From a total balance sheet perspective, this does not change the level of calibration (i.e. it does not change point of intervention), but it would change the capital ratios.

4.2 Criteria for Evaluating Scalar Methodologies

52. The Academy paper presents four general criteria for assessment of scalar methodologies: validity, reliability, ease of implementation and stability of parameters. The Academy paper’s description of these criteria is paraphrased below. After each description, there is a discussion of related AM Data Collection analysis including the role of the data being collected.
53. Validity means that the selected methodology generates values for available and required capital for an entity in a foreign jurisdiction that can appropriately be added to the values of available and required capital for entities in the home jurisdiction. There are two common ways in which validity of the scalar measures are evaluated: (1) the reasonableness of assumptions;

and (2) the correlation of the measure with other known measures of similar quantities. The Academy paper relies on reasonableness of assumptions. The AM Data Collection analysis also looks at how various benchmarks of capital adequacy compare to AM results and to each other. These benchmarks include financial strength ratings, distance to default, and the ICS.

54. Reliability means that any entity or group calculating a scalar will know with confidence they are using the same information which any other entity or group would use. This implies that the scaling methodology must be transparent, unambiguous, and based on broadly available and understood data. The scalars used in the AM Data Collection are publicly available (as will any scalars used in the final AM).
55. Ease of implementation is based on availability of data and compatibility with existing procedures. This includes consideration of the degree to which these data sources are available, understood, and compatible with existing procedures for analysis.
56. Stability of parameters is important if the parameters are to be useful. Depending on the purposes for which the scalars are to be used, more or less sensitivity to changing conditions might be appropriate. The Academy paper discusses sensitivity analysis in two different dimensions: (1) sensitivity of results to changes of parameters within a model; and (2) sensitivity of results to differences in methods of calculating scalars. Sensitivity analysis is performed on the AM Data Collection by reweighting entities, changing the size of different scalar options, and looking at the impact of individual categories of entities on individual and total results.

4.3 Methodologies Under Consideration

4.3.1 Provisional AM

57. This method serves as the default calculation while the AM is under development. It is 'unscaled' (i.e. scalars are 100%). The underlying assumption is that each regime uses the approach to valuation, capital resources and capital requirements that is best suited to the products within that jurisdiction and so the adjustments needed to best bring each regime to a comparable level are already made in the underlying regimes.

4.3.2 Pure Relative Ratio Approach (Pure RRA)

58. This method adjusts only the capital requirement of regulated entities for each local regulatory regime within the IAIG. Scalars are calculated through a comparison of the industry average capital ratio within each entity category. For example, if the average capital ratio within one jurisdiction is twice as large as another, then the scalar for that jurisdiction will be half as large. The US RBC category scalar is being tested at different intervention levels equivalent to 200% and 300% of the Authorized Control Level under NAIC Risk Based Capital. A decision on which level would be used will depend on which level (for the US and any equivalent jurisdictions) is considered most comparable to the ICS.

4.3.3 Excess Relative Ratio Approach

59. This method adjusts both available capital and required capital. It adds a step to the Pure RRA by looking at the excess capital (also referred to as free surplus) ratio above the first intervention level requirement. To calculate a jurisdiction's excess capital ratio, one would first calculate the amount of the capital ratio in excess of the capital ratio required at the selected intervention

level. This amount would then be divided by the capital ratio required at the selected intervention level; for an example of this calculation, see Appendix 2. This method is also being tested at different intervention levels equivalent to 200% and 300% of the Authorized Control Level under NAIC Risk Based Capital. A decision on which level would be used will depend on which level (for the US and any equivalent jurisdictions) is considered most comparable to the ICS.

4.3.4 99.5% Value at Risk

60. These are pure scalars that are calibrated to a level equivalent to a 99.5% Value at Risk over a one-year time horizon. For a jurisdiction that is calibrated to this (or an equivalent⁶) level, this method would be unscaled. Examples of equivalent levels are a 99% Tail Value at Risk over a one-year time horizon and a 0.5% probability of default over a one-year time horizon. The latter is sometimes referred to as a “minimum investment grade level”.

4.3.5 Supervisory Assessment Approach

61. This method uses the local PCR (or equivalent) as the required capital for regimes that produce comparable outcomes to the ICS including having an equivalent level of solvency protection. This would be similar, in practice, to the 99.5% Value at Risk methodology but would have additional qualitative consideration of other comparability criteria. In practice, the 99.5% VaR method is similar to the provisional AM and so this method also produces similar results to an unscaled approach.

4.4 Methodologies No Longer Under Consideration

62. Over the course of the monitoring period, analysis on scalars has narrowed the range of reasonable methodologies that have the potential to produce comparable outcomes to the ICS. While the following methodologies are no longer under consideration, these summaries are provided to help give an understanding of how the thought process around the use of scalars has evolved.
63. Reverse Engineered ICS: This method uses scalars that are calibrated to a level equivalent to the average level of ratios under the reference ICS (ICS Version 2.0 for the monitoring period). Initial indications showed that the method was highly sensitive to changes in weighting. Use of the reference ICS was problematic due to the valuation and the one-size-fits-all nature of the standard method for calculating the capital requirement. While it is possible that design changes to valuation in the candidate ICS may reduce these problems, reflecting the use of internal models in a scalar based method would remain.
64. Internal Model: This method includes scalars that a group’s internal models have determined are equivalent to a specified target calibration (e.g. a 99.5% Value at Risk over a one-year time horizon). While this method is not under consideration for the AM itself, it may be of use to

⁶ From ICP 17.8.3: “With regards to the choice of the risk measure and confidence level to which regulatory capital requirements are calibrated, the IAIS notes that some supervisors have set a confidence level for regulatory purposes which is comparable with a minimum investment grade level. Some examples have included a 99.5% VaR calibrated confidence level over a one year timeframe, 99% TVaR over one year and 95% TVaR over the term of the policy obligations.” (<https://www.iaisweb.org/icp-online-tool/13528-icp-17-capital-adequacy/>)

groups that use aggregation in their internal models that are used to calculate the ICS. Note that for this method to be considered appropriate for use as an other method of calculating the ICS capital requirement, a group would need to demonstrate to their supervisor that it meets the requirements for use as an internal model.

65. Banking Equivalent: This method is scaled to a level that local supervisors consider equivalent to Basel banking requirements. For most jurisdictions this would be equivalent to an unscaled approach. The ICS does not scale Basel banking requirements and so is intended to be scaled to the same level. For the US, analysis by the Federal Reserve indicates that Basel is equivalent to an RBC intervention level of 250%. While it produces similar indications as some other methods under consideration, this banking equivalent approach is not under consideration as it is not as directly focused on insurance risk.

5 Finalizing the AM

5.1 Selecting Final Methodology

66. This document describes the AM as envisaged for implementation subject to further changes which may be decided based on the outcome of the IAIS comparability assessment and analysis of the results of the annual AM Data Collection.
67. The AM template has the functionality to test (and back-test) any potential revisions, including those to scalars. The AM Data Collection includes a variety of scaling methodologies that represent a full range of reasonable methods of scaling local capital. These methods were selected based on analysis of data from the AM Data Collection and consideration of the comparability criteria, which were developed so as to not give the AM a free pass nor preclude comparability at the outset. While it is not yet known which method(s) will produce comparable results, the goal is to select a scalar methodology for the final AM that is meaningful from a prudential point of view, relevant for the monitoring of financial soundness and provides comparable outcomes to the ICS.

5.2 AM Implementation

68. Similar to the ICS, once finalized, jurisdictions using the AM will implement it into their group capital regime. For example, as a jurisdiction that has noted its intent to implement the AM, the US will implement the AM for US IAIGs via the Group Capital Calculation (GCC). This is a similar calculation to the AM but with additional disclosures and more specific guidance. The GCC provides analytical information to the group-wide supervisor for use in assessing group risks and capital adequacy. The GCC helps US state insurance supervisors perform an assessment of capital when combined with other information obtained by US state insurance supervisors. This includes group organizational information provided on Schedule Y, enterprise risk information on Form F, and internal risk self-assessment information in Own Risk and Solvency Assessment (ORSA) filings (where applicable).

5.3 Ongoing evolution of the AM

69. The AM will evolve with the local solvency regimes that it uses as building blocks. As these regimes adapt to changes in the legal entities owned by IAIGs, the AM will too. Any updates to

parameters will be done in a manner consistent with the current specifications for the AM. Local prescribed capital requirements (or equivalent) will be maintained through communication with local supervisors. Further maintenance of scalars will be a technical exercise done in accordance with principles underlying the selected methodology. Similar updates will be needed for parameters used in the ICS and any process for doing so will be considered for use in the AM as well. The components of the AM are inherent to any aggregation-based method and so will not change.

DRAFT

6 Appendix 1: Correlation Analysis on US Entities

- The US RBC capital regime has been relatively stable for many decades and allows a more direct consideration of correlation than is possible with the AM Data Collection. Without precluding whatever decision is made for the aggregation of all entities, the following correlation analysis can be performed specifically for US legal entities:
 - Similarity of Life RBC and P&C RBC
 - Correlation between P&C RBC and the ICS
 - Correlation between Life RBC and the ICS
- Note that scaling changes the quantum of change but multiplying by a constant does not impact correlation. This means that all potential scaling options are correlated with the provisional AM and a change to the scaling methodology will not impact analysis on the correlation between the AM and the ICS.

6.1 Life RBC vs P&C RBC

- While developing its own aggregation-based approach to group capital, the Federal Reserve analyzed historical results of life and property/casualty (P&C) entities. For this analysis, the Federal Reserve used logistic regressions to model the relation between solvency ratios and default rates. When analyzed separately, the regression produces very similar parameter estimates for life and P&C (see table below). The differences are not statistically significant. A test of differences yields two-sided p values above 50% for tests of both the slope and intercepts. The lack of a statistically significant difference of slopes indicates capital requirements are comparably conservative in the two frameworks. If one framework had less stringent requirements, then companies operating at a given multiple of the capital requirement would be more likely to default, which was not observed. The lack of a statistically significant difference of intercepts indicates capital resources are comparably conservative in the two frameworks. If one framework had significantly more conservatism embedded into its valuation or capital instrument qualification criteria, a company with a low stated capital ratio would be less likely to default because of the loss absorbing potential of the balance sheet.

	P&C Insurance	Life Insurance
Slope (b)	-0.714	-0.662
Robust Std. Err.	(0.052)	(0.102)
Intercept (a)	-0.402	-0.602
Robust Std. Err.	(0.178)	(0.440)
Observations	21,031	6,862
R²	23.3%	20.3%

- The results above show that Life RBC and P&C RBC provide statistically similar measures of solvency.

6.2 Correlation of P&C RBC with ICS

- As part of work on the AM Data Collection, Team USA has developed models that can approximate ICS results for any US P&C entity or group. This allows calculation of ICS results going back several decades, long enough to make direct calculations of correlation. The results show that the US RBC and the ICS are significantly correlated across a broad range of P&C business models and product mixes. As an example, the following chart shows year-over-year changes in the modeled ICS ratio versus actual changes in the RBC ratio from 2001 to 2020 for a large P&C entity. While the quantum of change differs, the chart shows a similar directional reaction to conditions over this period of time. Applying a Pearson test of correlation, these results have a p-value well below 1%. One can conclude that, for this entity, the results are not due to chance and are statistically significant. Similar results have been found for other entities that report NAIC P&C RBC.

Chart: Year-over-year change in ICS Ratio vs RBC ratio

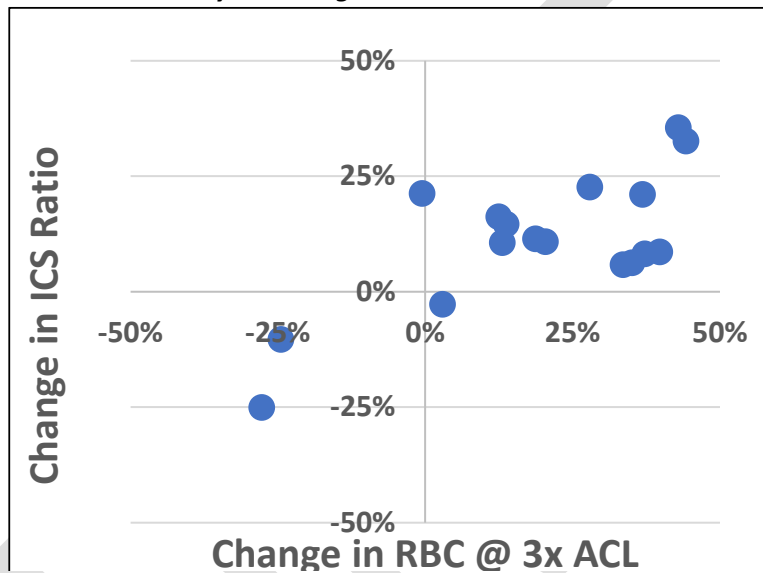


Table: Correlation test with null hypothesis that correlation is not zero

7 Appendix 2: Calculation of Excess Relative Ratio Approach

1. The following has been adapted from the 2022 instructions for the NAIC Group Capital Calculation. Included below are various steps to be taken in calculating the excess relative ratio approach to developing jurisdiction-specific scalars. In order to numerically demonstrate how this approach could work, hypothetical capital requirements and financial amounts have been developed for Country A. Based on preliminary research that has been performed by NAIC staff, it appears that the level of conservatism built into accounting and capital requirements within a jurisdiction may differ significantly for life insurers and non-life insurers. Therefore, ideally each jurisdiction would have two different scalars based on the type of business. The example below includes information related to life insurers in the US and Country A.

Step 1: Understand the Jurisdiction's Capital Requirements and Identify the First Intervention Level

- a. The first step in the process is to gain an understanding of the jurisdiction's capital requirements. This can be done in a variety of ways including reviewing publicly available information on the regulator's website, reviewing the jurisdiction's Financial Sector Assessment Program (FSAP) reports and discussions with the regulator.

In Country A, it assumes that the capital requirements for life insurers are based on a capital ratio, which is calculated as follows:

$$\text{Capital ratio} = \frac{\text{Total available capital}}{\text{Base required capital (BRC)}}$$

In the US, capital requirements are related to the insurer's RBC ratio. For purposes of the Relative Ratio Approach, an Anchor RBC ratio is used and calculated as follows:

$$\text{Anchor RBC ratio} = \frac{\text{Total adjusted capital}}{100\% \text{ Company Action Level RBC}^*}$$

* 100% Company Action Level RBC is equal to the Total RBC After Covariance including operational risk, without adjustment or 200% Authorized Control Level RBC.

- b. Similar to legal entity RBC requirements in the US, Country A utilizes an early intervention approach by establishing target capital levels above the prescribed minimums that provide an early signal so that intervention will be timely and for there to be a reasonable expectation that actions can successfully address difficulties. Presume that this target capital level is similar to the US Company Action Level (CAL) event, both of which can be considered the first intervention level in which some sort of action—either on the part of the insurer or the regulator—is mandated. A separate sensitivity calculation will be applied in the GCC template using trend test level RBC.

- c. For Country A, the target capital level is presumed to be a capital ratio of 150%. That is, the insurer's ratio of total available capital to its BRC should be above 150% to avoid the first level of regulatory intervention. Again, this is similar to the US CAL event, which is usually represented as an RBC ratio of 200% of Authorized Control Level (ACL) RBC (ignoring the RBC trend test). In the Relative Ratio approach, the Anchor RBC ratio represents the Company Action Level event (or first level of regulatory intervention) as 100% CAL RBC (instead of 200% ACL RBC), because CAL RBC is the reference point that is used to calibrate against other regimes. The Anchor RBC Ratio ($\text{Total Adjusted Capital} \div 100\% \text{ CAL RBC}$) tells how many "multiples of trigger level capital" that the company holds. Conceptualizing the CAL event as 100% CAL RBC allows the consistent definition of local capital ratios that are calibrated against a "multiples of the trigger level" approach, to ensure an "apples-to-apples" comparison.⁷

Step 2: Obtain Aggregate Industry Financial Data

2. The next step is to obtain aggregate industry financial data, and many jurisdictions include current aggregate industry data on their websites. Included below are the financial amounts for use in this exercise.

<p><i>U.S. Life Insurers – Aggregate Data</i></p> <p>Total Adjusted Capital = \$495B</p> <p>Authorized Control Level RBC = \$51B</p> <p>Company Action Level RBC = \$102B</p>
<p><i>Country A Life Insurers – Aggregate Data</i></p> <p>Total Available Capital = \$83B</p> <p>BRC = \$36B</p>

Step 3: Calculate a Jurisdiction's Industry Average Capital Ratio

3. To calculate a jurisdiction's average capital ratio, the aggregate total available capital for the industry would be divided by the minimum or base capital requirement for the industry in computing the applicable capital ratio. In Country A, this would be the BRC. In the US, this base or minimum capital requirement is usually seen as the ACL RBC, but because the Relative Ratio Approach is using 100% CAL RBC as a reference point to calibrate other regimes to, the Relative Ratio formula uses 100% CAL RBC as the baseline and the first-intervention level to calculate the Average Capital Ratio and Excess Capital Ratio. As a result, the scaled ratio of a non-US company should inform regulators how many multiples of first-intervention level capital the non-US company holds. Included below is the formula to calculate a jurisdiction's industry average capital ratio:

⁷ While it is mathematically equivalent to use 200% ACL RBC as the denominator, the Approach is designed to use the representation of first-intervention level capital levels as the conceptual underpinning of the Relative Ratio Approach, where 100% CAL RBC is the reference point to calibrate against other regimes.

Calculation of U.S. Industry Average Capital Ratio – Life Insurers

$$\frac{\$495\text{B (Total Adjusted Capital)}}{\$102\text{B (CAL RBC)}} = 485\%$$

Calculation of Country A Industry Average Capital Ratio – Life Insurers

$$\frac{\$83\text{B (Total Available Capital)}}{\$36\text{B (BRC)}} = 231\%$$

Step 4: Calculate a Jurisdiction's Excess Capital Ratio

4. The next step is to understand the level of capital the industry is holding above the first intervention level. Therefore, to calculate a jurisdiction's excess capital ratio, one would first need to calculate the amount of the capital ratio carried in excess of the capital ratio required at the first intervention level. This amount would then need to be divided by the capital ratio required at the first intervention level.

General Excess Capital Ratio Formula

$$\frac{\text{Average Capital Ratio} - \text{Capital Ratio at the First Intervention Level}}{\text{Capital Ratio at the First Intervention Level}}$$

5. Based on the formula above and information provided in Step 2 and Step 3, included below are how to calculate each jurisdiction's excess capital ratio.

NOTE: The first intervention level in the US is defined in the Relative Ratio Approach as 100% CAL RBC, while the first intervention level in Country A is a capital ratio of 150%.⁸

Calculation of U.S. Excess Capital Ratio – Life Insurers

$$\frac{485\% \text{ (Average Capital Ratio)} - 100\% \text{ (Capital Ratio at the First Intervention Level)}}{100\% \text{ (Capital Ratio at the First Intervention Level)}} = 385\%$$

Calculation of Country A Excess Capital Ratio – Life insurers

$$\frac{231\% \text{ (Average Capital Ratio)} - 150\% \text{ (Capital Ratio at the First Intervention Level)}}{150\% \text{ (Capital Ratio at the First Intervention Level)}} = 54\%$$

⁸ 100% CAL RBC translates to an ACL RBC level of 200%, but for conceptual purposes, the Relative Ratio Approach refers to the U.S. first intervention level as 100% CAL RBC, as 100% CAL RBC is the reference point to which the Relative Ratio Approach calibrates other regimes. In other words, 100% CAL RBC ensures that the scaled ratio of Country A results in a ratio that determines how many multiples of first-intervention level capital that the company in Country A is holding.

Step 5: Compare a Jurisdiction’s Excess Capital Ratio to the US Excess Capital Ratio to Develop the Scalar

6. Based on the information above, the US excess capital is 385%. In other words, life insurers in the US carry approximately 385% more capital than what is needed over the first intervention level. Country A’s excess capital ratio is 54%. That is, life insurers in Country A carry approximately 54% more capital than what is needed over the first intervention level.
7. To calculate the scalar, one would divide a jurisdiction’s excess capital ratio by the US excess capital ratio. Therefore, the calculation of Country A’s scalar for life insurers would be $54\% \div 385\% = 14\%$. Therefore, Country A’s scalar for life insurers would be 14%.

Step 6: Apply to the Scalar to the Non-US Insurer’s Amounts in the GCC

8. To demonstrate how the calculation of the scalar works, it would be best to provide a numerical example. For the purposes of this illustration, it assumes that a life insurer in Country A reports required capital of \$341,866 and total available capital of \$1,367,463. As noted previously, the above information and calculation suggests that US life insurers carry capital far above the minimum levels, while life insurers in Country A carry capital far closer to the minimum. Therefore, to equate the company’s \$341,866 of required capital, one must first calibrate the BRC to the first regulatory intervention level by multiplying it by 150%, or Country A’s capital ratio at the first intervention level. The resulting amount of \$512,799 is then multiplied by the scalar of 14% to get a scaled minimum required capital of \$71,792.
9. Further, the above rationale suggests that the available capital might also be overstated (because it does not use the same level of conservatism in the reserves) by the difference between the calibrated required capital of \$512,799 and the required capital after scaling of \$71,792, or \$441,007. Therefore, one should now deduct the \$441,007 from the total available capital of \$1,367,463 for a new total available capital of \$926,456. These two recalculated figures of required capital of \$71,792 and total available capital of \$926,456 is what would be included in the group’s capital calculation for this insurer. These figures are further demonstrated below.

<p><i>Calculation of Scaled Amounts for GCC Amounts</i></p> <p>as Reported by the Insurer in Country A</p> <hr/> <p>Total available capital = 1,367,463</p> <p>Minimum required capital (BRC) = 341,866</p> <p>Calibration of BRC to 1st Regulatory Intervention Level</p> <p>341,866 (BRC) * 150% = 512,799</p> <p>Scaling of Calibrated Minimum Required Capital</p> <hr/> <p>512,799 (Calibrated BRC) * 14% (Scalar) = 71,792 (Difference of 441,007)</p> <p>Scaled Total Available Capital</p> <hr/> <p>1,367,463 (Total Available Capital) – 441,007 (Difference in scaled required capital) = 926,456</p>
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10. Given these scaled amounts, one can calculate the numerical effect on the company's relative capital ratio by using the unscaled and scaled amounts included below.

	<i>Unscaled Amounts from Table Above</i>	<i>Scaled Amounts from Table Above</i>
Total Available Capital (TAC)	1,367,463	926,456
<u>Base Required Capital (BRC)</u>	<u>341,866</u>	<u>71,792</u>
Capital Ratio (= TAC ÷ BRC)	400%	1290%

11. Because life insurers in Country A hold much lower levels of capital over the first intervention level as compared to US life insurers, the change in the capital ratio from 400% (unscaled) to 1290% (scaled) appears reasonable and consistent with the level of conservatism that is built into the US life RBC formula driven primarily from the conservative reserve valuation.

Note: In the above example, the company has an unscaled ratio (400%) that is above the industry average in Country A (231%) and a scaled ratio (1290%) that is higher than the US life industry average (485%). If the company had an unscaled ratio that was lower than the industry average in Country A, its scaled ratio would be lower than the US life industry average. company with an unscaled ratio equal to its own country's industry average will have a scaled ratio equal to the anchor RBC ratio."

Data for industrywide US RBC ratios is sourced from the aggregate RBC Statistics maintained by the NAIC. Data for industrywide capital ratios for foreign insurance jurisdictions was derived from publicly available aggregate industry data. If this scalar methodology is retained, then the data will require periodic updating.

8 Appendix 3: Comparability Data for US Entities

[Note: data for the following are undergoing review and will be populated in the final version]

8.1 Comparison of Life Risks

ICS Risk	Is material ?	Is the risk captured in the local capital requirement?	If no, is the risk reflected in local valuation and/or capital resources?	Describe the calculation of local capital requirement by risk category including its components and interaction, if any, with valuation and capital resources
Life insurance				
Non-life				
Catastrophe				
Market				
Interest Rate				
Non-default Spread				
Risk				
Equity				
Real Estate				
Currency				
Asset Conc				
Credit				
Operational				
Other material risks not captured by ICS				

8.2 Comparison of Property/Casualty Risks

ICS Risk	Is material ?	Is the risk captured in the local capital requirement?	If no, is the risk reflected in local valuation and/or capital resources?	Describe the calculation of local capital requirement by risk category including its components and interaction, if any, with valuation and capital resources
Life insurance				
Non-life				
Catastrophe				
Market				
Interest Rate				
Non-default Spread				
Risk				
Equity				
Real Estate				
Currency				
Asset Conc				
Credit				
Operational				
Other material risks not captured by ICS				

8.3 Comparison of Capital Resources

ICS Resources (Other than Financial Instruments)	Approach used in the ICS (Table 3)	Approach in local capital regime?	Is material ?	If recognition of the item is deducted above specified limit or other, please describe the local capital regime treatment.
Additions to capital resources				
Retained earnings	Recognised			
Accumulated Other Comprehensive Income	Recognised			
Share premium	Recognised			
Contributed surplus (equity-settled stock)	Recognised			
Recognised reserves (eg AVR, IMR)	Recognised			
Other material additions to capital resources				
<Other item 1>				
<Other item 2>				
<Other item 3>				
Deductions from capital resources				
Goodwill, net of associated DTLs	Deducted			
Intangible Assets, net of associated DTLs	Deducted			
Computer Software Intangibles, net of DTLs	Deducted			
DTA from the balance sheet	Deducted			
Defined benefit pension fund assets	Deducted			
Direct and indirect investments in own financial instruments, not otherwise eliminated (eg treasury stock)	Deducted			
Reinsurance assets arising from non-qualifying reinsurance	Deducted			
Value of encumbered assets in excess of the value of relevant liabilities and capital	Deducted			
Other material deductions from capital resources				
<Other item 1>				
<Other item 2>				
<Other item 3>				

INNOVATION, CYBERSECURITY, AND TECHNOLOGY (H) COMMITTEE

Innovation, Cybersecurity, and Technology (H) Committee Aug. 13, 2023, Minutes.....	12-2
Big Data and Artificial Intelligence (H) Working Group Aug. 13, 2023, Minutes (Attachment One).....	12-9
Information in Technology and Regulation (H) Working Group April 27, 2023, Minutes (Attachment Two)	12-14
Privacy and Protections (H) Working Group Aug. 12, 2023, Minutes (Attachment Three).....	12-17
Privacy and Protections (H) Working Group July 25, 2023, Minutes (Attachment Three-A).....	12-24
Privacy and Protections (H) Working Group June 5–6, 2023, Minutes (Attachment Three-B).....	12-28
Privacy and Protections (H) Working Group May 16, 2023, Minutes (Attachment Three-C).....	12-35
Privacy and Protections (H) Working Group May 2, 2023, Minutes (Attachment Three-D).....	12-38
Privacy and Protections (H) Working Group April 18, 2023, Minutes (Attachment Three-E).....	12-42

Draft: 8/30/23

Innovation, Cybersecurity, and Technology (H) Committee
Seattle, Washington
August 13, 2023

The Innovation, Cybersecurity, and Technology (H) Committee met in Seattle, WA, Aug. 13, 2023. The following Committee members participated: Kathleen A. Birrane, Chair (MD); Michael Conway, Co-Vice Chair (CO); Doug Ommen, Co-Vice Chair (IA); Karima M. Woods (DC); John F. King (GA); Gordon I. Ito represented by Kathleen Nakasone (HI); Dana Popish Severinghaus represented by KC Stralka (IL); Chlora Lindley-Myers represented by Cynthia Amann (MO); Troy Downing (MT); Jon Godfread (ND); Adrienne A. Harris represented by John Finston (NY); Judith L. French (OH); Carter Lawrence represented by Stephanie Cope (TN); Kevin Gaffney (VT); and Mike Kreidler represented by Byron Welch (WA). Also participating were: Lori K. Wing-Heier (AK); Wanchin Chou (CT); Michael Humphreys (PA); and Katie Johnson (VA).

1. Adopted its 2023 Spring National Meeting Minutes

Executive Deputy Superintendent Finston made a motion, seconded by Commissioner King, to adopt the Committee's March 22 minutes (*see NAIC Proceedings – Spring 2023, Innovation, Cybersecurity, and Technology (H) Committee*). The motion passed unanimously.

2. Adopted the Reports of its Working Groups

A. Big Data and Artificial Intelligence (H) Working Group

Superintendent Dwyer said the Big Data and Artificial Intelligence (H) Working Group met the morning of Aug. 13 during the Summer National Meeting. Related to the Working Group's artificial intelligence (AI)/machine learning (ML) survey efforts, Superintendent Dwyer said the Working Group received a report from Commissioner Gaffney summarizing observations from the home insurance AI/ML survey. She also reported that the Working Group heard a presentation on generative AI from Casey Kacirek (Deloitte) and David Sherwood (Deloitte). The presentation addressed how generative AI currently works, the emerging capabilities of generative AI, how to measure and mitigate AI risk, insurance industry examples of the benefits of AI, and common AI terms and definitions.

B. Cybersecurity (H) Working Group

Amann stated that the Cybersecurity (H) Working Group met March 7 in lieu of the Spring National Meeting. Since then, the drafting group of state insurance regulators has been meeting to develop a Cybersecurity Event Response Plan (CERP), which will be a useful resource for regulators with less experience but who are charged with leading a department's response to cyber events at regulated entities. The Working Group requested input from the public and received input from trade associations, including the National Association of Mutual Insurance Companies (NAMIC), the American Council of Life Insurers (ACLI), and the American Land Title Association (ALTA). Amann also thanked the states of Connecticut, Kansas, Illinois, New York, North Dakota and Virginia for their contributions to the CERP drafting efforts. The Working Group will also continue monitoring federal and international developments. The Working Group anticipates a meeting in September based on the current progress of the CERP drafting.

C. E-Commerce (H) Working Group

Director French reported that the E-Commerce (H) Working Group chairs have now met several times to discuss the Working Group's next steps and to give NAIC staff guidance on drafting a framework that would serve as a guide for states looking to modernize their regulatory requirements. NAIC staff are currently in the process of scheduling a meeting to present the draft framework for comment, and the Working Group anticipates it will take place in early September.

D. Innovation in Technology and Regulation (H) Working Group

Commissioner Conway reported that the Working Group plans to meet Aug. 29 to hear presentations from the Global Insurance Accelerator (GIA) and InsurTech NY about their programming in support of insurtechs and to discuss what state insurance regulators can do to support the insurtech community. The Working Group is also planning a regulator-only meeting in September to hear from states on how they are using technology to improve regulatory processes.

E. Privacy Protections (H) Working Group

Johnson reported that following the Spring National Meeting, there were several items of note. The Working Group adopted minutes from the four open meetings the Working Group has held since the Spring National Meeting, as well as the minutes from the Spring National Meeting. The Working Group also heard updates from NAIC staff on federal and state privacy legislation efforts. The Working Group also heard comments on specific topics including marketing issues, as well as opt-in and opt-out language related to certain processes discussed in the new *Insurance Consumer Privacy Protections Model Law* (#674). Lastly, the Working Group also discussed asking for additional time to complete the model law. The Working Group will stop taking comments for the time being and will work through the 40 comments received thus far, leading to the exposure of a new draft of the model law. Based on the comments received for the updated model law draft, the Working Group will understand how much additional time would be needed to complete the drafting process.

Welch made a motion, seconded by Executive Deputy Superintendent Finston, to adopt the reports of the Big Data and Artificial Intelligence (H) Working Group (Attachment One); the Cybersecurity (H) Working Group; the E-Commerce (H) Working Group; the Innovation in Technology and Regulation (H) Working Group, including its April 27 minutes (Attachment Two); and the Privacy Protections Working Group (Attachment Three). The motion passed unanimously.

3. Received Comments on the Model Bulletin Exposure Draft

Commissioner Birrane said that the model bulletin draft on the use of algorithms, predictive models and AI was first discussed at the 2022 Fall National Meeting. During that meeting, state insurance regulators discussed that the bulletin would establish a regulatory framework for the use of AI. The regulators chose the approach of a model interpretive bulletin because AI is already subject to regulatory standards and authority. They settled on a principles-based approach with a high-level of standards that would apply generally, focusing on governance. They also acknowledged the importance of validation as part of industry's practices but also recognized practical limitations that sometimes exist. Finally, the regulators settled on placing responsibility for third-party activities on licensees with the expectation that licensees would conduct appropriate due diligence when dealing with third-party data and model vendors.

After deciding on a direction for the bulletin, the regulators convened into four drafting groups with 22 states participating in the drafting process supported by NAIC staff members, including the NAIC's general counsel.

Next, Commissioner Birrane provided a brief summary of the contents of the model bulletin. The bulletin was constructed as regulatory guidance and not as a model law or model regulation, as the regulators decided that existing state laws already apply to the decisions made by insurers using AI systems. The bulletin guides insurers on how to govern their development and use of AI systems that impact consumers, and it also offers guidance on what information and documentation insurers should provide to regulators.

Section 1 of the bulletin gives background and statutory authority in identifying the model laws that provide underlying authority. The regulators recognized that there is not complete uniformity in state laws, so they anticipate that states will adjust the text accordingly. The focus of the bulletin is also on market conduct evaluation and investigation and does not include financial standards for financial examination.

Section 2 identifies definitions for key terms used in the bulletin. The definitions were subject to robust discussion among drafting regulators. Commissioner Birrane specifically invited public comments on the definitions provided in the bulletin.

Section 3 sets the expectation that insurers will establish meaningful governance and risk management policies and procedures and that those policies and procedures will be commensurate with the insurer's AI use.

Section 4 reminds the public that insurers' decisions that are based on AI systems are like any other decisions and are, therefore, subject to review to ensure compliance with the law. The section also provides guidance on the types of information and requests a carrier might expect to see during regulatory reviews of insurer conduct.

With the introduction provided, Commissioner Birrane then opened the floor for discussion, inviting comments from speakers that specifically indicated interest before the meeting in addressing the contents of the model bulletin. Comments were heard from 10 speakers, and each speaker was given three minutes to provide their input.

Peter Kochenburger (Consumer Representative) said that the model bulletin does very little other than describe and expand on what was already expressed in the "NAIC Principles on Artificial Intelligence (AI)" (AI Principles) adopted three years ago. He said the model bulletin missed the opportunity to set guidance and documentation of what insurers need to do when using AI. Kochenburger noted that even for a model bulletin, the language is tentative in areas that it really should not be, such as when encouraging the development of a written automated indicator sharing (AIS) program, which Kochenburger said should be a minimum standard. He also suggested that testing should be required. That way, even in a principles-based approach, regulators can create guidance with teeth to it. Kochenburger also noted that the bulletin reminds insurers that they have to follow state law, but that is already expected as expressed in the AI Principles written three years ago. In some instances, he said the model bulletin represented a step back as well (e.g., when discussing the concept of proxy discrimination against protected classes). Kochenburger said he recognizes the importance of careful wording but after so many years, it is important for the regulators to agree on guidance on unintentional harm.

Dave Snyder (American Property Casualty Insurance Association—APCIA) said that during his years of participation at the NAIC, while there have always been issues and challenges, he did not recall an era where there was so much that was challenging and profoundly disturbing, and as seen with the catastrophe in Hawaii, even tragic. He said the moment calls on regulators and interested parties to work together for the benefit and support of the general public. Regarding the bulletin, Snyder expressed that the overall approach to the model bulletin was correct and that the APCIA appreciated the effort reflected in the draft. He also expressed appreciation for the proportionality and flexibility of the bulletin, as well as the priority that was placed on governance. He added that at first, the bulletin's scope appears to sweep in operations and data that are already adequately regulated and do not need additional regulation. Second, the bulletin's language reflects the current reality of the availability of data and the undesirability of obtaining certain types of data. The APCIA is concerned about any data collection that the public

does not want insurers to gather or use. Regarding third-party vendors, the APCIA's smaller insurer members would have some difficulty with these provisions, and that difficulty may extend to larger insurers, as well, in a way that deprives insurers and ultimately the public of beneficial innovation. Fourth, regarding terminology, Snyder emphasized that the legislative standards mentioned in the bulletin should govern the terms used in the bulletin and should not be undermined or modified in favor of any unlegislated standard or terminology. Fifth, the APCIA is concerned about the danger of unnecessary costs. Unless resolved, these issues could impose burdens and ultimately harm, not help, the public. These harms could include increased cost, subpar service, and less technology and information that could help prevent and manage loss. The APCIA asked to continue forward on a bulletin that is appropriately limited in scope, that reflects the realistic status and issues with testing for demographics, helps address third-party vendor regulatory issues without closing off access to the expertise and innovation of other players, adheres in all ways to legislated standards, and results in the most cost-effective bulletin for regulators, insurers, and ultimately, the public.

Dave Sandberg (American Academy of Actuaries—Academy) said that the Academy applauded the bulletin's focus on a framework to document and govern decisions based on AI systems. A focal point of decisions would be essential to assess the depth and breadth of the necessary documentation of governance. Sandberg also drew a comparison of the structure and implementation of governance requirements to the previous effort to implement the Own Risk and Solvency Assessment (ORSA) requirements. He said that the ORSA requirements focus on documenting key risk management principles, measures, and the governance being used by a company. Sandberg further noted that the ORSA requirements were created and drafted over a relatively short period of time. In contrast, he noted that the principles-based reserving requirements were derived over a 20-year period. Therefore, the Academy asked if the framing and implementation requirements of the bulletins were meant to be the same as or different from those used for the ORSA requirements. Sandberg noted that much of the work being done at the Academy and the other actuarial professions is in parallel to this draft bulletin and will be of use to the NAIC and insurance organizations regarding the guardrails and adequate governance needed for AI systems. He said that work at the Academy included content and resources developed by Academy committees, as well as the professional standards for actuarial work that are maintained by the Academy. He stated current applicable standards, include modeling, assumptions setting, and risk classification. Sandberg closed with a reference to the upcoming Center for Insurance Policy and Research (CIPR) educational event during which Dorothy Andrews (Academy) would be sharing further details on projects of the Academy that would be of most interest and applicable to the discussions on the bulletin.

Andrew Pauley (NAMIC) said that NAMIC appreciates the time and effort put into the task of providing a framework and guardrails for insurer use of AI/ML and associated technology systems. Pauley implored the Committee to embrace the many positive aspects of AI/ML that can have important and transformational results for policyholders and consumers. He further stated that NAMIC and its members do not want any legitimate harm to come to consumers or policyholders. NAMIC believes the model bulletin provides a draft framework that can accomplish the Committee's goals while finding common ground with industry and stakeholders. Pauley noted that NAMIC will offer suggestions in the areas of statutory authority to act in these instances; clarification of some of the definitional aspects, such as bias or algorithm; enhanced protections for industry information; risk-based understanding; and needed clarification on some of the principles elucidated in the model bulletin, such as testing and third-party vendor responsibility. He said that NAMIC looks forward to working with the Committee to arrive at solutions that protect and stabilize the insurance marketplace while fostering growth and innovation that benefit all stakeholders.

Brian Bayerle (ACLI) applauded the Committee's leadership for addressing the critical issue of consumer protection. He said that life insurers are increasingly leveraging technology to improve interactions with consumers to make it easier and more convenient to get the financial protections that they need. This includes greater use of technologies that simplify underwriting processes. He said that a regulatory framework designed to eliminate unfair discrimination must be balanced with emerging technologies that help expand the coverage

to underserved communities. Bayerle said the model bulletin would allow life insurers to use such technologies to meet consumer demands for an easier, less-intrusive underwriting process while advancing the objective to eliminate unfair discrimination of consumers. However, he said the ACLI has concerns about certain definitions and the imposition of impractical oversight and new contractual obligations on the use of third-party vendors, which will be challenging for smaller to mid-sized companies throughout the country.

Randi Chapman (Blue Cross Blue Shield Association—BCBSA) expressed appreciation for the Committee’s work on the model bulletin. She said the BCBSA believes it is important to continue researching and developing best practices and standards for the use of AI tools across all industries. These best practices and standards should focus on emerging risk mitigation that is grounded in the National Institute of Standards and Technology (NIST) *Artificial Intelligence Risk Management Framework*, which includes accountability, security and safety, privacy and confidentiality, transparency and explainability, reliability, fairness, and bias mitigation. The BCBSA supports the development of a risk-based approach that measures the need for appropriate protections without stifling innovation, and it encourages the NAIC to coordinate with federal regulatory partners, like NIST, to promote consistency in AI governance best practices. The BCBSA believes that consistent and uniform standards that address algorithm documentation, testing, and auditing, as well as stakeholder education, will foster greater trust and accountability in AI tools.

Michael DeLong (Consumer Representative), on behalf of the Consumer Federation of America (CFA), said consumer groups have long been concerned about protected class unfair discrimination generated by insurer use of data that are racially biased, which indirectly cause unfair discrimination on the basis of race. DeLong added that with insurers’ explosive growth in using new sources and the types and volumes of data and AI, state insurance regulators acknowledged the increased potential for racially biased data and algorithms to produce protected class unfair discrimination in 2020 with the adoption of the AI Principles. Shortly after the adoption of the AI Principles, the NAIC created the Special (EX) Committee on Race and Insurance, which is charged with determining if current practices exist in the insurance sector that potentially disadvantage minorities. DeLong said that while the NAIC has done much on diversity, equity, and inclusion (DE&I) among insurers and regulators, structural racism in insurance has not been addressed. He further stated that the model bulletin is not principles-based, but a prescriptive governance approach that does not expand on the AI Principles nor provide specific guidance, principles-based or otherwise, to NAIC committees, working groups, insurers, or regulators on how to implement the AI Principles. DeLong noted that it fails to provide essential definitions, does not define proxy discrimination, fails to address structural racism in insurance, and incorrectly tells insurers that testing for protected class bias may not be feasible.

Birny Birnbaum (Center for Economic Justice—CEJ) said that AI governance, risk management procedures, and documentation are necessary and important but not sufficient. Birnbaum stated the emphasis should be placed on testing consumer outcomes for fair and unfair discrimination during all phases of the insurance life cycle and in both model development and post-deployment. Birnbaum added that regulatory guidance is needed to generate this testing, including proxy discrimination defining, to establish at least one uniform testing methodology, reporting of testing results by insurers, and to establish thresholds for what constitutes proxy discrimination. Birnbaum said that for some issues such as for cybersecurity, it is necessary to rely on good hygiene or process guidance to try to prevent bad outcomes because there are not enough outcomes against which to apply predictive analytics. Insurers have and regulators can obtain the data and ability to ensure good market outcomes and compliance through testing of these outcomes for fair and unfair discrimination. Testing should be the central feature of governance. Meaningful guidance regarding the fairness prong of the AI Principles must include insurer data testing guidance. Testing for racial bias has been done for housing, employment, credit, and even insurance for five decades. There are well-accepted methods for such testing so that regulators do not have to invent their own methodology. Birnbaum gave an example of what would happen if a governance-only approach to financial solvency was enacted, but it would not make sense with metrics, such as risk-based capital (RBC), giving regulators the ability to quickly review and compare hundreds of insurers and their relative financial

condition. He added that the same logic behind a standard methodology and standard metrics for RBC should apply to establishing standard metrics and testing methodology for insurer's use of AI.

Jim Hodges (National Alliance of Life Companies—NALC) said that the principal-based approach is the correct approach. However, he stated that the NALC wanted to raise several issues, with the first being the uneven negotiating power of small versus large companies. Vendors in smaller companies may not enjoy the same level of cooperation or abilities to modify terms and conditions that the larger companies have. The second issue involves better defining specific terms around AI to discern between newer technologies versus algorithms that have been around for decades. Hodges also noted that other federal and state regulators are wrestling with the same issues and encouraged regulators to collaborate to provide consistent definitions to spur innovation and ensure a more consistent approach for consumers, insurers, and regulators. Hodges stated the importance of engaging with technology companies to share the sensitivity points of regulators and to try to have those issues addressed. He said an ongoing dialogue will lead to better products that address regulatory concerns and regulatory mandates. Hodges noted the bulletin also references the federal Unfair Trade Practices Act and is concerned that utilization of new AI tools may be deemed appropriate in one state and an unfair trade practice in another, which will discourage the use of innovative tools. Where possible, companies and regulators should work together to advance the use of innovative tools on a consistent and uniform basis. The NALC also believes that pilot initiatives around new regulatory approaches should be undertaken to test both effectiveness and fairness.

J.P. Wieske (American InsurTech Council—AITC) expressed appreciation for the time regulators have taken to work with industry representatives on the continued development of the model bulletin. Wieske further said the AITC appreciates that the bulletin requires insurers to have the same standard across anything they use fundamentally in their insurance products and gives regulatory authority that makes sense, is consistent, and is time-tested. Wieske said the AITC acknowledged that many concerns have been raised on what AI is and raised that the definitions in the model bulletin may need to be revised. He also expressed that AI is simply another tool available to insurers that should be held to the same standards that insurers have to meet today. Wieske said that while he understands that there are concerns on the use of AI, those concerns are likely reflective of already existing concerns in the current marketplace. The AITC would like the NAIC to consider the process that exists in market conduct, which is more generally around self-audit and comprehensive self-audit, and is not mentioned in this bulletin. Wieske encouraged the NAIC to work with large, medium, and small companies privately to better understand how AI is being used in insurance.

Commissioner Birrane then opened the floor for discussion from Committee membership, other regulators, or interested parties.

Commissioner Humphreys posed that a general question be issued to companies in order to incorporate feedback in written comments about the oversight of third-party groups regarding compliance with non-discrimination laws. He said he has heard from companies that do feel they have the power to require cooperation with insurance departments but is unsure if that would be true for companies of all sizes. Commissioner Humphreys has also heard from smaller companies that feel they have little to no power to negotiate such terms. He drew a comparison to pharmacy benefit managers and wondered about the possibility of licensing service providers similar to rating organizations where departments have to work with the service providers to get into compliance. Commissioner Humphreys asked for feedback on third-party oversight that would give companies comfort in knowing that the service providers are not discriminating.

Chou asked the Academy to elaborate on how effective ORSA is given that many companies treat the filing as a compliance exercise.

Sandberg responded to Chou that the value of ORSA is that it lays a foundation for productive conversations. Sandberg continued by noting that AI is emerging, and the ability to have a set of metrics will be a long process and will be a good foundation for having further productive conversations. He added the ORSA filings allow companies to engage with regulators about their controls and emerging risks. He drew a parallel to AI-related discussions, noting the process to develop a set of metrics that remain unchanged and are codified will require a foundation to be laid.

Commissioner Conway added to Commissioner Humphrey's commentary said on the third-party aspect of the bulletin. He noted that if the regulators are going to have an outcome-focused testing methodology, then third parties will necessarily need to be involved. Conway noted it is important for companies to address this testing, and if there is a problem with third-party agreements, he questioned how industries will respond if there is a problem with outcome-testing.

Commissioner Birrane then opened the floor to any others who did not sign up to speak ahead of the meeting. Brendan Bridgeland (Center for Insurance Research—CIR) pointed out one sentence in the bulletin that he found troubling, which he quoted: "Current limitations on the availability of reliable demographic data on consumers make it challenging for insurers and regulators to directly test these systems to determine whether the decisions made meet all applicable legal standards." Bridgeland stated this sentence should not be in the bulletin, as it undermines the power of regulatory authority, implying that regulators will not be able to deal with this in the future.

Director Wing-Heier said that the bulletin is a good working document. She said she appreciated the hours spent on it and acknowledged the bulletin has been a significant project and represents a good start.

Commissioner Birrane concluded by stating that when the Committee receives all the written public comments, the Working Group will meet in regulator-to-regulator session, and then it will present a second draft of the model bulletin at the end of September.

Having no further business, the Innovation, Cybersecurity, and Technology (H) Committee adjourned.

SharePoint/NAIC Support Staff Hub/Member Meetings/H Cmte/2023_Summer/H-Minutes/H-Cmte-Minutes081323 v4docx

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Big Data and Artificial Intelligence (H) Working Group
Seattle, Washington
August 13, 2023

The Big Data and Artificial Intelligence (H) Working Group of the Innovation, Cybersecurity, and Technology (H) Committee met in Seattle, WA, Aug. 13, 2023. The following Working Group members participated: Elizabeth Kelleher Dwyer, Chair (RI); Amy L. Beard, Co-Vice Chair, represented by Victoria Hastings and Alex Peck (IN); Doug Ommen, Co-Vice Chair (IA); Adrienne A. Harris, Co-Vice Chair, represented by John Finston (NY); Kevin Gaffney, Co-Vice Chair (VT); Mark Fowler (AL); Barbara D. Richardson (AZ); Michael Conway, Peg Brown, and Debra Judy (CO); Andrew N. Mais, George Bradner, and Wanchin Chou (CT); Susan Jennette (DE); Rebecca Smith (FL); Shannon Hohl (ID); Erica Weyhenmeyer (IL); Chuck Myers (LA); Rachel M. Davison (MA); Kathleen A. Birrane (MD); Timothy N. Schott (ME); Karen Dennis (MI); Phil Vigliaturo (MN); Cynthia Amann (MO); Colton Schulz (ND); Eric Dunning (NE); Christian Citarella (NH); Matt Walsh (OH); Teresa Green (OK); Alex Cheng (OR); Shannen Logue, Katie Merritt, and Michael McKenney (PA); Ryan Basnett (SC); Travis Jordan (SD); Stephanie Cope (TN); Mark Worman (TX); Scott A. White (VA); Bryon Welch (WA); Rachel Cissne Carabell (WI); and Erin K. Hunter (WV). Also participating were: John F. King (GA); and Matt Gendron (RI).

1. Adopted its Spring National Meeting Minutes

Commissioner Ommen made a motion, seconded by Commissioner Gaffney, to adopt the Working Group's March 22 minutes (*see NAIC Proceedings – Spring 2023, Innovation, Cybersecurity, and Technology (H) Committee, Attachment Two*). The motion passed unanimously.

2. Received an Update on the AI/ ML Surveys

Commissioner Gaffney said the Artificial Intelligence (AI)/Machine Learning (ML) surveys are being conducted to accomplish three goals: 1) gain a better understanding of the insurance industry's use and governance of big data and AI/ML; 2) seek information that could aid in the development of guidance or potential regulatory framework to support the insurance industry's use of big data and AI/ML; and 3) inform state insurance regulators as to the current and planned business practices of companies. Commissioner Gaffney said the public report of the Private Passenger Automobile (PPA) AI/ML survey was distributed at the 2022 Fall National Meeting and is posted on the NAIC website under the Big Data and Artificial Intelligence (H) Working Group.

Commissioner Gaffney said the public report of the Home AI/ML survey has been issued. The Home Insurance survey was conducted under the examination authority of 10 states (Connecticut, Illinois, Iowa, Louisiana, Nevada, North Dakota, Pennsylvania, Rhode Island, Vermont, and Wisconsin) and was issued to insurers having at least \$50 million in national homeowners written premium in 2020. Just like the PPA survey, the requesting states agreed the collected data will not be used to evaluate or determine a company's compliance with applicable laws and regulations and that all company-specific information will be kept confidential under state examination authority.

Commissioner Gaffney said the survey was focused on the use of AI models, which include ML, but it was specifically limited to exclude the use of more traditional generalized linear models (GLMs) in the areas of claims, fraud identification, marketing, rating, underwriting, and loss prevention. He said the survey also asked about data elements used by operational area, how consumers are notified of the use of data and their ability to request a correction to data being used, how governance is documented in the company's governance framework, and the names of third-party vendors providing data and/or external models.

Out of the 194 companies completing the survey, Commissioner Gaffney said 136 companies (or about 70%) use, plan to use, or plan to explore using AI in their operations. This is not quite as high as the 88% of the responses received from the PPA survey, which may be due to less usage of AI/ML claims models in homeowners insurance. Among insurer operations areas, Commissioner Gaffney said the percentage of companies using AI models in homeowners insurance were: 1) claims, 54%; 2) underwriting and marketing, both at 47%; 3) fraud detection, 42%; 4) rating, 35%; and 5) loss prevention, 14%. He said the main reasons reported for not using, not planning to use, and not exploring the use of AI for home insurance were: "no compelling business reason"; "waiting for regulatory guidance"; and "lack of resources and expertise." In the claims function, the home insurers reported using AI mostly for subrogation, claims triage, and evaluating images of loss.

Commissioner Gaffney said home and PPA insurers use claims models to analyze images of loss. Home insurers also use claims models to determine subrogation and for claims triage. He said home insurers do not use claims models to make claim assignment decisions or to determine settlement amounts as much as reported in the PPA survey. AI/ML claims models for both home and PPA were generally developed in-house except those used to evaluate images, which tend to be developed externally.

For fraud identification, Commissioner Gaffney said both PPA and home insurers reported using AI mainly to refer claims for further investigation, with some using AI to detect organized crime rings. Some home insurers also reported using social media for fraud identification. For both home and PPA, fraud models were mixed between internally and externally developed models.

For marketing, Commissioner Gaffney said both home and PPA insurers are generally using AI for targeted online advertising. Generally, the marketing models used in both PPA and home were reported about equally developed in-house and purchased from a third party.

For rating and underwriting, Commissioner Gaffney said there was less usage of advanced AI/ML models reported, mainly reflecting the transparency requirements by state insurance regulators, where more traditional GLMs provide this transparency. Almost all rating and underwriting models were developed in-house. Home insurers reported that most models used in underwriting were for automated or augmented denial decisions and for verification of policy characteristics.

For loss prevention, Commissioner Gaffney said 28 home insurers reported using AI mainly for guidance on loss control inspections, but only three PPA insurers reported using AI for loss prevention.

Commissioner Gaffney said a variety of typical data elements are being used in home and PPA insurance depending on the model purpose and that insurers are also looking at a lot of geo-demographic data externally sourced. For marketing, insurers are looking at a lot more types of data to identify prospects than would be allowed for use in ratemaking or underwriting, such as data on occupation, education, personal finance information, and income.

When asked about information provided to policyholders about how their data is being used and opportunities to correct their data, Commissioner Gaffney said there was a low response rate from insurers reporting they do more than what is required by existing statutes and regulations.

Regarding insurers' documented governance practices as aligning with the NAIC Principles on AI, Commissioner Gaffney said roughly half of insurers reported they have a documented governance program that considers the elements of the NAIC Principles on AI.

Commissioner Gaffney said potential next steps include exploring insurers' AI model usage and the level of decision-making, evaluating the regulatory framework for the use of third-party models, and determining whether additional white papers on best practices on subjects related to AI/ML would be useful. There were no additional comments or questions from the Working Group members or interested parties.

3. Heard a Presentation from Deloitte on Generative AI

Superintendent Dwyer said the next agenda item is to hear a presentation on generative AI from David Sherwood (Deloitte) and Casey Kacirek (Deloitte). Before hearing the presentation from Sherwood and Kacirek, Superintendent Dwyer said NAIC staff asked ChatGPT, which is an example of generative AI, to explain what Generative AI is. The following, edited for brevity, is what ChatGPT produced:

Generative AI refers to a category of artificial intelligence techniques that focus on creating or generating new content, data, or information. These techniques are particularly useful in tasks where creativity, imagination, and pattern recognition are required. When explaining generative AI to state insurance regulators, you can use the following approach: Generative AI involves training a computer program to generate content that is similar to, but not identical to, existing data. It's like teaching a computer to come up with its own versions of things it has seen before. Generative AI models are trained on large datasets to understand the patterns, styles, and structures present in the data. These models then use this knowledge to create new content that fits within the learned patterns. For example, a generative AI model trained on insurance claim data can generate new, plausible insurance claims based on the patterns it has learned.

Sherwood said AI has been around a long time, and credit card companies use it to detect fraud. Sherwood said generative AI is a hot topic of discussion. Sherwood said Deloitte has a concept called trustworthy AI, and organizations need to think about what controls are in place for AI conducting tasks.

Kacirek said AI is technology striving to mimic human behavior. This encompasses several technologies that work together, including ML, natural language processing, predictive analytics, and speech processing. In terms of the evolution of AI, Kacirek said generative AI is creating content based on human prompts by leveraging robust data sources that are either internally or externally available. Natural language processing (NLP) is another emerging technology, which is the ability to understand text and spoken words. Kacirek said Alexa and Siri are based on the ability to understand human language. Computer vision is another technology that has been in existence and is essentially image recognition, such as facial recognition to unlock a phone. She said Netflix and Hulu use near real-time interfacing to provide consumers recommendations based on the analysis of real-time data on how a consumer is selecting a show. Kacirek said these four technologies are driving the emerging capabilities of AI.

Kacirek said a business could have an initial draft of code written through generative AI and have that draft be the basis for a human coder to review and leverage. Generative AI can also be used for marketing and creative design work. Generative AI can produce a wide range of outputs depending on the specific application and type of data that is needed. Some common output types include text, video, code, image, and audio. Sherwood said generative AI is being used in insurance to create text. For example, draft job descriptions or consumer communications on certain types of claims might be prepared using generative AI. Insurers can then use a human in the loop to review these outputs. For call centers, insurers might use audio generative AI where a human is answering calls with generative AI listening and providing suggested prompts to the types of questions being asked.

Kacirek said the use of external data and third-party data requires monitoring and controls to be in place and that that a human should be responsible for the output. Sherwood said it is unlikely that insurers will be developing their own generative AI systems because there are already leaders in this field. Sherwood said it is important to understand how insurers integrate this technology with their existing technology and how both internal and external data might be leveraged.

Kacirek said there are potential risks with using generative AI, including bias since models are leveraging robust data sets. She said data may have unintentional bias, such as demographic data or protected class data. Because of this, there is a need to monitor for potential bias, and having some level of human supervision during the training of a model is one way to address bias risk. Periodic monitoring is also needed to assure the model continues to perform as anticipated. Kacirek said companies should consider whether the use of a model output is ethical to use. She said another risk is hallucination, which occurs when a model produces an output that sounds plausible but is factually incorrect. Kacirek said this may occur because of poor data quality. Sherwood said generative AI is mimicking human behavior and that risk and control are important because AI works at a higher velocity than humans.

Kacirek reviewed Deloitte's Trustworthy AI framework is intended to provide a framework to address the risks associated with the use of AI. She said the framework is rooted in the National Institute of Standards and Technology (NIST) AI framework. Kacirek said the Deloitte framework includes the following concepts:

- **Fair and impartial:** This involves assessing whether systems include internal and external checks to assure equitable application across all participants and that there is no bias towards certain groups or protected classes. Companies can assess this risk by conducting fairness testing and reviewing whether models are providing any discriminatory outcomes.
- **Transparent and explainable:** Participants can understand how their data is being used and how AI systems make decisions. This means questioning whether algorithms and attributes are open to inspection and whether the outcomes are explainable.
- **Responsible and accountable:** This involves making sure policies are in place to determine who is held ultimately responsible for the output of AI system decisions.
- **Robust and reliable:** This focuses on having the appropriate, minimum requirements or checks for reliability and consistency of an AI model prior to deployment. This also involves ongoing checks after deployment to make sure the model performs as intended.
- **Privacy:** This involves elevating consumer privacy to make sure customer data is not used beyond its intended and stated use.
- **Safe and secure:** This involves elevating safety and security to assure AI systems are protected from risks, including cyber risk.

Kacirek said approximately 50% of organizations have adopted some framework for governing the use of AI. She said companies have an opportunity to leverage existing risk management processes, which have roles and responsibilities, policies and procedures, processes and technology, and aspects of cross-functional compliance. Sherwood said a good example of leveraging existing model risk management is for a company to review the list of models being used and to identify which models are using AI. This might lead to further scrutiny about what data is being used and the third parties being used.

Kacriek said building a trustworthy AI environment involves the concept of establishing three lines of defense. The first line of defense is for the business users to own the model and its outputs. The second line of defense is for a company to establish governance and compliance requirements. The third line of defense is for a company to have an independent review of models. Kacirek said business owners should be performing testing and validation of a model before it is deployed, and there should then be validation, monitoring, and controls in place. She said it is important for companies to understand how quickly they can respond to unintended outcomes of an AI model.

Sherwood said companies should look at the use of AI throughout the value chain and upskill staff in the use of AI. He said there are tasks that may be automated to enhance consumer outcomes or eliminate costs for the company. Sherwood provided an example of the use of accelerated underwriting, chat features of call centers, and the use of AI in claims settlement and fraud detection.

Superintendent Dwyer said it is important for insurance companies to be able to explain how their AI models work. Commissioner Ommen said transparency is an important consumer protection. For example, insurance companies may not be able to adequately explain to a consumer why a claim is being delayed or denied. Sherwood said a model should be generating an outcome, which is reviewed by a human, who then communicates the outcome to the consumer.

Commissioner Birrane said insurers should be able to explain what is causing an adverse decision or outcome for a consumer. Kacirek said a model will evolve over time and that a company should be accessing decisions that are considered outliers. The company can then assess the frequency of these outcomes and use these outcomes for possible training of the model within established guardrails.

Commissioner Gaffney asked how to minimize the risk of overreliance on data. Kacirek said there should be controls to monitor the completeness and accuracy of data prior to its use and ongoing monitoring. Companies should also make sure the data is fit for the intended purpose of the model. In response to Commissioner Gaffney's question about upskilling of state insurance regulators, Sherwood said upskilling should be completed in layers with foundational education provided to a broader set of staff and then more specific training provided to staff based upon their specific role. Sherwood said state insurance regulators should understand control environments and engage with industry to understand challenges. In response to Commissioner Gaffney's question about how AI could be used to reach underserved markets, Sherwood said automation of functions may help lower costs and could potentially lead to more affordable and available insurance.

Having no further business, the Big Data and Artificial Intelligence (H) Working Group adjourned.

SharePoint/NAIC Support Staff Hub/Committees/H CMTE/2023_Summer/WG-BDAI/BDAI Minutes 081323.docx

Draft: 6/26/23

Innovation in Technology and Regulation (H) Working Group
Virtual Meeting
April 27, 2023

The Innovation in Technology and Regulation (H) Working Group of the Innovation, Cybersecurity, and Technology (H) Committee met April 27, 2023. The following Working Group members participated: Jason Lapham, Chair (CO); Dana Popish Severinghaus and C.J. Metcalf, Co-Vice Chairs (IL); Matt Walsh, Co-Vice Chair (OH); Erick Wright (AL); Letty Hardee (AR); Lucy Jabourian (CA); George Bradner (CT); Dana Sheppard (DC); Tim Li (DE); Gordon I. Ito (HI); Jared Kirby (IA); Weston Trexler (ID); Shannon Lloyd (KS); Abigail Gall (KY); Rachel M. Davison (MA); Kory Boone (MD); Sandra Darby (ME); Chad Arnold (MI); Cynthia Amann (MO); Ryan Blakeney (MS); Chris Aufenthie and Colton Schulz (ND); Cassie Soucy (OR); Shannen Logue (PA); Joe McElrath (TX); Melissa Gerachis (VA); Eric Slavich (WA); Jennifer Stegall and Timothy Cornelius (WI); and Juanita Wimmer (WV).

1. Discussed an Overview of its 2023 Work Plan

Lapham said the Working Group's 2023 work plan was submitted to the Innovation, Cybersecurity, and Technology (H) Committee leadership. At the Spring National Meeting, Commissioner Michael Conway (CO) gave an overview of the work plan during the Committee's meeting. He said the Working Group plans to develop a SupTech Forum to allow state insurance regulators to share insights on current innovations and technologies they use in their respective states. He said the Working Group is also looking to develop an Insurtech Forum that will allow state insurance regulators to have one-on-one discussions with insurers and third-party insurtechs that work with insurers about the types of technologies and innovations those insurers and third parties are using, as well as the regulatory barriers and opportunities that exist around those technologies. He said the Working Group will monitor industry developments and create insurtech training for state insurance regulators. As issues arise, the Working Group will pass along referrals to the appropriate NAIC working group or committee.

2. Discussed the Development of a SupTech Forum

Lapham said the idea of a SupTech Forum is for a regulator-to-regulator webinar that would be a forum for states to present on supervisory technologies they are using, which would be beneficial for other state insurance regulators to hear about. He said the point of the webinar is to foster innovative thinking on how state insurance regulators do their jobs. He said one example of supervisory technology is the North Dakota project using blockchain technology to collect uninsured motorist data.

Brander said he would volunteer to present a webinar on Connecticut's use of artificial intelligence (AI) and machine learning (ML) to review files.

Boone said Maryland has many projects it is working on. He said examples include digitizing portable document formats (PDF files) to make it easier for people to fill out forms on their tablets or smartphones using a ticketing system to track complaints and upgrading enterprise accounting software.

Lapham said the goal is to display various supervisory technologies because not all technologies will work in every state. He said small technology upgrades are just as important to showcase as large, innovative projects.

3. Discussed the Development of an Insurtech Forum

Lapham said Working Group leadership and NAIC staff drafted an outline of an Insurtech Forum program to be held at the 2023 NAIC Insurance Summit. He said the Working Group is looking for volunteers to assist with designing and participating in the program.

Lapham said the forum's objective is to facilitate conversations between state insurance regulators, insurers, insurtechs, and interested parties about the types of innovations and technologies available to insurers and insurtechs and the potential regulatory barriers and opportunities. He said the goal is to invite four to six insurtech companies to engage in conversations with the participants in a round-robin style setting. He said it would be helpful to hear from state insurance regulators and interested parties that have participated in similar events to finetune the forum before the launch at the Insurance Summit.

Logue said she would support this effort. She said Pennsylvania created a pipeline that facilitates these conversations with insurers and insurtechs to discuss their innovative technologies with state insurance regulators. She said a forum like this would be a good opportunity to have state insurance regulators from multiple states weighing in on the conversations.

Amman suggested contacting the Insurance Regulatory Examiners Society (IRES) and the Society of Financial Examiners (SOFE) to ask about possible presenters or volunteers for both the SupTech Forum and Insurtech Forum initiatives.

Miguel Romero (NAIC) said the perspective from interested parties would benefit the program's design and implementation.

4. Heard a Presentation from the Aite-Novarica Group on ChatGPT

John Keddy (Aite-Novarica Group) said ChatGPT and other emerging technologies are the hottest topics across all insurance industry sectors. He said the Aite-Novarica Group surveyed the industry and collected data on various technologies. He said in the property/casualty (P/C) industry, interest lies in cloud computing, low-code and no-code technologies, and AI. He said there is also a developing interest in unstructured data. He said the life, annuities, and benefits industry has shown similar interest, with an even higher deployment rate of these technologies driven by larger carriers. He said chatbots have a high deployment rate across the industry, but that technology differs from the technology behind ChatGPT.

Keddy said large insurers especially are taking advantage of data lakes to transform enterprise data management. He said insurers of all types recognize the value of "big data" sources. He said interest in blockchain technology remains more modest.

Keddy said P/C insurers have invested heavily in ML and unstructured text capabilities. He said data is used to drive the training of algorithms in AI. He said the life, annuities, and benefits industry has a higher deployment rate of unstructured text capabilities and voice recognition technology.

Keddy said the survey results show that sustained investment in data, plus broad interest in AI, investment in cloud technology, and fervor around technologies like ChatGPT means now is the time for engagement in AI topics.

Keddy said when discussing AI, it is best first to define the technology, as there are many different technologies under the AI umbrella. He said the trajectory of the AI conversation has rapidly increased in 2023 due to the excitement around ChatGPT. He said ChatGPT is just one technology under the natural language processing part of AI. He said it is best for companies to not only focus on ChatGPT but to look holistically at AI and its uses within the company.

Keddy said outside of the insurance industry, AI has already arrived. He said examples include home security, medical scanning for tumors or diseases, and cybersecurity.

Keddy said his perspective on AI technology is that it should remove abstractions and work within reality, and AI decisions must be explainable and compared to human decisions.

Keddy said technologies and data scientists testing out new models and approaches have more risks. He said automated ML allows people who do not understand the technologies, statistics, or data to create new models, which is a high-risk activity.

Keddy said the takeaways of this discussion include the following: 1) due to sustained investment and recent fervor, now is the time for a conversation on emerging technologies; 2) ChatGPT is an incredibly powerful tool, but the industry should focus on the larger conversation of AI; and 3) the force must be respected, but fundamental principles must not be abandoned.

Lapham said the Working Group will continue to monitor these fast-moving emerging technologies and consider the possibility of developing state insurance regulator training on these technologies.

Having no further business, the Innovation in Technology and Regulation (H) Working Group adjourned.

SharePoint/NAIC Support Staff Hub/Member Meetings/H CMTE/ Summer 2023/WG-ITR/Inn In Tech and Reg WG Minutes Final 042723.docx

Draft: 8/30/23

Privacy Protections (H) Working Group
Seattle, Washington
August 13, 2023

The Privacy Protections (H) Working Group of the Innovation, Cybersecurity, and Technology (H) Committee met in Seattle, WA, Aug. 13, 2023. The following Working Group members participated: Katie Johnson, Chair (VA); Cynthia Amann, Vice Chair (MO); Lori K. Wing-Heier (AK); Catherine O’Neil (AZ); Damon Diederich (CA); George Bradner (CT); Erica Weyhenmeyer (IL); LeAnn Crow (KS); Ron Kreiter (KY); Van Dorsey (MD); Robert Wake and Sandra Darby (ME); Jeff Hayden (MI); T.J. Patton (MN); Santana Edison represented by Colton Schulz (ND); Martin Swanson (NE); Teresa Green (OK); Raven Collins (OR); Gary Jones (PA); Patrick Smock (RI); Frank Marnell (SD); Todd Dixon (WA); Rachel Cissne Carabell and Timothy Cornelius (WI). Also participating were: Sarah Bailey and Heather Carpenter (AK); Peg Brown (CO); Doug Ommen (IA); Victoria Hastings (IN); Jamie Sexton (MD); Eric Dunning (NE); Judith L. French (OH); Matthew Tarpley (TX); and Don Beatty (VA).

1. Heard Opening Remarks

Johnson said the Working Group has what looks like a simple agenda, but it has important discussions ahead of it. She said she and the Working Group would like to thank everyone who has been and continues to be an important part of this transparent, collegial, and collaborative process, especially those who spent considerable time, money, and input for two full days—four days including travel time—to dig into seven important issues with the model.

Johnson said she would like to give an update on the Working Group’s activities to ensure all stakeholders are on the same page going forward. She said the 60-day comment period for the first draft of the new *Insurance Consumer Privacy Protections Model Law* (#674) ended April 3.

Johnson said the drafting group met with companies privately to discuss current consumer data practices on May 9, May 4, April 28, April 27, April 20, April 13, April 12, April 11, April 6, and April 5.

Johnson said the Working Group met July 25, June 5–6 at an in-person meeting in Kansas City, MO; May 16; May 2; April 18; and at the Spring National Meeting to discuss comments received and collaborate on workable language. She said the interim meeting sessions were working sessions focused on the drafting of model language. She said the 112 in-person attendees—29 state insurance regulators, including one commissioner; three NAIC consumer representatives; 68 industry representatives; and 12 NAIC staff members—were asked to be prepared to consider new language and offer their pros and cons. She said participants were asked to keep their comments specific to the topic under discussion. She said topics already discussed in open meetings were not revisited during this meeting.

Johnson said a drafting group met Aug. 9, July 20, July 10, July 7, June 30, June 29, June 26, June 23, June 2, May 17, May 12, and May 5 in regulator-to-regulator session.

Johnson said because Version 1.2 of the new Model #674 was based on changes discussed at the interim meeting, the Working Group exposed it July 11 for a public comment period ending July 28. She said the drafting group privately continued its meetings with industry trades and companies to discuss current consumer data practices Aug. 9, meetings with two different companies on Aug. 3, Aug. 2, and July 28.

Johnson said the Working Group sent interested parties an invitation that it would continue scheduling private calls with trades, companies, and other interested parties. She said the Working Group also notified interested parties that so many comment letters had been received since the interim meeting that the Working Group has been unable to post them all prior to the Summer National Meeting. She said the Working Group will continue posting comments to the website after the national meeting. She said due to the sheer volume of comments and the number of one-on-one calls requested, the Working Group has determined that more time is needed to engage the public and continue drafting the model.

2. Adopted its July 25, June 5–6, May 16, May 2, April 18, and Spring National Meeting Minutes

Johnson said the Working Group met July 25, June 5–6, May 16, May 2, and April 18. During its meetings, the Working Group took the following action:

- A. Discussed comments received and collaborated on workable language regarding the following seven topics:
 - i. Third-party service providers, including the definition of third-party service providers, third-party service providers not related to an insurance transaction but that have access to consumers' personal information, and contracts with third-party service providers.
 - ii. Definitions of insurance transactions and additional permitted transactions.
 - iii. Marketing, including marketing insurance products to consumers using consumers' personal information, marketing other products to consumers using consumers' personal information, and affiliate marketing.
 - iv. Joint marketing agreements (JMAs), JMAs with affiliates, and JMAs with non-affiliated third parties.
 - v. Opt-in versus opt-out consent to marketing and the difference between marketing insurance and non-insurance products.
 - vi. Notice of Consumer Privacy Practices – Contents.
 - vii. Notice of Consumer Privacy Protections – Frequency and Methodology of Delivery.
- B. Drafted Model #674 language. In-person attendees were asked to be prepared to consider the new language and offer pros and cons. Participants were asked to keep their comments specific to the topic under discussion. Topics already discussed in open meetings were not revisited during this meeting.
- C. Exposed Version 1.2 of the new Model #674 on July 11 because it was based on changes discussed at an interim meeting, with a public comment period ending July 28. The drafting group continued its meetings with industry trade companies privately Aug. 9, Aug. 3, Aug. 2, and July 28 to discuss current consumer data practices.
- D. Notified interested parties that so many comment letters have been received since the interim meeting that the Working Group has been unable to post them all prior to the Summer National Meeting. The Working Group will continue posting comments to the website after the national meeting. Due to the sheer volume of comments and the number of one-on-one calls requested, the Working Group has determined that more time is needed to engage the public and continue drafting Model #674.
- E. Discussed comments received and engaged the public to continue drafting Model #674.

The Working Group also met Aug. 12 in regulator-to-regulator session, pursuant to paragraph 4 (internal or administrative matters of the NAIC or any NAIC member) of the NAIC Policy Statement on Open Meetings.

Amann made a motion, seconded by Diederich, to adopt the Working Group’s July 26 (Attachment Three-A), June 5–6 (Attachment Three-B), May 16 (Attachment Three-C), May 2 (Attachment Three-D), April 18 (Attachment Three-E), and March 22 (see *NAIC Proceedings – Spring 2023, Innovation, Cybersecurity, and Technology (H) Committee, Attachment Three*) minutes. The motion passed unanimously.

3. Heard Updates from NAIC Staff on State and Federal Privacy Legislation

Jennifer Neuerburg (NAIC) said in the continuing absence of congressional action on a comprehensive U.S. federal privacy law, many states have enacted state data privacy laws or are considering legislative action. She said on June 30, the Delaware legislature passed the Delaware Personal Data Privacy Act (HB 154), and the bill is ready for governor consideration. She said assuming that the bill becomes law, Delaware will become the 12th state—the seventh this year—to pass a consumer data privacy law. The other states that have passed bills this year are Indiana, Iowa, Montana, Oregon, Tennessee, and Texas. Neuerburg said at least 16 additional states have introduced data privacy bills during the current legislative cycle that are either comprehensive in nature or address a range of data privacy issues, and if anyone wants to read more about these bills, there are charts tracking state legislation on the Working Group’s web page.

Shana Oppenheim (NAIC) said the privacy legal and regulatory landscape is changing quickly in the U.S., particularly for financial institutions, which hold significant volumes of consumer data. She said at the federal level last year, the U.S. Congress (Congress) made significant bipartisan progress on comprehensive federal privacy legislation, advancing the proposed federal American Data Privacy and Protection Act (ADPPA), which passed out of the U.S. House of Representatives (House) Committee on Energy and Commerce with a 53-2 vote and almost made it to a House floor vote. Earlier this year, she said the House Committee on Energy and Commerce’s new Subcommittee on Innovation, Data, and Commerce held a hearing in March titled “Promoting United States Innovation and Individual Liberty Through a National Standard for Data Privacy.” Additionally, she said House Financial Services Committee Chair, Patrick McHenry’s, financial data privacy bill, the Data Privacy Act of 2023 (H.R. 1165), passed out of the Committee along party lines in February. She said it would: 1) revamp existing financial privacy protections for consumers under the federal Gramm-Leach-Bliley Act (GLBA); and 2) create a preemptive ceiling and floor to create a uniform federal standard. She said the current bill allows for enforcement by functional regulators, provides a new deletion right for consumers, and allows consumers to stop collecting and disclosing their data, among other provisions. She said Representative Maxine Waters (D-CA) and the Democrats have been critical of any preemption because it would hinder the states’ ability to act as a laboratory for innovation while establishing a weak federal standard. She said although there seemed to be some legislative momentum earlier this year, nothing has yet come of it. She said more limited/focused data privacy actions seem more likely. For example: 1) the House Judiciary Committee also approved a bill in July that would ban law enforcement agencies from buying people’s sensitive information from data brokers—the Fourth Amendment Is Not For Sale Act; and 2) for the second consecutive year, the U.S. Senate (Senate) has approved two children’s online privacy measures—the Kids Online Safety Act (KOSA)—for floor consideration just before departing for the month-long August recess. Oppenheim said KOSA is focused on social media companies and children’s data. She said U.S. state insurance regulators are also drafting several regulations that may be pertinent: 1) the Consumer Financial Protection Bureau (CFPB) is in the process of issuing a rule for the long-awaited implementation of Section 1033 of the federal Dodd-Frank Wall Street Reform and Consumer Protection Act (Dodd-Frank Act), which would require that consumers be able to access their financial data. She said the rule may specifically affect checking, savings, and credit card accounts. It is expected later this year with a final rule slated for 2024; 2) the CFPB also launched an inquiry into data brokers under the federal Fair Credit Reporting Act (FCRA), and it is attempting to understand the “full scope and breadth of data brokers and their business practices, their impact on the daily lives of consumers, and whether they are all playing by the same rules.” She said the Federal Trade

Commission (FTC) is also investigating commercial surveillance industries, which it defines as collecting, analyzing, and profiting from information about people. She said the term encompasses the collection, aggregation, analysis, retention, transfer, or monetization of consumer data. She also said in an advanced notice of proposed rulemaking in August 2022, the FTC posed 95 questions about consumer harm, data security, and related topics to commercial surveillance companies.

4. Discussed an Extension to Develop the New Model #674

Johnson said the Working Group would like to discuss an extension of the time to develop the new Model #674 due to the sheer volume of comments received on Version 1.2 from July 11 through Aug. 8 and the number of requests for private calls with trade associations, consumer representatives, and companies.

Johnson said the 15 comment letters received prior to the July 28 due date are posted to the Working Group's web page and the meeting platform in the Summer National Meeting Event App. She also said the eight comment letters received after the July 28 due date will be posted to the Working Group's web page following the Summer National Meeting. She said the Working Group received 32 separate comments and redlined language documents in total. Additionally, she said the Working Group needs to review previously received comments to ensure all comments have been considered.

Johnson said extending the timeline would give the Working Group the time it needs to review all the comments submitted and have conversations with those who submitted the comments to ensure all stakeholders are heard and all parties understand the functional differences between different licensees and the various types of insurance being offered to consumers.

Johnson said the next version of the draft would be a redline that includes comments submitted, and the exposure draft period would allow a reasonable time of four to six weeks to review and comment on it. She said the Working Group will probably have another interim meeting before the Fall National Meeting, when a new timeline will be presented. Crow read a statement indicating that more work and time is needed for the state to support the draft model. Hastings thanked the Working Group for all its efforts in drafting a model that could work for all stakeholders, and she said Indiana has concerns that the interested state insurance regulators will work with the Working Group to resolve.

5. Discussed the Sections on Marketing, Consumer Notices, and Opt-Out/Opt-In in the Second Exposure Draft of Model #674

Johnson said the next item on the agenda is to discuss the topics on which the most comments were received; i.e., marketing, consumer notices, and opt-in/opt-out. She said the Working Group would hear from anyone who would like to talk about these topics. She asked that each stakeholder limit their comments to three minutes if possible and please focus on what, in their opinion, works and what does not. She said this will give Working Group members and other state insurance regulators time to ask questions and discuss the issues presented. Marnell reiterated the comments he submitted on the first exposure draft of the model prior to the Working Group's interim meeting in June, indicating that South Dakota could not support Version 1.2 of the model in its current form. Swanson said Nebraska agreed with the comments submitted by Marnell.

Shelby Schoensee (American Property Casualty Insurance Association—APCIA) said she appreciates all the hard work the Working Group put into Version 1.2 of the model, but she is disappointed that it did not include all of the APCIA's comments from the interim meeting in June. She said it was a patchwork of extensive regulatory

changes that included unworkable notice requirements, such as obtaining consumers' signed consent for insurance data retention, sharing, and annually renewable data review, so it needs more work.

Kristin Abbott (American Council of Life Insurers—ACLI) said the drafting group was clearly dedicated given the tremendous amount of work that had already been accomplished, and she said she appreciated working with the drafting group on specific issues of concern to her members. She said, however, that a redline document would allow the most constructive feedback to be given to avoid conflicting verbiage. She also said she was extremely disappointed that the ACLI's ideas about JMAs, marketing, retention, deletion, and data correction had not been included.

Karrol Kitt (University of Texas at Austin) said state insurance regulators need to know that consumers need this revised model desperately, and consumers need their help in protecting personally identifiable information because most insurance consumers do not understand the implications of what happens to their data once companies share it with other non-insurance companies.

Lauren Pachman (National Association of Professional Insurance Agents—PIA) said she submitted comments on behalf of the PIA's members last week and was surprised that the adverse underwriting decision language had been kept in Version 1.2 of the model. At the interim meeting in June, she said she asked that the National Flood Insurance Program (NFIP) be fit into the draft model because only 10% of consumers buy flood insurance directly through the NFIP. Agents are selling it to the other 90% of consumers through an arrangement with the federal government—via federal government borrowing money or the Federal Emergency Management Agency (FEMA) through upstream and downstream agreements—that could be considered a JMA in this model. Pachman said most flood policies sold cover \$250,000, and agents sell flood insurance for homes over that amount to ensure full coverage for homeowners. She asked how agents could offer this excess coverage under the model and if agents would need to get the consumer's approval in advance via written consent, which would be a potential errors and omissions (E&O) problem for consumers.

Johnson said she would be happy to set up a call with Pachman to discuss the sale of flood insurance further, as this concern was an unintentional consequence. She said she still believes state insurance regulation is better for consumers than federal regulation. Diederich said he believes the model has the same definition of financial institution as the federal government. Johnson confirmed that it is in Version 1.2.

Harry Ting (Health Consumer Advocate) said the new state insurance regulatory protections are sorely needed. He said the model is not confusing to consumers. For Sections 9 and 10 of Model #674, he suggested creating a standard template for consumer notices that could be clearly understood and uniform; i.e., like those created for the Medicare program.

Matthew J. Smith (Coalition Against Insurance Fraud—CAIF) said he submitted written comments on July 27 and urged state insurance regulators to update the model to protect consumers against insurance fraud. He asked the Working Group to focus on two issues: 1) consider making sure investigations of insurance fraud can continue by taking care not to prevent such investigations inadvertently; and 2) take the opportunity to designate fraud prevention clearly.

Peter Kochenburger (Southern University Law School) said he supports the revision of the model and understands that whether consumers should be given the opportunity to opt-in or opt-out of sharing their personal information is always the question. He said opt-in should be the default because opt-out means companies will share a consumer's personally identifiable information with their affiliates. Industry understands this, so that is what they

prefer. Kochenburger said it is up to the Working Group to determine if consumers can have the protection of an opt-in consent that would provide the opportunity for consumers to know what they are agreeing to. He said he recently signed up for the highest level of Wi-Fi access, and the acceptance of the terms included several pages of legalism in very small print that was hard to read, even for an attorney. He said the only realistic opportunity for consumers to control the use of their data is an opt-in consent form. Kochenburger said the creation of an opt-in consent form is a complicated topic that needs further consideration. He said the Working Group has done a great job of putting together real consumer protection provided through state insurance regulation, whereas the federal government could adopt a broad bill.

Diederich said due to the GLBA, JMAs make it difficult to do this, and he needs ideas from Kochenburger on banks.

Wes Bissett (Independent Insurance Agents & Brokers of America—IIABA) said his members have threshold concerns, and he agrees that privacy is important, as is uniformity. He said the disagreement is on how to do it. He said the GLBA is wonderful, and the Working Group needs to use it. He said he has carried a lot of water for state insurance regulation over federal insurance oversight throughout the years because he supports state insurance regulation. However, he said he believes the Working Group should discontinue drafting a new model to replace the *NAIC Insurance Information and Privacy Protection Model Act* (#670) and the *Privacy of Consumer Financial and Health Information Regulation* (#672). He also said Model #670 and Model #672 only need minor adjustments, as they have worked well for many years.

Amann said she was actively involved when Model #672 was drafted in 1992, and the new model is being conscientiously drafted with language referred from Model #670 and Model #672. She said it would be helpful if Bissett could tell the Working Group where exactly it went off the rails because lines of business are different, as are companies' business processes. She also said new technologies have been and are being brought to the table, which is why the Working Group would appreciate any direction regarding Bissett's members' concerns.

Cate Paolino (National Association of Mutual Insurance Companies—NAMIC) said she appreciates the drafting group's willingness to discuss issues of concern in the model with her members. She highlighted the importance of making the new model more workable for companies, and she asked that it be more like California's privacy regulations. She pointed out that the timeline in Section 5 of Version 1.2 is three times longer than it is in California; instead, it should be in alignment with California, like railroad tracks, rather than trying to change the entire landscape of privacy, which would take a major effort on the part of insurance companies. She asked if there was any need to go beyond what California or Model #672 did, particularly Sections A.6 and A.7 of the new model. She said these sections address marketing across jurisdictions, which should not be a topic for a privacy discussion. She said her members continue to be willing to work with the Working Group to revise the wording in Version 1.2 to address these outstanding issues.

Erica Eversman (Automotive Education & Policy Institute—AEPI) said she echoes the thoughts of the other consumer representatives, and she suggested specifically identifying certain types of data categories by looking to California, as companies are already complying with it. She said other personally identifiable information, such as commercial, financial, banking, internet, browsing, fingerprints, voice prints, geo data, audio, visual, education, and professional/employer information, should be considered as inferences that industry could use to create a profile that could lead to automotive insurance disputes. She said bodily injury under personal injury protection (PIP) auto insurance requires that the consumer waives federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) rights to give access to health information for claims. She asked if this gives other companies access to medical data that they would not normally have due to HIPAA protections.

Eric Ellsworth (Consumers' Checkbook) said he is a data scientist with both an information technology (IT) and a HIPAA background who believes in strong data protection. He said there has been a lot of discussion about the inability of companies to access data in legacy systems to correct or delete a specific consumer's data when it is no longer needed. He said while it is true that legacy systems require a lot of maintenance and a lot of work, it is not true that data in legacy systems is safe because companies cannot access it. He said an experienced data scientist can access data located anywhere and from any type of system, including a legacy system. He said it is also true that companies may not know what data they have or where the data they have accumulated, especially through agreements, mergers, and acquisitions of blocks of business from other companies, is located. He said contrary to what is being said about consumers having to pay higher premiums to cover the additional costs companies will incur to comply with the new privacy act, history has proven that not to be the case. He said the same thing was said about HIPAA and California's privacy law, yet neither HIPAA nor California privacy compliance has bankrupted any insurers. He said state insurance regulators need to bind companies to the same rules as HIPAA, and he encouraged state insurance regulators to maintain this level of control over consumers' data.

Diederich said the Parliament of India recently enacted very strong data privacy protections with a data fiduciary requiring consent. He said this is a level setting, as the U.S. is very technologically advanced but not very advanced in privacy protection.

6. Discussed Other Matters

Johnson reminded attendees about the Insurance Summit, Sept. 11–14.

Having no further business, the Privacy Protections (H) Working Group adjourned.

SharePoint/NAIC Support Staff Hub/Committees/H Committee/2023 Summer/WG-Privacy/2023 Summer National Mtg/Minutes_Summer 23
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Privacy Protections (H) Working Group
Conference Call
July 25, 2023

The Privacy Protections (H) Working Group of the Innovation, Cybersecurity, and Technology (H) Committee met July 25, 2023. The following Working Group members participated: Katie Johnson, Chair (VA); Cynthia Amann, Vice Chair (MO); Damon Diederich and Jennifer Bender (CA); George Bradner and Anthony Francini (CT); Erica Weyhenmeyer (IL); LeAnn Crow (KS); Van Dorsey (MD); Robert Wake and Sandra Darby (ME); Jeff Hayden (MI); T.J. Patton (MN); Santana Edison (ND); Martin Swanson (NE); Richard Hendrickson and Gary Jones (PA); Patrick Smock (RI); Frank Marnell (SD); Mike Walker (WA); and Rachel Cissne Carabell and Timothy Cornelius (WI). Also participating were: Doug Ommen (IA); and Garth Shipman (VA).

1. Discussed Comments Received on the Draft of Model #674.

Johnson said that the revised work plan dated July 10, 2023, is posted on the Working Group's web page and indicates that the exposure draft of the new *Insurance Consumer Privacy Protection Model Law* (#674) was distributed July 11 for a comment period ending July 28. She said it also lists Sept. 12 as the date that bi-weekly Working Group open meetings will resume to discuss comments received. Johnson said the Working Group will hear comments on the new Model #674, starting with those from NAIC consumer representatives. Karrol Kitt (The University of Texas at Austin) said she is good with the revisions to Sections 17–20. Harry Ting (Health Consumer Advocate) said he would submit written comments by the end of the week that would include replacing the 10-year time for companies to comply with consent, use, and deletion of consumer data requirements with a more reasonable time frame that would include exceptions to be granted by the Commissioner. He said opt-in and opt-out needed expiration dates that are consistent in each section, as consumers tend to forget to whom they gave consent two years ago. Dr. Ting said he agreed with discussions during the interim meeting that included changing notice requirements to the 11 categories defined in the California Consumer Privacy Act (CCPA). He said that he opposed the adverse underwriting decisions section of the model that would require consumers to send a letter to request the reason for such denial because doing so would cause unnecessary delays and effort by consumers. He also said the option for a private right of action needs to include some individual remedy for significant breaches like that in the CCPA. Diederich asked if expiration dates should be included for consent only or other areas of the model.

Jeff Klein (McIntyre & Lemon, PLLC and the American Bankers Association—ABA) said changes to opt-in and opt-out have been narrowed to not include financial institutions; sensitive personal information (SPI) now includes emails; and the sharing of information now includes publicly available information. He said the ABA benefited from the private calls with the drafting group and that they would suggest adding the *Privacy of Consumer Financial and Health Information Regulation* (#672) sections verbatim to avoid state and federal conflicts.

Klein agreed with Wes Bissett's (Independent Insurance Agents and Brokers Association—IIABA) comment letter that the new Model #674 should consider the 13 state privacy laws that have already been enacted.

Helen Dalziel (International Underwriting Association—IUA) said the IUA represents alien insurers with NAIC surplus lines written and asked that adverse underwriting decisions exclude lawful surplus lines because the definition of a licensee means that there is a relationship with companies, not with consumers but that brokers licensed to sell these should send notices to individual consumers. She said Article 3 (8) A (2) needs to include surplus and excess lines.

Jennifer McAdam (American Council of Life Insurers—ALCI) said the ACLI supports changes to private right of action and that the ACLI still has concerns with the new Joint Marketing Agreements section and the annual review of consumer data. She said the time to comply with the requirement to move away from legacy systems should be extended to 20 years and that the delivery of notice requirements needed to be modernized. McAdam expressed concern about the time left in the work plan and the amount of work still needed. She said ACLI members have been meeting weekly to discuss changes in the new model, and sometimes they meet more often. McAdam said more explanation is needed from drafters as to why the changes suggested by the ACLI were not made. She said ACLI members agree that progress has been made but that the language is unworkable for their members as revised.

Diederich said the Working Group wanted to make sure the legacy system issue does not limit real-time response and deletion. He asked the ACLI what time frame would work from its standpoint, as 10 years seemed generous to him. McAdam said that thousands of policyholders have been their customers for decades, so ACLI members need more than 10 years to change the systems in which the data for those policyholders' is recorded. Johnson said the Working Group recognized that there are difficulties but that some companies said 10 years was plenty of time. Even so, she said the Working Group gave commissioners discretion for individual company exclusions or extensions and that specific suggestions as to the desirable time frame are needed.

Swanson asked how much it would cost companies to make this change and how much of that companies would pass along to consumers. McAdam said she did not know how much it would cost or how much would be passed on. Peter Kochenburger (Southern University Law School—SULS) said legacy systems are not upgraded as frequently and are more vulnerable to hacking, so there is a greater need to end legacy systems to avoid giving hackers access. McAdam said she did not know about the technical part of it but that she is not so much concerned about it as companies are still subject to the *Insurance Data Security Model Law* (#668). Kitt said legacy systems cannot make modifications, so companies will have to change them so that the cost would be there to replace the legacy system with a new system or to keep the old one updated. Johnson said that at the NAIC International Forum, she heard that the cost of maintaining legacy systems is tremendous but that they still have lost costs compared to new systems.

Sabrina Miesowitz (Lloyd's Underwriting) said surplus lines are different as they go through brokers, not direct to consumers, and that Lloyd's Underwriting agrees with the IUA's comments on adverse underwriting decisions.

Shelby Schoensee (American Property Casualty Insurance Association—APCIA) said the APCIA received significant additional changes to the notice content and delivery; joint marketing agreements; definitions; the cover letter's intent versus the changes made; and removal of the sharing of data with overseas affiliates and the private right of action sections of the initial draft of the model. She said the APCIA will submit additional comments in writing but that they need more time to do so.

Bissett suggested the deletion of personal information, notices, etc., and that the Working Group step back to reassess if a new model could be adopted at state legislatures. He said the Working Group should add to a successfully operating framework already in place. Bissett asked what problem the model is trying to solve. He said the National Conference of Insurance Legislators (NCOIL) does not like nor support state passage of the new model. Bissett said the Working Group should limit its changes just to existing marketing models. He also said that the IIBA will oppose the new model. Diederich said the old models were written pre-digital and that the Working Group is trying to address new digital processes because under the federal Gramm-Leach-Bliley Act (GLBA), there was no right of access, limited joint marketing agreements, and limited control of what happens to a consumer's personal information. Bissett said the U.S. House Committee drafted a new module to the GLBA with changes to consumer notices that indicated consumer data uses should be addressed. He also said that no new types of data have been used since then.

Diederich asked Bissett if he had any guardrails to suggest so all parties could find a middle ground. Bissett said not having to disclose uses of client data and removal of the mandatory deletion within 90 days after the consumer is no longer a client takes away the agent's rights. Bissett suggested the Working Group see the New York State Department of Financial Services' (DFS') cybersecurity regulations.

Johnson said she disagrees with Bissett because the model has several reasons under which agents can keep consumer data. Bissett said the words on the page say consumer data can be kept while there is an ongoing business relationship, which he reads to mean that agents have 90 days after the policy closes. Johnson asked Bissett to give the Working Group language that is clearer for use in the new model. Bissett said he would not provide any. Marnell said the Working Group is performing an important task but that his state would not support this draft of the model. He said he does not support it as a model and that the Working Group has not listened closely enough to industry. Marnell said the model needs lots of redrafting, as noted in the redline he submitted. Swanson said he agreed with Marnell and supports the changes noted in Marnell's redline submission. Swanson said he thinks this is true in a lot of other states.

Cate Paolino (National Association of Mutual Insurance Companies—NAMIC) said she appreciated the Working Group's attention to industry's comments. She said the Working Group has taken a novel approach with radical changes but that she likes the old system because Model #672 was a success of uniformity that just needs a few modifications to list third parties, allow deletions, and clarify permitted use of public information. Paolino said a pause is needed as she wants to understand why the Working Group has not made industry changes. Johnson said the Working Group still has changes needed and that the goal is to have a new redline draft (version 1.3) before the Summer National Meeting. She said the drafting group is still having private meetings because it still needs continual input to get to a workable model. Johnson said she disagrees that the new model is radically different and reiterated that the existing models needed changes, as noted by NAIC leadership and privacy working groups over the past four years. She said the goal is to develop a model that protects the privacy of consumers' data when it is used for insurance transactions.

Johnson asked regulators, industry, and consumer representatives to submit ongoing specific wording changes to the model in redline because the Working Group reads all comments and takes parts of the language changes from everyone. She asked that interested parties read all the comments submitted and take note of the fact that they do not all agree on the wording, as each type of insurance and licensee has its own areas of concern due to differences in how their business is conducted. Johnson said the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) safe harbor is being revised as recommended by America's Health Insurance Plans (AHIP).

2. Discussed Other Matters

Johnson thanked everyone for their comments, discussion, and collaboration during the meeting. She said she looked forward to receiving additional comments on the draft and to continuing collaboration at the Summer National Meeting. She said the due date for changes on model 1.2 is July 28 and that comments received no later than Aug. 7 would be considered at that meeting. Johnson said the Privacy Protections (H) Working Group is scheduled to meet Aug. 13 from 11:30 a.m. to 1:00 p.m. PT (Pacific Time). She said there would also be a regulator-to-regulator meeting Aug. 12 from 4:00 p.m. to 5:00 p.m. PT. Both meetings will have virtual participation with the ability to speak (with requests submitted via the chat feature).

Having no further business, the Privacy Protections (H) Working Group adjourned.

SharePoint/NAIC Support Staff Hub/H CMTE/2023 Summer/WG-Privacy/072523 Call/Minutes_PPWG Call_072523.docx

Draft: 8/9/23

Privacy Protections (H) Working Group
Interim Meeting
June 5–6, 2023

The Privacy Protections (H) Working Group of the Innovation, Cybersecurity, and Technology (H) Committee met June 5, 2023, and June 6, 2023. The following Working Group members participated: Katie Johnson, Chair (VA); Cynthia Amann, Co-Vice Chair (MO); Chris Aufenthie, Co-Vice Chair (ND); Damon Diederich and Jennifer Bender (CA); George Bradner and Anthony Francini (CT); Erica Weyhenmeyer (IL); Justin McFarland (KS); Ron Kreiter (KY); Van Dorsey (MD); Robert Wake (ME); Jeff Hayden (MI); T.J. Patton (MN); Molly Plummer (MT); Santana Edison (ND); Martin Swanson (NE); Teresa Green (OK); Richard Hendrickson and Gary Jones (PA); Patrick Smock (RI); Amy Teshera (WA); and Rachel Cissne Carabell and Timothy Cornelius (WI). Also participating were: Doug Ommen (IA); Sandra Darby (ME); and Garth Shipman (VA).

MONDAY, JUNE 5, 2023

1. Discussed the Definition of Third-Party Service Providers Related to an Insurance Transaction, Third-Party Service Providers Not Related to an Insurance Transaction That Have Access to Consumers' Personal Information, and Contracts with Third-Party Service Providers

Johnson reminded attendees that these sessions are working sessions, and the Working Group would be focused on the drafting of model language. She asked everyone to be prepared to consider new language and offer their pros and cons. She said comments must be specific to the topic under discussion, and topics already discussed in open meetings would not be revisited during this meeting. Diederich said the Working Group has heard a lot about individual companies' excellent oversight of service providers and strong contractual protections with respect to these arrangements. He said the Working Group has asked for contract language but has not yet received it. He said the Working Group would appreciate the submission of language or standards for consideration and a set of best practices that the Working Group could apply to third parties.

Wake said state insurance regulators want to make sure promises that service providers make to consumers remain in place when data is shared. In addition, he said insurers should ensure that their promises made to consumers are upheld by the service providers who are provided access to the data, as the type of data shared may require different protections. Swanson said Nebraska could not offer up this model as is as a bill in the legislature. Aufenthie asked about third parties who get consumers' personal information from the insurer and who do not have a contract with the insurer in the classic tow truck example. He asked to what extent state insurance regulators can require an advance contract for every type of situation, or whether it should be stated that the state department of insurance (DOI) has jurisdiction. Then, if the tow trucks go beyond what they need to do for the claim, it is criminal theft. Wake said this is where privacy meets security. Chris Petersen (Arbor Strategies LLC and the Coalition of Health Insurers) asked if the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) safe harbor applies. If it does, he said the Business Associate (BA) rules would apply. Without knowing whether that applies, he said the Coalition of Health Insurers would push for privacy regulation that looks like the HIPAA Privacy Rule so that health plans that already comply with HIPAA would follow these rules and everyone else would have different rules. He said there is a distinction between a breach and misuse of information, so this is a security versus privacy issue. He said in the HIPAA world, the BA is responsible for any misuse, and under the safe harbor, the state DOI could determine if there are enough of those violations so the entity is not complying with HIPAA. Then, the safe harbor would disappear, and the state DOI could go after them.

Katie Koelling (Thrivent Financial) said there is a difference between privacy and security, so imposing the same obligations on all types of vendors is not possible. She said Thrivent Financial is legally required to perform third-party due diligence, and it uses a third-party due diligence questionnaire. She said she believes the model should be more risk-based than prescriptive. Peter Albert (Progressive) said: 1) care needs to be taken toward accurately defining what a service provider is; 2) there need to be exceptions; and 3) redundancy within existing laws needs to be avoided. He also said when Progressive dispatches a tow truck, it does it through third parties with whom it already has contracts. Wes Bissett (Independent Insurance Agents & Brokers of America—IIABA) said the model has significant problems because the definition of a third party includes licensee, and it should not because it treats agent/insurer relations as a third-party relationship, which is not the case. Therefore, the definition should not include licensee. Bissett also suggested referring to the definitions in the National Institute of Standards and Technology (NIST) as an amendment to the federal Gramm-Leach-Bliley Act (GLBA). Cate Paolino (National Association of Mutual Insurance Companies—NAMIC) said the contract management process is a big lift and takes a lot of work, so the Working Group should consider grandfathering for contractual provisions and include wording in an appendix about third-party contracts, safe harbors, and compliance. Lauren Pachman (National Association of Professional Insurance Agents—PIA) said the internet requires that consumers accept terms and conditions, and consumers opt into the internet. Kristin Abbott (American Council of Life Insurers—ACLI) said the ACLI will submit specific language. Jessica Waltman (National Association of Benefits and Insurance Professionals—NABIP) said a safe harbor for HIPAA should extend to the whole model or as a standard for all insurers because it is a known entity, so it would be easier for vendors to follow where there is a power imbalance. Al Sand (Committee of Annuity Insurance) said the contractual language around third parties makes it so licensees do not choose the best third party but rather the ones who will agree to the contract language.

Johnson asked if there were some groups of third parties that should be treated differently than others. Petersen replied that those with incidental exposure should be. He said there should also be differences between first-party data and second-party data when the first relates to getting insurance and the second relates to non-insurance, such as tow truck vendors. Koelling said the definition is too broad because it does not include a person who obtains a consumer's information, and she said she would send a suggested definition with exclusions to address it.

2. Discussed Definitions of Insurance Transactions and Additional Permitted Transactions

Tricia Wood (Liberty Mutual) said that normal processing activity should be reasonably anticipated by a consumer, and the model should include language that covers business purpose catchall. She said there should not be an opt-out for any part of an insurance transaction; however, she said for additional permitted transactions (APTs), there needs to be an opt-out provision. Shelby Schoensee (American Property Casualty Insurance Association—APCIA) said the definition of information technology (IT) is too narrow. She said in Article §2, Section 4(B), the uses of data should be included, and any mathematical-based decisions should be deleted. Aufenthie said this was included to cover artificial intelligence (AI) and APTs, but it does not think the existing language captures the intent. Petersen said he does not believe “by or on behalf of licensee” works because disclosures are permitted that do not fall under that; i.e., sharing with law enforcement. Albert said the IT definition is too narrow, and he suggested that the Working Group reflect on existing model definitions because certain marketing actions may fall under IT. He said if an insurer is giving data to their own affiliates to offer supplemental coverage, the transaction should not be subject to opt-in or opt-out. He said APTs and product development should be included in this category as well. Bissett said IT, as used in Section 4A(1), says personal information (PI) cannot be collected, processed, or shared unless it fits into categories in the definition of IT. He said the federal Fair Credit Reporting Act (FCRA) preempts some of this, including the exchange between affiliates, and it is an unconstitutional restriction of free speech if IT is content or speaker-based. Jennifer McAdam (ACLI) said if IT means any transaction or service by, or on behalf of, licensees, the Working Group should add “or affiliates” and “or any functions that

support the above.” She also said marketing is important for consumers to be supported in a holistic manner. Paolino said opt-out is the only approach that makes sense for APTs, such as research activities and product development, so it makes sense to include, and there could be more areas to expand upon, such as internal analytics. Sand said updating data is difficult and puts insurers at a competitive disadvantage. He said a better framework would be to focus on consumer empowerment and not try to figure out ahead of time what is appropriate to offer to consumers. McAdam asked what revelations the Working Group has been having or bad practices the Working Group has seen. Johnson said there is always someone who wants to push the envelope, and state insurance regulators need the power to rein them in when that happens. Harry Ting (Health Consumer Advocate) said regarding the company’s comments about future developments and products, the consumer cannot know what to consent to when the consumer does not know what these future products could be.

3. Discussed Marketing Insurance Products to Consumers Using Consumers’ PI, Marketing Other Products to Consumers Using Consumers’ PI, and Affiliate Marketing

Johnson said the Working Group is concerned about companies marketing something other than insurance and inundation of unwanted ads on consumers. Petersen said there is a need for a definition of marketing. Sand said restrictive marketing standards will put insurers at a competitive disadvantage. He said consumers may not be opposed to marketing, but they may not take the time to give consent if there is an opt-in standard. He said this will lead to a competitive disadvantage, and it is especially problematic for annuity companies when a broker/dealer is also marketing a competitive product, such as a mutual fund. He said consumers need to be made aware of all products, and it is not fundamentally bad to make consumers aware of insurance products. Wake said the issue is how to get to reasonable limits so consumers are not inundated with marketing materials. He said the opt-out notice might be a good marketing opportunity, where a company could tell a consumer what information they might be giving up by opting out.

Sand said limiting information to consumers does not create a more informed consumer. He said it is better for a consumer to be contacted and then allow the consumer to tell the insurance company they do not want to receive additional marketing information on a particular topic or product. He also expressed concerns with Section 4G. Albert said restrictions on marketing are unworkable. He also expressed concerns with the ambiguity of the term “marketing.” He said the focus should be on insurance-specific marketing concerns, insurers should be able to market products without consumer consent, and there should be an opt-out standard consistent with existing federal law. He provided an example of how an insurer could not obtain affirmative consent to market an insurance product to a consumer who does a Google search for “I want cheap car auto insurance.” He said an opt-in standard would also prevent an insurance company from mailing a consumer an offer for home insurance after a consumer’s purchase of a home. He said if an insurance company is sharing information with an affiliate, the company must offer the consumer an opt-out under the FCRA. He said Progressive has affiliates throughout the U.S., but the affiliates share one database. Pachman expressed concerns about restrictions on marketing and gave an example of flood insurance coverage and the potential inability of an agent to market home insurance coverage to provide greater than the \$250,000 coverage offered through the National Flood Insurance Program (NFIP).

Johnson asked what, if anything, agents should be prohibited from doing. Pachman said selling a consumer’s data without their consent should be prohibited. Johnson asked if an agent should be prohibited from having the ability to sell products other than insurance to a consumer. Johnson replied that it is important to identify what product is related to an insurance product. She said one way to make this determination is to determine if the related product is tied to risk mitigation. She said state insurance regulators are okay with the sale of additional products, but they do not want an insurance agent to sell information to a company selling canoes, such as Land’s End, after the purchase of a lake house.

McAdam said prior consent language will deny consumers the opportunity to learn about products and services. Glenn Daly (John Hancock) said this is a data-driven world, and he suggested the development of a one-pager for consumer education. Paolino said that risks evolve for consumers, and technology is continuing to change, so state insurance regulators should think about this as the model framework is developed. Bissett said the definition of marketing is important, but the more important question is whether we are looking at an opt-in standard for marketing. Wake asked if do-not-call lists are unconstitutional. Bissett said he believes there would be a problem if a state adopts a law saying only insurers cannot market, but everyone else can, and this would be considered a discriminatory standard.

4. Discussed JMAs with Affiliates and with Non-Affiliated Third Parties

Abbott said a prohibition of joint marketing agreements (JMAs) by affiliates would be problematic, and standards for joint marketing should be the same for all financial institutions. Schoensee suggested keeping the joint marketing structure in the *Privacy of Consumer Financial and Health Information Regulation* (#672). Sand said he read the six elements of joint marketing from Model #672, and this reflects the fact that smaller institutions will not be able to offer all products. He said joint marketing allows the offering of a larger option of products, and joint marketing allows insurance products to be brought to consumers that would not otherwise be offered. Wake asked why an opt-out standard for joint marketing is not appropriate. Sabrina Guenther Frigo (CUNA Mutual Group—CUNA) said CUNA partners with credit unions to bring products to consumers, and joint marketing standards should be the same across all financial institutions. Johnson asked if banks give CUNA a list of names for marketing and if then the consumer can opt out after the initial offer. Guenther Frigo said this is the case. Aufenthie asked whether CUNA gets information from a credit union and if then a consumer can opt out of marketing. He also asked if CUNA then honors the request and deletes the consumer's information. Guenther Frigo said CUNA honors the consumer's request, and the deletion of consumer information is based on legal requirements.

TUESDAY, JUNE 6, 2023

5. Discussed Opt-In vs. Opt-Out Consent to Marketing and the Difference Between Marketing Insurance and Non-Insurance Products

Schoensee expressed concerns about moving to opt-out. She said opting out makes it difficult to identify coverage gaps and for insurers to conduct business. Wake said marketing is generally an opt-out standard, but there is an opt-in for health under both the GLBA and Model #672. He asked what people think about opting out of marketing and opting in for the use of sensitive data that is appropriately defined. Wood said cookies are attached if a consumer accesses the company's website. She said the cookies notify the company if the consumer goes to another website so the company can place an ad on the other website. At the same time, though, she said the company does not have any information about the consumer. She also said California has an opt-out regime for cross-context and behavioral advertising, and she encouraged consistency with the California standard.

Diederich asked if anonymized data ever becomes associated with an individual. Wood replied that it does not, and any information associated with an individual would come from the customer and not from the cookie. She said the company only knows that a consumer came to their website. Albert said Facebook and other tech companies have a lot of information about consumers. He said Progressive will attach cookies to take a consumer back to its web page, but Progressive does not know anything else about the consumer. He said there are also third-party cookies being dropped by Amazon, Google, and Facebook. He said if Progressive is interested in a certain consumer profile, Progressive puts the information through a hashing program. He said service providers, like Google, know other websites that a consumer has visited, and Progressive can then work with the service providers to obtain a list of consumers who might be interested in insurance products. He said service providers track consumers across all websites. He also said insurance companies need a consistent standard across all states

to eliminate redundancies and consumer confusion. Aufenthie asked why Progressive did not apply standards of the California Consumer Privacy Act (CCPA) to all states. Albert said the CCPA is a complicated law, and Progressive is still working through its implementation of it to assess the impact on its business in California. For example, he said when a consumer requests the deletion of information, it leads to the manual deletion of the information at Progressive, which is a complicated endeavor. Wake suggested using opt-out for marketing except for certain types of data. He said this is a regulatory regime worth exploring; i.e., carve out certain types of sensitive information, such as health information, from the opt-out standard. Albert suggested caution around carving out health information because a property/casualty (P/C) company settling a claim would need access to health information. Wake suggested an opt-out regime for general marketing purposes but to carve out specific sensitive personal information to be under an opt-in regime. He also suggested defining sensitive PI as it is in the *NAIC Insurance Information and Privacy Protection Model Act* (#670) when companies use precise geo-locations to adjust a consumer's insurance rate when hard accelerations, late-night driving, etc., result in higher risk factors or for ancillary services like dispatching emergency services.

Paolino said an opt-in approach for marketing would make insurance an exception and put less information in the hands of consumers. Sands said it is important to maintain a level playing field within the financial services industry. He said an opt-in approach for marketing would limit the marketing of annuities compared to mutual funds. Johnson said the Working Group heard industry wants a level playing field, and opt-ins are difficult. She asked if any insurance companies use sensitive information for marketing. Daly said he is concerned about the broad definition of sensitive information in the current draft. He said opting in and the need for consumer consent would inhibit companies from providing products to consumers, especially personalized products.

Diederich asked what type of sensitive information is being used in marketing for diversity, equity, and inclusion (DE&I). Daly said an example is LGBTQ data. Diederich expressed concerns about what information a consumer wants to be available to the public and what information they want to keep private. Daly agreed but said there is a need to maintain a level playing field so insurance products that consumers need can be made available to those consumers. Wake agreed but said there is a need to balance benefits and harms. Daly said companies respect what they know about consumers and reiterated companies' need for a level playing field. Teshera asked what marketing information is provided. Daly said every consumer's mobile device is segmented in the advertising world. Daly said a company can then identify what segment of the market they want to target with their advertising because advertising and marketing is a very complicated process that begins when a consumer query is captured in the data world. He said this does not mean the consumer is identified, but it does mean a company can identify a consumer's interest for marketing purposes. Daly also said the definition of sensitive information is very broad in the current draft of the model. Diederich said cross-contextual advertising is anonymized, and he asked if companies need individual consumer information. Daly responded that they do not need individual consumer information.

6. Discussed the Contents Necessary to Have in a Notice of Consumer Privacy Practices

Albert said privacy notices are complicated because the content is mandated by state insurance regulators, and he suggested selecting one of the abbreviated disclosure notices from Model #672 to avoid the requirements of privacy notices that contain more prescriptive statements. He said privacy notice requirements should specify what categories to cover but should not become too prescriptive. For example, he said Progressive discloses that information is shared with rental car companies rather than listing the names of each specific rental car company. He is concerned with the use of wording like "specific types" because it sounds like state insurance regulators want an exhaustive list.

Schoensee suggested that the Working Group add a safe harbor for companies using federal privacy forms. Sands said if disclosures become too specific, it will be difficult for companies to comply, and generalized disclosures

that are principle-based would be more appropriate. He said the current language of Model #674 would prohibit insurers from using the federal privacy form, and he questioned what consumer benefit is derived from the disclosure of a specific service provider's name rather than disclosure of a broader category of service provider that provides "x" services. Diederich said the names of specific providers help consumers track where information goes in case there is a service provider breach. Sands said there are other state laws regarding notification of breaches. Wood said a privacy risk is not best addressed through privacy notices to consumers, especially with a detailed list of specific vendors, because the notices would become inaccurate very quickly if specific vendors are required to be listed. She said the posting and disclosure of vendors also increase the security risk for a company, and a vendor may also consider its contract with a company to be confidential. Diederich asked if companies would make the names of specific vendors available to consumers upon request. Wood said they would not because while this request sounds reasonable, such disclosure may not be a good idea. For example, she said a company may use Amazon Web Services (AWS), and AWS does not do anything with the data. She asked why the company would need to disclose it. Similarly, she asked why it would be necessary to disclose the name of a vendor used for a company's accounting. She also questioned how this would benefit a consumer because the company would not change the use of certain vendors due to its business needs.

Paolino encouraged the use of a safe harbor for sample notices and continued the use of the federal privacy forms that are included by reference in Model #672. Petersen questioned the usefulness of a notice unless a consumer can do something in response to the notice. He said this is not the case today with privacy notices given to consumers, as the notices simply disclose that the company uses personal information in compliance with current law. Johnson said a consumer can switch companies if they do not like how a company is using their data. Petersen said price point, company reputation, and service usually drive consumer behavior, and he questioned whether a consumer would change companies based on information in a company's privacy notice. Wake said even if a consumer may not be able to do anything, a consumer may still want to know, and that it is also important for them to know if a company has a policy more restrictive than what is permitted by law. Daly said disclosure of specific vendors will increase the privacy risk to customers.

7. Discussed the Frequency and Methodology of Delivery for the Notice of Consumer Privacy Protections

Schoensee said the timing of notices should be consistent with the direction provided in the NAIC's most recent privacy bulletin from 2016 that incorporated the federal Fixing America's Surface Transportation (FAST) Act amendments regarding the frequency of privacy notices. She also has concerns with notices that might be required for group insurance, reinsurance, and the need to include beneficiaries in notices because this could lead to the premature disclosure of a consumer's estate plan. Johnson asked if the model should allow consumers to continue receiving notices via paper delivery. Paolino encouraged guidance on the timing of notices set forth in the FAST Act. She also suggested consideration of how a group of companies may interact and send notices on a consolidated basis. Diederich asked about potential conflicts with the Uniform Electronic Transactions Act (UETA) and its requirement for companies to receive consumers' affirmative consent for electronic transactions. Dorsey said electronic notice would also violate Maryland law. Johnson said the Working Group may look at a requirement of paper notice for the initial notice and then for companies to provide consumers with an option to opt out of paper notices in the future. Daly said consumers without internet access can call the company, and any company using beneficiary information for marketing should have disclosed this in their initial privacy notice.

8. Discussed Other Matters

Jeff Klein (McIntyre & Lemon PLLC) asked procedural questions on the next draft because the GLBA was about much more than privacy. He said no state may prevent or significantly interfere in insurance sales or cross-marketing, and there are 13 safe harbors outlined in the GLBA. He also said the current draft of Model #674 raises preemption issues. Johnson asked companies to let the Working Group get the next draft out, as it may address

many of these issues. McAdam asked if the notice provisions would apply to reinsurers or group insurance, as the current provisions require them to provide consumer notices. Johnson said the Working Group is not going to require reinsurers or group insurance to provide consumer notices in the next draft. Dr. Ting asked the Working Group to include special safeguards in notices to maintain privacy in cases of domestic abuse.

Having no further business, the Privacy Protections (H) Working Group adjourned.

SharePoint/NAIC Support Staff Hub/H CMTE/2023 Summer/WG-Privacy/Interim In Person PPWG/Minutes_PPWG Interim Mtg_060523-060623.docx

Draft: 5/22/23

Privacy Protections (H) Working Group
Virtual Meeting
May 16, 2023

The Privacy Protections (H) Working Group of the Innovation, Cybersecurity, and Technology (H) Committee met May 16, 2023. The following Working Group members participated: Katie Johnson, Chair (VA); Cynthia Amann, Co-Vice Chair (MO); Chris Aufenthie, Co-Vice Chair (ND); Chelsy Maller (AK); Gio Espinosa and Catherine O’Neil (AZ); Damon Diederich (CA); George Bradner and Hicham Bourjaili (CT); Ron Kreiter (KY); Van Dorsey (MD); Jeff Hayden, Renee Campbell, Danielle Torres, and Julie Merriman (MI); T.J. Patton (MN); Molly Plummer (MT); Santana Edison (ND); Connie Van Slyke (NE); Teresa Green (OK); Scott D. Martin (OR); Gary Jones and Richard Hendrickson (PA); Matt Gendron and Raymond Santilli (RI); Frank Marnell (SD); Shari Maier and Michael Walker (WA); and Timothy Cornelius, Rachel Cissne Carabell, and Barbara Belling (WI). Also participating were Janice Davis, Scott Woods, and Rebecca Smid (FL); Paula Shamburger (GA); Joseph Fraioli and Sonya Sellmeyer (IA); Hermoliva Abejar (ID); Tanji J. Northup (UT); Garth Shipman (VA); and Mary Block and Karla Nuisl (VT).

1. Discussed Sharing Consumer Information with a Person Outside the Jurisdiction of the U.S., Section 4. A (5)

Johnson said the Working Group would discuss the sharing of consumer information with a person outside the jurisdiction of the U.S., including the consent provision (Section 4. A (5)) and the guardrails around sending consumer information outside the jurisdiction of the U.S.

Chris Petersen (Arbor Strategies) said he has legal and political concerns about this provision. He said that he believes federal labor laws pre-empt this type of provision at the state level and that this is a security breach issue rather than a privacy issue. Petersen said companies are becoming global and recommends that this provision be stricken from the model. Sarah Wood (Insured Retirement Institute—IRI) reiterated the comments in the IRI’s letter. She said this provision would disrupt annuity supply chains by being overly burdensome in requiring operational changes, so implementation would not be feasible. Johnson asked Wood if she was referring to costs being prohibitive.

Jordan Heiber (U.S. Chamber of Commerce) said its members are concerned with this provision as drafted because it would limit or prevent companies from outsourcing functions, prevent access to information, and lead to increased costs that would be passed on to consumers. He said mandatory consent requirements would confuse companies and consumers as to what information is needed. Heiber said it conflicts with U.S. legal, contractual, and recent state legislation in California and other states. He said these requirements are unnecessarily restrictive and conflict with the G7 requirements in the Organisation for Economic Co-operation and Development (OECD), which is moving forward with its plan for the free flow of data and trust globally.

Kristin Abbott (American Council of Life Insurers—ACLI) said this provision appears to give consumers consent. However, in her April 3 comment letter, she said it is better for companies to address consumer consent questions through vendor oversight and contractual obligations. She said this provision would severely limit global insurers and reinsurers, as well as cause them to lose 24/7 customer service. Abbott also said that the *Insurance Data Security Model Law* (#668) already covers this, so she suggests the provision be removed from the new model, *the Insurance Consumer Privacy Protection Model Law* (#674).

Sabrina Miesowitz (Lloyd’s of London—Lloyd’s) said the comment letter Lloyd’s submitted included a definition of “licensee” that includes unauthorized insurers like Lloyd’s, which are non-U.S. based. She said this is different from other models in that most models say this means “surplus lines licensees.” Shelby Shoensee (American Property

Casualty Insurance Association—APCIA) said this provision would ban global servicing, as it goes against the G7 financial dialogue. She said the protection of data is a function of both security and systems and is concerned it would block a company's functionality, even within the company itself. Shoensee said it would cause companies to become less efficient over time and would limit a company's ability to respond to subpoenas from outside the U.S.; therefore, the provision should be stricken from the model. Bob Ridgeway (America's Health Insurance Plans—AHIP) and Tom Smith (American Reinsurance Association—ARA) both said they agreed with the others who had spoken. Ridgeway said companies help consumers save money and that the risk is on the carrier if anything happens.

Joseph Whitlock (Global Data Alliance—GDA) said he represents a coalition of 70 companies that rely on data transfer around the world. He said there are three cybersecurity, fraud, and privacy concerns: 1) domestic; 2) international obligations; and 3) international policy. Whitlock said this provision is more restrictive than federal laws and that it raises Article 1 constitutional concerns, as well as international case law concerns. He said there are cross-data requirements, as the provision is more restrictive than in other countries or jurisdictions that have very strict laws with contract-based consent, like China, Vietnam, and Africa. Petersen said privacy is about how and when data can be used and what companies need to do to protect it. If a third party misuses data, it is a legal breach and, therefore, a security issue. He said there are two victims—the company and the consumer—and that the provision as written says, "as permitted in the U.S." (not outside the U.S.). Ridgeway said that the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) does not cover lots of information and that HIPAA data is controlled by contracts that are standard business association forms. He said companies could consent to jurisdiction, perhaps.

Diederich said he appreciated the comments and is sensitive to the concerns presented by companies and trade associations but that he was more concerned with consumer understanding and consent. With strong vetting, security, and contracts, he would like free-flowing data with trust. Diederich asked what the minimum boundary conditions, standards, and requirements would be to get companies to build out this type of system. Johnson said the Working Group has asked companies and trades for these types of industry standards many times. Diederich said state insurance regulators keep hearing that the carrier is the victim when data breaches occur and that the real problem is how to ensure there are safeguards on the front end. He said this is very helpful to build in protections for consumers in place of consent to prevent injury down the line.

Silvia Yee (Disability Rights Education & Defense Fund—DREDF) said she would love to see a legal opinion that HIPAA has the authority over U.S. companies that operate overseas. She asked how companies can be held accountable because HIPAA is fairly limited as to what type of data is included.

2. Discussed Other Matters

Johnson reminded attendees about the in-person interim Working Group meeting to be held in Kansas City, MO, on June 5–6. She said the purpose of this meeting is to collaborate with state insurance regulators, consumer representatives, and industry members on revised wording for the most complex topics in the new draft of Model #674. Johnson thanked state insurance regulators, consumer representatives, and industry members who had submitted requests to be added to the registration invitation for this meeting, as the venue limits seating. Ridgeway asked when the agenda for the interim meeting will be available. Johnson said the agenda should be distributed and posted by May 22.

Cate Paolino (National Association of Mutual Insurance Companies—NAMIC) asked when the revised draft of Model #674 would be available. Johnson said a revised draft would be posted after the interim meeting and after the Working Group meets in regulator-to-regulator session. Shoensee asked about the logistics for the interim meeting. Johnson said the room would be set up like it was for the Working Group at the Spring National Meeting

and that the attendees may break into table rounds to discuss issues separately should the need arise during the meeting. She said the Working Group will have suggested language to start the conversations and that Lois E. Alexander (NAIC) will distribute and post the dial-in information a week prior to the meeting for those who will participate in listen-only mode.

Having no further business, the Privacy Protections (H) Working Group adjourned.

SharePoint/NAIC Support Staff Hub/Committees/H Cmte/051623 Call/WG-Privacy/Minutes_PPWG_051623.docx

Draft: 5/23/23

Privacy Protections (H) Working Group
Virtual Meeting
May 2, 2023

The Privacy Protections (H) Working Group of the Innovation, Cybersecurity, and Technology (H) Committee met May 2, 2023. The following Working Group members participated: Katie Johnson, Chair (VA); Cynthia Amann, Co-Vice Chair, and Jo LeDuc (MO); Chris Aufenthie, Co-Vice Chair (ND); Chelsy Maller (AK); Gio Espinosa and Catherine O'Neil (AZ); Damon Diederich (CA); Kristin Fabian, Hicham Bourjaili, Anthony Francini, and Kurt Swan (CT); Erica Weyhenmeyer (IL); LeAnn Crow and Shannon Lloyd (KS); Alexander Borkowski (MD); Jeff Hayden, Chad Arnold, Renee Campbell, Danielle Torres, and Julie Merriman (MI); Molly Plummer (MT); Santana Edison and Colton Schulz (ND); Martin Swanson (NE); Teresa Green (OK); Raven Collins and Thomas Hojem (OR); Gary Jones (PA); Patrick Smock and Matt Gendron (RI); Frank Marnell (SD); Shari Maier, Amy Teshera, and Michael Walker (WA); and Lauren Van Buren, Timothy Cornelius, Rachel Cissne Carabell, and Barbara Belling (WI). Also participating were Rachael Lozano and Rebecca Smid (FL); Joseph Fraioli (IA); Hermoliva Abejar (ID); Shelley Wiseman (UT); Rebecca Nichols and Garth Shipman (VA); and Mary Block, Karla Nuisssl, and Isabelle Turpin Keiser (VT).

1. Discussed Confidentiality (Section 21)

Johnson said the Working Group would like to discuss the use of the *Insurance Data Security Model Law* (#668) confidentiality wording in Section 21 of the new *Insurance Consumer Privacy Protection Model Law* (#674).

Bob Ridgeway (America's Health Insurance Plans—AHIP) said he disagreed with the frequently asked questions (FAQ) because question one noted a slight difference, but the wording in Model #668 deleted one-third of the Own Risk and Solvency Assessment (ORSA) wording. He said AHIP had argued that “shall” should not have been changed to “may” in Model #668 when referencing regulators receiving written agreement (i.e., third-party), but instead to give notice only if subpoenaed on ownership. However, AHIP had lost that battle, so it was proposing limited language again, as Model #668 was less deserving of protection. Ridgeway said AHIP members want the longer language and reiterated the same arguments they had used during discussions of Model #668. Kristin Abbott (American Council of Life Insurers—ACLI) said the confidentiality of intellectual property must be protected to avoid infringement. For Section 21 C. 3 and Section 21 C. 4, she said the ACLI prefers the stronger ORSA provisions. Cate Paolino (National Association of Mutual Insurance Companies—NAMIC) said NAMIC would submit comments similar to those mentioned by the ACLI on using the wording from Model #668 in Model #674.

Birny Birnbaum (Center for Economic Justice—CEJ) said Section 21 should be deleted because consumers need to have access to any market conduct exam that is already considered confidential. The wording he suggested is that the privacy disclosure to consumers would be confidential if submitted to regulators and that the FAQ are proprietary because they apply to consumers, who need to be able to see what is being disputed by the company. Birnbaum said consumers need to be empowered to compare companies using all information, so nothing should be considered confidential or be kept from consumers' review.

Johnson asked those commenting to submit suggested wordings in writing following the meeting. She said the Virginia Bureau of Insurance is not subject to the federal Freedom of Information Act (FOIA), but Virginia laws are. Johnson said privacy policies must be posted on company websites. Teshera said records are not held in confidence in Washington state and that the department of insurance's (DOI's) responses are not held in confidence either. Diederich said the Working Group's intention was not that information automatically would be confidential simply because it was given to regulators.

2. Discussed Retention and Deletion of Consumers' Information (Section 5) and Record Retention (Section 22)

Johnson said the Working Group would discuss the retention and deletion of consumers' information wording in Section 5 and the record retention wording in Section 22 of Model #674 next. She said the Working Group intends that companies would be allowed to keep consumers' information for as long as it is needed, but they would delete it within 90 days of the date when it is determined the information is no longer needed to conduct the business with the consumer. She said private calls with companies before this meeting have indicated that this requirement is easy for new companies to do. However, it is very difficult, if not impossible, for companies with old, legacy-based systems.

Shelby Schoensee (American Property Casualty Insurance Association—APCIA) said the section regarding “applicable to any within Section 5 (A)” should be deleted, as well as changes to Section 5 (A) (1) and Section 5 (A)(9). She asked for redress from the 90-day requirement, as it is impossible for legacy companies especially. She also said that exceptions from the federal Gramm-Leach-Bliley Act (GLBA) 502 (b) are also needed and that she had similar concerns about Section 21 and Section 22. Jennifer McAdam (ACLI) asked how Section 5 (A) and Section 5 (B) (i) could be administered without being retroactive, especially with regard to in-force business with regard to information obtained prior to the effective date of Model #674. She noted that the ACLI would like to revisit this section later as others had indicated earlier. She asked that the Working Group add experience studies regarding company insolvencies to Section 5 (b) along with 90-day deletion concerns and the notice from the company on third parties, as the deadline is unfeasible and could damage financial reporting. McAdam suggested a risk-based approach with a reasonable amount of time, along with possibly considering wording similar to that in the California Privacy Rights Act (CPRA). She said Section 5 (b) (3) should read the same as the APCIA had indicated and that the ACLI would be submitting its additional comments in writing. Paolino said she agreed with what the other trade associations had provided.

Wes Bissett (Independent Insurance Agents & Brokers of America—IIABA) said the IIABA had several concerns with these sections, as the duty to remove data is very comprehensive with new concepts above what the federal requirement indicates. He wondered why the insurance industry was so strict compared to other non-insurance businesses. Bissett said he is worried that most states would not pick up nor pass such a model, so there would be no uniformity. He said Model #674 is a wholesale rewrite when a tune-up was needed—not a complete overhaul. Bissett said he agreed with the ACLI on Section 5 (b) (3), especially the requirement that small businesses need to control third parties that they do business with.

Diederich said the Working Group's job is to draft the new model so state insurance regulators can use it to regulate for the future. The old models were written several decades ago when legacy systems were written so data could not be deleted in order to avoid theft. He said that now it is known that any data can be stolen, and the only data that is theft-proof is data that is not stored. Deleted data cannot be stolen. He asked companies what state insurance regulators can do to help move them forward with new systems that replace the antiquated legacy systems. Johnson said the Working Group is looking for what would be workable, such as, perhaps, changing the 90-day rule to guardrails for licensees to use or de-identifying the data and keeping it.

Lauren Pachman (National Association of Professional Insurance Agents—PIA) asked how companies would determine when a consumer's data was no longer needed. Johnson said it would be up to the licensee to determine how long the data is needed. She said it would also be up to the licensee to write up their policy and follow it. Tricia Wood (Liberty Mutual Insurance) said, with regard to privacy and records retention, that there is a business purpose for the business records that they keep and that they are looking at not all consumer information. She also said they need a longer period to replace their existing systems.

Elizabeth Magana (Privacy4Cars) said she proposed keeping the requirements closer to the Internet of Things' (IOT's) data retention policy, which allows companies to keep the data as long as they have a legitimate business purpose. Jim Hurst said legacy systems were designed to be write once, read many (WORM), and kept forever, so historical data in such systems simply cannot comply with newer, more modern data privacy requirements. Patrick Simpson (Erie Insurance) said his company has a mix of legacy and new systems and that under New York cyber regulation, what may be feasible today should be periodically reviewed with plans for the future being brought to state insurance regulators, regardless of whether it is for a new system or changes to legacy systems. He said carriers do not want to keep legacy systems because it would not be competitive and because the more data a carrier has, the greater the risk to the company. Simpson said true de-identification would not permit re-identification. He said that as a property/casualty (P/C) insurer, Erie Insurance does have some legacy and some modern systems, as well as some changes from mainframe to cloud issues. He also said how long a change would take depends on the business, but on average, it could take less than 10 years. Hurst said he had no idea how long it would take to switch systems but that he would work to draft a final plan by the end of this year as a possibility.

Silvia Yee (Disability Rights Education & Defense Fund—DREDF) said she understood the need to maintain consumer data for claims. However, she said it seems the data to be collected is mammoth and that the carrier that gets the data can keep it forever. She advocated for a standard across the board so that consumers do not have to track down their data for every company or individual who gets it. Erica Eversman (Automotive Education & Policy Institute—AEPI) said companies need more modern equipment and systems that promote or incentivize the implementation of new technologies. Birnbaum said there is a need to have guidelines for implementing such technologies. Karrol Kitt (The University of Texas at Austin) said this is a technical issue and agrees with Simpson that legacy systems need to be replaced. Birnbaum said the infeasibility of taking data from a legacy system makes it even more imperative to strengthen the Model on the uses of consumer data due to the wide distribution of such systems.

Diederich said the new Model #674 must deal with the information being shared today, as well as with the new data that will be shared in the future. Johnson said some models have a step-up schedule with certain goals for the future and wondered if this type of schedule might work for the privacy model as well. Aufenthie said the question for those using a legacy or WORM system to answer is how long it would take to switch these systems. He also asked if companies could let state insurance regulators know how long it would take. Amann said the company would already have determined the data that is not needed before the 90-day period starts. Diederich said companies are requesting standards rather than prescriptive solutions, so companies need to let the Working Group know if they are following the National Institute of Standards and Technology (NIST), Insurance Services Office (ISO), or any other type of industry data standard.

3. Discussed Other Matters

Johnson reminded attendees about the in-person interim Working Group meeting to be held in Kansas City, MO, June 5–6. She said the purpose of this meeting is to collaborate with state insurance regulators, consumer representatives, and industry members on revised wording for the most complex topics in the new draft of Model #674. Johnson thanked state insurance regulators, consumer representatives, and industry members who had submitted requests to be added to the registration invitation for this meeting, as the venue limits seating.

Having no further business, the Privacy Protections (H) Working Group adjourned.

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Draft: 5/4/23

Privacy Protections (H) Working Group
Virtual Meeting
April 18, 2023

The Privacy Protections (H) Working Group of the Innovation, Cybersecurity, and Technology (H) Committee met April 18, 2023. The following Working Group members participated: Katie Johnson, Chair (VA); Cynthia Amann, Co-Vice Chair (MO); Chris Aufenthie, Co-Vice Chair (ND); Chelsy Maller (AK); Gio Espinosa and Catherine O'Neil (AZ); Damon Diederich (CA); C.J. Metcalf and Erica Weyhenmeyer (IL); LeAnn Crow (KS); Ron Kreiter (KY); Alexander Borkowski and Van Dorsey (MD); Jeff Hayden (MI); Santana Edison (ND); Teresa Green (OK); Gary Jones (PA); Patrick Smock (RI); and Todd Dixon (WA). Also participating was Doug Ommen (IA).

1. Discussed Private Right of Action (Section 28—Individual Remedies)

Johnson said the Working Group would be discussing the use of the following private right of action wording from the *Insurance Data Security Model Law* (#668) in place of the wording in Section 28(A) and (B) in the new *Insurance Consumer Privacy Protection Model Law* (#674):

This Act may not be construed to create or imply a private cause of action for violation of its provisions, nor may it be construed to curtail a private cause of action which would otherwise exist in the absence of this Act.

Shelby Schoensee (American Property Casualty Insurance Association—APCIA) said the APCIA would be okay with the wording, as it is better than that in the original Feb. 1 exposure draft. Bob Ridgeway (America's Health Insurance Plans—AHIP) said he is okay with it, but he reserved the right to change his opinion in the future if necessary. Kristin Abbott (American Council of Life Insurers—ACLI) said she welcomes the change, particularly the removal of Part B. Chris Petersen (Arbor Strategies LLC), representing the Health Coalition, said legislators and state insurance regulators he had spoken with are against including a new private right of action, as the current version in Model #668 would maintain the status quo and not take away any protection from consumers.

Birny Birnbaum (Center for Economic Justice—CEJ) asked for the reason for this change. Johnson said it is because comments received were leaning strongly against the new wording, and no comments had been received leaning strongly in favor of the new wording. Birnbaum asked why the NAIC needs consumer representatives if state insurance regulators are going to do what industry members say. He said privacy differs from security, and the set of company actions differs. He said Model #668 is based on the federal Fair Credit Reporting Act (FCRA), which has a private cause of action, so Model #674 should have it. He posited that if a company takes data without the consumer's consent and the consumer's personal information is stolen, the consumer is harmed. He said a private cause of action would give the consumer an opportunity for redress. He also said this comment is in the comment letter submitted and signed by seven NAIC consumer representatives. Karrol Kitt (University of Texas at Austin) said she supports what Birnbaum is trying to say. She asked how else consumers would get redress. Peter Kochenburger (Southern University School of Law) said he supports what Birnbaum said, and industry never supports any private right of action. Michael DeLong (Consumer Federation of America—CFA) said he agrees with Birnbaum that not having a private right of action would hurt consumers, and it appears state insurance regulators are carrying water for industry. Bonnie Burns (Consultant to Consumer Groups) said she also supports Birnbaum's comments, and it appears that state insurance regulators and industry are on one side of this issue while consumer representatives are on the other side. Birnbaum said there is no evidence or reason for industry to oppose this except for the fact that state insurance regulators can enforce and protect consumers. Harry Ting (Consumer

Healthcare Advocate) said Europe has not been able to control this issue. Birnbaum said there is no status quo on consumers' data. He said we must have a surveillance economy now, and the consequences of losing data are great.

Smock said this change does not affect existing private right of action regulations. He said it depends on the jurisdiction as to whether it has or does not have a private right of action. The new wording allows each state to keep the private right of action or lack thereof that it currently has under law.

2. Discussed the HIPAA Safe Harbor

Johnson said the next topic to be discussed is the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Safe Harbor in Section 19 of Model #674. Petersen said the Health Coalition's comment letter noted that HIPAA preempts state law where it does not conflict and includes a safe harbor that will apply to all HIPAA-compliant companies. He said Model #674 should remove the words "subject to" and only use "compliant with," which is stronger wording. Johnson said Model #674 currently says, "subject to and compliant with." Ridgeway echoed what Petersen said because larger holding companies have health insurers and non-health insurers or companies, so HIPAA should apply to both. He also said the Working Group should want to adopt the most rigid structure regarding data privacy that it can. Birnbaum said the redline in question should say, "... if compliant with HIPAA; not subject to #674," and that it would give safe harbor. He also asked if states would go in to check on whether the companies are HIPAA-compliant. He asked that it be limited to companies that are subject to HIPAA. He also said this is the same as in the *Suitability in Annuity Transactions Model Regulation* (#275), which has caused lots of problems and tremendous confusion holding up even the frequently asked questions (FAQ) document explaining it. Johnson told Birnbaum what he meant by the phrase, "there is no agency to enforce it." Birnbaum said the wording, "subject to HIPAA" would require state and federal oversight of a company that is not subject to HIPAA.

Bradner asked what other lines are only subject to HIPAA, such as health services and property/casualty (P/C) companies compliant with HIPAA. He asked if other lines are subject to HIPAA or Model #674. Birnbaum asked if State Farm says it is compliant with HIPAA, whether states only look at HIPAA or state insurance regulators look at state insurance laws. Petersen said all personal information is protected the same as protected information. He said this is not new. It is in the federal Gramm-Leach-Bliley Act (GLBA) via the *Privacy of Consumer Financial and Health Information Regulation* (#672) and other state legislation via cybersecurity as "compliant with HIPAA." Ridgeway said the concern in California was that companies with HIPAA and non-HIPAA companies both used HIPAA for all lines to create administrative efficiencies, and he is trying to do the same for Model #674. He said an inquiry from the state would resolve any issues, which usually end up checking for clerical error. Aufenthie said it was unclear from the comments submitted by the Blue Cross Blue Shield Association (BCBSA) whether they agreed with the edits being suggested by Ridgeway during this call. Johnson said the comments submitted by the BCBSA referenced personal health information and not the broader term "all personal information," so it was unclear whether the BCBSA was suggesting the same edits as AHIP. She asked Randi Chapman (BCBSA) if she could shed some light on this question. Chapman said she needs to check with her policy person. Johnson asked Chapman to let Lois E. Alexander (NAIC) know if their policy references personal health information or the broader term "all personal information."

3. Discussed Other Matters

Johnson reminded attendees about the in-person interim Working Group meeting to be held in Kansas City, MO, on Monday, June 5, and Tuesday, June 6. She said the purpose of this meeting is to collaborate with state insurance regulators, consumer representatives, and industry members on revised wording for the most complex topics in the new draft of Model #674. Johnson thanked state insurance regulators, consumer representatives, and industry members who had submitted requests to be added to the registration invitation for this meeting, as the venue limits seating.

Having no further business, the Privacy Protections (H) Working Group adjourned.

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NAIC/CONSUMER LIAISON COMMITTEE

NAIC/Consumer Liaison Committee Aug. 12, 2023, Minutes 13-2
NAIC/American Indian and Alaska Native Liaison Committee Aug. 13, 2023, Minutes
(Attachment One) 13-8

Draft: 8/28/23

NAIC/Consumer Liaison Committee
Seattle, Washington
August 12, 2023

The NAIC/Consumer Liaison Committee met in Seattle, WA, Aug. 12, 2023. The following Liaison Committee members participated: Andrew R. Stolfi, Chair (OR); Grace Arnold, Vice Chair (MN); Lori K. Wing-Heier represented by Heather Carpenter (AK); Mark Fowler (AL); Ricardo Lara (CA); Michael Conway (CO); Andrew N. Mais represented by Kurt Swan (CT); Michael Yaworsky (FL); Dean L. Cameron represented by Randy Pipal (ID); Dana Popish-Severinghaus represented by KC Stralka (IL); Vicki Schmidt represented by LeAnn Crow (KS); James J. Donelon represented by Ron Henderson (LA); Kathleen A. Birrane represented by Jamie Sexton (MD); Anita G. Fox represented by Renee Campbell (MI); Chlora Lindley-Myers represented by Carrie Couch (MO); Mike Causey represented by Angela Hatchell (NC); Jon Godfread represented by Jacob Just (ND); Eric Dunning represented by Martin Swanson (NE); Scott Kipper represented by David Cassetty (NV); Judith L. French represented by Jana Jarrett (OH); Michael Humphreys represented by Jodi Frantz (PA); Cassie Brown represented by Randall Evans (TX); Jon Pike represented by Tanji Northup (UT); Scott A. White represented by Don Beatty (VA); Mike Kreidler (WA); Nathan Houdek represented by Sarah Smith (WI); and Allan L. McVey represented by Erin K. Hunter (WV). Also participating was Paige Duhamel (NM).

1. Adopted its Spring National Meeting Minutes

Commissioner Lara made a motion, seconded by Ron Henderson, to adopt the Committee's March 21 minutes (see *NAIC Proceedings – Spring 2023, NAIC/Consumer Liaison Committee*). The motion passed unanimously.

2. Heard a Report on the Consumer Board of Trustees Meeting

Commissioner Stolfi said the Consumer Board of Trustees is combining the different applications for the NAIC Consumer Participation Program into one application. He said there have been different applications, depending on whether a person is applying as a funded or unfunded consumer representative and whether a person is in the first or second year as a consumer representative. He said the combined application will be used for individuals applying to participate in the NAIC Consumer Participation Program in 2024. He said the Board discussed a request for action submitted by Erica Eversman (Automotive Education & Policy Institute—AEPI) for the NAIC to amend the NAIC *After Market Parts Model Regulation* (#891) to redefine “aftermarket” parts and establish criteria for insurers to inform consumers about the use of aftermarket parts. He said the Board discussed a potential conflict of interest submitted by a consumer representative.

3. Heard a Presentation from the CEJ on “A Meaningful Framework for Supervision of Insurer’s Use of Big Data and Artificial Intelligence”

Birny Birnbaum (Center for Economic Justice—CEJ) said the purpose of market conduct regulation is to ensure the fair treatment of consumers. He said unfair discrimination, from an actuarial perspective, is treating similarly situated consumers differently in rating or claims. He said this is defined as an unfair trade practice. He said unfair discrimination is also defined as discriminating against a person because of their race, religion, or national origin. He said discriminating against an individual is unfair and prohibited even if the treatment is actuarially fair. He said insurers may use data that is racially biased, which indirectly causes unfair discrimination based on race. He said industry claims a risk classification and scoring algorithm that is predictive is fair and that protected class discrimination can only mean explicit and intentional discrimination against a protected class.

Birnbaum said state insurance regulators in 2020 acknowledged the increased potential for the use of racially biased data and algorithms to result in the unfair discrimination of protected classes when the NAIC adopted the Principles on Artificial Intelligence (AI). He said following the adoption of the principles, George Floyd was murdered by police in Minneapolis, and the U.S. was confronted with the fact that structural racism persists throughout the country. State insurance regulators recognized this watershed moment to declare action against racism in insurance, which led to the appointment of the Special (EX) Committee on Race and Insurance. Since that time, Birnbaum said the NAIC has made great strides in diversity, equity, and inclusion (DE&I) education and initiatives, but he questioned the progress the NAIC has made in addressing structural racism in insurance.

Birnbaum said the Innovation, Cybersecurity, and Technology (H) Committee's draft AI Model Bulletin fails to respond to the challenges and promises made by the NAIC in 2020. He said the bulletin does not expand on the AI Principles or offer guidance on how state insurance regulators should implement the principles. He said the bulletin tells insurers what they already know, which is that the use of AI must comply with the law and insurers should have oversight of their AI. He said the bulletin fails to provide essential definitions and does not define proxy discrimination.

Birnbaum said state insurance regulators should focus on consumer outcomes and not the process. He said AI governance and risk management procedures are necessary and important but not sufficient. He said insurers should be testing to ensure their data, algorithms, and applications do not result in unfair discrimination on both an actuarial basis and a protected class basis in all phases of the insurance life cycle. He said regulatory guidance is needed to define proxy discrimination and disparate impact to help establish at least one uniform testing methodology. He said this should include the reporting of test results by insurers.

Birnbaum said a governance requirement should include a requirement that insurers' AI outcomes are disputable, which is a broader requirement than transparency. He said the governance- only approach, which is called principles-based, does not make sense for addressing the regulatory oversight of AI. He said state insurance regulators can obtain the data and ability to ensure good consumer outcomes and compliance with state laws through testing for unfair discrimination, and that testing should be a central feature of state insurance regulatory oversight of AI.

Birnbaum said state insurance regulators need to define proxy discrimination and establish thresholds for testing results that would be considered proxy discrimination. He said the CEJ has proposed guidance for these. He said insurers should be able to identify and explain why a consumer outcome occurred and trace the outcome to a particular characteristic of the consumer. This would provide consumers with the ability to dispute the outcome, which is a broader requirement that an insurer explain how a model or algorithm works.

In response to a question from Commissioner Stolfi about the difference between governance and testing, Birnbaum said financial regulators use risk-based capital (RBC) with specific guidance on how insurers should measure their capital to produce an RBC ratio. Without this type of testing and guidance, insurers would have only a governance approach, and each insurer could define risk in any way they want. Birnbaum said the framework for RBC is the framework needed for the oversight of AI. This framework sets common metrics for testing and goes beyond pure governance.

Commissioner Lara asked about testing for unfair discrimination based on sexual orientation. Birnbaum suggested a phase-in approach and starting testing for unfair racial discrimination since data on race is available. Insurers, at some point, should be willing to ask policyholders for protective class characteristics on a voluntary basis.

4. Heard a Presentation from the UP and the AEPI on the Appraisal Process for Automotive and Property Damage Claims

Amy Bach (United Policyholders—UP) said the UP has a Roadmap to Recovery Program to help consumers after a catastrophe and a Roadmap to Preparedness Program to help eliminate protection gaps and engage in consumer advocacy and action. She said the UP is working to restore confidence and fairness to the property claims appraisal process. She said disputes between insurers and insureds over the extent of damage and repair costs are extremely common. This leads to wasted time and judicial resources since appraisals can be completed without attorneys and litigation.

Bach provided an overview of how the insurance appraisal process is supposed to work, which is intended to be a faster and cheaper process than litigation in resolving a valuation dispute between an insurance company and a policyholder. She said each side picks their appraiser, and then the two appraisers are supposed to agree on an umpire to resolve any discrepancies in the valuation. For example, she said the appraisal process should resolve issues, such as how many square feet of lumber are needed or the grade of lumber needed, by engaging with experts in construction and labor costs rather than taking these types of disputes to court.

Bach said some insurers have removed appraisal clauses from their policies in states that do not require an appraisal clause. This means disputes have a higher likelihood of ending up in litigation. Bach said there are some variations in appraisal clauses. She provided an example of an appraisal clause that specifies that each party must select their appraiser within 20 days after the demand is received, and then an umpire is to be selected. She said not every company or state needs to have the exact same rules.

Bach said there are a lot of points of contention around initiating appraisals. For example, she said parties may be working to resolve a dispute, and then either the insurer or insurance company may demand to initiate an appraisal process. The parties can then face disputes about what umpire to select, which is when courts often need to get involved. Bach said there may also be questions about whether an appeal is binding, the effect of the appraisal process in a lawsuit, and whether the use of the appraisal process precludes a bad faith case. She encouraged the Property and Casualty Insurance (C) Committee to review this issue and work to reform the appraisal process.

Eversman said the appraisal clause is intended to be an alternative dispute resolution mechanism used to determine property loss claim value. She said it is not intended to determine liability. She said some appraisal clauses are more definitive, but they are usually not very detailed in private passenger automobile (PPA) policies. She said typical auto appraisal disputes arise with partial losses and focus on the types of parts to be used, the cost of parts, and whether a part should be repaired or replaced. She said there are new parts, aftermarket parts, and salvage parts. She said total loss values can also be contentious. She said insurers use appraisals as a shield by which an insurer will not use an appraisal until an insured sues in court to demand an appraisal. Insurers will also use appraisals as a sword to try to resolve non-monetary issues.

Eversman recommended that state insurance regulators mandate appraisal clauses in automobile policies for both full and partial property losses; require insurers to notify consumers that the right to an appraisal exists if they disagree with an offer; require insurers to use independent umpires; and establish a time frame for the right to an appraisal, along with a maximum consumer expense permitted. She said appraisal requirements must also have details, such as who may serve an appraiser and penalties for failure to comply with the appraisal requirements.

Eversman requested that the Property and Casualty Insurance (C) Committee establish a workstream to address the appraisal process for auto losses. Crow asked what the recommended maximum a consumer should pay for an appraisal is. Bach said the cost is a deterrent for consumers, and she suggested that insurers should advance

the cost of the appraisal and then deduct half the cost of the appraisal from the final settlement. Eversman suggested a maximum cost of between \$500 to \$800 for auto claim appraisals. She said states should mandate appraisal clauses in policies, and either the insurer or insured should have the right to request an appraisal.

5. Heard a Presentation from the DREDF, the Whitman-Walker Institute, and the LLS on Federal Health Updates

Kellan Baker (Whitman-Walker Institute) said the Consolidated Appropriations Act of 2023 delinked continuous enrollment in Medicaid and the public health emergency (PHE), which ended continuous Medicaid enrollment on March 31. He said Medicaid enrollment grew by an estimated 23 million (32%) to 95 million individuals between 2020 and 2023. He said this stopped the churn between Medicaid coverage and private marketplace coverage. He said 7.8 to 24.4 million individuals will lose Medicaid coverage during the PHE unwinding, and states are moving at different speeds to complete PHE unwinding and Medicaid eligibility redeterminations. He said 74% of people who dropped from Medicaid coverage were disenrolled for procedural reasons during the unwinding, and many disenrolled beneficiaries are likely still eligible for Medicaid coverage.

Baker said state insurance regulators can help mitigate the impact of disenrollment from Medicaid by enhancing in-person assistance; working with insurers and state Medicaid agencies to develop outreach toolkits; ensuring that accurate information is available to consumers about inexpensive but potentially insufficient coverage alternatives; and monitoring qualified health plans (QHPs) for marketing, enrollment, and network adequacy. He said states should also consider an “unwinding” open enrollment period, expand continuity of care protections, and require pro-rating of out-of-pocket costs for mid-year transitions.

Silvia Yee (Disability Rights Education and Defense Fund—DREDF) said the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) applies to fully insured and self-insured health plans, as well as non-federal governmental group plans. She said enforcement authority is held by the U.S. Department of Labor (DOL), the federal Centers for Medicare & Medicaid Services (CMS), and state insurance regulators. She said racial and ethnic minorities often have worse mental health outcomes due to inaccessibility to quality mental health care services. There is also discrimination and a lack of awareness about mental health. Yee said there was a proposed rule issued on July 25 addressing non-quantitative treatment limitations (NQTLs) under the MHPAEA. This guidance provides 13 factual examples for review. One key change is that the proposed rule would classify certain benefits, conditions, and disorders based on “generally recognized independent standards of current medical practice.” Yee encouraged state insurance regulators to comment on the proposed rule to provide insights on how state and federal cooperation can best be operationalized to ensure consumer access to care for mental health and substance use disorder (MH/SUD).

Lucy Culp (Leukemia & Lymphoma Society—LLS) said Georgetown University has completed several “secret shopper” studies, and there is a trend of misleading marketing as people lose their Medicaid coverage. She said the proposed rule on short-term, limited-duration (STLD) insurance defines STLD insurance as being no more than a three-month contract term and no more than four months with the same insurer within a 12-month period. The rule prohibits stacking by issuers and applies to new policies. For on-coordinate excepted benefits, she said the proposed rule requires individual market indemnity products to be paid on a per-period basis, and hospital or other fixed indemnity products must be paid as a fixed dollar amount, regardless of expenses incurred. She recommended that state insurance regulators support the definition of STLD insurance in the proposed rule, support the proposal for hospital indemnity and other fixed indemnity insurance to qualify as an excepted benefit, and offer additional insights regarding products sold across state lines through association plans.

Commissioner Stolfi said Oregon passed a law that required three free primary care visits, and consumers could pick whether the three free visits would be for medical or mental health purposes. Due to established federal methodology requiring insurers to estimate which costs would be for medical care versus mental health care, Oregon had to amend the law to require a \$5 copay for these visits. Commissioner Stolfi said Oregon would be

submitting comments about this since the implementation of a \$5 copay is not something Oregon wanted to impose on consumers.

6. Heard a Presentation from the Consumers' Checkbook, Georgians for a Healthy Future, and the United States of Care on Preventative Health Services

Caitlin Westerson (United States of Care) said the federal Affordable Care Act (ACA) requires most private health plans (e.g., non-grandfathered individual, group, and self-funded) to cover more than 100 preventive health services without cost sharing. She said the decision in the case of *Braidwood Management Inc. v. Becerra*, while temporarily stayed, puts access to critical preventive care at risk for more than 150 million people, including approximately 37 million children. If the decision is upheld and applies nationwide, she said two in five adults would skip necessary preventive care, and historically underserved communities will be disproportionately affected. She said even a small copay could deter those with low incomes from receiving preventive care. She said the following key preventive services, if eliminated, would disproportionately affect consumers with limited access to health care: 1) smoking cessation; 2) pre-exposure prophylaxis for the prevention of HIV; 3) colorectal cancer screening; and 4) postpartum depression screening. The communities most affected would be Native Americans, African Americans, Hispanic individuals, and rural populations.

Eric Ellsworth (Consumers' Checkbook) said documentation for providers and consumers regarding preventive services and payer guidance documents is extremely burdensome to search on insurers' websites. He said consumers equate not finding information on a benefit with that benefit not being available. He said plan formularies often do not distinguish coverage from preventive and non-preventive drugs. He said payer guidance documents that inform claims adjudication policies were often incomplete. He said it is especially hard for consumers to get complete information when an intervention includes both a medical and pharmacy benefit.

Yosha Dotson (Georgians for a Healthy Future) provided the following six recommendations for state insurance regulators: 1) utilize data calls and market conduct exams to assess compliance with preventive and cost-sharing requirements; 2) ensure continued preventive protections with state legislative and regulatory action; 3) enforce appeals protections for mis-adjudicated or denied preventive services claims; 4) ensure that QHP certification assesses formularies and other plan documents; 5) hold plans accountable for educating consumers and providers on preventive services requirements; and 6) establish uniform billing and coding standards.

7. Heard a Presentation from the AKF and the HIV+Hepatitis Policy Institute on Health Care Appeals and Denials

Deb Darcy (American Kidney Fund—AKF) said the number of health care denials is a concern, and she referenced a ProPublica report that stated that one health insurer denied 60,000 claims in one month without a human reviewing the claims. She said health insurers must follow the laws, and doctors are expected to examine a patient's medical records before a health insurer can reject a claim for not being medically necessary. She said the U.S. House of Representatives (House) Committee on Energy and Commerce is looking into the activities of this company. In addition, she said a class action lawsuit was filed against the insurance company in the Eastern District of California. The class action lawsuit notes that the insurer rejected 300,000 claims over a two-month period, which indicates that the insurer spent an average of 1.2 seconds on each claim.

Darcy said the Kaiser Family Foundation (KFF) released a survey on consumer experience with health insurance and whether consumers understand what services will and will not be covered. She said the KFF survey reflects that 17% of health claims were denied for ACA plans, and less than 1% of denied claims were appeals. She said the survey reflected that 16% of consumers said their insurance company delayed or denied needed care and prior authorizations; 27% of consumers said their health insurance paid less than what they expected; 18% of consumers said insurance did not cover any of the care they received; and 23% said their insurance did not cover a needed prescription. She said the survey reflected that 40% of adults surveyed did not know they have the right

to appeal a claim denial, and 24% of the consumers surveyed did not know who to contact when they have a problem with their health insurance.

Carl Schmid (HIV+Hepatitis Policy Institute) said there are 20 consumer representatives focusing on health insurance issues, and he suggested that state insurance regulators review existing data collected on health insurer denials. He suggested that state insurance regulators meet with representatives of the KFF, the federal Center for Consumer Information and Insurance Oversight (CCIIO), and the DOL. Regarding prior authorization, he suggested that states have a better understanding of individual state actions and proposed federal regulations through state presentations, federal presentations, and presentations by consumer groups and the American Medical Association (AMA). He also suggested that the NAIC update its models to address prior authorization. Regarding appeals and denials, he suggested that state insurance regulators better understand the reasons for denials, better understand why a low number of appeals are approved, and work to shift provider behaviors around appeals. He said state insurance regulators should work to encourage consumer knowledge of their rights to appeal a denial. He said state insurance regulators should investigate new ways in which to communicate with consumers and engage with each other to exchange ideas on how to enhance communication with consumers. He said state insurance regulators should review the use of AI for health claims, and he encouraged state insurance regulators to invite insurers to present on their use of AI. He also encouraged state insurance regulators with expertise in health insurance to work with the Innovation, Cybersecurity, and Technology (H) Committee to develop guidance on the use of AI.

Schmid said consumer representatives have submitted formal requests for action for an additional review of these issues by the Health Insurance and Managed Care (B) Committee; the Market Regulation and Consumer Affairs (D) Committee; and the Innovation, Cybersecurity, and Technology (H) Committee. Duhamel suggested that the denial of health claims would be a good topic for NAIC Zone meetings. Crow said the Consumer Information (B) Subgroup is working on how to increase consumers' knowledge regarding their rights to appeal a health claim denial.

Having no further business, the NAIC/Consumer Liaison Committee adjourned.

SharePoint/NAIC Support Staff Hub/Committees/Consumer Cmte/2023 Summer/Consumer_08 Min

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NAIC/American Indian and Alaska Native Liaison Committee
Seattle, Washington
August 13, 2023

The NAIC/American Indian and Alaska Native Liaison Committee met in Seattle, WA, Aug. 13, 2023. The following Committee members participated: Glen Mulready, Chair (OK); Trinidad Navarro, Vice Chair (DE); Lori K. Wing-Heier (AK); Dean L. Cameron represented by Randy Pipal (ID); Grace Arnold (MN); Chlora Lindley-Myers represented by Carrie Couch (MO); Troy Downing represented by Bob Biskupiak (MT); Mike Causey represented by Angela Hatchell (NC); Jon Godfread represented by John Arnold (ND); Alice T. Kane represented by Colin Baillio and Paige Duhamel (NM); Andrew R. Stolfi represented by TK Keen (OR); Larry D. Deiter represented by Tony Dorschner (SD); Jon Pike (UT); Mike Kreidler represented by Todd Dixon (WA); Nathan Houdek (WI); and Jeff Rude (WY). Also participating were: Peni Itula Sapini Teo (AS); Diane Carter (OK); Patrick Smock (RI); Carter Lawrence (TN); and Cassie Brown (TX).

1. Adopted its Spring National Meeting Minutes

Commissioner Navarro said the Committee meets to discuss insurance issues of importance to tribal members to promote education, understanding, and collaboration to enhance consumer protection in Indian country. Navarro said he would conduct the meeting on behalf of Commissioner Mulready, who was unable to be at the meeting in person due to a conflict but would be participating virtually.

Director Wing-Heier made a motion, seconded by Commissioner Rude, to adopt the Committee's March 25 minutes (see *NAIC Proceedings – Spring 2023, NAIC/Consumer Liaison Committee, Attachment One*). The motion passed unanimously.

2. Heard an Update from Oklahoma on the *McGirt v. Oklahoma* U.S. Supreme Court Case

Mithun Mansinghani (Lehotsky Keller Cohn LLP) said the *McGirt v. Oklahoma* case that was brought before the U.S. Supreme Court was about tribal sovereignty in that it took away land from tribes' reservations and gave it to Oklahoma for state government. He said it has remained that way for 100 years and was looked at by the U.S. Congress (Congress) due to a criminal case. Mansinghani said the case of *Worster v. Georgia* in 1830 was the first case about state versus tribal sovereignty. However, it ended with an abandoned decision. He said increased assertion of tribal sovereignty was seen before land was carved out for Indian-owned casinos. Mansinghani said it was also at the forefront when tribal lending cases led to tribal members avoiding state and federal usury laws. He said tribes were then given patent ownership over pharmaceuticals, which non-tribal members tried to use to avoid state taxation and regulation. He said the Sovereign Nation Insurance Company (SNIC) has challenged state sovereignty through several laws in different states. Mansinghani said the scope of immunity being sought is higher in Indian country, with *McGirt v. Oklahoma* being recently cited for life and health insurance in New York and Wisconsin, as well as with regard to short-term disability insurance.

3. Heard a Presentation from HCSC on the Effect of Risk Adjustment Treatment of Tribal Enrollees Under the ACA

Josh Goldberg (Health Care Services Corporation—HCSC) gave a presentation on the effect of risk adjustment treatment of tribal enrollees under the federal Affordable Care Act (ACA). He said his colleagues spoke at the tribal

roundtable last week about the challenges and successes of their work with the Oklahoma Department of Insurance (DOI) and that he would like to give a brief refresher at this meeting on the issue. He said when comparing the risk term and the rating term with regard to cost-sharing reduction (CSR) and the induced demand factor (IDF), the old model indicated that the silver zero cost-sharing plan was rated as number one and the limited cost-sharing plan was rated as number two. However, this is no longer true in the current marketplace. Goldberg said when comparing the predictive results to the actual results for accuracy and CSR Electronic Medical Records-EMR in all states, the silver plan rated above predictive in the chart, indicating it was higher or over-predicted. The limited plan rated under in the chart, indicating it was lower or under-predicted, which resulted in the company being underpaid because the zero cost sharing predictive ratio was too low, at 0.71. He said this had no effect at the federal level but varied at the state level, so there is a financial disincentive for companies to sell these plans to tribal populations.

Goldberg said the Milliman Analysis compared two companies with zero split—one at 90% and the other at 10% by recalibrating the CSR factors to be at the higher level. When looking at the bronze plan, he said the modeling results magnified by 4% when added to additional benefits, while the preferred is equal for both companies. Goldberg said the federal government stopped making restitution of cost sharing in 2016 due to rating term consideration. He said Milliman produced a white paper in 2021 at the national level but did not have state-specific data, so it went back to get more granular data. The federal Centers for Medicare & Medicaid Services (CMS) has been working on this recently as well, so it is taking this new study seriously.

4. Heard an Update from Alaska on the Risk Adjustment Treatment of Alaska Native Enrollees Under the ACA

Director Wing-Heier said health care clinics in Alaska enroll patients in the National Tribal Health Care (NTHC), and Alaska pays one month's premium for the silver plan when Alaska Natives come in for health care services, and the charges for medical care are usually significant. She said the NTHC sued Primera over this. However, this involves native politics, so the state cannot get involved in it. Director Wing-Heier said the issue is substance abuse, and Alaska natives are being targeted to enroll in the Alaska plan and being taken to out-of-state facilities for drug abuse treatment because Alaska pays for such treatment at a much higher rate. She said they are looking for the bad lead generators that are doing this and are taking action to stop them because such policies are not legal due to the fraudulent applications that are not approved in Alaska, and the care is being done in facilities that are not licensed. However, this has caused another problem. The patients are being thrown out of these facilities in another state with no way to get back home to Alaska. Commissioner Navarro said the recent revisions to the NAIC's *Unfair Trade Practices Act* (#880) from the Improper Marketing of Health Insurance (D) Working Group will help stop this type of fraudulent activity. Duhamel said New Mexicans are being sent to similar facilities, and she will circulate an article through Lois Alexander (NAIC) to all Committee members.

5. Considered Drafting a Letter to the CMS Regarding Native American Issues Under the ACA

Commissioner Navarro asked if any committee members would like to speak to this suggestion but received no input.

6. Discussed Other Matters

Commissioner Pike said the Sovereign Nation Health Consortium (SNHC) consisted of three tribes. He said Utah sent a letter to the SNHC attorney asking them to put in writing their intent about marketing to non-tribal members because the attorney had previously said SNHC would not be selling to non-tribal members. However,

Commissioner Pike said that SNHC was selling insurance coverage to non-tribal members outside of tribal lands. SNHC's attorney has not responded.

Having no further business, the NAIC/American Indian and Alaska Native Liaison Committee adjourned.

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